EXPLORING HELPER AND CONSUMER PARTNERSHIPS THAT FACILITATE RECOVERY FROM SEVERE MENTAL ILLNESS

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A Dissertation

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ABSTRACT

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The purpose of this dissertation was to explore the helping partnerships that facilitate recovery from severe mental illness (SMI). Given that recovery from these illnesses was a relatively new concept and that the little research available suggested supportive relationships assist consumers in their recovery process, the research questions were written to understand these helping relationships: (a) what are the consumers’ experiences of recovery from SMI? (b) How do consumers describe the experience of their helping partnerships that facilitate recovery? (c) What are the underlying themes and contexts that account for the experience of partnerships that facilitate recovery? (d) Where in the recovery do these partnerships form?

The co-researchers included 10 non-hospitalized adults with a self-reported diagnosis of schizophrenia (4), bipolar disorder (3) or major depression (3) from a midwestern state. Participants were purposefully chosen from a group of 69 volunteers who completed the Mental Health Recovery Measure (Young & Bullock, 2003), which was the quantitative phase of this study. In the second phase, two to three face-to-face interviews were conducted with nine of the ten participants. Phenomenological qualitative analysis with a psychological approach was accomplished using word for word transcripts of the interviews.

The intent of this study was to learn how the consumer experiences the helping partnerships that facilitate recovery to inform, families, professionals and peers about meaningful actions and strategies that promote healing. Six key themes emerged from the data and included: networks of helping partnerships, medication adherence, teaching/learning, spirituality, creative
drive and time. The experiences of each co-researcher were analyzed and described and used to create a composite description for the group. From the composite description, characteristics and behaviors of helping partners were identified, as well as their impact on the co-researchers. In addition structures that facilitated the development of the helping partnerships became visible from the composite experiences.

Through interaction of the themes that emerged, the co-researchers were able to move through recovery with astounding resolve. Helping partners that exhibited a deep commitment to participants over time, using respect, care and knowledge, facilitated their progress. In conclusion, it is recommended that consumers, families, mental health professionals and the public be educated about how to facilitate recovery for the benefit of human potential of every individual with a diagnosis of severe mental illness and the financial solvency of society. Understanding networks of helping partnerships, the role of spirituality and creativity, the benefits from medication and therapy and the impact of learning on progressing through recovery can go a long way toward eliminating the mystery and fear associated with mental illness.
LONGINGS

I sometimes feel trapped in a mind, which won’t cooperate…

A soul lost in half tones of truth.

Much of my life is make-believe and memories…

Joined together-yet fighting each other.

Children laughing-no longer a part of my future…

A future with promise yet temporarily clouded.

My boundaries of walls and windows are shattered by noises of every day longings-longings not for me, ever again.

Help me out of this shell, easily broken and dangerously bruised.

Be gentle with my life and longings and don’t open me too quickly or what’s inside may be torn apart.

Michaela

(Co-researcher)
This dissertation would never have existed without the lessons learned from these individuals and the ever-present strength and guidance from God, my highest power.

I dedicate this dissertation to the following significant teachers in my life:

my grandparents, Ida and Levi Premo for nurturing my creativity and spirit;

my parents, Hope and James Fletcher for teaching me to think critically and to imagine; my husband, Brian Anthony for support, keeping me grounded and showing me how to face my demons, my niece, Martha Lee Hutchinson for starting the fourth generation of helpers in the family, and a dear friend, Michael Kuhn for doing the best he could to come through his depression.

Finally, I dedicate this work to Bree, Al, Anzel, Carlos, James, Kim, Michaela, David, Beth and Harry who had the courage and spirit to share their journeys through the darkness of mental illness toward their transformations to help others with severe mental illnesses learn the way forward.
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CHAPTER I. INTRODUCTION

Background

Recovery from severe mental illness has emerged as a promising new vision in the 1990’s. It evolved from deinstitutionalization of the 1970’s and 1980’s and development of new treatment sciences and programs that grew out of the deinstitutionalized process, such as the Community Support Model. Also, studies of patients discharged from mental institutions in the 1960’s and 1970’s show that up to 68% of these people have no symptoms of mental illness or experienced a decrease in severity of their symptoms of mental illness (DeMasi et al. 1996). In addition, they found that these people integrated into their communities. Finally, personal accounts of recovery from severe mental illness (SMI) by consumers indicated that in spite of their illnesses these people developed new meaning and purpose in their lives and accomplished lifelong goals (Deegan, 1996).

According to William Anthony (1993), recovery from severe mental illness was a new concept in need of research. He claimed that even though recovery itself has not been researched yet, elements of the process were identified in quasi-experimental research. Anthony, Rogers and Farkas (2003) and Mueser et al. (2002) agreed that recovery was a complex process and was driven by needs and goals of individual consumers. It included elements such as hope, self-determination, and meaningful roles in society, minimized impact of illness and reduced discrimination for having a severe mental illness.

Statement of the Problem

A common theme in the recovery literature was the supportive helper/helpee relationship that encourages the consumer to engage in recovery (Anthony et al. 2003). However, the specific nature of these relationships and how they work to facilitate recovery has not been identified.
Therefore, this study endeavored to delineate how relationships/partnerships between helpers (consumer defined) and consumers positively impact the recovery process.

**Purpose of the Study**

Anthony et al. (2003) recommended that researchers study the helper/consumer relationship because the few studies thus far about the recovery process suggested that the helper relationship had an important role in the recovery from severe mental illness. In addition, these researchers pointed out that most research about treating mental illnesses was pre-recovery research. In other words, they elucidated that most treatment approaches for people with severe mental illness were largely developed and implemented without input from people with the illnesses. Also, these treatment strategies were created before research in the 1990’s demonstrated that people with these illnesses could effectively manage their illness symptoms and lead productive lives in spite of their severe mental illness. Thus, Anthony, et al. concluded that the earlier research and treatments were not grounded in consumer goals, empowerment, and well-being. Therefore, the purpose of this study was to focus on the perception and experience of consumers about their helping partnerships that fostered their recovery throughout the process.

**Significance of the Study**

This study was important because people with SMI require relevant services to recover from their illnesses, and the public has limited resources to provide services. Therefore, it was very important from a human and financial resource perspective to clarify the concept of recovery and to determine the critical services and relationships that facilitate the process.

According to the first Surgeon General’s Mental Health Report (1999) and the President’s New Freedom Commission on Mental Health Final Report (2003), severe mental illnesses, major depression, schizophrenia, manic depressive disorder and obsessive-compulsive
disorder, were the leading causes of disability for persons over the age of five. Also, they reported that the World Health Organization and World Bank found that mental illnesses were four of the ten top causes of disability, resulting in a “Global Burden of Disease” and contributors to mortality, with suicide being one of the leading preventable causes of death in the world.

Overview of Methodology

The primary nature of this study was qualitative, phenomenological, and it strove for understanding of the essence of how consumers with SMI experience partnerships with helper(s) who facilitate their recovery. This research was based on the assumption that persons who have a severe mental illness have unique experiences and have made sense of their recovery that exists in multiple mental constructs in which facts and values are intertwined. The researcher intended to capture these mental constructs from the perspectives of the consumers through face-to-face contact and process focused interviewing.

The study took place in spring and summer of 2005 at a variety of locations in a midwestern state with people who were accessed through community mental health centers, consumer advocacy organizations and word of mouth. Adults in outpatient treatment with a diagnosis of schizophrenia, bipolar disorder or major depression (Severe Mental Illness, SMI) were the focus of this study.

Consumers recovering from SMI were identified using the Mental Health Recovery Measure (MHRM) created by Young and Bullock (2003). The MHRM was a quantitative outcome measure validated to identify mental health consumers’ stages in the recovery process. Ten consumers that represented a broad spectrum of consumers at different stages of recovery,
diverse age, cultural and educational backgrounds were identified and asked to participate in face-to-face interviews.

The MHRM was distributed to mental health consumers throughout the state. The respondents who wanted to be interviewed were asked to identify themselves on the tool and informed that their anonymity would be protected. Only the researcher and her advisor were able to identify those who choose to be interviewed. After the research analysis was completed, all names were removed from the tool to preserve the participants’ confidentiality.

The Recovery Partnership Interview Tool (RPIT) of open-ended questions was designed and pre-tested by the researcher for use with the consumer population in this study. Refer to the Method Chapter (p.42) for more detail regarding the instrument. The RPIT was used to interview ten participants in two to three 1-1.5 hour sessions for a total of 23 interviews. The goal of using this tool was to start gathering the consumers’ perspectives about helper partnerships that facilitate their recovery. It was not intended to be inclusive of all questions and was modified as the interviews progressed, until saturation of data was achieved.

Questions were developed from the recovery literature, the researcher’s experience, collaboration with other researchers and they were pilot tested with a sample of persons with SMI. Raw data were fractured through identifying themes and categorizing the data. Then categories were coded as part of the analysis. Also, member feedback was used to help validate the researcher’s analysis of the data.

Analysis in this study was based on rich, in-depth data from two to three interviews with nine consumers and one interview with an individual participant who chose to withdraw from the study. Due to the researcher’s efforts to use a diverse sample, the data can generally inform professionals and consumers about the essence of partnerships that facilitate recovery with
individuals who have received a SMI diagnosis. Given the nature of qualitative research, generalization of the data in this study is not expected to be a goal. More specific information about methodology can be found in Chapter Three.

Research Questions

1. What are the consumers’ experiences of recovery from SMI?
2. How do consumers describe the experience of their helper partnerships that facilitate recovery?
3. What are the underlying themes and contexts that account for the experience of partnerships that facilitate recovery?
4. Where in the recovery process do these partnerships form?

Definition of Terms

1. Consumer – A person with a SMI diagnosis, who is actively working on managing the symptoms of the mental illness, is building meaningful roles in the community and accomplishing life goals.
2. Co-researcher – A consumer chosen to take part in this study was referred to as co-researcher and participant throughout this document.
3. Helper – A professional mental health worker, peer, family member or other identified by mental health consumers, who significantly facilitated their recovery from SMI.
4. Partnership – A collaborative relationship between a SMI consumer and a self defined helper/mentor that focused on developing and evaluating SMI recovery strategies, and was manifested by mutual respect, trust and goals (Harvath & Luborsky, 1993).
5. Recovery – A process including active efforts to build meaningful roles, manage symptoms of mental illness and accomplish life goals in the presence of SMI (Anthony, 1993).

CHAPTER II. REVIEW OF THE LITERATURE

Introduction

The recovery from severe mental illness literature review was conducted using computer databases, such as Ohiolink and ERIC as well as search engines, such as Google and Metacrawler to identify relevant research and theories. Also, key government documents regarding the mental health of the world, the *Surgeon General’s Mental Health Report* (1999) and in the US, the *Final Report* of The President’s New Freedom Commission on Mental Health (2003), were extensively reviewed. In addition, *New Research in Mental Health* published every two years by the Ohio Department of Mental Health provided a wealth of mental health studies that were funded and carried out throughout the state from 1996 through 2001. Also, personal accounts of recovery from severe mental illness were examined to understand the process from those who have experienced it. Deegan (1993) and Schiller and Bennett (1994) presented powerful accounts of recovery that demonstrated the importance of hope and connections with others to the success of their journeys. Finally, the nature and structure of phenomenological research with a psychological approach to this type of qualitative research was reviewed. Qualitative research texts and articles as well as professional papers were examined to gain understanding of this complex method of research.

Recovery Theory

The theoretical foundation of recovery from severe mental illness (SMI) developed recently. Anthony (1993) an Anthony et al. (2003), Borkin (2000) and Ralph (2000) described the emerging concept of recovery that they believe is replacing the traditional perception of SMI as an intractable group of mental illnesses that is beyond the control of people with the illnesses. Given the development of new psychotropic medications in the last 15 years, studies of patients
who were released from long-term hospitalizations in the 1960’s and 1970’s, DeSisto, Harding, McCormick, Ashikaga and Brooks (1996), and the consumer movement in mental health, empirical evidence that recovery from SMI is possible evolved.

Authors like (Wright, 1983) described healing from mental illness similarly to recovery from physical disabilities, such as deafness, blindness or loss of physical mobility. Despite the impairment of mental functioning associated with SMI, people are able to learn to control the symptoms of their illness accomplish personal and professional goals and experience quality of life. Even though the illness is not cured, and symptoms may not disappear, the person can recover role function and goal accomplishment.

Anthony (1993) claimed that the individual in the process of recovery from SMI goes through a very personal process that includes the development of a new meaning and purpose in life that goes beyond the effects of illness. He said that all of us have experienced the recovery process related to the tragedies of life, such as death of a loved one, loss of bodily function or natural disasters. Since the decade of the brain (1990s), where mental illnesses were scientifically recognized as brain disorders (Surgeon General Report, 1999), the recovery process was strengthened as a credible and achievable course.

New medications that relieve the disabling symptoms of SMI, allowed mental health professionals to focus on psychosocial aspects of mental disabilities through the rehabilitation model (Anthony, 1991; Cohen, Nemec, Farkas & Forbess, 1990). These authors stated that recovery is what people with mental illness do and treatment and rehabilitation are what helpers do to facilitate recovery. Anthony (1991) claimed that we are at the early stage of understanding recovery, but that some studies have measured elements of the process. He stated that it is a multi dimensional concept that includes hope, self-esteem, adaptation to disability, personal
empowerment and self-determination. Also, he said that the role of professionals is to facilitate recovery rather than to direct it, so that consumers can take charge of their illnesses and lives. In addition, he pointed out that peers, families and friends have a valuable role in recovery as supporters and facilitators of the process.

For the first time in the history of the US, the Surgeon General authored a report on mental health (1999). In this science-based report he asserted that mental health is basic to health, and that the efficacy of mental health treatments was well documented. Also, in the report the Surgeon General clearly stated that a range of treatments was developed for most mental disorders, including severe mental illnesses. The Office of the Surgeon General reviewed over 3,000 articles and studies and many first-person accounts of recovery, which provided the basis of his recommendations. He concluded that there were serious barriers to people with severe mental illnesses obtaining treatment, such as stigma against those with the illnesses that rob these people of their dignity and prevents their full participation in society.

In the 1999 Surgeon General’s Report on Mental Health, it was documented that mental illness defined in the DSM-IV (1994) was the second largest disease burden in the industrialized world and that depression was the largest cause of disability in the world. Given the tremendous cost of mental illness, he made the following recommendations in this report: continue to build a treatment science base, increase public awareness of effective treatments, eliminate stigma, ensure adequate supply of services, adapt services to age, gender, race and culture, facilitate access to services and reduce financial barriers to treatment.

The President’s New Freedom Commission on Mental Health (2003) reported that 5% to 7% of adults have a severe mental illness in any given year. President George W. Bush was quoted in the Final Report of the Commission, “…Americans must understand and send this
message: mental disability is not a scandal - it is an illness. And like physical illness, it is treatable, especially when the treatment comes early.” According to Ion and Beer (2003), historically, negative stereotypes about people with mentally illness led to stigma against them. So, many people with a diagnosis of mental illness experienced shame and fear that prevented them from seeking treatment. The Commission recommended that an anti-stigma campaign was critical to breaking barriers to treatment and recovery from mental illness in the US.

In the Commission’s report, adults with serious mental illness were described as 18 and older, who currently have a diagnosed (DSM-IV TR, 2000) mental disorder that resulted in functional impairment that significantly impairs one or more life activities, such as activities of daily living (eating, bathing, dressing), basic living skills (mobility, managing a household or money) or family/social role function. Dr. Hogan (2003) who chaired the New Freedom Commission stated that severe mental illnesses were: schizophrenia, bi polar disorder, major depression and obsessive-compulsive disorder. In the Commission’s final report, it is stated that serious mental illness ranks first among all illnesses that cause long term disability in the US, Canada and Western Europe. Therefore, these illnesses pose a major public health challenge. Also, the Commission’s Final Report claimed the World Health Organization reported that suicide worldwide causes more deaths every year than homicide or war.

In the final report from the New Freedom Commission (2003), the goal of a transformed mental health system was identified as recovery to achieve community living, access to current treatments and support services for everyone with mental illness. Recovery in this report referred to the process in which consumers are able to live, work, learn and participate fully in their communities. Like Anthony (1993) described, this Commission claimed it is possible for many individuals to live satisfying and productive lives even though they have a severe mental
illness. Also, for some consumers recovery means full or partial remission of the symptoms of their illness. Finally, the report identified research showed that consumers with hope play an important positive role in the person’s recovery. Throughout the recovery literature, consumers and helpers having hope for recovery was identified as a key component of healing (Deegan, 1993; Anthony, 1993; Frese, 2001; Schiller & Bennet, 1994).

Moore (2004) approached recovery from a new perspective that included honoring the “dark nights” of human tragedy that encompassed severe mental illness. He theorized that learning from humanity’s darkest moments could lead to opportunities to identify our deepest needs and provide healing and a new understanding of life’s meaning. He incorporated links between creativity, spirituality and emotional struggles that assist the process of learning and development of spirituality involved in recovery. He called periods of loss, frustration or emotional distress that are so long lasting and disturbing, dark nights of the soul. Furthermore, he normalized these periods as part of everyone’s life and full of opportunities to strengthen the spirit and soul. He looked at these disturbing episodes as valuable times of transformation to new meaning and connection to life and others.

*Serious Mental Illnesses*

The DSM-IV (1994) and DSM-IV TR (2000) described the mental illnesses that were referred to as severe mental illnesses in the current study. A brief overview of the illnesses was presented to put the data from consumers about facilitation of their recovery into a meaningful context, and all facts and theories in these descriptions come from the DSM-IV and DSM-IV TR.

These mental disorders are characterized by severe and persistent symptoms of mental illness that often interfere with life functions of people with these diagnoses. Consumers with these disorders may go into remission from episodes with long periods of mild or no symptoms,
and then may periodically relapse and experience severe symptoms with role disruption and sensory impairment.

**Schizophrenia**

This is a mental illness that lasts for at least six months which includes at least one month of active symptoms. The active symptoms include at least two of the following: hallucinations, speech and behavior disorganization, delusions and negative symptoms. Only one symptom is needed if hallucinations include a voice that is persistent or delusions are bizarre. Negative symptoms include: cognitive impairment, flattening of emotions, decreased speech and goal oriented behavior. The most common hallucinations noted with this illness are auditory, and people experiencing them hear voices that they perceive to be separate from their thoughts. Auditory hallucinations are often persecutory in nature. Hallucinations are experienced through sensory modalities and also can be visual, olfactory (smell), gustatory (taste) or tactile (touch). Delusions are distortions in perception and manifested by erroneous beliefs. Disorganized thinking must be severe enough to impair effective communication to be considered a symptom of schizophrenia. Finally, this illness includes dysfunction in one or more areas of daily functioning. Relationships, work, self-care or education can be severely impaired and functioning in these areas is significantly decreased as compared to the person’s pre illness level.

Schizophrenia can be diagnosed in childhood or adulthood. Most frequently it emerges in late adolescence or early adulthood up to the mid 30s. Childhood incidence of the illness is relatively rare as is later life occurrences (60s). About as many men as women develop the illness, although some studies show that women have a better prognosis. People from various cultures may manifest the illness dissimilarly. Studies show that those in developing cultures
have a more acute course and better outcome than those with schizophrenia in Western countries. This illness is often chronic and has an incidence of about 1 per 10,000 per year.

*Bipolar Disorder*

Bipolar disorders and major depression are included in the category of mood disorders because the primary feature in both illnesses is a disturbance in mood over time. Bipolar disorder may be characterized by one or more episodes of manic or mixed episodes and is often accompanied by major depressive episodes. So, it is associated with manic and depressed moods that may alternate throughout the course of the illness. Manic episodes are manifested by periods of abnormally and persistently elevated or irritable mood. This elevated mood must be at least one week in duration, unless hospitalization is required, and accompanied by at least three of the following symptoms, or four if mood is irritable, that are not caused by a medical condition: inflated self-esteem, decreased sleep, racing thoughts or flight of ideas, talkative or pressure to continue talking, increase in goal directed behavior and hyperactivity, distractibility and extreme involvement in pleasurable activities that can have painful consequences such as spending money, sexual activity and precipitous investments.

Usually, the first manic episode occurs in the early 20s and in a few cases can start in adolescence or later in the 50s. Onset is sudden and often precipitated by extreme stress. Episodes typically last from weeks to months and end more quickly than major depressive episodes. In 50-60% of the cases, the depressive episode precedes or follows the manic episode. Cultural considerations with manic episodes are similar to those noted in the major depressive disorder description below.
**Major Depression**

This disorder is characterized by one or more major depressive episodes that include depressed mood or loss of interest that lasts at least two weeks. Also, depressed mood and loss of interest must be associated with a minimum of four other symptoms of depression from the following group that are not due to a medical illness and persist almost daily: body change, without dieting, of 5% or more of body weight, insomnia or too much sleep, fatigue or loss of energy, feelings of worthlessness, psychomotor agitation or retardation, difficulty concentrating or indecisiveness, feelings of worthlessness or guilt and reoccurring thoughts of death, suicide, suicide attempts or specific plans of suicide.

Major depression usually develops over days or weeks and can be of 6 months duration, if untreated. This illness can occur at any age and symptoms that do not meet the criteria for major depressive episode may continue for years. Remissions and relapses can occur over the course of a lifetime or a person may have only one episode.

A person’s culture can influence the expression of depression. In many cultures, the symptoms are experienced somatically and depression often goes untreated because ethnicity is not taken into consideration in assessment and diagnosis. For instance, Chinese and other Asian cultures experience problems of the heart when they are depressed and in Latino cultures symptoms are expressed as tiredness or weakness, while in Western cultures sadness and guilt are expressed emotions related to depression. Finally, data has shown that depression occurs twice as frequently in women as in men.

**Therapeutic Partnership**

The therapeutic relationship has been considered a major aspect of the effectiveness of psychiatric treatment since Freud (1913) identified the value of the analyst developing and
maintaining a positive alliance with the patient and described its impact on the success of psychotherapy. He described how a serious and sympathetic understanding of the patient permitted the healthy part of the person to form a positive attachment with the analyst, which was used as the foundation of the change experience of the therapy. Also, Freud included the concept of the reality grounded patient-therapist attachment having a positive effect on the treatment, thus enabling the person to move toward mental health.

Edinger (2002) described the basic concepts of Jung’s (1960) complex theory of the human psyche, which was the basis of analytical psychology. In psychotherapy, Jung’s concepts were used primarily as a method for analysts to get in touch with the patient’s inner turmoil, through the context of a therapeutic alliance. Edinger’s summary included Jung’s description of the universal, primitive images developed from the deepest layers of the unconscious mind. These primitive images were called archetypes of the collective unconscious. According to Edinger, Jung described amazing parallels between these unconscious images in human dreams to universal designs found in religions and myths across time. The collective unconscious took the realm of psychotherapy out of the area of psychopathology and into the arena of the evolution of the human psyche, which opened up the idea of psychological development for everyone.

The collective unconscious, or more recently named the objective psyche, was identified as the deepest layer of the unconscious mind. Edinger stated that its nature is universal and non-individual, and that its signs are often identified with spirituality. Jung called the contents of the collective unconscious archetypes and their manifestations, archetypal images. These archetypes were theorized to be experienced individually through universal, recurring images: the Great Mother, Spiritual Father, the Transformation and The Self. The Transformation relates to the
psychic process of growth, change and transition. Also, these images emerged through dreams, visions, profound emotional experiences and severe mental illnesses.

The archetype of transformation expressed itself in many ways, such as perilous journeys, exploration of dark places, decent to the underworld or the bottom of the sea. Edinger said the theme of death and rebirth were characteristic of this process and associated it with climbing mountains, salvation and recovery of something lost. Furthermore, he indicated that whenever these images occur in dreams, visions or great emotional disturbance they are expressions of the archetype of transformation. And he concluded that in psychotherapy in addition to dreams that imaginative drawing, painting and writing can serve as a means of analyzing unconscious images for growth and development of the mind. Unlike many other theorists, Jung believed that individuals could develop their minds by using his concepts outside the therapeutic alliance.

Many researchers and authors have studied the nature and outcome of the therapeutic alliance (Bordin, 1976, 1980 & 1989; Geenson, 1965; Horvath & Luborsky, 1993; Hall & Torres, 2002; Krupnick et al., 1996; Luborsky, 1976; Saunders, 2001). All these researchers emphasized the importance of reality based collaboration between a therapist and client and Greenson (1965) coined the term “working alliance” to describe this relationship. In the current study, the therapeutic partnership was based on the therapeutic alliance literature, but this concept was used as a starting point to a more widely understood helper-consumer therapeutic partnership.

One of the early refinements of the therapeutic alliance concept was founded on the Penn State Psychotherapy Project, according to Luborsky (1976). He suggested that the alliance is dynamic and responds to the needs of different phases of therapy. In this work, two types of alliances were described: (1), early in the relationship and (2), in the later phases. Further
description of the changing alliance included: a sense of working together in a shared struggle against the patient’s mental illness, a shared responsibility for working on treatment goals and a collaboration, similar to the idea of a mutually defined partnership. Hovath and Luborsky (1993) and Diorio (2001) further clarified that clients need to feel that power and authority is shared in a therapeutic relationship and that the therapist is accepting and supportive of the wellbeing of the client. In addition they made a connection between the sense of collaboration and positive regard to the positive outcomes of the therapy.

The positive connection between a therapeutic alliance and successful treatment was reasonably documented (Freud, 1913; Greenson, 1965; Luborsky, 1976). However according to Hovath and Luborsky (1993), it is now critical to identify specific actions that facilitate alliances from the clients’ perspectives, as well as actions that foster recovery from their mental illnesses. Like Anthony et al. (2003), they suggested that mental health treatment often lacks the consumer’s input and goals, and until it does reflect these, it cannot reach its maximum potential in the recovery process from mental illness.

Saunders (2001) defined the therapeutic alliance as the feelings, attitudes, thoughts and behaviors that the therapist and client experience and communicate to each other in the process of therapy. He agreed with the other researchers cited above that research has established that the therapeutic alliance is an important part of successful therapy. Given the importance to the outcome of therapy Saunders attempted to identify pretreatment determinants of the value of the relationship. He studied 141 participants in therapy by administering questionnaires at the first and third sessions, during which the therapeutic bond commonly occurs. Most of the participants were women and had a diagnosis of depressive or anxiety disorder. Interpersonal problems and levels of distress were measured in this qualitative study. Means and standard deviations were
calculated from pretreatment variables’ subscales. Most intercorrelations were significant, indicating that clients experiencing high levels of interpersonal problems also tended to experience higher levels of symptom distress. Since the least educated clients reported less symptom distress, the education level was controlled, using ANOVAs.

Saunders (2001) concluded that interpersonal problems related to being overly detached were associated with a poorer bond, while being too controlling and self-effacing was not. Also, low self-esteem was associated with a poor bond and higher levels of distress were not. He said the results suggested that clients who have low self-esteem are demoralized and having difficulty with life roles will have problems feeling that a therapist understands them. Clients who are overly detached and have low self-esteem will have trouble sensing empathy, respect and caring. Implications for the therapist included: directly addressing issues of empathy, emotional distance and support with the consumer.

Anthony et al. (2003) strongly stated that the recovery process needs to focus on the outcomes that are important to consumers. They recommended more studies be conducted on the therapeutic relationships that appear to be an important part of recovery. Also, they pointed out evidence-based practice that has been proposed by mental health professionals in the past 15 years is based on research that preceded the recovery model, so it is deficient in incorporating the consumer’s goals. Therefore, they suggested that there might be a relationship between lack of research demonstrating the effectiveness of evidenced–based practices on recovery outcomes and its deficiency in recovery values.

Hall and Torres (2002) studied partnerships in preventing adolescent stress that can lead to development of mental illness. They stated that traditional mental health services focus on remediation, secondary and tertiary treatments; thereby they lack primary prevention and a focus
on skill strengthening. They found that prevention works in averting the need for secondary and tertiary treatment by creating and maintaining gains of early interventions, using behavioral and cognitive-behavioral techniques. Also, these researchers found that building partnerships among schools, mental health professionals and families was effective in early efforts to relieve adolescent stress. These partnerships were found to be successful in securing the services adolescents and their families needed to deal with mental health challenges.

Guidelines for developing partnerships were provided by the US Department of Health & Services (HRSA, 1996). These guidelines have important elements of creating partnerships that may be relevant to relationships that facilitate recovery for adults as well as prevention of mental illnesses for adolescents. They were identified as follows. Partnerships must (a) include community members in the design and implementation of services, (b) identify risk groups during a crisis, (c) reach out to adolescents in their communities and provide coordinated services, (d) clearly demonstrate community ownership of problems and solutions, (e) provide education to professionals and community members, so that holistic and coordinated care can be provided and (f) must create new structures that integrate fragmented care systems.

The concepts in these HSRA (1996) guidelines were evident in the goals of the recommendations made in the President’s New Freedom Commission (2003). The guidelines were as follows: Americans understand that mental health is essential to overall health (holistic care), mental health care is consumer and family driven (inclusion and ownership), disparities in mental health services are eliminated (reach out), early mental health screening, assessment and referral to services are common practice (identify risk groups), excellent mental health care is delivered and research is accelerated (coordination and education) and technology is used to access mental health care and information (access and integration).
Barabasi (2002), a physicist, pulled together interdisciplinary research of mathematicians, physicists and biologists into a new science of networks. His theory stated that all networks have a deep underlying order and function according to powerful rules. He started his research with links and nodes and in conjunction with other researchers, has mapped networks. He found that social networks, computer networks, corporations and biological cells are more similar than different. These discoveries shed light on the interconnected world around us. Furthermore, he described the structure and behavior of networks that can be used to design a business, social support network or stop a disease outbreak. In placing maps of computer systems, of interactions between species in ecosystems, genetic and social systems side by side he found that the maps followed a common blueprint. This common structure may hold promise to stimulate the creation of new systems, such as partnership systems for individuals with severe mental illness.

Barabasi showed how small the world is even though its complexity is astounding. He unwrapped complex networks and demonstrated how they work by following laws of self-organization in amazingly consistent architecture. Finally, he identified that intricate collaborative webs are behind networks such as the economy, the Web, social systems, language and ecosystems. He concluded that having a common language of networks could help society unlock the mysteries of many complex systems, and begin to comprehend the interconnections in the universe.

_Recovery Research_

Because recovery is a relatively new concept, there was limited research available to review. Ralph (2000) conducted a review of recovery related literature and research that described some elements of the process. His literature review was one of three aspects of the Recovery Project conducted by the National Directors of State Mental Health Program Directors
The other parts of the project focused on establishing a Recovery Advisory Group of consumer leaders and the development of a group of instruments to measure recovery. His findings agreed with Anthony (1993) that recovery was a new concept that was not defined until the late 1980s and the early 1990s. Ralph quoted from Webster (1984) that the word recovery means to restore (oneself) to a normal state and that up until the late 1980s that it was used extensively in the field of substance abuse.

In addition, Ralph (2000) found that in mental health recovery was defined in the writings of consumers or people with a diagnosis of mental illness. From analysis of consumers’ writings he discovered that recovery is a process or way of life that includes creation of a new sense of integrity and purpose. Evidence from consumers indicated that it is a personal process and different for every person who commits to the process. Common ingredients of recovery were identified by him as: hope, connections with others, and acknowledgement of a spiritual self. This researcher discovered through personal accounts of persons with a mental illness that internal and external factors were involved in recovery. The internal factors were awareness of illness and insight and the external factors were interconnectedness with others. Another factor was empowerment, a combination of internal strength and positive interconnectedness with others to help self and others. In his qualitative study of service planning for recovery, Diorio (2001), found support for positive interconnectedness with professionals and consumers in facilitating empowerment and recovery. He discovered that when clients and service providers partner together, recovery outcomes improved in comparison to traditional provider focused treatment planning.

Also, Ralph, Lambert and Kidder (2002) in their review of the research discovered that recovery from mental illness research was new and limited because of the way the concept was
operationalized. DeMasi et al. (1996) created a recovery model that described it in terms of three areas of wellness: mental and physical health, including self-esteem, hope and coping and social health that incorporates economic and interpersonal quality of life. They used a number of measurement scales to create their Self-Help Survey that tested the validity of their recovery model with citizens of NYS. They mailed 956 surveys and 612 were returned, and using confirmatory factor analysis their hypothesized model was supported. Their results indicated that recovery goes beyond the mental health system into all areas of social services: fiscal, housing and health resources, and is facilitated by a combination of support services. Also, germane to the current study, they discovered that the partnership between consumer and clinician in traditional mental health services and alternative services were critical to the recovery process.

According to Ralph et al. (2002), the classic recovery outcome study was conducted by Harding, Brooks, Ashikaga and Strauss (1987). They did a 32-year longitudinal study with patients from Vermont State Psychiatric Hospital to explore recovery from severe mental illness and the impact of rehabilitation services had on recovery. The definition of recovery used in this study stated that the criteria for recovery is: inability to detect that the person was ever hospitalized for mental illness, absence of current symptoms of mental illness, absence of psychiatric medications, employment, good relations with family and friends and integration into the community.

A sample of 269 long-term patients were chosen by Harding et al. (1987) in the mid 1950s with an average of 16 years of being diagnosed with a mental illness and continuously hospitalized for 6 years. These patients participated in a new rehabilitation process and were discharged with community supports in place. In follow-up 32 years later 262 patients from the original sample were evaluated. Of the group, 34% with a diagnosis of schizophrenia
experienced a full recovery, psychiatrically and socially. Another 34% of the people in this group who attended the Vermont Rehabilitation Program were significantly improved in regards to their mental illness and social integration into the community. Given the stringent criteria for recovery in this study, the outcome of 34% completely recovered and 34% significantly recovered was a remarkable finding.

Fisher (1994) and Fisher and Ahern (1999) wrote about another recovery model that was developed by the National Empowerment Center. This was a consumer-operated technical assistance center funded by the Center for Mental Health Services. This group emphasized that people labeled with mental illness are more disabled by the interruption of their social roles than by their illness. They stated that recovery is facilitated by a combination of social supports that are necessary to re-establish their major social role and the self-management skills that are needed to make major life decisions. Therefore, by combining these supports and new skill sets, consumers regain their roles in society and their sense of being a whole person.

Likewise, The National Alliance for the Mentally Ill (2003) of DuPage County, Illinois established a program, Awakenings, dedicated to empowering persons with mental illness through art. This consumer organization strives to facilitate recovery using creative talents and to educate the public about the potential of artists who are survivors of mental illness.

Mowbray and Moxley et al. (1998) studied the 3-year research demonstration project Work Incentives and Needs Study (WINS), a case-management vocational program for individuals with a diagnosis of severe mental illness, using consumers as peer support specialists. These researchers identified benefits and drawbacks to consumer-employee roles. Mowbray, Moxley, Jasper and Howell (1997) found that mental health programs are increasingly hiring consumers for service delivery roles because professional staff cannot meet all the needs of
individuals with severe mental illness. Roles such as: case manager, crisis worker, employment coach, peer counselor, advocate and clinician were designated as positions for service providers. Solomon and Draine (1995) found in a one-year outcome study that consumers functioned with distinctiveness and performed effectively as case-managers. In their study of WINS, an integrated case management and vocational services demonstration project, Mowbray and Moxley et al. interviewed 11 of 20 consumer providers 12 or more months after their employment as peer support specialists. Using semi-structured interviews, they gathered data about the peer specialists’ perception of the benefits and limitations to themselves and the organizations they worked with during their employment.

In WINS the role of the peer support specialist (PSS) was to work with vocational specialists (VS) on case management teams assigned to about 20 patients. The PSS staff provided services like, learning the transportation system, preparing resumes, buying clothes for work and setting up bank accounts and balancing checking accounts. They had about 20 hours of training for their positions, worked about 7 hours a week with 4-5 clients and were paid an hourly rate. Eleven PSS’s were interviewed, 5 women and 6 men with ages ranging from 32 to 53. Work duration was from a few weeks (1) to the full 2.5 years (2). At the end of the program the 6 PSS employees working wanted to continue their employment, 2 had left for other positions, 1 left in the training part of the program, 1 had trouble coping with the responsibilities and 1 was asked to leave. Pre PSS employment ranged from none (4) to 30 (1) year full timework history, several years (2), had own business (1) and 3-4 years in healthcare and food service (3). In conclusion, personal benefits identified were: earning money, having a job, learning from other team members how to present self in the best way, daily structure, becoming more assertive, safe job environment, presentation skills, practicing different coping skills,
positive feedback from team and clients, personal growth and new relationships with team members. Organization benefits identified were: increased resources for clients and teams, helped alter negative attitudes toward people with a diagnosis of mental illness, institutionalized the concept of peer support in the community and decreased stigma toward them. Negative Outcomes for PSS employees were: frustration about lack of client receptiveness to their help, clients coming late or not at appointments, lack of confidence in helping clients experiencing psychosis, high job stress, guilt over not being able to help some clients, lack of understanding on how to do the job, did not show up for some meetings, too much responsibility without sufficient training, disappointment about the end of the project, boundary issues – can I be a friend as a support specialist? How much information do I give about myself, could not get enough hours of work, needed more support from team members, more care in matching up client and PSS.

Finally, implications for Mental Health Services suggested by Mowbray and Moxley et al. were: consumers experienced personal growth through these creative PSS roles; however they paid a high price at times in high stress levels in their transition from client to consumer support specialist. PSS employees were clearly in need of more support and supervision from non-consumer staff, especially about complex boundary issues. They strongly recommended that systematic supports be built into these consumer/employee initiatives to promote their competency, success and growth. In this project the consumer bore the brunt of the risk and cost of taking on this new role. Professional staff appeared to marginalize the consumer workers and have to be committed to integrating them into the team if they are to be successful. Proactively building consensus and commitment to consumer employees must be accomplished before starting such a program for the health of the employees and the organization.
DeSisto et al. (1995) conducted an outcome study with a group of people who were long-term mental patients in Maine and Vermont. They used a follow-back study that matched a group of patients from Maine and Vermont by age, sex and diagnosis and then compared outcomes of the two groups. Of the two groups they found that generally the Vermont group had fewer symptoms and demonstrated better functioning, including community adaptation. Of the two states, authors found that Vermont offered the rehabilitation programs needed by consumers to adjust to the community with a variety of housing, vocational and social opportunities. They speculated that the Vermont Rehabilitation Program was positively correlated with the higher functioning of the patient groups and their inclusion into the community.

Segal, Silverman and Temkin (1993) raised research questions about the impact of self-help agency practice and empowerment on people with a diagnosis of severe mental illness. They compared the theory of self-help programs with traditional helpers from a social services perspective and found that each approach had a primary goal of helping consumers to live better lives. Self-helpers were defined as a people with a mutual problem attempting to assist each other in taking control over their lives. The assumption was that people who have a diagnosis of SMI are more able to understand and reach another with the same disability. The traditional helper was described as a mental health professional that attempts to assist a person with SMI to improve their quality of life through mental health services. However, they found that self-helpers, especially those in multi service agencies, also known as client-run services, believed that traditional helpers disempowered consumers, while the self-help approach empowers consumers. Some examples of activities and processes that empower consumers, according to the self-help paradigm, include: peer counseling, skill development, advocacy to remove environmental barriers to independent living, social acceptance of consumers in spite of
disabilities, support to assume effective roles in their communities and control over their own services. Rappaport et al. (1985) described this type of approach as consumers reaching across a structure to help each other instead of up and down. On the other hand, the traditional paradigm of mental health services was viewed by the self-help agencies as disempowering because they treat consumers with disabilities who have little understanding of their problems beyond illness and restrict consumer participation in deciding what resources are needed and delivered. Segal et al. concluded their analysis of the self-helping agencies by pointing out that their functions and services appear to offer hope for empowerment of consumers, but that they are often poorly documented and even more poorly understood. They recommended that questions need to be addressed and their functions and outcomes studied to find out how they empower consumers, who is most likely to benefit from this approach and how they can work with traditional services to alleviate the problems associated with severe mental illness.

Mueser et al. (2002) reviewed research that included the idea of incorporating recovery values into illness management. Using a meta analysis he found that controlled research studies indicated; when illness management incorporated a group of specific interventions to effectively treat consumers with severe mental illnesses it was called evidence-based practice. Also, Mueser found that symptoms of severe mental illness were minimally affected by psycho education, but that the activity was critical to informed consent for treatment. In addition, he discovered that behavioral tailoring was effective in increasing medication compliance due to decreasing the need to take medications multiple times per day without decreasing the overall dosage. Also, Mueser found that coping skills training decreased the severity of symptoms and cognitive-behavioral therapy helped reduce the severity of psychosis. However, he found that consumer goals and social roles were not impacted by these evidence-based practices. Therefore, Mueser
concluded that even though there were some promising positive outcomes for some symptoms of mental illness using these specific practices, it was important to include the goals and input from consumers in the process of illness management to increase its relevance to consumers’ priorities. A final suggestion was that consumers and families needed to be educated to understand illness management strategies and professionals needed to be trained about the importance of recovery principles and values to maximize the effectiveness of evidence-based practices.

Frese, Stanley, Fress and Vogel-Scibilia (2001) suggested integrating evidence-based practices and the recovery model as a result of their examining the goals and consumer roles in each conceptual approach. These authors pointed out that the aims of consumers and mental health practitioners were often significantly different and to get them and consumer advocates to buy into these practices their approaches must include the principles of recovery. For example, the researchers claimed that early in the recovery process most consumers would need evidenced-based practices to manage the symptoms of severe mental illness even though they may not realize it because of the cognitive impairment of severe mental illness. However, later in the recovery process, when consumers are more able to manage their illnesses, they are more likely to be interested in recovery-based support. As consumers recover, the practitioners must facilitate greater autonomy and control of the process by the consumers, if they are to recover to their highest level. Finally, these researchers suggested an integration of the two models with the development of a hybrid theory that maximizes the strengths and minimizes the weaknesses of the two models.

Frese et al. reported that a quasi–randomized, stratified (rural and urban groups) study of 890 mental health consumers by the Ohio Department of Mental Health (ODMH) showed the
consumers had three general areas of concern. The first area was lack of, or shortage of needed support services, such as crisis stabilization, secure residential programs, clubhouse services, housing, job retraining and placement as well as consumer-run services. The second area they thought was needed and available included (a) emotional and social support, (b) stabilization services, (c) education and (d) financial support. In the third area they wanted services that were effective, resembling evidence-based practice.

However, when Frese et al. compared the needs of consumers further along in their recovery expressed by the National Mental Health Consumer’s Association (NMHCA), the ODMH consumers had very different priorities. In the NMHCA group, priorities included: employment, housing, recovery oriented mental health systems, self-help, programs to fight the stigma of mental illness and benefits that are conducive to an adequate quality of life. So, given the diverse needs and priorities of consumers at various levels of managing their mental illnesses and recovery, Frese et al. suggested the new integrated model of evidenced-based practice and recovery. Smith (2002) agreed that illness management and recovery go hand in hand to achieve positive outcomes and eventually consumer self-management. So, she aimed for partnerships between professionals and consumers in developing the Illness Management & Recovery Center for Excellence in Northwest Ohio to increase the quality of life for consumers diagnosed with a severe mental Illness. In her model of treatment, Dr. Smith used illness management best practices focusing on symptom reduction, relapse prevention and empowerment of consumers to pursue their life goals.

Bullock, Ensing, Alloy and Weddle (2000) measured the effectiveness of a program to facilitate recovery from psychiatric disabilities. A 16-week psycho educational program was evaluated to determine its impact on preparing persons with SMI to become active members on
boards of community mental health agencies. Using experimental and wait-list control groups as well as pre and post assessments, they found that participation in the program was statistically linked with improvement over a range of psychometric measures evaluating the recovery processes. Significant improvements were in the areas of symptom reduction, self-efficacy, attitude toward recovery, empowerment and community living skills (including vocational skills). Six months later significant improvement was still evident for vocational skills, self-efficacy and empowerment. Symptoms for a significant number of participants deteriorated, as did their attitude toward recovery. The researchers concluded that empowerment and self-efficacy were more reliable indicators of recovery than severity of psychiatric symptoms, which was consistent with Deegan (1993 & 1996). From this study Young and Bullock (2003) developed a recovery measurement tool used in the current study.

Other researchers (Borkin, 2000; Capinello, Knight, Markowitz and Pease 2000; Young & Bullock, 2003) developed instruments to measure recovery from mental illness. Young and Bullock (2003) developed the Mental Health Recovery Measure (MHRM) used in this dissertation in Appendix A. Their instrument was developed from a “grounded theory” model of recovery based on the phenomenology of recovery from the consumers’ perspectives (Young & Ensing, 1999). The MHRM consisted of 30 behavioral items with eight conceptual subscales: (a) Basic functioning, (b) self-empowerment, (c) learning and self-redefinition, (d) overall wellbeing, (e) overall stuckness, (f) new potentials, (g) advocacy/quality of life and (h) spirituality.

Bond et al. (2001) found that competitive employment improved outcomes of recovery from severe mental illness, stating this type of employment had cumulative positive effects on symptoms, quality of life, self-esteem and finances. In tracking 149 clients with SMI over an 18-
month period they discovered that the clients in competitive employment had significantly better outcomes than those employed in sheltered workshops, employed minimally or unemployed.

Smith (2000) conducted a qualitative study from the personal stories of 10 persons with persistent and severe mental illness (schizophrenia, bipolar disorder and major depression) to develop some understanding about recovery from those who have experienced it. She accessed her sample from a group of 15 volunteers from a consumer-operated agency. Several of the volunteers dropped out and she had 10 who completed the interview process (average of 1.7 hrs.) with the researcher and analyzed her transcribed interview data using QRS NUD*IST software. She had asked for volunteers who considered themselves in the recovery process and discovered several major themes in their responses. Although the study was small and homogeneous, the findings can be used to advise mental health practitioners and policy makers. The average age of the participants was 48; there were 5 men and 5 women, and an average of 6.2 hospitalizations for severe mental illness. Several themes emerged from the data: the meaning of recovery, turning towards recovery, critical elements of recovery, barriers and strategies to facilitate recovery.

First, Smith (2000) found that recovery is a long and complex process that includes learning to manage symptoms of severe mental illness and struggling toward positive goals. For most of the participants the recovery process began when they acknowledged they had a mental illness and it took some people over 10 years to achieve this insight. All of the participants sought out help from others to start their recovery process. Critical factors in recovery were identified as the right medication, supportive people, meaningful activities, a positive outlook, a sense of control over one’s lives and a strong desire to recover. Barriers to recovery were intense for these consumers: stigma against them due to their mental illness by self and others was the
strongest barrier, the symptoms of mental illness and side effects of medications, lack of financial resources which negatively impacted on access to services and vulnerability to life stressors. Ten key strategies to maintain their recovery included (a) believe in recovery in the face of acceptance of mental illness, (b) take responsibility for managing own mental illness and stability, (c) create daily structure and keep active, (d) educate self about mental illness, (e) seek out support from others and (f) take extra care of self to protect recovery. The researcher made recommendations for practice and policy from this data. She suggested that practitioners and consumers can learn about the recovery process together and because consumers recover at different rates practitioners keep vigilant for their patients’ readiness to embark on the recovery journey. Also, hope for recovery is just as important for the practitioner as it is for the consumer and there are many potential sources of support for the recovering person, such as peer, family, consumer advocacy organizations.

Smith’s research (2000) added some valuable detail to the recovery process from the perspectives of consumers that is important for policy makers and practitioners to understand. In order to facilitate the process instead of impede it, especially related to empowering consumers to manage their lives and illnesses, practitioners must be willing to gradually turn over the control of treatment and recovery to the consumer. The empowerment aspect of recovery that came out of this study was consistent with the recommendations from Frese et al. (2001), Deegan (2003) and Manning (2000) about the shift of control from the practitioner or advocate to the consumers as their recovery progresses.

*Personal Accounts*

In this literature review, there was a common theme that it is critical for the consumers to have an active role in facilitating their recovery processes. Some of the researchers and authors
(Anthony et al. 2003; Frese et al. 2001; The President’s New Freedom Commission, 2003) have stated that recovery is only possible when consumers drive their own recovery process and mental health services. Several consumers have written intense, informative and insightful accounts of their personal recovery journeys that can help policy makers; practitioners; consumers and advocates understand how to facilitate recovery from severe mental illness for many people.

Schiller and Bennet (1994) co-authored Schiller’s long and incredibly painful struggle with schizophrenia that told a day by day moving story of her recovery. Lori Schiller was diagnosed with schizophrenia after a lonely struggle to keep her threatening hallucinations under control from early adolescence. It was almost 15 years before she had the insight into her illness to make a commitment to her recovery and make the professional and family support connections that helped her get control over her illness and healing process. This autobiographical account of her journey included information from her clinical records, interviews with therapists, nursing staff, psychiatrists, family members, friends and peers.

Lori Schiller experienced incredible terror and emotional pain for years before she realized she was seriously ill. She denied that she was ill for a long time and tried to medicate herself with street drugs, like cocaine, while trying to deal with almost constant suicidal thoughts as a way to try to look for an escape from self-deprecating hallucinations that were continuous for years. Many psychiatric professionals tried to help Ms. Schiller to accept her illness and face it. Dr. Dollar, her psychiatrist, taught her the meaning of partnership and they were able to work together to facilitate her recovery from schizophrenia. A new medication, Clozapine, helped Ms. Schiller to recover her ability to face her illness and accept that she needed professional help, a persistently supportive family, the courage to stay connected to family when her voices told her
they were trying to kill her and many dedicated nursing staff and therapists along her recovery journey were all a part of facilitating the process.

Another important part of her recovery included helping others with severe mental illness. She worked in the mental health field and made presentations all over the country to help people understand recovery from schizophrenia.

Professionals and family that never gave up on her, Ms. Schiller’s strength and willingness to accept responsibility for her recovery and Clozapine, a breakthrough in psychotropic medications played major roles in her progress. Also, connection with others was a powerful tool in her recovery. In addition, she had the strength and insight to recognize that negative defense mechanisms, like using cocaine, were harmful to her recovery and she was able to give them up. Finally, her ability to bond with others and trust them to help her was instrumental in her recovery.

Her experiences and successes were an inspiration to others who suffer from this terrible brain disease, and offer many insights into facilitating recovery from schizophrenia. Even though Ms. Schiller still struggles with the symptoms of mental illness, she learned to manage them and has a productive, fulfilling life (Schiller, 2003).

So, this powerful account of one woman’s recovery journey described in great detail some of the aspects necessary for recovery that others have identified. Like all the authors, consumers and researchers that have described recovery in this literature review, she made it very clear that practitioners and family who never gave up on her were instrumental in helping her admit that she had a serious mental illness and commit to recovery. Also, Ms. Schiller identified that her connection with others was vital to fighting her illness, and without these
relationships she would not have been able to ignore her hallucinations that were continually
telling her she was worthless and deserved to die.

Another major contribution of this account (Schiller and Bennett, 1994) was that Ms. Schiller described in detail her partnership with the psychiatrist that was the turning point in her illness. Even though it appeared that the new psychotropic medication was the cornerstone of her recovery, her doctor believed that her trust in their relationship and her courage to face her illness was her true turning point. This emphasized the key role of helping partnerships in recovery.

Deegan (1993 and 1996) poignantly described the traumatic and dehumanizing experience of being told as an adolescent that she was a schizophrenic and on her second hospitalization that she was a chronic schizophrenic. In later years, upon reflection, Pat Deegan said she actually felt a devaluing, dehumanizing change from being a young person with dreams for the future to being an illness. She experienced a deep sense of loneliness related to the fact that, although people were trying to treat her they were doing things and talking about her symptoms with her instead of really engaging about how she was feeling. She desperately needed someone to acknowledge her pain and assure her that there was hope for her to recover. Particularly, she believed she would have benefited from someone who had a diagnosis of schizophrenia telling her she would get better and was there to help her if she needed it. When Ms. Deegan started to move in her grieving process toward recovery and became angry, she was faced with professionals that tried to medicate her anger away, not understanding that the anger was a necessary part of dealing with her illness and mistook it for a symptom of the illness. She made it clear that she had a mental illness and was not a mental illness, a distinction that providers have to make or else they risk being a barrier to recovery.
Ms. Deegan helped the reader see that she and many others were traumatized in mental hospitals by abuse and internalization of the stigma of mental illness. Also, she explained that the experience of severe mental illness for her was manifested by poverty, unemployment and humiliation.

She discovered in her recovery journey that recovery is a process and not a destination and that healing from mental illness is not being cured, but living a valuable, satisfying life in spite of the illness. She became empowered to manage her illness and use medication, hospitals, peer support and therapy as different ways of facilitating her journey. She chose to work with professionals who understood recovery and that relapse was not a failure on her part, but part of the ongoing recovery struggle. Ms. Deegan told us that recovery was about starting the journey of recovery and finding good people along the way who will provide support to wherever the journey leads.

A myriad of other mental health consumers (Fox, 2000; Holst, 2000; Thomas, 2000) have contributed to the understanding of the recovery process. A common theme that emerged from these personal accounts was that symptoms come and go but, recovery goes on and there are many ways consumers cope with the stresses that impact their lives. Also, many consumers have been stressed by the mental health system and the messages they have repeatedly received from professionals that their illnesses are due to a chemical imbalance in the brain, and they have to live with this problem. Like Deegan and Schiller, these consumers experienced the despair and sense of hopelessness that was connected to these disempowering messages and the disrespectful treatment they received from some service providers.

The critical aspect of the recovery process from these accounts (Fox, 2000; Holst, 2000; Thomas, 2000) seemed to be the acknowledgement and commitment to taking responsibility for
managing their illness and their lives. To avoid professionals adding to the trauma and pain, which consumers experienced in the process of their recovery, mental health providers have to learn what they can do to facilitate the recovery process. In order to stop doing what was making recovery more difficult for consumers, professionals have to replace these actions with what helps improve the quality of their lives. Otherwise, helpers will be hindering progress and harming the vary people they are intending to assist. Thomas (2000) pointed out that the consumers are the primary decision makers in the recovery process and professionals can facilitate the process by engaging in a problem-solving approach to illness management and relapse prevention, instead of rushing to the psychiatrist for more medication.

Phenomenological Research

Creswell (1998), Fraenkel and Wallen (2003), Maxwell (1996), and Moustakas (1994) defined and described the process of phenomenological research. According to Creswell (1998) and Moustakas (1994), this type of research had its roots in philosophy and was first defined by Edmund Husserl (1859-1938) as the search for wisdom. This research process included entering the perception of the person who has experienced the phenomenon being studied. By suspending the researcher’s ideas about the meaning of the phenomenon, the researcher could enter the person’s lived experience and examine how it was displayed.

The psychological approach to phenomenological research centered on the individual person’s meaning of the experience and explored the structures of consciousness in human experience contained in images, memory and meaning. Creswell (1998) pointed out Husserl believed that consciousness of human beings was always directed toward an object and that the reality of the object was always connected to their consciousness. To enter that consciousness was to reach understanding of the phenomenon, if interference was avoided and the person could
communicate it. He further explained that the reality of an object could only be perceived within the meaning of the person’s experience, and never by others.

In phenomenological research, the investigator collected words, pictures and emotions that reflected a person’s experience of a phenomenon. Through in-depth interviews that reveal rich descriptions of the phenomenon, researcher reflection and descriptions of previously developed artistic works, Polkinghorne (1994) stated that others could understand the essence of the lived experience. So, in this study to obtain an understanding of the true meaning of a facilitator of recovery from the consumer’s perspective, it was necessary to cross the threshold of consciousness into the consumer’s lived experience.

Fraenkel and Wallen (2003), Maxwell (1996) and Moustakas (1994), delineated the method of data analysis used in qualitative research and relevant to this phenomenological study. From multiple realities of the participants, using methodological reduction identifies themes and patterns. From descriptions of lived experience, statements are analyzed for clusters of meanings, which are expressed in psychological and phenomenological concepts. Then, themes of experience are integrated into a narrative to describe the essence of the experience for the consumers. A search is conducted for all possible meanings, so the phenomenon can be described with authenticity. Data analysis is ongoing and interactive with all aspects of the study. Fraenkel and Wallen stated that interpretations continue throughout the study and are interactive with other elements of the study such as: prior research, researcher subjectivities, observations, contextual data, artifacts and data analysis. Moustakas suggested conducting single-person analysis before inter subject analysis to obtain clarity of meaning for each person before proceeding to group comparison. Coding decisions are made and represented with numbers in
each category of data. Frequencies of response and percentages of responses are identified to
arrive at themes that are then used as the basis of the data description.

Diorio (2001), Fraenkel and Wallen (2003) and Morse, Barrett, Mayan, Olson and Spiers
(2002) described the concepts of validity in qualitative research. Validity in qualitative research
was determined to be attainable by these and other authors, such as Maxwell (1996). They
claimed that a variety of processes interacting could achieve validity. One process was to
conduct multiple interviews with the same person, and interview a group of people who
experienced the phenomenon to be studied. By doing this, the researcher had a chance to
compare data from one interview to another from the same participant and could then compare
this data to data from others with similar experiences. Also, triangulation of data can work
toward achieving validity. For example, analyzing interview data and information from artifacts
related to the participant can allow the researcher to determine consistency of meaning from
different sources. Also, expert feedback and participant checks were tools to increase validity of
the data analysis.

Finally Morse et al. (2002) claimed that validity and reliability could be reached by
rigorously applying several qualitative research techniques. First, there has to be methodological
coherence between the research question and the method of data collection and analysis. Also,
she emphasized that saturation of data must be achieved which means there is sufficient data to
account for all elements of the phenomenon and theoretical thinking has to be used through out
the data collection and analysis. Further, she described theoretical thinking as confirming
emerging data with new data and alternating from the micro to macro perspectives in the process
to reach conceptual understanding from the information. All the qualitative researchers and
theorists quoted, indicated that the biggest threats to validity were bias and reactivity, which could be averted by implementing the processes described above.

Glesne (1999) elaborated on the ethics of qualitative research that always must be foremost in the mind of the researcher. She asserted that participants must always have sufficient information to make informed decisions about taking part in the study throughout the process. Also, all unnecessary risks to participants have to be eliminated in the study design. According to her any risk to participants must be carefully weighed and that the researcher has to be qualified to conduct the study and to preserve the safety of the participants.

Summary

Recovering from severe mental illness was a new concept and in need of research, particularly from the perspective of the people suffering from these chronic and debilitating illnesses (Anthony, 1993 and 2003; The Final Report of the President’s New Freedom Commission on Mental Illness, 2003; The Surgeon General’s Report on Mental the Illness, 1999). Research showed that people with SMI can and do recover with relevant services, Harding (1987) and DeSisto (1995), even though they have not been cured. Due to the tremendous human and financial cost of SMI to the world and the US, the World Health Organization and U.S. Government strongly endorsed access to appropriate mental health services, education programs to eliminate stigma from mental illness and the right of people inflicted with these illnesses to quality lives.

Consumers, who have advanced in their recovery, such as Ms. Schiller in Schiller and Bennet (1994) and Deegan (1996), identified the very personal nature of the process and the continued determination and hope that is necessary to make the commitment to recover. A critical element that they and others, Smith (2000), have identified in the positive outcome of this
process is the connection and help of others throughout its course. As early as 1913, Freud identified that a positive alliance with a person with mental illness lead to a positive outcome. Since then numerous theorist and researchers have reinforced this theory (Deegan, 2003; Diorio, 2000; Luborsky, 1976). Also, Frese et al. (2001) recommended that consumers have an active role in planning and implementing their recovery as soon as they are able to do so, suggesting that the role of the professional changes as consumers’ progress.

So, there was considerable evidence that helping relationships facilitate recovery, but there were many unanswered questions about how this occurs (Anthony et al., 2003). The intent of this study is to use a qualitative, phenomenological method with a psychological approach to better understand how helping relationships facilitate recovery. In-depth interviews with people having a SMI diagnosis and thereby entering the lived experience of helping partnerships was the method that may have the best chance of getting at their true essence. According to experts in phenomenological research, Creswell (1998) and Moustakas (1994), all consciousness was directed toward an object and to understand the meaning of the object, in this case the helping partnership, the researcher had to enter the experience of this relationship through the consumer’s perception of its reality. Therefore, the researcher conducted extensive interviews with consumers to obtain their reality of these relationships and used numerous strategies to identify their meaning.
CHAPTER III. METHOD

General Perspective

In beginning a phenomenological study it was important for the researcher to clearly identify her perception of the phenomenon being examined. This was key to the concept of bracketing, described by Edmund Husserl in Carr’s (1970) translation, and used to identify the researcher’s perception of the phenomenon at the beginning of the study to differentiate it from the findings from the participants, thereby, avoiding bias in the results.

Recovery from severe mental illness from the researcher’s perspective was a very personal and lifelong healing process from a disabling mental illness. It involved a struggle with symptoms that interfere with daily life activities, caused profound emotional distress and presented a barrier to the individuals with the mental illness from accomplishing their dreams. The recovery or healing from these illnesses was perceived as a gradual course that depends on many variables, such as, personal strengths, emotional support from others and access to resources needed to persist in the process. The outcome of recovery was defined by the person in the struggle, and accomplished overtime with periods of stability, relapse, growth spurts and insights.

In addition, the healing process began when individuals acknowledged their illness and reached out for help, as the researcher did not believe it was possible to recover without some outside assistance. It was the strong belief that individuals do not recover in a vacuum that motivated this researcher to study the helping partnerships that facilitate recovery from severe mental illness.

The helping partnership was the next important concept for the researcher to bracket. This relationship was perceived to be developed overtime and manifested by trust and mutual
respect. The power base in the helping partnership was equal, overall, and at times might lean to
the helper or helpee depending on the stage of the relationship. Goals were mutually negotiated
and the focus of the relationship was the growth and wellbeing of the individuals with mental
illness. Each brought expertise and strength to the relationship that facilitated the recovery from
severe mental illness. Examples of these skills brought to the partnership were: knowledge of
mental illness, personal experience of healing from the tragedies of life, such as death of a loved
one, loss of health, and ability to connect consistently with another person in a relationship.
Finally, the researcher believed that the helping partnership was a voluntary one that either party
could choose to re-negotiate.

This study took place in two phases. First, there was the quantitative component, which
consisted of using Young and Bullock’s (2003) Mental Health Recovery Measure (MHRM) to
select a purposeful sample for the second phase, the qualitative component. The sample chosen
for the qualitative phase was intentional to ensure that overall the participants experienced
recovery from severe mental illness from various parts of the continuum: early, middle and
advanced recovery. The participants self-reported their diagnosis of mental illness, and their
stage of recovery was determined using the scoring process from the MHRM.

Primarily this was a qualitative, phenomenological study with a psychological approach,
and it was designed to understand the nature of helping partnerships that facilitate recovery from
the perspective of individuals diagnosed with a severe mental illness (SMI). This study was
founded on the assumption that consumers with SMI experienced or are experiencing a
relationship that facilitated their recovery and that through in-depth interviewing these
perceptions and experiences contained in numerous mental constructs could be communicated to
the researcher. In phenomenological inquiry, the researcher’s reflections on the data were an
integral part of identifying and describing the consumers’ experiences. The experiential lens of the consumers and the researcher’s analysis created meaning from the data that accurately reflected the consumers’ perception of their helping relationships. The ultimate goal of this research was to generate a portrait of the actual common experiences from the consumers in the study that could be used to help others understand characteristics of partnerships that facilitate recovery from SMI.

Research Context

The study took place in 2005 at a variety of locations in a midwestern state with individuals who were accessed through Community Mental Health Centers, Consumer advocacy organizations and word of mouth. These access sites were described as follows.

Community Mental Health Agencies – These are publicly funded treatment centers designed to provide mental health services for people with mental illnesses, specializing in services for those with a diagnosis of SMI. They are located throughout the state and funded through the State Mental Health Department, tax levies and donations.

Consumer Advocacy Organizations – These are publicly funded groups focused on providing support, education and advocacy services to consumers and or family members of persons with SMI. Most of the consumer-focused groups are staffed by consumers and operate in the context of peer and self help models.

Word of Mouth – When a consumer heard about this study through contact with another consumer, mental health professional, family member or organization and decided to participate in the study, he/she was accessed through the word of mouth process.
**Research Participants**

Adults in outpatient treatment with a diagnosis of schizophrenia, bipolar disorder or major depression in this midwestern state were the focus of the study. Consumers recovering from these severe mental illnesses (SMI) were identified using the MHRM (Young and Bullock, 2003). The MHRM was designed to determine where respondents were on a continuum of recovery stages in their recovery from SMI and to identify characteristics of the recovery process. For this study, ten consumers that represented a range of consumers at different stages of recovery, diverse age, cultural and educational backgrounds were identified and asked to participate in face-to-face interviews. Each person that agreed to take part in the study was interviewed two to three times within a two-four week time period. Only one participant dropped out of the study after completing just one interview.

The sample participants had a self-reported SMI diagnosis and were engaged with professionals, peers, family members or others in the process of their recovery. The 23 face-to-face interviews were information rich and accessed largely through consumer organizations and community mental health centers in the state. From the consumers who volunteered to participate in the study, the sample of ten that were interviewed was purposefully selected to provide for a maximum variation sample. These participants were found to be richly informative about their experiences with helping partnerships that facilitate recovery from SMI.

The sources of data for this qualitative study were the spoken word and artifacts, including but not limited to, visual and literary artwork and photographs created by the participants interviewed. When individuals interviewed identified artwork, poetry or photographs that were a significant component of their recovery process, the researcher requested another interview with the participant to gather data about how the artifacts reflected their recovery...
experiences and helping relationships. Using diverse, multifaceted data from the selected sample added to the validity and richness of the spoken word about the experiences of helping partnerships that augment the recovery process.

Data Collection

The MHRM, located in the Appendix A, was distributed to mental health consumers throughout the state. The MHRM was validated and proved reliable by Bullock and Young (2003) for determining the stage of recovery with the population having a diagnosis of severe mental illness. Respondents who wanted to be interviewed were asked to identify themselves on the tool and were informed that no one other than the researcher and her advisor would be able to identify those who chose to be interviewed in order to protect their anonymity. After the research analysis and the dissertation were completed all names were removed from the tool to protect their confidentiality. Also, all audiotapes were erased upon completion of the dissertation process.

The Recovery Partnership Interview Tool (RPIT) of open-ended questions (Appendix B) was designed and pilot tested by the researcher for use with the consumer population in this study. The RIPT questions were developed from the recovery literature, the researcher’s experience, and collaboration with other researchers. A pilot test of the tool with a sample of persons with SMI was conducted in a focus group format before the interviews to ensure that the questions were applicable to the research questions. This semi-structured interview tool ensured that all interviews had a consistent basis to strengthen inferences made about the responses.

The Recovery Research Demographics Questionnaire (RRDQ) was created to capture demographic information about the participants and can be found in Appendix C. Only the consumers interested in being interviewed for the qualitative phase of the research were asked to
complete this instrument. The data was used to select as diverse a sample of co-researchers as possible. Using the MHRM and the RRDQ to select participants enabled the researcher to make sure consumers at various stages of recovery and with varying cultural backgrounds; ages and educational levels were selected to be interviewed.

Pilot Study

A group of six consumers with a diagnosis of severe mental illness were interviewed in a focus group format using the instrument. The pilot test took place at a consumer advocacy agency. At the conclusion of the 90-minute interview, the consumers determined that the tool contained key questions to gain information about the study topic. A transcript of the pilot study was reviewed and analyzed, using the RPIT. The consumers concurred with the researcher on the data relevance to the research questions.

The RPIT was used to interview 10 participants for 23 interviews from 60-80 minutes. The goal of using this tool was to start gathering the consumers’ perspectives about helper partnerships that facilitated their recovery. The tool was not intended to be inclusive of all questions and was modified as the interviews progressed, until saturation of data was achieved. During the interviews, it became clear that the process of accepting help was complex and some questions were added to get more information about how co-researchers became ready to accept help.

Phenomenological Data Analysis

Using Moustakas’ modification (1994) of the Stevick-Colaizzi-Keen Method, the researcher analyzed each transcript as a unique experience. Moustakas’ method of arranging and analyzing phenomenological data included the following steps:

1. Obtain a full description of the co-researcher’s experience of the phenomenon.
2. Complete the following steps using the verbatim transcript from the participant’s experience of the phenomenon.
   a. Consider each statement as it relates to the description of the phenomenon.
   b. Document all related statements.
   c. Record all non-repetitive statements: meaning units of the experience.
   d. Theme the invariant meaning units by comparing and clustering them.
   e. Using verbatim examples create a description of the textures of the experience by synthesizing the themes and invariant meaning units.
   f. Using imaginative variation, reflect on the textural description and create a structural description of the participant’s experience.
   g. Create a textural-structural description of the meanings and essences of the participant’s experience.

3. Analysis of each co-researcher’s experience was completed using the above steps.

4. A composite description of all the co-researchers’ experience was created from all the individual textural-structural descriptions, integrating all descriptions into a universal description that represents the group of participants.

*Member Checks*

Glesne (1999) suggested that giving the participants the descriptions and analyses of their experiences were critical to make sure the researcher understood the experiences and represented them accurately. Even though this was time consuming as Glesne indicated, it helped to correct factual errors in the documents and added some ideas to the analysis for the researcher.

After I reviewed, analyzed, themed and wrote individual textural and structural descriptions for 9 of the 10 co-researchers that completed the study, the individual descriptions
were mailed to them for feedback. All 9 participants gave feedback about the analysis. Individualized letters were sent with the descriptions, restating my intent to understand their experience of helping partnerships that facilitate their recovery. Also, in the letters they were asked to add, delete or correct information that they perceived as incorrect, incomplete or misinterpreted by me. A sample member check letter can be found in Appendix D.

The co-researchers overwhelmingly validated the content and themes of their descriptions and chose fictitious names to be used in the dissertation. Several participants corrected information such as, age when diagnosed, age range of a helper in the description, time when first medication was prescribed or a fact about a relative in the description. Otherwise, they made comments that validated the descriptions and their themes.

**Triangulation**

Glesne (1999) and Maxwell (1996) discussed the potential benefits of collecting information from a diverse range of individuals and settings. The researcher chose as diverse of a sample of 10 participants as possible from 69 consumers who wanted to be interviewed. Also, all but one participant was interviewed from 2-3 times and transcripts of all interviews were compared for trustworthiness of perceptions and experiences. In addition, artifacts were reviewed and discussed for 5 of the 10 co-researchers. A third interview was added for further reliability of the data. Finally, the data from the pilot group was another opportunity to compare information for consistent themes and experiences. Comparing qualitative interviews with the nine participants who finished the interview process, demonstrated sound coherence, and dependability of information collected between and among first, second and third interviews. With several participants’ transcripts, the researcher had to compare transcripts word for word
because the first and second interviews sounded like the same interviews for extended sections of
the dialogue.

Research Procedures

Access to consumers was achieved through several processes. First, flyers explaining the
purpose, method (written tool and interview), timing, duration and place of the research were
disseminated to community mental health agencies and consumer advocacy groups. The generic
flyer used to recruit participants is found in Appendix E. Also, the researcher visited the selected
sites to describe the research project and answer questions about it. Then, the researcher met with
the consumers who wanted to participate in the study to administer the MHRM, the RRDQ and
consent form. Finally, the researcher explained the process for follow up interviews.

When consumers identified themselves on the survey, indicating an interest in being
interviewed, the results of the MHRM and RRDQ were analyzed to obtain numbers of
respondents from a diverse range of consumers by stage of recovery, age, gender, education, and
cultural group. Then a purposeful sample was chosen to achieve a maximum variation sample
from the identified categories.

The ten participants chosen for face-to-face interviews were contacted and an
appointment to be interviewed in a private space was scheduled at the community mental health
agency or consumer advocacy agency. The process of the qualitative interview was further
explained to each participant, including the audiotaping, and participants were given an
opportunity to review their consent documents and ask questions. The consent form is located in
Appendix F.

Participants in the study were paid $20 per hour after each interview. When consumers
identified that they had artifacts that added to the description of their recovery experiences,
including their helper partnerships during the process, they had a third interview to discuss the artifacts. The Recovery Artifact Interview Tool is located in Appendix G. These interviews were taped, as well.

All interviews were audiotaped, using two standard commercial audiotape recorders, compatible with a transcription machine. After each interview, the audiotapes were transcribed in their entirety for analysis of the data. Also, the researcher took notes related to the context and process of each interview. The notes were used to accompany each tape transcription for contextual information and to strengthen the validity of the data.

**Data Analysis**

After transcription of each audiotape, the raw data was reduced to elements that describe the consumers’ mental constructs related to their recovery and partnerships that facilitate the process. Elements were arranged and rearranged into categories that allowed comparisons and analysis of data within categories. This fracturing of the data allowed for themes to emerge from the descriptive data and facilitated checking participants’ descriptions against each other.

Coding and categorizing continued until the data reached the saturation point. This was the point beyond which no new elements/categories or themes emerged from the raw data. Other experts in the field of mental health were asked to review the transcripts and to give feedback about the categorization process.

Preliminary analyses and interpretations were drafted and fed back to the relevant participants for validation. Also, when data from artifacts were categorized, they were compared with the interview data of the same participant for validation and fed back to the individual for external validation.
These analyses and interpretations and validation processes were ongoing throughout the study. This included the contextual notes taken by the researcher at the time of the interviews that were added to the consumer’s descriptions and researcher’s journal of the whole process.

The researcher addressed internal validation thoroughly, rigorously using member checking throughout data collection and analysis. Also, the researcher identified her biases related to recovery and helping partnerships before data collection occurred to bracket them and decrease the chance that they would interfere with objective analysis. Finally, the researcher collaborated with other researchers about preventing bias from contaminating the qualitative process through external auditing.

Summary

A variety of methods were used to gather data and to promote the vigor of the analysis and related inferences. The MHRM, a valid and reliable instrument in determining the consumers’ stage of recovery, was administered to a large number of adults in outpatient treatment with a SMI diagnosis, and then used to choose a diverse sample for this qualitative study. The RIPT was designed and pre-tested with a group of people with a SMI diagnosis to elicit rich and deep data about their experiences and perceptions of a partnership that facilitated their recovery process. Triangulation of data obtained in multiple interviews to reduce inconsistencies and in comparison of participant’s responses against each other was intended to further the objectivity of the researcher’s perceptions and inferences in the data analysis.

Audiotaping, analyzing verbatim transcripts, triangulation and member checking throughout the analysis stage of this research, and external auditing by an expert in the field helped the researcher to use her expertise and experience in the field and avoid the risk of bias in the analysis of the data.
CHAPTER IV. RESULTS

Introduction

From the experiences with severe mental illness and recovery of 10 co-researchers, I constructed a guide from their collective knowledge and understanding to inspire and instruct those of us wanting to facilitate recovery. I actively listened and interacted with the co-researchers from experience and education related to psychiatric/mental health nursing that touched on 5 decades. My goal was to enter the essence of each individual’s experience of helping partnerships that facilitate recovery, and then to shed light on the themes as well as pull their experiences together into a meaningful whole. At times this research process was filled with anguish and at other times with hope and admiration. I impacted and was impacted by the content of the interviews, and will never look at recovery the same, again.

In telling the collaborative story of the co-researchers, I used the phenomenological qualitative analysis technique that included imaginative variation to structurally understand how the helping partnerships developed that facilitated their recovery. Having decided that this part of the analysis was at the core of pulling the experiences together, I determined the best way to present the composite of ten co-researchers was to lie out the process of each co-researchers analysis and description and then, to present the composite description of the group’s experiences. After all, that is how they came together.

First, an overview of the co-researcher sample is displayed in Figure 1. Then, individually each participant description is presented in Chapters V-XV. Finally, in Chapter XVI the collective experiences are described as a composite. Fictitious names were chosen to protect the confidentiality of the participants, and are used throughout the dissertation. Themes that emerge from the composite are presented near the conclusion of Chapter XVI.
Role of Researcher

Before presenting the results of this study, I will briefly describe the role I had in this research and the impact that the analysis of the data had on me. As with any qualitative research study, I became a part of the process. I met with every co-researcher face to face two to three times, except in one case when the participant decided to withdraw from the study, after one interview. From word by word transcripts of all the interviews, an analysis of what the participants’ experienced of helping partnerships (textural) and how these relationships were created (structural) were accomplished. Next, I pulled the textural and structural analyses together and wrote ten individual composite descriptions. Finally, all composites were analyzed and the overall composite that included the essence of the experiences from the co-researchers was created.

Many readings of the transcripts, textural and structural analyses and individual composites were completed to get to the process of integrating all of these descriptions into a group analysis and composite description. As with any qualitative study, I endeavored to enter the essence of the participants’ experiences. In this study, the context of the helping partnerships that facilitate recovery was the co-researchers’ understanding of their mental illness and perceptions of their treatment and recovery process. So, participants opened up their symptoms and emotions about mental illness to me. I entered their lives at some of the best and worst times. I moved into their joys and terrors. I believe I reached the soul of 9 of the 10 co-researchers’ experience of their mental illness and helping partnerships that facilitate their recovery.

The process of entering the experience of the co-researchers went far beyond my expectations. It was a long and painful process that precipitated nightmares and anxiety along with hope and admiration for the courage it took these individuals to move on in their recovery.
Every time I read a transcript, wrote a description and analyzed a participant’s experiences their emotions and mine collided. At first, no matter how objective I attempted to be with their experiences, I could not achieve objectivity. Then it dawned on me that entering the soul of individuals’ perception of their mental illnesses and helper experiences could not be understood objectively before it was perceived through the eyes, hearts and souls of the participants. Hence, their subjective perceptions and emotions became mine. Together the participants’ and my perceptions and feelings interacted with the data and evolved over time to trustworthy knowledge.

A long history of providing mental health services, including therapy to individuals, groups and families, did not adequately prepare me for the intensity and power of entering the co-researchers’ experiences. The degree of separation that was part of therapeutic partnerships with consumers was absent in my relationships with the participants of this study. In fact, boundaries between the co-researchers and me had to be bridged to get to the core of their experiences. In the interviews I actively felt the struggle between the role of therapist and the role of researcher. Simply said, the purpose of my previous role as a therapist was to facilitate recovery from SMI and my present role is to understand how helping partnerships facilitate recovery. There is a vast difference in these roles and far less emotional protection in the latter.

In conclusion, the role of qualitative researcher has its risks and is not for the faint of heart, in my opinion. I caution researchers who intend on moving within another’s experience to focus on staying grounded with their purpose and support system. Because entering into the world of those with severe mental illness was dangerous to my heart, but strengthened my mind and soul.
Phase I Quantitative

The Mental Health Recovery Measure (MHRM) was used to determine the sample of co-researchers for this study. Ten participants were selected from 69 consumers who completed the MHRM, the study demographic tool and consent form. The following participants were selected in an effort to have as diverse a group as possible with ten co-researchers. In Figure 1 the participants are identified along with their MHRM scores, ages, genders, races, diagnoses and education levels. In selecting the sample, the criteria for the early stage of recovery is in the range of 45-70, the middle stage is 71-95 and the advanced stage is 96-120. Three co-researchers were selected in the early stage, 4 were selected in the middle stage and 3 were selected in the advanced stage. The highest possible score on the MHRM was 120.

Also, ages range from 25 to 58 and there are 6 men and 4 women in the participant group. Seven of the sample participants are Caucasian and 3 are African American. Four participants have a diagnosis of schizophrenia, 3 a diagnosis of bipolar disorder and 3 a diagnosis of major depression. Two of the participants with a diagnosis of major depression have psychotic features as well. In addition, 5 co-researchers have a high school education and 5 a college education from associate degree to master’s degrees.

Finally, the mean MHRM score for the participants in this study is 87.48. Young and Bullock (2003) had a mean of 80 with their sample of participants. The higher mean in this research may be related to the use of recovery principles and concepts in the mental health agencies and medical education system in the area where the study was conducted. All co-researchers heard about the recovery process and most attended recovery oriented classes.
Figure 1. Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>MHRM</th>
<th>Age</th>
<th>Gender</th>
<th>Race</th>
<th>Diagnosis</th>
<th>Education</th>
</tr>
</thead>
<tbody>
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<td>49</td>
<td>Female</td>
<td>Caucasian</td>
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<tr>
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<td>Female</td>
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<td>Caucasian</td>
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Phase II – Qualitative Method

Interview Process

The individual research interviews took place in an office or meeting room at mental health agencies, consumer advocacy groups or at mental health board offices. I scheduled each interview ahead of time, and a reminder call was made the day before the interview took place. Every co-researcher was present and on time for all interviews. The only participant who withdrew from the study called and left a message to inform me that he would no be continuing the study, explaining he was not getting anything out of it. I called him back to discuss his decision and he did not return my call.

All interviews were audiotaped, using two recorders. In most cases, the participants and I sat at a table and in a couple of instances, there was no table in the room and a chair was used for the tape recorders. There were 23 interviews of from 60-80 minutes in duration. Meetings for all
co-researchers were scheduled at least two weeks apart. So, interviews took place from March through July 2005. Verbatim transcripts were created from the tapes of the interviews and used to analyze and describe the data.

As described in Chapter III the phenomenological qualitative analysis process was used to review all statements in 23 transcripts. Then, I reduced the raw data to all statements relevant to the phenomenon of helping partnerships that facilitate recovery from severe mental illness. Further reduction was accomplished by documenting all non-overlapping statements relevant to the phenomenon, and these were clustered according to themes. Then using the clusters of themes, I described the textures of the phenomenon that each co-researcher experienced. Having a detailed description of what the experience was like and using imaginative variation, I proceeded to create the structural description of the context and process of how the phenomenon occurred. Finally, a composite description, textural and structural was developed for each individual. This process was repeated for all co-researchers and then, again for the group as a whole and finally, to create the universal group experience of helping partnerships that facilitate recovery.

Co-researchers were sent their individual composite description of their experiences. Nine of the 10 participants returned the documents with feedback. All nine felt the essence of their experiences and how they occurred were portrayed richly and accurately. Three participants identified several factual corrections, which were made in the dissertation.

Summary

The guide to helping partnerships starts with choosing a diverse sample of co-researchers who experienced the phenomenon. In the quantitative phase of the study, the MHRM (Young and Bullock, 2003) was used to identify 10 participants from 69 volunteer consumers who
wanted to take part in the study. My intent was to choose participants that represent early, middle and advanced stages of recovery, which the MHRM was designed to accomplish. Also, I was striving for a sample with diverse diagnoses, ages, educational backgrounds, races and genders.

With a sample of participants chosen, I proceeded to the qualitative phase of the research and interviewed them face-to-face to obtain rich descriptions of their helping partnerships that facilitate recovery. Twenty-three interviews were conducted. Then, after word for word transcripts were generated from audiotapes of the interviews, I reviewed and analyzed all interviews and developed textural and structural descriptions for all individuals in the study. Finally, I created a composite description of the phenomenon from all the participants combined.

Now, the individual descriptions are presented to tell the story of helping partnerships that facilitate recovery from the co-researchers’ experiences. It is my hope that these descriptions will bring the experiences of the co-researchers to life for the reader like they do for me. Then, the composite description brings together the experiences into a universal picture of how to reach the essence of helping partnerships and their meaning.
CHAPTER V. BREE

“Peer support is a lot of what recovery is all about. My peer/friend is willing to confront me. She’s willing to point out that something is not working and she does it from a position of I’ve been there, I know you. I point this out and you don’t have to do anything about it, but I wish you would.”

(Bree)

Introduction

Bree is a 49-year-old married, but separated mother with a diagnosis of bipolar disorder. She scored 111 on the MHRM, which put her in an advanced stage of recovery. Also, she has a masters’ degree in psychology and is currently unemployed. When this study began she was in an operations director position at a consumer advocacy agency, but during the study process lost this job because she perceived she had a personality conflict with the financial director.

The first time I talked with Bree on the telephone she was extremely enthusiastic about the recovery study and facilitated me meeting with a group of consumers to conduct the pilot study for my Recovery Research Interview Tool. She warmly opened the door to her agency to me, and was delighted to find out she was selected to be interviewed. We connected right away and stayed in contact throughout the interview and member check process.

Experiences

The experience of helping partnerships that facilitated Bree’s recovery from SMI included a complex network of relationships at various times throughout the course of her mental illness and recovery. The fundamental nature of her helping relationships began with her long battle with depression, guilt, mood swings and drug abuse that started in adolescence. Bree was sexually abused in the transition between childhood and adolescence and suffered guilt and depression that lead to severe emotional withdrawal as a teenager.
“I have a constant feeling that I’m doing things wrong. I try to do things right, but that’s a sham, that’s like not real when I’m doing things right. It’s an act. I just have this constant feeling of always being wrong, guilty.”

At 17 years of age, her parents realized the seriousness of her emotional problems and took her to a therapist for the first time. Bree was diagnosed with major depression and treated with talk therapy. Even though her parents were involved in her childhood abuse, she experienced them as concerned for her well-being. They could see that she was turning her feelings of guilt and depression against herself. Bree felt they sought professional treatment for her early symptoms of mental illness because they cared for her, and identified this as the point in time when her recovery process began. Also, her father wanted her to have a chance at a normal life and he apologized to Bree for the abuse.

Therapists and MD’s had a significant, though sporadic and episodic, impact on her recovery. Bree liked what they did with her by providing education about her illness, giving emotional support, and helping her sort through problems and accountabilities for her behavior. In fact, Bree liked what they did so much that she decided to become a psychologist later in her life.

However, she never experienced a consistent therapeutic relationship with any of these professional helpers. Bree believed that she would engage with a therapist at times when she needed the emotional support and objective perception of her illness and get what she could from the professional helper. Then she stopped seeing the helper and when she needed this kind of help again, she would start therapy with another therapist.

“I would go for awhile and things would get better then I would stop going. Then I would go to a different one and things would get better and
I’d stop. I don’t recall picking up with the same therapist ever.””

So, there was no special professional helper in her recovery, but Bree periodically felt the need for professional treatment.

Bree continued to have problems with alcohol and other drug abuse into adulthood, marriage and child bearing. During her abuse of drugs, she became disconnected from self and others, but her continual feelings of guilt and despair were numbed. However, whenever she was pregnant, she did not use any drugs. She was very proud of the fact that she used no drugs at these times to protect her children. She experienced a profound sense of parental responsibility that lead to a temporary cessation of her self-destructive drug use, during pregnancy. Her parents cared for her, and she cared for her babies.

During her marriage, it became clear to Bree that she and her husband probably would not always be married, due to extramarital relationships, and this realization precipitated her decision to go to college.

“Sometime in that process my mother said that if I ever wanted to go back to school she would pay for it. That was very handy and I decided to be a therapist because I went to therapists on and off since I was 17.”

She felt a need to be able to support her, and chose to major in psychology because she had positive experiences with therapists and liked what they did. Therapists helped her, and she chose a helping profession.

In the course of her education, which her mother financed, Bree learned a great deal about behavioral motivation and defense mechanisms, such as drug abuse and addictions. Learning was a process that always came easy to her, and was a primary method she used to understand herself and others. In her therapy there was a major learning component that included
education about mental illness, psychiatric treatments and critical thinking/problem-solving. So, it was natural for her to start looking at her own behavior and drug use when studying these topics in her classes.

“Somewhere along the way there was awareness, that the drinking was not right. My folks didn’t drink.”

This was the first time she began to think she might have a problem with drugs, but she did not allow this thinking to go further than intellectual consideration until later in her recovery.

Bree experienced her mother financially supporting her college education as integral in her recovery. Her mother continued to fund college through her Master’s degree. Learning and education was a very important part of Bree’s recovery and emotional growth, and by paying for her formal education, Bree’s mother strongly supported this aspect of her healing process.

Also, Bree learned from her parents that her drug use was not normal through role modeling. She believed that this absence of alcohol and drug use by them helped her later in her illness to realize she had a serious problem. As she was learning about motivation of human behavior and addiction issues in college, she began to question her own behavior on an intellectual level, even though she was still in denial about her own behavior and drug addiction. So, even though Bree experienced numerous problems with her parents, she saw them as her first helpers in her lengthy recovery.

Bree’s most powerful experience of helping relationships that promoted her healing from mental illness was related to peer/friend relationships. She met a friend, who struggled with mental illness, in college and this friend became critical in Bree’s understanding of her dysfunctional behavior and subsequent entry into drug rehabilitation.

“She is always there for me and makes connections I can’t see.”
Bree knew that her friend was aware that she was an avid learner and curious about intra and interpersonal dynamics of motivation and behavior.

“She knows when I am ready to learn and when I am ready for help. She respectfully points out problems and leaves it at that.”

Her friend experienced her own struggles with mental illness and was perceived by Bree as respectful of her need to be accepted where she was at emotionally and sensitive to the timing of constructive behavioral feedback. She would say,

“I point this out and you don’t have to do anything about it, but I hope you do.”

Connecting and constructing a mutually respectful relationship was an integral part of this helping partnership. Also having experienced mental illness gave her friend’s feedback a powerful credibility delivered at a point in time that Bree was able to hear her. Given this compelling partnership, she was able to mentally process and often accept the wisdom of her friend’s insight.

The friend was at her home one day, while Bree was using drugs. Her friend told Bree that she was afraid to be in her home while she was doing drugs, and this was a defining moment for Bree. Feeling her friend’s fear and anxiety about being with her, at this time, suddenly allowed her to see the dysfunction and threat to her wellbeing that the drug abuse was creating! As a result of this insight, Bree started participating in drug related self-help groups.

Bree trusted her friend and began to see herself through the friend’s eyes. The process of seeing her behavior this way signified a higher level of linkage with her understanding of self, using her friend as a conduit for self-awareness. This insight opened a new avenue of recovery for Bree and she took it.
“Sometimes connections are just beyond my window. It might be something I have learned before, but I’m not seeing the connection. She has been able to make the connection.”

Her friend was able to get Bree linked to several peer support groups. As she joined these groups and participated in their activities, Bree experienced a consistency and quality of support she never had previously. She learned that she was not the only person wrestling with mental illness, recovery and relapse. Initially, she participated with substance abuse self-help groups and later became connected to and employed by a consumer advocacy group. She experienced acceptance, daily support and sometimes multiple times per day assistance. Bree learned about managing symptoms of mental illness and addiction as well as their underlying emotional triggers. She experienced positive regard and respect that she did not feel for herself. And over time was able to incorporate these positive feelings about her and offer positive regard and support to others.

Peer helpers and groups became a cornerstone in Bree’s recovery process.

“A whole lot of people believed in me, when I didn’t believe in myself and convinced me I could.”

Peers accepted Bree where she was at, respected her work and progress in recovery and offered continual emotional support. Also, she learned, so much from the stories of others in recovery.

“Being able to hear, I was there, Oh, my gosh!”

She expressed that she received a kind of encouragement from her peers that she internalized over time.

Peers respected and valued Bree for her work and progress in recovery. She felt validated by them and was not blamed for her history of abuse or relapses. Her peer helping relationships
were built on qualities and behaviors of acceptance, respect and validation over time that resulted in Bree feeling empowered. Her choices were respected even when peers believed they were wrong, which revealed another dimension of these partnerships; acceptance of her with differences as well as similarities. She was offered respect for her need to be where she was and make mistakes, learn and grow at her own pace, not to the specifications or expectations of the group. Bree brought this level of respect to light when she said,

“It’s allowing them to just be where they have to be and realizing that they have a right to be there!” A right to believe and act according to one’s own needs instead of according to someone else’s or a group’s needs and expectations. You get enough days of them accepting where you are in a row and by gosh you start believing in yourself.”

As well as being given support, she was able to offer and receive feedback about the help and support she provided to others. This reciprocal offering and receiving help was an important part of Bree’s recovery process. There was an interweaving of acceptance, encouragement and respect that was experienced as powerful and empowering by her.

The strong message that she mattered was highly valued by Bree, and this message counteracted the invalidation she experienced as a person with a diagnosis of severe mental illness. She believed that stigma related to mental illness led to annulment of the self over time.

“You know I think maybe the biggest thing about mental illness is that we don’t matter.”

Also, in the consumer advocacy group, Bree saw the role of relapse, her own and others’, as helpful to the process of recovery.

“Relapses and flaws in judgment are OK; they are a part of the learning process.”
She described them as opportunities to refine healing skills and to grow and create strengths leading to new life directions. Mastery of dysfunction and symptoms of mental illness led to more resilience for Bree.

In addition, she experienced and gave tough love to peers. Part of this process was respecting choices she and others made without passing judgment.

“It’s giving encouragement without expecting behavior or enabling.
You know I respect you and have faith that you can handle your life and you’re going to take care of yourself and please close the door on your way out.”

The primary helping partnerships in Bree’s recovery process were with her friends and peers. These were long term and ongoing through her major learning and growth periods during her healing. She felt huge support; gained knowledge and experienced positive regard from others she did not feel for herself.

Other people that Bree identified as helpful in her process were her husband and her college professors and fellow students. These partnerships had a positive impact on her because of focused support functions. Her husband maintained his employment over time and paid for her treatment and medications. Even though they were not living together she experienced him as a person who loved her and someone she could count on for medical expenses. Finally, her professors and fellow students had clear expectations of her detailed in the college syllabus, and helped her to learn and build confidence by earning their respect.

Summary

Bree’s experiences of this network of helping partnerships that facilitated her recovery from severe mental illness included 7 primary textural themes: 1) respect
and acceptance of her as a person, 2) faith/trust in her ability to manage her life, 3) financial support, 4) teaching/learning, 5) emotional support, 6) empowerment and 7) dependability.

The structures that evoked Bree’s experience of helping partnerships interacted over time to facilitate her recovery from severe mental illness. The primary structures were learning about and accepting herself with her abuse history and mental illness, connecting and relating with others, changing behaviors in time of crisis and creating a support network.

The dynamics of these relationships had some common themes, even though her relationship partners varied and were critical at different stages of her recovery. The helping partner had to be respectful, caring, trustworthy and capable of teaching and learning related to mental illness and recovery. Also, timing was a key element in the evolution and maintenance of these partnerships. In times of crisis, when Bree’s emotional and financial resources were not sufficient to meet the challenge of the demand, Bree was more receptive to help and more motivated to change her behavior. For example, when she discovered that her husband had a relationship with another woman, she realized she would have to prepare herself to be financially independent. This insight motivated her to enter college in preparation for a helping career in psychology. And during her college education Bree met her friend/peer who helped her learn to use her knowledge about psychology in her recovery.

Bree’s parents were her first helpers that started her in recovery. Also, her mother enabled her to obtain the college education that furthered her recovery through the learning process and confidence building experiences. After this, her peer/friend was Bree’s most significant partner in facilitating her recovery. And through this friend she connected with a
group of peers and became part of an intricate support system. All together, these partnerships with helpers created a complex support network for her recovery from severe mental illness.

The essence of all Bree’s helping partnerships was deeply connected to trust in and acceptance of her by others, helping her to trust and accept herself. The foundation of this trust being a mutually respectful and dynamic teaching/learning process focused on emotional growth and advocacy for persons with a diagnosis of severe mental illness.

Her helping partnerships were forged when Bree experienced a crisis that unfroze patterns of her behaviors and escalated her fears and sense of helplessness, hopelessness, and alienation. During these times, she was most motivated to connect with helpers. Frequently, the connections with helping relationships during crisis facilitated growth spurts in her recovery leading to redefinition of her identity and life goals.

Bree’s recovery was a long and halting, developmental process. It was much like the growth of a great oak tree in a challenging environment. Her recovery depended on help from a variety of sources, primarily friends and peers that accepted her, but challenged her to learn and change. Through connections with peer helpers and their gifts of respect and nurturance, Bree developed trust in herself and courage to reach for new horizons, building strength and confidence in her abilities. Then, she used her strength to nurture the seeds of others’ growth, thus being an important element of creating a network of power beyond the number of peers.
CHAPTER VI. AL

“You’re screwed when you’re hanging from a thread.”
   (Al)

Introduction

Al is a 42-year-old divorced father. He has a diagnosis of schizophrenia, and with a score of 89 on the MHRM, he is in the upper middle stage of recovery. At the time our interviews started, Al was unemployed, but during the process he got a job in a mechanic shop.

When I called Al to tell him he was selected to be interviewed, he was pleased and said he hoped he could help with the study. We made a good connection at the first interview that became stronger through the third interview. He called me to see what was happening when he had not heard from me in a few weeks and promptly returned his member check feedback to me that consisted of “I would like my name to be Al.”

Experiences

Al always felt there was something wrong with him, but did not understand why. He was quiet, nervous and paranoid.

“I had a dark cloud around me, in my mind, and couldn’t see the light.”

The dark cloud kept him disconnected from others and in a perpetual state of anxiety. His mother tried to get through, but Al could not hear or respond to her. She tried to reach him through her gentle voice, and his father tried to reach him with violent verbal outbursts. The rest of his family was frustrated by his lack of motivation to do chores or communicate.

The structures that describe how Al experienced helping relationships that facilitated his recovery started in early childhood. He was always perceived by himself and his family as different. He lived in the dark cloud of schizophrenia that separated him from others. Al stayed out of touch from everyone most of his first 17 years of life.
There were a variety of helpers that assisted Al in his recovery from schizophrenia. He identified that his higher power had a major role, since he was 13 years of age. He accepted God at this age and said God accepted him. Al said that God inspired him to start writing poetry at this time and it was a great relief to express his emotions because he could not tell anyone what he was feeling.

Also at 13, Al started using marijuana on a daily basis, which increased his paranoia and made him feel like a “zombie”. When smoking, he could not feel himself breathe or hear his heart. In addition, his grades started falling from A’s and B’s at this time. Therefore, he became further withdrawn from others and his schoolwork, and his ability to function deteriorated.

At 17, when he experienced rejection from a young girl who really never acknowledged his attentions, Al could not cope and overdosed. Fortunately, his mother heard him fall in the bathroom. Al believed that it was his higher power that made sure she found him and got him the help he desperately needed. At this time, the psychiatrist told him that he had a diagnosis of schizophrenia and he was referred to the local mental health system (MHS) for treatment.

At first, Al did not want to believe he had a diagnosis of mental illness, but his “higher power” told him to listen to this guy.

"My mind said don’t listen to him, I’m not mentally ill.

I didn’t want to believe it or accept it."

Al believed strongly that God helped him accept the help from his first psychiatrist. In his mind, he did not believe he had a diagnosis of schizophrenia and did not want to take medications, but God guided him to listen to the doctor. Basically, he thought that God, whom he trusted, was directing him to trust this doctor and he did.
When Al started taking psychotropic medications he entered a new perceptual world. The dark cloud of mental illness no longer blocked his sight, hearing and thoughts. He could hear people, was not afraid of them and started “talking and talking and talking.” Through multiple resources in the local mental health system (MHS), Al learned social and vocational skills. Also, he learned how to live outside his family’s home. Through the gentle, friendly and positive communications with counselors and case managers, Al was able to open himself up to interpersonal learning experiences and built up his self-esteem. These new skills and abilities helped him to leave a local half way house with 24-hour staff support and supervision. Then, he was able to get his first job. He experienced the whole system as supportive. And he always perceived that someone was there for him in case he got afraid or needed help solving problems.

The mental health system was a main source of respect and help in Al’s recovery. The first doctor he saw after his overdose started Al on medications and referred him to the local MHS for a variety of services. He experienced just about everyone in the system as helpful to his healing process and especially the half way house staff in his early treatment.

“Without these people and the medications I would have been a zombie.”

The counselors, case managers and nurses were friendly to him, showed they cared and always talked with him. After starting on medications he opened up and communicated with the staff. He engaged in numerous activities and treatment: crafts, job skills training, social skills and living skills. Social skills were very important because he did not learn to communicate and share his thoughts with people when he was a child. In addition, he did not learn to be self-motivated in caring for his living space, cooking and planning a budget.

Also, a great part of his treatment centered on education about his mental illness and accepting his diagnosis, so he could get on with his life.
“Education is the key to becoming ready to accept help.”

Most of this education came from counselors, doctors and case managers in the MHS.

“These helpers understood my mental illness and
were able to act without being judgmental or negative.”

Through a series of relapses when Al stopped taking his medications, he learned that he
started experiencing paranoia and fear again. Then, his symptoms would become a barrier to
communicating with others. Subsequently, he would have some kind of crisis that would get him
back in contact with the MHS and back on his medications. After starting treatment again, he
would start feeling less afraid and paranoid and begin communicating.

“Getting help opens your eyes and lets you feel the
caring from others, even in your darkest moments.”

Al felt that if he had not gotten into the MHS he would have committed suicide.

“If you follow the recovery program, take your
medication, listen and learn it works!”

The counselors and case managers helped Al work through his denial about having a diagnosis
of schizophrenia.

“It is easy to stray from recovery and it has no finish. I will need
medications the rest of my life. There will be good days and
bad, but with the help I have gotten they are mostly good days.”

The case managers helped Al move to more independent housing after six months in the
half way house.

“They were always there for me. The case mangers would come
to the supervised apartment and see if I was OK, eating right,
taking care of myself and the apartment.”

His current case manager, also a Substance Abuse and Mental Illness (SAMI) Nurse worked with Al for one year. He experienced her as very understanding and always there for him. Knowledge, good advice, education about the impact of alcohol on the body and interactions with medications, transportation, healthcare (glasses, dentist), and social skills were some of the services she provided him. How she expressed her knowledge and advice by using a kind tone of voice helped him trust her.

“She is always smiling and was helpful to me right away. I trusted her right away, it was hard, but I could talk about my relationship with father and drinking. She educated me and cares about me, but I am kind of sad that she is getting paid for it.”

The medication had a special role in Al’s recovery.

“It really opened my mind where I could share my thoughts with other people and trust other people. I was no longer afraid of them, so I could share my thoughts.”

Al learned through multiple cycles of stopping his medications, relapse and getting back into treatment that the dark cloud would surround him again when he stopped taking the antipsychotic and anti depressant medication.

“Teachers and parents could save a lot of lives if they watched Zoloft commercials and see that lots of kids are depressed and want to kill themselves. For me it is like when you get your foot wet before you step in the water, you know, and it is like when I go off my medication I want to try something new. Sometimes the new seems, well this isn’t so bad, so I’ll just stay
off my medications and go swimming or something and pretty soon the water gets dark and cloudy, and I came to the point where I got in a fist fight with my brothers to make me realize I need that medication again before I do something really ignorant.”

Al’s parents taught him some values that he later experienced as helpful in recovering from his mental illness. They structured him and provided guidance as a child and taught him the work ethic.

“My parents always worked and had me do chores. They fed me, bought me good clothes, and provided a roof over my head, and when I overdosed my mother got me help. She tried to get me to open up over the years, but I could not really hear her or let her in because of the paranoia and black cloud.”

He expressed that she and his sister respected and cared for him, but they really did not understand that he had a mental illness and could not really help him. Al believed his father might have had a mental illness as he had violent verbal outbursts and seemed especially frustrated by Al’s symptoms.

As a child and teenager, Al had only a couple of friends. When in treatment at the halfway house, he made a lot of friends with a diagnosis of mental illness and made friends since then without much difficulty.

“I need positive friends who are willing to support and encourage me. When they say you can do it instead of you won’t amount to anything, it helps bring up my self-esteem and helps me control my symptoms.”

As an adult he developed friends that help him to cope with his mental illness and learn from his mistakes.
Peers/friends were a big part of Al’s healing process, too. As his symptoms of schizophrenia stabilized, having friends and their support became a priority for him. So, as he moved through the beginning steps of healing, the MHS decreased somewhat as a facilitator of his recovery and friends/peers increased in their importance in the process. He became aware, that the people in the MHS, such as his current case manager, were paid to help him, while friends and peers helped him because they liked him and he helped them. Having friends to call on day or night and support groups like Alcoholics Anonymous where he could find a group any day of the week for guidance and personal validation, made up his most important helper system at this stage in his recovery.

However, some friends added stress to Al, not by saying negative things to him, but by wanting to drink alcohol that contributed to relapse of his symptoms. When his girlfriend brought beer to his apartment, he was in a conflict because drinking was destructive, but he wanted the relationship with the girl.

“Friendship is very important to me right now. Friendliness, cheerfulness and loving care from friends are important to recovery.”

Volunteering to help others with a diagnosis of severe mental illness was a positive experience for Al. It kept him busy increased his confidence and allowed him to focus on others, instead of always getting the attention in relationships. Al reached a stage in his recovery where other’s needs came before his, at times, and he believed that he was pretty normal at this point in his life. Also, his dreams were coming true.

“I have a girlfriend, a job; I am religious and have a new apartment!

Now, my goals are to buy a house, build a church and get a car and motorcycle.”
Al’s ability to write poetry was encouraged by his high school English teacher, but he believed poetry came from his higher power. He experienced writing poetry as a great form of expression, a learning tool and release mechanism for his strong emotions of anxiety and fear. In other words, writing poetry had a key role in his recovery. When he could not talk with others and had no one to communicate with, writing allowed him to capture and share his experiences and ordeals.

“\textit{When Push Comes To shove You Have Got to Show Your Love:}\n
\textit{Don’t be weak, turn the other cheek, help your friends and love your enemies to the end, open your eyes and see so the Lord may shine down on you through thick and thin, through black and blue.}”

Basically, Al’s poetry reflected what he went through and how he felt about his life. Writing allowed him to express and then reflect on his emotions over time, and helped him to connect and communicate with others.

Al believed that poetry had religious origins for him and that it simplified emotions and ideas, so they could be better understood. He created his poetry as he walked down the road and wrote at home.

“I get in good spirits when I walk down the road, especially if it is a nice day, like today. The sky, traffic, anything can inspire me. My higher power is everywhere and inspires me and guides me to write.”

Poetry was always a powerful communication and learning tool in Al’s healing. His higher power, English teacher and counselors had inspired him to develop this method of self discovery, and through it he learned to identify emotions and experiences, reflect on them and share them with others. Also, he learned to turn scary feelings and events into humorous ones
through his poetry. Al was able to turn anger into humor in his writings and he experienced this as a critical part of his healing process.

“I’m Losing My Mind expressed my hard times

with women and fear of rejection and loneliness.”

In the poem, *She Asked if She Can See the Phone*, he found humor in a frightening experience and it helped him let go of his anxiety and anger.

**Summary**

The mental health system including, case managers, and counselors had the major partnership role that facilitated his recovery, early in his recovery. In middle recovery peers/friends became his key source of support, even though he still was connected to a case manager and psychiatrist for his medications. Al came a long way and had numerous relapses before he committed to taking his medications “for life”, but learned that without them he became withdrawn and paranoid. He moved on in his healing and took the employment step and with his poetry and support system of case manager, doctor, peers and peer groups has a solid system of backing to accomplish his dreams.

Al used his God given talent, intelligence and his hard earned knowledge of schizophrenia to progress in recovery. He moved out of the darkness of mental illness and into the light of his human potential. His dreams of friendship, job and home were coming true largely because of his faith, and the helpers who assisted his movement in this lifelong journey out of the darkness of schizophrenia toward his destiny.
CHAPTER VII. ANZEL

“I realized I had enough faith to move a mountain, but not enough faith to take three pills everyday.”
(Anzel)

Introduction

Anzel is a 40-year-old married father, who with a score of 93 on the MHRM puts him in the upper middle stage of recovery. He has a diagnosis of bipolar disorder and is an African American. He said his diagnosis was bipolar plus because he had psychosis along with mood swings when he was not stabilized. Anzel has an associate’s degree and writes poetry and spiritual works.

Anzel being an extraverted man did not hold back his enthusiasm for taking part in this study. He gave me an enthusiastic handshake and we developed a rapport right away. When I sent him my description and analysis of his story of helping partnerships he was excited. He said that he couldn’t believe how on target it was and that it matched a comprehensive report his doctor had just completed and his psychological testing, also.

Experiences

Anzel was diagnosed with bipolar disorder, at the age of 23. Previous to his first episode of mania, Anzel was an A student in college, a business major, and an outgoing, social person. Also, he was holding down a management position on third shift at his place of work. He believed that the stress of his new job and lack of sleep precipitated the manifestation of his illness.

Anzel’s recovery was facilitated by his incredible spiritual will and the “angels that his higher power put in his life.” In early adulthood, Anzel was diagnosed with bipolar disorder and hospitalized, which he experienced as an unbelievable trauma. He had no clue that he was in
store for a life with a severe mental illness (SMI). He was an excellent collage student and athlete. Also, he had a commanding personality and physical presence, and he expected a life of success and fulfillment. Then, without warning he was committed to a state mental hospital.

His first angels after he was diagnosed with a SMI were the staff members in the state hospital. These “wonderful, dedicated people” saw the strength of character and potential for recovery in Anzel and started educating him about his diagnosis and how to manage it.

Having a manic episode and being diagnosed with bipolar disorder was a shock to his whole system. There was no warning or transition for him in this process. All at once he found himself committed to a state hospital and was told he had bipolar illness.

“It was like an unanticipated army invasion into a new country.”

This was the beginning of a long struggle with mental illness consisting of many hospitalizations, periods of being on medications and then periods of going off medications.

“I was a tough case. I had the Sampson Syndrome. I didn’t like taking medication and I didn’t like admitting I had a mental illness.”

He experienced having a diagnosis of severe mental illness as a weakness of character and spirit for many years.

Anzel, being the independent, willful person he was, decided he had to fight his illness in his own way. After leaving the hospital, he would wake up feeling great in a couple of days and determined he did not need his prescribed medications and therapy. Then, he flushed his medications down the toilet. So, the cycle of involuntary commitments to the state hospital, treatment, remission of symptoms of bipolar disorder and relapse began.
Accepting his diagnosis was a long trip for Anzel that took about 13 years.

“I was going to take care of myself and I was going to will myself not to be sick. I tried everything but just to accept that I had the problem and let the communities that God had set up take hold and take their place in my life.”

When he was in this state of denial about his diagnosis, Anzel started consuming alcohol and then he started having depressive cycles as well as mania. He stated that he was very quick to accept the stigma of mental illness, but slow to accept that he had a diagnosis. He thought he accepted the stigma first, because he saw it as a weakness in himself that he had to overcome, therefore, Anzel fought the assistance from others.

After years of the Sampson Syndrome, Anzel found himself in the hospital with depressive as well as manic episodes and with dark, psychotic experiences. Also, he began to realize his thoughts were not as clear, his thinking ability was diminished and his spirit had weakened. So, after 13 years of fighting the acceptance of his diagnosis, he determined that it was time to work with professionals, friends and family members that tried to help him, since he was diagnosed with bipolar disorder.

God had a major role in Anzel’s recovery.

“God allowed my life to shatter and gave me another life: A more quiet and peaceful life. I’m evolving into a different kind of person, more sensitive and helpful to others.”

According to Anzel, the Lord kept reaching out to him every day, and brought people into his life that were eventually able to help him accept his illness and start his healing process.

Spirituality always was in his life, but became the center of his life as he made progress. He
believed that God gave him a strong spirituality and that there was nothing more important for him and his recovery than his spirituality.

Anzel continued to be motivated by his higher power throughout his recovery journey.

“God helped me manage mental illness through prayer, professionals, medications, my wife and friends. Also, he saw fit to give me that Social Security Insurance (SSI) benefit, so I had choices in my recovery. I don’t have to take a job that I could not handle that would set me back.”

He stated a lot of people who do not understand mental illness think he should just take any job, no matter the cost. Anzel embraced the concept of a job being important to mental health, so he made the choice to take on the job of helping others. He said part of his life dream was to help his community by opening a business such as childcare or feeding the homeless.

Helpers who facilitated Anzel’s recovery from SMI included: doctors, nurses, peers/friends and family, specifically, mother, wife, and children. He experienced these people as his angels that the Lord put into his life. They sat him down and gave him talks/lectures with a consistent message. “We know how you feel, but you need the medications and therapy.” Listening to his “angels” got him started toward acceptance of his diagnosis and related treatments.

Next to God, Anzel’s wife, who had a diagnosis of mental illness, had the major role in his healing process. They met at a Christian Center, working on an advocacy program for the mentally ill. Characteristics about her that contributed to their helping partnership were: intelligence, intuitiveness, nurturance, prayerfulness and love of children.

“She was my teacher and my dearest friend. She would say, Honey, you stopped sleeping for two days and you were in the zone. She was right.”
She helped him learn that mania feeds on lack of sleep, and getting rest was a critical part of achieving stability with his illness. She was his coach and provided structure and consistency when he could not provide this for himself.

Also, his wife was the first person who visited Anzel in his darkest times at the state hospital, and that is when he realized she was going to be a major player in his recovery.

“When my family did not show up to visit me, my soon to be wife showed up and that was good.”

She showed him that she cared and would be there for him during his dark times.

In addition, the psychiatrist at the state hospital had a critical role as a partner who facilitated his recovery. He was described as a wonderful doctor by Anzel, who took the time to really connect with him and listened to what Anzel had to say.

“He taught me to be aware of my symptoms and realize that my illness was managing me, instead of me managing my illness. He cared enough about me to tell me that I needed to stay in the community and to stop coming back to the state hospital.”

This psychiatrist taught Anzel a great deal about mental illness and helped him accept and start to take charge of his illness. Finally, Anzel’s doctor impressed upon him the risks of frequent relapses and eventually he was able to hear that he could loose the ability to respond positively to treatment with so many remissions and relapses of his illness.

Characteristics of the key psychiatrist at the beginning of his struggle with bipolar disorder were identified as: knowledgeable, comforting, nurturing, perceptive, positive. Also, he treated Anzel with dignity, listened to him and involved him in decisions about his care. He was calm and always smiled which gave Anzel hope and faith in the doctor.
“He helped me understand that I have a lot to say about my progress in
treatment. Also, he helped me to understand that I have to adjust to changes
in me created by my illness, like getting enough rest and proper nutrition.”

A psychiatric nurse at the state hospital assisted him in deciding to take his medications consistently. She stayed after her shift to talk with him. She was able to connect prescribed medications with his spiritual values and belief system. The nurse told Anzel that having faith was good, but he needed to let the help along with the faith get him to where he wanted to be: stabilized.

“I realized I had enough faith to move a mountain,
but not enough faith to take three pills everyday.”

In addition, his psychiatric nurse was able to get Anzel to hear that the medications could augment faith in the process of healing, and they were not inconsistent with the natural world of cures.

“She was a Christian lady and helped me see that
medications were a part of God’s creation and this
thinking appealed to me. She asked me to agree to
take the medication and I did because what she
said made sense.”

This nurse taught Anzel how his medication worked to correct the chemical imbalance in his body. He was able to hear and accept her scientific explanation because she respected his spiritual values and she connected his treatment to his analytic way of understanding the world.

Also, at the time he began listening to his professional helpers Anzel met his future wife, who cared enough about him and understood enough about severe mental illness to be his first
visitor in the hospital. She would not allow Anzel to throw away his medications and made sure he took them as prescribed after discharge. The time was right and the helpers were there for him to accept help and cease his frequent relapses.

The culmination of his wife’s stabilizing effect, his education about symptom management and strengthening his spirituality came with the birth of his first child.

“She was my saving grace. Acceptance of my bipolar disorder kicked in when she was born.”

He had a child to understand and teach. Anzel decided he had to do whatever it took to be healthy so he would be there for her. At her birth he decided not to go back to the state hospital, and his admissions there went from every few weeks to 2-3 times in 8-10 years.

So, struggling for years with hospitalizations for mental illness, hearing education from his professional helpers, and receiving consistent support from his wife and higher power worked in concert to prepare Anzel for commitment to his healing. Having a child to be responsible for was the precipitating event that made him want to fully undertake recovery.

Anzel came from a large family, and one of his sisters was diagnosed with bipolar disorder, before he was diagnosed. He talked with her a lot and tried to help her with her day-to-day struggles. When he started treatment they created a mutual support system that he named the buddy system.

However, when Anzel was hospitalized none of his family members would come to see him. When he was discharged, some family members were very helpful in providing encouragement.

“My brother said, Brother medication is like your food, you have to eat to live. You have to have the medication like you
have to have food. Food is a blessing and medication is a blessing.

Brother what can we do for you?”

Looking back on his early recovery, Anzel saw that his family had a fear of mental illness. His sister was diagnosed with bipolar disorder and then he was diagnosed with the same severe mental illness. He understood that his family, much like many others in society had a fear of mental illness that led to stigma.

“Fear and lack of knowledge behind it can even cause family members to turn against a person with mental illness.”

He believed most of his family members bought into the stigma of mental illness and did not want to be around him during his times of active symptoms.

On the other hand, his wife did not have fear of mental illness because she experienced it and did not avoid Anzel, when he needed support the most.

“She is my greatest companion and my soul mate.”

Her belief in him and her giving, nurturing nature, have enabled Anzel to trust her and from there to believe in himself. Also, his wife’s family accepted him and was available to support and encourage his recovery.

“All my wife’s sisters are like angels to me, especially her oldest sister, who is a wonderful Christian lady. She has always been understanding and supportive. She cooks for me and makes me feel good.”

Also, his brother in law, a businessman, was a role model for him. Anzel spent some time with him at the time he was trying to calm down and stabilize his illness. Anzel said he was very helpful, very professional and that he learned a lot from him. And his stepdaughter who was 12
years old when he and his wife were married was identified as an important helper in his recovery.

“She would say what she had to say and leave it. I found her ability to offer a suggestion or opinion and then drop it without lectures supportive and I was really able to hear her message.”

Finally, Anzel’s mother had a significant impact on his healing. Early in his life, Anzel and his mother had a relationship with a lot of conflict. However, when he was ill as a boy, all he wanted was his mother. She was a hard working woman who at first did not understand or want to deal with his mental illness. She would tell him if life gives you lemon make lemonade. Since she had two strokes and was in rehabilitation they have connected in a new way.

“We have come together in the spirit of mother and son. We see each other’s strengths and weaknesses and we can spend quiet time together. We openly communicate, and I am making peace with her.”

As he progressed in recovery, Anzel transferred his focus from mental health providers to friends/peers. He discovered that being around people with a diagnosis of mental illness and hearing their stories of courage and learning was a powerful means of healing. Hearing about their daily struggles and resolutions, inspired him to apply new strategies to his recovery and to help others. Then, he started participating in support groups that taught him parenting and coping skills. Two group facilitators made a positive impact on Anzel’s insight about raising his children by providing education and role modeling. He learned to identify emotions that can hinder positive parenting and how to recognize child problems that can develop in a family with one or more members diagnosed with a mental illness.
Support groups and peer validation became of major importance in Anzel’s healing.

“The groups and the group members are almost as effective as the medications! They are incredibly helpful and I can not be without them.”

The facilitators from the parenting group become friends that enriched his life. Also, the group members offered fellowship as well as education to Anzel and his family.

Early in his struggle with bipolar disorder, Anzel started writing, and it had an important role in his progress through recovery. He started by writing his thoughts and feelings and then reflecting on what he wrote.

“When I would get a flood of thoughts coming into my mind,
I started writing down what I was thinking and saying, wait a minute... Hmm. Those thoughts are not part of my basic principles of life. Anything that was not part of my base, I rejected.”

Anzel used this method to determine if thoughts were delusional or reality based, and to start focusing his thoughts in a positive direction. He started writing on his own initiative, but believed the Lord gave him the will and ability to use it as a healing tool.

Over time, the writing, analyzing and reflecting process served as a learning tool and assisted Anzel in recognizing and accepting that he had a diagnosis of bipolar disorder. His writing became a tool to develop self-awareness.

“Once you begin to reflect and meditate on your thoughts and feelings, consider what you can and can not accept, you can make changes. You start to live in peace, and accept yourself in spite of the mental illness. Then, you are beyond the disease and focusing on your life.”
By writing, reflecting, comparing thoughts and feelings, eventually Anzel learned the patterns of his thoughts and emotions. Then, he was able to organize his plans for changing thoughts that he did not see as part of the healthy person he wanted to be.

“*My writing had a powerful effect on my recovery. It helped me to be more aware and begin to develop a sense of responsibility for my thoughts and feelings.*”

In the process of writing, evaluating, and learning about him, Anzel was more aware of and took more responsibility for his thoughts, thereby increasing his sense of self-control and positive self-esteem.

Also, Anzel sensed his writing ability was a gift from God and he used it to develop his spirituality. His Biblical writings said a lot to him and others. One of them, *The Tree of Knowledge*, had similarities to his recovery.

“The tree of knowledge was something that God did not want Adam to partake of because it was a test for him, and God was saying I am going to give you everything that you need. I don’t think that the tree of knowledge would have been forbidden forever but God had put a limit on what Adam could do at that time. So it’s a story for everybody. All of us have something that we’re not supposed to do. We have to have limits in life. We’ve got to say; I’m not going to do that because if I do, I may get me in trouble. It was just something that the Lord did not want him to do. It’s what happened ... it was the birth of the ego. The ego is independent and has to be disciplined. Man is an independent creature because of Adam’s act. We are free agents like in football.
Adam separated himself from God through his act and became a free agent.

Later Adam reunited with God and he became a dwelling place for God, then they were no longer separated. Like Adam, God is within us all.”

He reported feeling peaceful when he wrote *The Tree of Knowledge*. According to Anzel, like Adam, his ego has to be kept in its place through discipline and he as well as everyone has to work on this continuously. He added that the ego dwells in the soul. But he could not describe the soul because it was beyond human understanding.

“The soul is like the wind; it is there and you feel it. You see its effects but you do not see it. You know its beauty and comfort, but you cannot really describe it. We know it best when we are at peace.”

Later in his life, Anzel’s writings became a way to connect with others, particularly children. The scriptures in the Bible inspired him to create spiritual writings that he used to teach children the messages of God.

“These writings come from my soul, not my intellect. Someday, I want to write my own Bible, like a living Bible, to construct scriptures into meaningful stories and messages, so everyone can understand.”

Anzel experienced his daily struggle between mental illness and mental health as the most important part of his recovery journey. When he was battling between darkness and light, sickness and health, Anzel perceived that he started to learn to take one day at a time, and began to realize he had the power to have a good day. He said that he strongly believed that mental health training had to include learning to recognize the power of positive thinking and expectations. He experienced that he had a choice to learn and develop self-control, instead of allowing mental illness to control him.
“My recovery is continuous, but it is a whole lot healthier than
saying my mental illness is continuous. I’ll never let my mental
illness gets back to where it was before I entered recovery.”

Anzel learned that he has to take care of himself to effectively manage his diagnosis of bipolar disorder. Rest, consistently taking medications, spending time communicating with his family, learning about mental illness and helping others to learn worked together to form a healthy way of living for him. To Anzel, rest meant trust.

“I had to find at least one person I trusted for me to rest.

For me this person was my wife, my coach, who I could share
my thoughts with and she could share hers with me.”

Being quiet together and trusting her, allowed Anzel to consistently feel safe enough to get the rest he needed, thereby stabilizing his symptoms of mental illness.

Anzel’s understanding of his recovery developed gradually. He described his perception of the process in four levels that occurred with time, educational and emotional support. He depicted that level one of the healing process was recognition and acceptance of a diagnosis of severe mental illness. He claimed it took admitting that he had a diagnosis of bi polar disorder and being willing to accept help to reach this beginning level of treatment and healing. Level two was described as taking prescribed medications and being complaint with treatment. Anzel, said that in this stage negotiating with the doctor and therapists about treatment was important, and the more stable he became the more empowered he was to collaborate with them at this level.

The “wilderness” was what he stated existed between level two and three.

The wildness was explained as an emotional state when consumers are compliant with treatment and they experience good and bad days. Good days led to hope and bad days were
lived in a dark place, the dungeon of life. Until Anzel became stable and stopped the relapses, he lived in the wilderness. When he took control of his mental illness and stopped the frequent relapses, he moved into level three, recovery. At this level, he was more in control of his treatment and his life.

“At this point, the bipolar moved from being the center of my life to a box off to the side of my life.”

His illness was no longer the driving force in his existence. In level four, he described mental health as the focus. Here, mental illness exists, but is not active and other people do not know it exists in his life. He said living was normal here, and a mental illness was managed like any other illness.

Summary

Anzel, through the caring and facilitation of many helpers and his strength of faith reached some peace of mind and a strong position in his recovery. His advice to those who want to facilitate the recovery of others included: 1) know the science behind recovery, 2) listen to the people you want to help, 3) understand the trauma of having a diagnosis of mental illness and communicate that understanding, 4) give direction and information, 5) avoid lectures, 6) empower caring families to have some authority before consumers are able to enter recovery and 7) focus on building trust and consistent medication early in the process.

Recovery was a model that Anzel had learned about a year ago in a consumer advocacy agency. Even though he learned a lot of the concepts of recovery in his 19 years of experience with bipolar disorder, he had never pulled them all together and determined what his journey meant to him, until last year. His road to recovery took a new direction with Anzel at the helm.
and his angels and God at his back. His diagnosis no longer defined him or determined the direction of his life.

“Bipolar disorder can not stop God or my spirit and intuition from guiding me through life. Mental illness has to stay where it belongs. There is a place for us beyond mental illness. There is place of beauty, where we become creative, we write poetry, we begin to write books, we begin to start support groups. Do you see what is happening with the recovery movement? Recovery, I never saw that word when I was first sick. The word recovery was not in my vocabulary, now I see it everywhere! People are coming out. People are blossoming.”
CHAPTER VIII. CARLOS

“My doctor cares, has a lot of insight and he believes in what he is doing. He helped me right away because he listened and gave me feedback. He gives me hope.”

(Carlos)

Introduction

Carlos is a 49-year-old single man with a diagnosis of schizophrenia. He scored 106 on the MHRM and is in the advanced stage of recovery. He is Caucasian and has a Bachelor of Arts degree in education. He is in his third year of working on his master’s degree in social work. He has a great jest for life and has a creative side as well. He paints, draws and writes poetry.

When I contacted Carlos to participate in the study he expressed that he was committed to recovery and wanted to do what he could to develop knowledge about the process. Also, he loves to talk and taking part in the interviews gave him an opportunity to reflect on progress he has made in his recovery journey. We clicked right away and he opened up quickly.

Experiences

Carlos was diagnosed with schizophrenia in his early twenties.

“I think I have the illness beat and I’m fine, but then boom things happened.

My mood goes down; I lose spontaneity, and feel like I just want to give up,
don’t feel like I have recovered and I get bummed out about that.”

He described that he took medications and was mostly in remission, but he still had mood shifts and difficulties with social skills.

The structures behind Carlos’ experience of partnerships that facilitated his recovery from schizophrenia began to develop in his family of origin with values he incorporated from his parents. His perception was that they focused on analyzing problems to the extent that they denied feelings experienced by family members. So, as a college student, when he started having
confused thoughts, anger and fears, his mother tried to intellectually reach an understanding with him about what was happening. No one considered that Carlos was having early signs of mental illness, so he attempted to get relief from his painful thoughts and feelings through drugs, art and withdrawing from others.

Other structures that led to Carlos’ experience of helpers along his recovery journey began to develop when he left home. As he was exposed to new approaches to understanding and coping with his emotional pain, he started learning to take risks by expressing and experimenting with his feelings. While in college, Carlos experienced periods of intense anger, confusion, fears and social anxiety that eventually caused him to leave school. Carlos perceived that his first major helper in his recovery was his college professor, several years before he knew about his diagnosis. He said the professor was a wonderful person and role model to him at a time when he had a lot of emotional turmoil. The professor made Carlos feel valued.

“He taught me to be passionate and to deal more maturely with feelings like anger.”

Descriptors of his college professor included: genuine, natural, energetic, passionate and well spoken. Carlos, felt calmed by him and challenged to be his best at the same time.

“I decided I wanted to face my fears and not run away from them. He gave me the courage to be objective about my fears, to try to understand them, to try to work them through without giving up or whining and blaming others.”

Carlos experienced that his professor helped him become an empowered individual. Also, the professor taught him a self-development strategy by role modeling, and Carlos used it throughout his recovery. The concept of an impeccable act, quoted by Carlos from writings of C. Castaneda, consisted of making a decision and following it through to completion to the best of one’s ability.
“I wanted to be like him, objective not making value judgments, experiencing and exploring life as it was meant to be. My professor wanted to see me grow, and I wanted to please him. And like him I wanted to be a warrior doing impeccable acts to be a better person, growing and getting person power from completing impeccable acts.”

Finally, Carlos perceived that his professor had a lot to do with him setting education goals and becoming a successful social worker, later in his recovery. Through out the years, he set a goal for a two year degree, then a 4 year degree and later a Master’s degree. Even though Carlos saw the professor infrequently, after leaving collage, they kept contact and he had a profound positive impact on Carlos’ personal and professional development.

As his anxiety and fears worsened, he saw a psychiatric resident who prescribed medications. Carlos decided not to take the medications because of side effects and stigma. Instead, he medicated himself with marijuana, saying it made him feel better and expanded his thinking ability. He went back to living with his parents after leaving college and worked at odd jobs for a few years.

Living with his parents worked for a while, but eventually deteriorated. When his symptoms of anger and social anxiety continued to get worse, he had continual arguments with his parents, so they asked him to leave their home. From there, Carlos decided to go to New York City to see if he could make a go of his artistic talents. He believed he was a disturbed artist and thought he might become famous like Van Gogh. Also, he was excited about being on his own and had saved some money to live independently for a while.

In New York City, he took art classes and got lost in art galleries and movie theaters. Carlos was withdrawn, using marijuana daily and essentially isolated from all human contact. He
became psychotic, believing he was kidnapped and tortured after seeing a disturbing film about the atrocities of World War II. At that time, his brother, who lived in New York, took him home.

Carlos was hospitalized for six weeks and was diagnosed with schizophrenia. He saw the same doctor he had seen a few years earlier and continued treatment with him for over 25 years. The doctor started him on antipsychotic medication and Carlos reported that his psychotic symptoms stabilized right away. However, he continued to have negative symptoms of flattened affect, low energy, sleeping 12-16 hours per day and low tolerance for stimulation.

When Carlos learned his diagnosis he was greatly relieved. Up until this point, he did not understand what was causing his symptoms, and now he knew. He was reassured to know his diagnosis and that there was treatment for his illness. He began to understand what was wrong with him, and started researching schizophrenia.

“I was not bothered by the label. I saw it as a badge of experience and courage.”

Another key helping partner was Carlos’ psychiatrist. He trusted the doctor right away due to his caring, respectful manner and continued to be treated by him up to the present.

“We clicked right away. I learned a lot from him and wanted to be like him. He listened to me, gave me feedback, and I respected him.”

Carlos felt the doctor was a dedicated professional who believed in treating consumers with a diagnosis of severe mental illness. They connected early in the relationship and Carlos received support and guidance from him ever since that time.

Carlos started his recovery process when he learned his diagnosis. He stayed in treatment and took his medications, thereby managing his psychotic thinking. Even though he had a long way to go in his recovery, he stayed out of the hospital and slowly healed. He went back to live
with his parents after his hospitalization, but started to make his own decisions as his self-esteem improved.

He always believed his mother cared about him and tried to help him recover when she understood what was happening with him. After his hospitalization, she facilitated his connection to psychosocial rehabilitation at the local mental health center (MHC). Even before they knew he had a diagnosis of schizophrenia, his mother would talk with him for hours, to try to help him figure out what was happening to him.

“She was always supportive in trying to help me to figure things out and what was wrong with me. We never considered mental illness as part of the problem.”

Later, she educated herself about mental illness and started a consumer advocacy organization. So, she continued to be a partner in Carlos’ recovery, and created a structure for many consumers and families to receive support.

His parents provided Carlos with a safe home, made him feel a sense of belonging and loved him even though they did not understand him. He expressed that they helped him by caring about him and welcoming him back home after he was discharged from the psychiatric hospital. Carlos had more conflict in his relationship with his father than with his mother because his father was authoritative and often tried to tell him what to do. But, as Carlos matured in his recovery they repaired the relationship.

At the MHC, Carlos made his first group of friends. His peers were a great source of support and he could call them when he felt lonely or stressed out. He restarted his daily use of marijuana with them and thought this was helpful in coping with his low moods and boredom.
He felt that his peers understood what was happening to him and he understood their struggles, and helped them as much as they helped him to recover.

For many years, Carlos chose to smoke marijuana, believing it eased some of his emotional pain and facilitated the development of his creativity and spirituality.

“I was so miserable, but the pot eased the pain and got me into a creative dimension along with other spiritual dimensions that I felt were helpful in my recovery.”

One of his case managers at the mental health center was identified by Carlos as a significant partner in his early recovery. He was described as very supportive. Also, the case manager made the connection for him with a parapsychology group that was to provide him with great encouragement in understanding his feelings and increasing his self-esteem. In addition, Carlos experienced him as a genuine person with good communication skills and a sense of humor.

“He was a good guy who wanted to help me and he did. I realized he was helping me when I started to respect him and look up to him. He encouraged me to seek independent housing and to go back to school, and was able to instill hope in me, so I could accomplish these important goals in my healing process.”

Finally, he encouraged Carlos to do the best he could and to have some fun doing it. The case manager was only a couple of years older than him, so his easygoing manner helped Carlos to loosen up and approach working on his goals with less anxiety.

His case manager referred Carlos to a parapsychology group, when he learned that Carlos was interested in “new age” ideas. He joined the group and attended for years. He was welcomed
and he loved it. For 15 years, he experienced that the group facilitator had a great positive influence on his recovery. She was a psychic and he felt she was imaginative, intelligent and verbal. She made him feel special and gave him her undivided attention. Carlos stated he idealized her, as well as his professor, doctor and mother. Her classes and groups provided him structure and growth experiences, during his early recovery, when he had a lot of trouble getting motivated to do anything.

“I was fascinated with what I was learning from her and she gave me hope, inspiration and encouragement which were very useful to my personal development and self-esteem.”

When he first started attending the parapsychology group, he felt emotionally numb. Carlos described that he never learned to identify and deal with his emotions in his family because feelings were ignored there and everything was analyzed and intellectualized. In the group, he was taught how to recognize his feelings and encouraged to express them.

God was another life long partner, helping Carlos negotiate his recovery.

“God has an important role in my recovery, along with the parapsychology classes that helped me get in touch with my spirituality. I have a clear idea of what God is and isn’t.

I think he’s all compassionate and loving."

Carlos claimed that Jesus and Buddha were two of his most important role models. He found inspiration and hopes in how they lived their lives by being constructive, productive and building character. He believed that God wants us to grow and to serve others, thereby developing spiritual strength. His spirituality inspired him to help others and live a quality life that has been
important to his self-esteem. Also, through his spiritual development Carlos figured out a paradigm of reality, heaven and hell that made him feel safe and hopeful in his life.

Two years ago, Carlos took another big step in his recovery. He decided to stop smoking marijuana because he figured out it wasn’t normal and it was inhibiting his personal growth. He started graduate school in social work, and realized he wanted to be a role model to his clients, and that using “pot” every day was not conducive with his professional career. His psychiatrist helped Carlos get into a drug rehabilitation program. During his tenure with the outpatient rehabilitation, Carlos was referred to Alcoholics and Narcotics Anonymous. These support groups taught him how to recognize triggers of his drug use and avoid relapse. Also, the groups were a constant source of support early in his drug rehabilitation. Carlos had a home group and sponsor. They provided education, emotional support and recovery stories, whenever he needed inspiration.

In addition to Carlos’ helping partnerships, art had an important role in Carlos’ recovery until just a couple of years ago when he entered graduate school. He learned to get into the flow of coming up with an idea or feeling and seeing how it looked on paper or canvass. He was able to lose track of time and his emotional pain and get totally absorbed in his art. Also, it provided a form of expression that in early recovery he was not able to express verbally. He studied art in New York City with the hopes that he had the talent to be a moneymaking, famous artist. Even though he did not have this level of talent, his art was a great ally in his fight against his mental illness.

“The good thing with art was that it was an effective meditation technique. It helped me to learn to gaze and understand the importance of gazing that stopped my internal chatter.”
So, he was able to slow his racing thoughts and alleviate his anxiety while focusing on an art project.

In high school, Carlos started his fascination with art and continued it until the last two years. His high school art teacher encouraged his work, but mostly he encouraged himself to create and try different techniques. His early art reflected his confusion and dark moods, telling about his emotional suffering. After being in recovery for a few years, the colors reflecting his moods became softer and they reflected more hopeful themes.

Drawing was a release of energy, tension and feeling for Carlos. It was work done privately, and he felt the beautiful experience of creating a piece of art as the payoff for his efforts. He was high on marijuana when he drew and said it relaxed him enough to get into the flow of the art and avoid worrying about the end product. He used his art to understand and to tell a story about him. As he built confidence, he began to show his work to friends and brought pieces to mental health programs. Sometimes he sold pieces of his work, and often received positive feedback.

Carlos used colors to express moods and shapes to define structure and set boundaries in his work. He loved creating his art and experimented with it, using many techniques. He found it stimulating and was very excited to find out what he would create. His art was very meaningful to him, and he would become so absorbed in his work that he would lose track of time. Sometimes he had no specific idea or feeling in mind when he started a piece, but would project his inner self on the canvass. He called this technique, subliminal drawing. Then, upon completion he would interpret the work and it became a narrative piece that told a story.

Some of Carlos’ art took the place of relating to others. Before he started recovery, he would paint to prove that he was a person.
“In New York City I had no friends, socially I couldn’t relate to people and I was in a big city and I was anonymous and wanted to be somebody. To be a separate individual and I couldn’t really do it at that time except through art and this allowed me to feel like I was somebody.”

*The Mentor* was a self-portrait showing a mentor talking with him. Carlos was depicted sitting in a shell, a glass onion or bubble, which he saw as the shape of his soul. The protective shell represented the challenges he was going to have to go through to come out of his confusion and dark emotions over the next 20 years. The soft cool colors that he said were nurturing colors represented the help he was going to need to recover from his mental illness.

In one of Carlos’ pieces that were discussed in the study, he painted himself sleeping in his bedroom dreaming of an expansive landscape and sky. He said he got a lot of relaxation and peace from sleep because it was a good escape for him.

“This piece is very peaceful and it makes a lot of sense to me because that was some of the only peace I got, when I was sleeping because I was often miserable being awake.”

He stated the orange, a warm color, was balanced with soft cool colors and shows that he was integrating his feelings of anxiety and thoughts to achieve a peaceful state.

“My work is all about projection and what’s in my subconscious. As I interpret these paintings it will become clear that they are based on my inner self and what I am thinking and feeling. That will be a common theme.”

Helpers whom instilled hope in Carlos inspired him in his art. According to Carlos, they taught him to believe that he had value and promise for a successful future. His professor and
parapsychology facilitator instructed him to get into the flow of whatever he decided to do and this skill worked to his advantage in creating artwork. Even though he was primarily self-motivated to pursue his artistic talents, his partners in recovery gave him encouragement to challenge himself to take on meaningful activities, and so he chose to do this through art.

Recovery was described by Carlos as a long war and a serious process that never ends. Even after he stabilized his symptoms of psychosis he experienced many symptoms that made moving on with his life difficult.

“I slept 16 hours a day, had no energy. I just wanted to die. I wasn’t suicidal, but in early recovery, I couldn’t see the light at the end of the tunnel.”

Over time he gradually got better by working with counselors and peers at psycho social rehabilitation, volunteer work and staying on his prescribed medications. Later in his recovery, Carlos stated that he still had to pick himself up, when his illness emotionally knocks him down. Sometimes when he cannot get up by himself, he had to ask for help.

“Sometimes my ego gets me in trouble and I think I can do this alone, and then I get knocked down and need to ask for help.”

Summary

The advice that Carlos offered to helpers trying to facilitate recovery for consumers with a diagnosis of mental illness was qualified, according to the stage the consumers were in at the time. He believed everybody was in a different stage and had different needs. For example, in the beginning stage, soothing communication, encouragement and instilling hope were priorities. In graduate school, he found that instilling hope was an important aspect of his recovery. In later
stages, encouragement and challenging growth were described as important to help the consumer to move forward. A key element of helping behavior was identified as listening and making sure the helper understands what the consumer is saying. Finally, helpers have to show respect and really care about the consumers.

He clarified that the helper can identify consumers’ stages by observing their behavior as well as talking with them and listening carefully. When consumers reject help, he added that it is important to stay connected to them, be polite and show them respect.

“Sometimes out of the blue they might come up

and ask a question, show interest about something

or show curiosity and it is really cool and I respond

and give them encouragement.”

Carlos added that finding a common ground for communication and establishing a connection was essential to begin a helping partnership from his own experience and that of working with consumers as a social worker.

It was made clear by Carlos’ account, that he used his talents and sensitivity to understand his mental illness and craft his recovery process. In addition, his strong caring nature enabled him to help others to enter recovery, thereby moving him forward as well. Even though Carlos struggled to connect with others socially, he was able to use his creativity to capture his thoughts and feelings, learn from them and communicate with others through images. With these character strengths and the continuity of his helping partners in recovery, over time he moved forward through the darkness of his illness into the light of his life beyond schizophrenia.
CHAPTER IX. JAMES

“Different people come in and out of your life, depending on how you are doing, circumstances at the time of what you are doing. These relationships do help. They don’t want to see you going bad, they’re there for a reason, that’s to help you along the process of getting well, and they will do anything within reason to help you.”

(James)

Introduction

James at 25 is the youngest participant in this study. He has a diagnosis of schizophrenia and scored 83, which put him in the upper middle stage of recovery. He is African American and has a high school education. When he was diagnosed he was in his third year of college working towards a degree in economics.

He was happy to participate in the study, and relaxed into the interviews after about 30 minutes. He appeared shy and was articulate with a lot of wisdom about himself and recovery in spite of his young age. We connected well and he thought that I captured all the important information about his helping partners.

Experiences

James, a single man, was diagnosed with schizophrenia at age 22. His experience of receiving this diagnosis was difficult; feeling like people saw him differently.

“It’s pretty rough having that diagnosis. People look at you different and they figure you are slow or something’s wrong with you but, you’re just normal except for having a mental illness.”

He believed people did not realize that just like with physical illnesses, he went to a doctor and was given medication. At 25 he perceived he was normal, except for his diagnosis of schizophrenia.
His keen intellect and drive to be in charge of his destiny, along with a gentle nature were character traits that combined with his helping relationships worked to facilitate James’ recovery. When he initially experienced symptoms of schizophrenia, his character strengths drove him away from helping resources, but he soon learned he had a serious illness. Henceforth, he connected with his partners in recovery with the same intensity that he had when he was running from them.

James was in college, when his illness started to occur, majoring in economics. He had started studying in a 2-year community college and moved on to a large university for his 4-year degree with “wonderful grades.” James was working very hard, having several part time jobs and carrying a full schedule of classes. He reported experiencing a lot of stress at this time. His first sign that something was wrong was his inability to concentrate on his studies. He started becoming preoccupied with the Bible and books about religion, and stopped going to classes. Soon thereafter, James left college and went to live with his aunt.

After leaving college James started hearing voices leading to confusion and later to laughter that other people could not understand. He knew he had a problem because other people couldn’t hear these voices. The voices made fun of people and when James laughed those around him knew something was wrong. At first, he tried coping with the voices by ignoring them, but this strategy did not work and he would break into laughter.

His mother believed James had a mental illness and took him to a hospital for a psychiatric evaluation. She was a social worker and recognized symptoms of mental illness in his behaviors. Also, James’ father had a diagnosis of schizophrenia, so she was concerned about James’ state of mind and wanted to get him help right away. After James’ evaluation, he was offered treatment at the hospital, but he refused, believing that there was nothing wrong with him
that he could not deal with himself. He perceived that his mother was “butting in” his life, by encouraging him to take psychotropic medications. James felt she was not listening to him and that she was wrong about him having a mental illness.

Leaving town and his family was an attempt by James, to be independent and to get control of his life. However, his grip on reality continued to loosen and he started believing that the television actors were talking to him and subsequently he experienced feelings of paranoia and fear. His confusion increased and he started having arguments with others because he was out of touch with what was happening around him.

At a store he was arrested because of an argument with the clerk, who did not believe that James was going to pay for his purchases. James had every intention of paying for them, but was wandering around the store confused and paranoid. In the confrontation, the clerk shoved James and he shoved back. The police took him to jail, and James told them he was hearing voices and needed to go to a hospital.

His hospitalization was 3 months in duration, and the doctors wanted him on medication for psychosis. At first, James was reluctant to take medication because he thought the voices might go away with other treatment. However, the voices did not go away without the medicine, so James was put on antipsychotic medication. Later in the hospitalization, he stopped taking the medication and he was put on the injection form of his antipsychotic drug.

“I needed the medication and they were afraid I wouldn’t take it, so they put me on the shots. I realized it worked better when I took it.”

Being a quick learner, he began to see that the injections were successfully treating his psychosis. He started researching schizophrenia. Soon he could see himself in the descriptions because he had many of the symptoms of this mental illness. He researched the medication and
how it worked in his brain and discovered the doctors were trying to help him rather than control him. So, seeing other people in the hospital who looked normal to him, except they were taking medications for mental illness, feeling the positive impact of the medication on his symptoms and learning about schizophrenia and its treatments lead him to believe that he needed the treatment that was being prescribed.

“I found out what’s a psychotic episode, how long it lasts, the symptoms and I fit a lot of them like a glove. The paranoia and the laughter, and I guess it is being educated about it, because if I didn’t understand it, I probably would still think nothing was wrong with me. It had to get bad, like it did.”

James stopped believing that his mother was butting into his life by trying to get him into treatment. He realized after his symptoms worsened and he was arrested that she was right about wanting him in treatment.

“I didn’t see her as butting in anymore, because if I listened to her I would have avoided a lot of trouble. I was bullheaded at the time and didn’t pay attention, but she was right. I had to face up to myself and see that the voices were part of an illness.”

James identified his mother as his first helping partner in the process of healing from schizophrenia. She recognized that he had emotional problems and tried to get him into treatment. He refused the treatment that was offered after being evaluated at a local hospital, but she continued to stay connected to him and offered support. He perceived her as a loving, caring mother who always stayed in contact with him. After his mother and father divorced, she supported him, his brother and sister by working two jobs. Also, she went to college at this time.
She provided emotional and financial support as she could and talked with him, his doctor and case manager on a regular basis.

“She lets me know that she still loves me and that I’ll make it through this illness, that it’s just a matter of time. She encourages me to stay on medication. She comforts me and treats me like I am still her son.”

At the beginning of recovery, James said his family was most helpful. The doctors were important, too, but they only knew what James told them. He said it was important to have his family communicate with the doctors so they had the whole story about his symptoms.

A local mental health agency provided James with services after his discharge from the hospital. His case manager helped James find an apartment and got him connected to psychiatric appointments and structured activities in the community. He was placed on oral medications while in outpatient treatment. James did well for a while, and then stopped taking his medications. He lost his apartment because he stopped paying rent and then told his doctor and case manager what happened. They recommended that he go on medication injections because the medication worked best when he took it consistently. He agreed and avoided rehospitalization.

Through several cycles of stopping his medications for psychosis, James learned that he wasn’t going to be able to speed through recovery from schizophrenia. He felt like he needed to hurry up and deal with his mental illness, so he could get back to his education and the rest of his life.

“I didn’t know recovery was a lifelong process at the time. I didn’t have a lot of the information at the time, but I just
felt like I had to hurry up and finish it. That’s why I stopped
taking my medication, I wanted to be done with it and I thought
I was getting better. Then I learned the voices and paranoia come
back without it. I learned that the medications allow me to feel
better because it corrects my brain chemistry.”

At this time, James with the support of his doctor and case manager recognized that he
needed a more structured, supportive living situation. He wanted to live in his own apartment,
but when he became psychotic again because he wasn’t taking his medications, he developed
insight that he was pushing his independence, too fast.

“I’m working toward my independence. I would like to be back on my
own, but I wasn’t taking my meds at the time, so the group home
worked out for me because they remind me to take my meds every day.”

His first case manager at the mental health agency was another key partner that James
said facilitated his recovery. He had about a 2-year relationship with her, when he started
receiving services at the mental health agency. She assisted him by providing transportation to
appointments, purchasing clothing and looking for a place to live. She was there if he needed to
ask questions or needed help with any of his financial business. James described her as nice,
friendly, gentle, and prompt. He said she was always smiling and that she had a sweet character.

“She always had time for me if I needed anything.
She was always there and I never realized she had
a huge caseload like I found out later.”
James realized she listened to him, because she gave him feedback and wrote down some of the things he said. A lot of times he stated she repeated the things he said to make sure she understood. Also, she gave him information about housing, so he could find a place to live.

In addition, his case manager worked with him to acquire funds through the Department of Social Services.

“I was on welfare for a while and it was really rough! I didn’t think I would ever go there. I didn’t deal with being on welfare well. This was around the time I stopped my medications. I was just trying to run away from the problem and not facing it head on. I wanted to stop taking the medicine get back to school and get working again.”

Even though his second case manager was different than his first one, James said she had an important role in his progress. He saw her about a year and described her as prompt, tenacious, consistent and caring. James claimed that she dependably asks the same questions about his group home, how he’s doing and about financial issues. Unlike his doctor, her inquiries were business related as opposed to more personal concerns.

Also, he described the second case manager as a gentle communicator, who shows concern about his recovery. He stated he could hear and feel the caring in her words. However, he perceived that she spent less time with him than his first case manager did, due to an increased caseload. James realized she was helping him when she called the various programs at the mental health center to get him into groups and worked with him on goals.

When James’ second case manager helped him work toward going back to complete his economics degree he recognized she was an advocate for his goals. Getting beyond his illness and continuing with his dreams was very important to him. He experienced that going back to
school was a true indicator of getting back to his life and beyond mental illness, so when she
backed this goal she made a deep connection to him. He trusted that she was a real advocate of
what he needed and wanted.

Finally, his second case manager worked with him on setting goals to move him forward
in his recovery. Setting and achieving goals was a new way of thinking about his life and
keeping track of what’s important to him.

“Well, I was enthused about achieving goals and she
helped me with that. A lot of my business has been taken
care of and I think I’m a step closer to accomplishing
some things like enrolling in vocational rehabilitation.”

James had the same doctor at the mental health agency, since the beginning of his
outpatient treatment in 2002. He described her as nice, caring, patient, likable and assertive. He
stated that she knows how to communicate and that he feels comfortable talking with her and
telling her what is wrong. Additionally, he experienced her as a very good listener, who paused
to make sure he finished talking before she responded.

“She takes the time to listen in detail and gives me feedback.”

James’ psychiatrist was a patient listener who respected his information about how he
was responding to medications. Also, she wanted to know what was going on in his life beyond
the medications. He realized she was helping him about 6 months into the relationship when she
expressed concern for how James felt he was doing. She wanted to know about his financial and
living situations. He perceived the caring behind her words. Thus, she became an additional
helping partner to James.
“I was happy and kind of filled with joy because I knew I could
talk with her about anything. I felt I could communicate with her
and she would understand. I felt she wanted to stay on my problems.”

With this kind of professional support, James was able to focus on getting better, and
knew he had the helpers he needed to do it. He improved significantly and was able to decrease
his visits with her from several times per week to every other week.

“I’m in a better place in my life because of my communication
with my doctor. I feel that I’m on the road to improvement, to
recovery, taking my medication, having learned how important that is.”

When James stopped taking his medications, she was very patient with him and tried to
understand what happened.

In addition, James recognized God as critical to his healing. He had a lifelong and firm
faith in God and regularly attended church.

“She wakes me up in the morning. He oversees my steps and he
is someone who won’t let me down. With God I am never alone.”

James’ family, particularly his mother, nurtured his faith in God. She transitioned from a social
worker to a minister and took a full time ministry in a church out of the area. James read the
Bible obsessively when he first started having symptoms and other religious books to figure out
what happened to him and why. Later as his symptoms stabilized he read to understand how to
heal. James depended on his faith in God and his spirituality to move him along in recovery, and
they were a major source of comfort and motivation for him in the process.

Spirituality had a great deal to do with James’ healing. He felt God provided extra
support through internal strength and discipline that facilitated his continued efforts to be
mentally and physically fit. He believed that there are three levels of health in a person, spiritual, mental and physical. According to his beliefs, spiritual health makes mental and physical health possible.

James stated he builds his spiritual fitness by going to church regularly. He found companionship with the people at church, who did not know he has a diagnosis of schizophrenia. Also, he experienced strong support from the parishioners in developing his faith. He found that it was refreshing to relate with people who are not focused on mental illness.

In the family, James received a lot of support. However, his father was diagnosed with schizophrenia and they did not really communicate about his illness, until James was diagnosed. He left the home, when James was a child of 8 years of age. James had sporadic contact with him over the years. When James started having symptoms of schizophrenia, his father told him that he had similar experiences.

“He told me once I got older and started going through the same thing
that he had some of the same things happen to him. Now, we talk about
it and it is comforting because he knows what I am going through.”

Coping with his mental illness helped James to get on with his life. He identified services at the mental health agencies as important to his healing: social activities, reading religious books, taking medications and meeting with his doctor and case manager. Also, James stayed physically active in sports, such as basketball and football. He stayed physically fit and in contact with friends through participating in sports.

When James learned and started to accept his diagnosis, he entered the treatment stage of recovery.

“I’m at the stage of treatment where I’m getting treated for my actual
illness and know that they’ll be able to treat me. Treating the symptoms and my diagnosis helps a lot at this stage because without them, the situation would be even worse and I would get worse over time.”

He built relationships with his doctor, case manager, and mental health program facilitators, so he felt comfortable talking with them about his treatment. He relieved a lot of his stress by talking with them about his problems and goals.

Also, he learned a great deal about mental illness in classes at the local mental health agencies. He became familiar with different types of mental illness and learned about his medications as well as how they affect the body and mind.

“Knowledge is power. It gives me the self-awareness about what is happening and what I want to accomplish right now.”

James researched schizophrenia and his medications, so he has information to use in planning his recovery. The more he learned, the more he wanted to learn.

Friends/peers have helped James in his recovery because they can relate to his struggle with schizophrenia. Also, they could relate to him without fear because they understand mental illness. He stated he enjoys playing ball with several other consumers, too.

“Well, I guess you can say that they do have a major role because I’ll view them and see how they are doing. My friends discuss taking medication and I learn from it. They have turned out all right and are doing pretty fine. They still have lives even though they have a mental illness. Watching them helps me out a lot.”

James was inspired by his friends’ recovery and it gave him hope for his healing.
“I wouldn’t be able to face this alone. Having to go through this alone would have been hell. I’d be in jail or somewhere dead, so by me having support groups and hearing that other people have mental illness, it lets me know that it is not rare and I can get better. It really helps to see them grow.”

Advice from James to those who want to help consumers’ recovery from severe mental illness included: being patient, showing them that you care, being clear and teaching consumers about mental illness and the impact of medications on the body and mind.

“Show them that you care about their wellness and well-being and that they get better on the road to recovery. Let them know that they have got to take the medication and give them all the information that’s available.”

Summary

Being patient is key to helping consumers recover from severe mental illness, according to James. With psychosis, depression and mood swings he said that consumers might not be able to understand everything at once. Therefore, teaching as much as a person can take in at one time and then going over it again is important to understanding information.

“I might not understand everything once it is told to me. I might have to experience some of the things myself. Sometimes people do not understand the seriousness of having a mental illness as far as going to the doctor, like when you are physically hurt.”

When James started experiencing symptoms of schizophrenia, his whole life was interrupted. He planned on completing his economic degree and then majoring in law, and found himself unable to concentrate, obsessed with religious books and confused. So, his life as planned stopped and he faced an unfamiliar journey into the mental health system. James’
mother could see he had symptoms of mental illness, but he did not and could not at the time agree with her. Therefore, he got into the psychiatric hospital through the jail system after being arrested.

He had to put his dreams on hold. James’ vision of his life included a law degree, a career in real estate law, a wife and children. He has not forsaken his dreams, but has postponed them.

“I want to go back to school, but I am not ready for a relationship, now. I’m not financially secure, not stable enough, yet. I’d like to be more independent and more on my own before I put myself in a relationship with someone. I want to make sure I can take care of myself and that I won’t go through another psychosis.”

He learned that he had to be really prepared mentally and emotionally to have a good relationship from reading self-help literature, which meant taking care of him before trying to connect intimately with a woman.

James learned a great deal about recovery in the last 3 years.

“Different people come in and out of your life according to how you’re doing, the circumstances at the time and what you’re doing. But it’s up to me to really want to recover, so I won’t relapse and go back into the same old habits or have another psychotic breakdown. It’s up to me if I really want to get well, get better. It is up to the individual, but these relationships do help as far as the people around you. They want to help and don’t want to see me go bad, they are there for a reason, that’s to help me get well and they will do anything within reason to help me.”
There was a strong learning component in James’ recovery. He discovered that learning about his illness and the medications helped to decrease his fears about what was happening to him. He gained knowledge and confidence in his ability to successfully deal with his illness that was a major gain for him.

“It’s a learning experience and there’s something to be gained by going through this illness. I would not choose it or want my children to go through it, but I am going to get through it. I want to thank my mother and the people working with me for helping me get through this.”

Through the learning process and his partners in recovery, James progressed in his recovery quickly. His intelligence and drive to make his dreams come true, in spite of his mental illness, pushed him to use the resources in his family and the mental health system to facilitate his recovery. James’ gentleness made him approachable to his helpers and his insight as well as early progress was inspirational to his helping partners. His experience demonstrated how effective the recovery process could work with a motivated, engaging consumer who has access to knowledgeable helpers.
CHAPTER X. KIM

“Well my family takes care of whoever is sick in the family. My mother was there for me and when she passed away my sisters are always there for me.”

(Kim)

Introduction

Kim is a 56-year-old single woman who lives with her sister. She scored 111 on the MHRM, which puts her in the advanced state of recovery. She is African American and is diagnosed with major depression with psychotic features. She completed high school and took a couple of semesters at a technology college.

When I contacted Kim to take part in the study she was delighted. We made contact quickly. She was excited about the interviews and felt good about helping to learn more about helping partnerships in recovery.

Experiences

At 21, Kim received a diagnosis of major depression with psychotic features.

“I was hearing voices. I felt like I was going to go crazy. My head was real light and I couldn’t concentrate. My mind wasn’t strong enough to just keep the thoughts that I was thinking about and I felt real sleepy, like I wanted to sleep and it just seemed like I was hallucinating, paranoid.”

Kim’s primary partners in facilitating her healing were her family members. At first her mother noticed that she would not get out of bed and became concerned. Two years ago, when her mother died her sisters took on the role of helping her recover from her mental illness. Her family system was a close network of relatives who watched out for each other and they provided the structures that created her group of helping partnerships.
“Well, my family takes care of whoever is sick in the family. My mother and father passed away, but my sister lives nearby and her husband always came for me. When I was admitted in and out of the hospital my sister took care of me. I was hearing voices, depressed and I just had a breakdown of the mind. You know my sister and family are always there for me.”

When Kim was told her diagnosis at the local public psychiatric hospital, she couldn’t believe it, initially.

“Well I accepted the diagnosis, and they gave me some medication. I was on Thorazine and Stelazine and I felt much better, but when the doctor told me I said I couldn’t believe it. He said Kim you have a major depression and you can’t take sounds, and you’re nervous. I just didn’t know what to do. I asked the doctor if he could help me and he said he could get me on some medication that would help me.”

After 5-6 months in the hospital, Kim was discharged and she lived with her parents. Because she felt much better, she stopped taking the medication and soon felt like she did not have enough energy to get out of bed. She was re hospitalized about 3-4 times because she stopped taking the medications and subsequently became depressed and paranoid.

Learning that she became depressed and psychotic when she ceased taking her medications, Kim decided she needed to continue taking them. However, she had problems remembering to take them, so her mother and then her sister kept it and reminded her to take the medication at the prescribed time. While Kim was learning she had to take the medication to stabilize, she stayed at home and was not involved in active treatment.
“I felt better with the medicine, but I wasn’t trying to work or go to group or anything.”

Kim worked hard over the years to stay active, and to get out of bed. Several years into her recovery, she attempted to work 2-3 years in a sheltered workshop. Kim did not earn a lot of money, but enjoyed the work. However, she was informed by social services that she would have to give them the salary she had earned because she could not earn money while on social services benefits. Unfortunately, Kim quit her job since she could not afford to lose her benefits and medical insurance.

Unlike today (Social Security Administration, 2002), there were no incentives to help consumers on disability to get back to work three decades ago. Kim benefited socially, mentally and financially when she was employed. But, she had to choose to work or to be on public financial benefits. She chose to quite her job because she had less income with the job and reduced benefits than she did with no job and public benefits. At the time, the lack of flexibility in human services discouraged employment that facilitated recovery, so Kim left employment and her recovery was interrupted.

Coping mechanisms that Kim used to deal with her symptoms of depression and paranoia included: participating in activities and groups at the local mental health agency, doing chores around the house, visiting with family and walking or riding her exercise bike. Also, Kim expressed that she loved writing and has written lots of letters for her sister. In addition, she said she takes her medication, eats right and makes sure she gets enough sleep.

“I feel like I’m being active and creative. I love to be creative and do things that make me feel good and other people feel good.

I say, well, I’m going to do something. I’m not just going to feel
*fatigue and lay down. I wash dishes, run the sweeper or take a walk.”* 

Her mother was the first person to notice Kim was having mental health problems and took her to the mental health agency in the area for an evaluation. She identified her mother as the most important helping partner she had in facilitating her healing. Kim’s mother assisted her in accepting her diagnosis and consistently taking medications. She patiently helped Kim through multiple hospitalizations and discharges.

Kim described her mother as nice and loving. Her mother was an excellent cook and let her eat what she wanted, unlike her sisters who are concerned about her weight.

*“She always reminded me of my appointments and was concerned when I lay down too much. She was a loving mother. She always took care of my health problems, too. Like one time my eyes went so blurry and I couldn’t see and she right away called an eye doctor. Then, my father took me to see him, and the blurriness went away.”* 

When Kim was feeling very depressed and “dropped a lot of pills” she realized her mother was helping her.

*“I felt so depressed and isolated and I dropped a lot of pills and I fell to the floor in the kitchen. My mother stood there and she said Kim you’re going to be all right. She called the ambulance. I came to and she helped me to get up off the floor. I was trying to stop the depression with the pills and she said I was going to be all right. I never did that again and she was always there for me. She took me to the doctor when I felt so bad that I couldn’t get out of bed.”*
Her mother set rules for her when she was a teen to protect her and Kim felt this was because she loved her. Also, she let Kim move at her own pace with managing her illness and independence.

“When I got older, she said, ‘I’ll get you an apartment and I was shocked. I said, Well, I would love to have an apartment, but I don’t think I am ready for one. In an apartment, you have to pay rent and I am not ready for that.’”

Eventually, Kim was the only one of 10 children left in the family home, so she did not leave.

After Kim’s mother and father died, her sisters who lived in the area divided up her care and support. For example, she lived with one sister, another came to town for all her doctor appointments and a different sister took her shopping. Still another sister, who was a preacher, came from out of town and took her to visit on holidays. Therefore, collectively her sisters have taken over the caretaker role of Kim that her mother fulfilled for over 30 years.

Kim stated that the sister she lived with was pretty good to her.

“She gives me my medicine and makes up my bed. She could be a nurse; she gives me my meds and checks my blood pressure.”

This sister helped Kim watch her weight because of her high blood pressure. She cooked healthy meals and helped Kim stay on track with avoiding junk food. She added that her sister wouldn’t let her eat too much. Her sister lets her know when her feet were swelling and she should not drink any more pop, in addition to buying low calorie foods for her to prevent weight gain. Also, Kim said they talk about things and are able to say they love each other.

“If she didn’t care about me I’d be very big.”
One of her sisters determined that the doctor she was seeing for many years was not helping her. He prescribed medication, sometimes without seeing Kim. So, her sister found a doctor at the local mental health agency and negotiated various psychosocial rehabilitation services for her.

“It was a surprise to me, but I accepted it you know, and I wanted all the different groups and trips available at this agency.”

Another sister became Kim’s financial payee because she was giving some of her money away to her niece. Kim stated that she believed it was time to revisit her payee status because she was more capable of managing it. Also, the finances were a source of conflict between the sisters at times.

Her sisters comprised Kim’s support system outside of the mental health network. She used to have a lot of friends, but she said that she doesn’t spend time with them anymore preferring to spend time with her family.

“I enjoy talking with them. Sometimes we argue, sometimes we don’t and we just talk and talk.”

Kim expressed feeling that she really has to know and trust people before she could open up with them. Her trust was in her family and her doctor and the trusting bonds were the vehicles for her experience of helping partnerships that facilitated her recovery.

Another important partner in Kim’s recovery was her psychiatrist of ten years. She said that her doctor was sensitive to her needs and made her comfortable.

“She’s very much a part of my recovery. She writes all my prescriptions and we talk about my sister trying to make it to all my appointments.”
I always talk with her about my problems. One time I walked into her
office and I said I’m scared, I’m so frightful. She had some new medicine
on the desk that she was going to prescribe for me."

The psychiatrist was described as very helpful, a good listener, responsive to concerns
and nice. Kim believed that she could talk with her about how she really felt because she trusted
her. Also, the doctor focused on her whole health and educated her about how her medication
affected the body and how the mind affected the body.

“She will take my weight and blood pressure and she’ll tell me how the
mind controls the body. She helps my sisters and me to solve problems.
Like one day when my sister was worried about my money, the doctor
rested my mind about giving the rest of it to my sister. Also, she taught
me to take my medication with food because it upset my stomach sometimes."

Kim and her mother always went to church together. She took Kim to Sunday school and
then to church. God and church were important in her family. Also, her father was a deacon and
her mother sang in the choir. Her parents were dedicated to the church and Kim stated she still
attends church regularly. Since her parents died, Kim claimed that she goes to church with one of
her sisters who lived right across the street. Another sister from out of town went to church with
them when she visited. Kim said the Lord helped her and her sisters, and her faith was an
important part of her life. Also, at times she wondered if God was trying to scare her because she
could get, so frightful. She did not know why God would want to frighten her and thought that
her fear was probably in her mind.
In addition, Kim said the most important thing for her to get better was to stay active, not to lie in bed and to get involved. She added that being creative and sharing ideas was important to her healing.

“**I’ve been pushing myself and working very hard to get out of bed, see the doctor and go to group.**”

Talking with peers in-group brought her some positive feedback that felt good to Kim. She gave some encouragement to peers about being valuable and staying on their meds and received affirming responses from them.

Attending classes and groups at the mental health agency assisted Kim to understand side effects of medications, the nature of mental illness and how activities worked to help her to feel better. In a class about medications, she discovered that a lot of consumers get sleepy from their medicine. Also, she learned about the recovery process, and that she and others can actually lead satisfying lives with a mental illness. Therefore, the mental health agency and its programs were instrumental in facilitating Kim’s knowledge of her illness and treatments. In addition, in the programs she obtained reading resources that helped her understand that mental illness doesn’t have to be the focus of her life.

“**I think what’s important is when people can stand up for themselves do stuff for themselves and not feel like they’re in a wheelchair or on crutches, you can walk for yourself.**”

Before, Kim was diagnosed with a mental illness; she attended a semester of college at a community college. She felt she received an education and when she was diagnosed with major depression she perceived that she lost a lot of her knowledge. She expressed that she was not sure if it was the medications or the illness, but that she could not use her mind as effectively as
she could before her illness. Later in her recovery, she started working with a vocational rehabilitation program. She went through an assessment and job preparation program and would like to get back to work. Kim stated she intended to continue with the job program.

“As I got older, my mind played tricks on me. I was in art class and I really exercised my mind. I think now I’m going to draw this, I’m going to color this you know, I’ll be thinking, but I don’t know and I will lose track of what I was thinking. I’m thinking the medication worked in the past for me, but all these young people like all these new medications. I want to learn about how the mind works and how these new medications work.”

Through Kim’s recovery oriented classes, she started to question what was happening in her mind and how medication impacted her thinking. Subsequently, she became more interested and actively engaged in thinking about her treatment. Also, she started to question her medication, which indicated a movement from a somewhat passive role in her care, letting her sisters and doctor take the lead, to a more active role in planning her future.

**Summary**

Advice that Kim said she would give to people trying to help others recover from mental illness included: talk with them, make the consumer feel comfortable, be gentle and make it clear that you are trying to help.

“Well, I’d try to make them feel comfortable and not to scare them, and I’d refer them to the best doctor that I can think of. I’d say, I’m not trying to scare you, I’m only trying to help you and I think you should keep in mind that you should see your doctor or your psychiatrist,
stay on your meds and continue to get help from your family."

Kim described recovery as moving on with your life in the face of mental illness.

“It’s after you get on with your life. Maybe volunteer, work or go to
church. Stay on your medication. I know we talked about this in-group.

It’s one out of ten or fifteen that do recover. They just have a normal life
back again you know. I think I’m not normal but I’m doing much better.”

People with mental illness can and do change, according to Kim. Some of her peers want to work and do, others are not able to work and don’t worry about it. She saw everyone in a different place in getting better. Also, she believed some peers show their pain and others hide it.

For 34 years Kim made great efforts to deal with her mental illness. Her family and her doctors were her strongest helping partners in the challenge of getting beyond her symptoms to an active, satisfying life. Even though Kim made strides in managing her acute symptoms of major depression with psychosis, she has many challenges to face with her social benefit program in order to get back to work. In addition, she depended on her family to care for her and faces the challenge of moving toward interdependence without losing the invaluable support her sisters collectively provided.

The structures that enabled her helping partnerships to facilitate her recovery were family cohesiveness, recovery oriented treatment and education. The close-knit family had a value of taking care of its own members. When Kim’s parents died it was natural that her sisters would move into the role of caring for her. And the recovery oriented classes and treatment taught Kim about new medications how they work and how to advocate for herself. She began the empowerment process to be an active partner with her sisters and doctor.
CHAPTER XI. MICHAELA

“I think I knew my therapist wanted to help me right away, but I think I really knew when she started visiting me in the hospital. It was above and beyond what anybody else had ever done.”

(Michaela)

Introduction

Michaela is a 56-year-old single woman who is diagnosed with bipolar disorder with psychosis. She scored 81 on the MHRM and therefore is in the lower middle stage of recovery. She is Caucasian and has a master’s degree in education.

Even though Michaela is suffering from physical problems she very much wanted to participate in the study. She is committed to educating professionals and the public about mental illness and saw being part of this study as a way to pursue knowledge about what facilitates recovery. We made an excellent connection at the start of the first interview. When I was about to mail out her analysis and description for her feedback she told me she was going to be hospitalized for a course of ECT. She wanted me to mail her document to the hospital, so she could give me timely feedback.

Experiences

At about 12 years of age, Michaela experienced difficulty concentrating, anorexia and long periods of non-communicativeness. She was sexually molested by her father before this time, and was being picked on by children at school. Thoughts of her abuse and the stress of the bullying accelerated her symptoms of distress.

“I was a depressed child. I don’t remember being any different from way back then. It started a long time ago…”

She left school for most of a year because she would not talk or respond to anyone.
“I could hear what the principle was saying. I just stared down and I kept turning a quarter I had in my hand until it went through my skin. They decided not to send me to school anymore that year, but I received no therapy.”

Michaela stayed at home and lay in bed watching television. Her grades were good enough that she did not need home schooling. Her abuse continued and one day she approached her father and told him not to molest her anymore.

“I told him, Daddy don’t do it anymore and he cried and didn’t stop crying and then I felt bad because I made him cry. I took everything on myself and I thought that it was so easy to get him to stop that maybe it was my fault he had done it because I made it stop you know.”

The responsibility for the abuse was taken on by Michaela and her shame and guilt was internalized. The depression she experienced while the sexual abuse was happening went under ground for a couple of years. She did not discuss the abuse with anyone for a long time and was able to go back to school the next year. She finished high school with honors, and though she did not have a happy adolescence, Michaela was active in the honor society and band.

Up until age 7, Michaela’s family life was happy. She was the youngest of 5 and called her family the “Brady Bunch.” Then she said her family started deteriorating when her brother had to be institutionalized for epilepsy. Her sister ran away because of physical beatings by her father, and her brothers left the home for the army. So, she was then the only child left at home at about age 9 and stated she became accessible to her father’s abuse.

A bright spot in her family relationships was her connection to her fraternal grandparents, especially her grandmother.
"I loved her more than anybody in the whole world. She was the perfect lady and so special. She was kind and she always loved and protected me. I remember when visiting her at the farm she had this big silver bed and she let me sleep in it, but she always put a high backed chair against the bed, so I wouldn’t fall out."

This was a relationship where she felt unconditionally loved and protected. Thus, Michaela experienced a safe nurturing bond in her family that would be a foundation for being capable of developing trusting relationships later in her life.

In college, Michaela had two to three hospitalizations in a public psychiatric hospital. She was diagnosed with “bad personality” and later with depression. She tried to kill herself with an overdose of aspirin. Her cousin had killed herself with an aspirin overdose, so she knew it could be done. She got scared about dying and walked to a hospital and had her stomach pumped and then was sent to the psychiatric hospital. Even so, she graduated from college early with honors.

"I didn’t really want to die but I got scared and felt so bad."

While in the hospital she had terrible experiences. She was given Thorazine and bug spray to keep the cockroaches out of her bed.

"It was not a happy time. I remember there were not enough chairs for everyone to sit down, roaches everywhere and lying on the floor and drooling because I was so medicated."

She did not accept that she had a mental illness when the hospital doctor told her she had a personality disorder and depression.
Michaela did not accept that she had a mental illness for a long time. She thought it was just something she could overcome. Also, she thought since her diagnosis was bad personality that she could think herself out of it and everything would be better.

After discharge from her first hospitalization, Michaela was expelled from college for drug abuse, the aspirin overdose, until she saw a psychiatrist. She went into outpatient treatment and was acquiescent with medications then and throughout most of her illness.

“I very seldom went off the meds on my own. I was always compliant.

But I always wondered if it wasn’t true that I had a mental illness. Even now I sometimes wonder deep down is this something that I don’t really have. Then, when I look back at my history of...I’ve had almost 50 years of pain and if it wasn’t true what was it?”

It was not surprising that Michaela had doubts about her diagnosis. She was diagnosed with bad personality, drug abuse, major depression, borderline personality and bipolar disorder with psychotic features over a 40-year period. She had a lifelong struggle to trust anyone, including herself. Her mother gave Michaela’s first psychiatrist her private writings about her child abuse without Michaela’s permission.

“It was very difficult. I told the psychiatrist that I had writings at home that might help him understand he and me pulled them out of his briefcase.

I felt so betrayed! It took me years to write again.”

This blew any trust that Michaela started to develop with the doctor.

Her father went to see her psychiatrist and told him about the abuse. When the psychiatrist asked Michaela if the abuse bothered her, she looked at the floor and told him it didn’t bother her. Therefore, because she felt no trust for the doctor she denied that the abuse
was the beginning of her depression and self-abuse, and the psychiatrist did not bring up the
topic of abuse again. So, the betrayal she felt delayed creation of the structures that were needed
to develop a helping partnership with her for a long time.

After graduating from college, she taught for several years and met a man who asked her
to marry him. She discovered that her fiancé was bi-sexual and broke off the engagement.

“I couldn’t handle it. I took all my medications and over the counter
drugs that I could get my hands on and I actually died that night. I
was pronounced dead in the intensive care and my mother was calling
my sister to come to the funeral and the doctors came out and said we
don’t know why but she’s back.”

Thus, once again, Michaela felt betrayed, that time by her fiancé, and she almost succeeded in
killing herself. Subsequently, she had a long psychiatric hospitalization from her near fatal
suicide attempt at 22 years old. During this lengthy hospitalization, she was diagnosed with
major depression.

Later, Michaela developed a long history of self-abuse. She burned and cut herself
repeatedly that led to serious internal injuries and a drop in red blood counts that led to heart
failure. By this time she had seriously distorted thinking and delusions. She imagined that by
hurting herself she could save others from death or pain. She was then diagnosed with bipolar
disorder with psychosis.

Medications helped Michaela to control her delusions and hallucinations.

“I can’t say I am doing really terrifically right now, but I’m not
delusional. I still get depressed, but because of the medication I’m
on I don’t have the psychosis part of it, which is really terrific. I
don’t have the voices anymore and I don’t cut and burn myself anymore.

I don’t see the things I used to see. In fact, I have a video that I made in 
college in one of my photography courses that shows the hallucination 
I used to have. It’s pretty scary. I haven’t had it in a long time because 
of a new antipsychotic medication that I’m taking.”

Michaela stated she significantly started healing about five years ago. Even though she had grown all along in her understanding of her symptoms and medications that brought her some relief, she did not start recovery until a few years ago. Michaela thought she started to heal when she realized that hurting herself was perpetuating the abuse. She believed she was perpetuating what her father had done.

“I was perpetuating the pain and I needed to 
stop that. It was not easy. I still fight it.”

Developing coping mechanisms was difficult for Michaela. She tried to stay involved in the community outside the mental health system as well as inside it. She started a small photography business and made greeting cards using her photographs. She attended group therapy at a local mental health agency and was active on a photography and mental health board. Groups kept her focused on her mental health and the boards kept her focused on the larger community and helping others. She presented speeches to churches, psychology classes and other community groups to teach the public to understand that mental illness is a physical illness like diabetes or asthma. She was committed to decreasing stigma against individuals with a diagnosis of severe mental illness.

Also, Michaela said she has three cats and five fish that helped her cope. The cats were a great source of comfort. They comforted her by being great company and her leash cat went for
daily walks with her. In addition, she took one of her cats to nursing homes to cheer up the residents.

“Before my car broke down, one of my cats that walks
on a lease and I would go to nursing homes and visit
with people. She loved to go and visit.”

Poetry and photography were identified as two major ways Michaela dealt with her mental illness. Her healing process was facilitated by her poetry and photography.

“It’s a way of expressing me. I’m not a great artist as far
as drawing but with photography I can express myself,
my inner self. To me that’s important.”

Balance has been an important coping mechanism for Michaela. She wanted to maximize her benefits from mental health treatment, but wanted to be well anchored in the non-mental health world. Subsequently, she made sure she had a foot in both realities, which was important to her recovery throughout her struggle with mood swings. Also, Michaela made sure she gave back to the community by publishing her stories, writings and lecturing about mental illness. These activities were therapeutic for her and very effective educational opportunities for society.

The first helping partnership that facilitated Michaela’s recovery was with her 7th grade science teacher. She took all the science classes she could from him from junior high through high school. She even decided to be a science teacher because of his role modeling.

“I used to pretend he was my father. When I was in college
and after I attempted suicide, I wrote him a long letter. He
was the first person I told about the abuse. He wrote back to
encourage me and I still call him every few weeks… I don’t
think I would have gone to college without this relationship.””

The year that she was taken out of school the science teacher tried to help her. Michaela was ill, recovering from pneumonia, and she threw up in class.

“I coughed so hard I threw up and I remember he just picked me up in his arms and took me to the nurse’s office. The kids teased me about throwing up for weeks. He tried to understand me and rewarded me in class.”

She described him as a very good teacher, a kind man and a good listener. She knew he listened because he remembered what she said. He encouraged Michaela to do her best, and nominated her to be on the honor society. Also, when he lifted her out of the classroom during her illness, he made a very special connection with her.

“It was a very parenting thing to do. He knew I was embarrassed and got me out of there. I think that’s where I decided I wanted him to be my dad. I was surprised that someone would do that for me. It was comforting because I was scared, I was sick, I was embarrassed.”

Another important partnership that facilitated Michaela getting some relief from depression was with one of her early psychologists. She made a major step forward with her psychologist, when she asked herself where her mother was when her father was abusing her. Michaela was hospitalized at the time. They were talking about her mother and she took in a deep breath and asked the question about where her mother was all the years she was being abused. From then on the psychologist helped her develop some coping abilities and they could talk openly about the whole situation.
She described the psychologist as open and really into listening to anything she said. She was close to Michaela’s age but felt nurtured by her. Also, she was kind and willing to take the time to understand. They had a five-year relationship, and Michaela realized that the psychologist was helping her when she came to the hospital to visit her.

“It was above and beyond what anybody else had ever done.

I was desperate at the time, on a rollercoaster. I was hurting myself all the time. I was so grateful to her. I didn’t know if I could live up to the commitment she was giving me. I wanted to, but I was afraid I couldn’t live up to it. I was astonished that anybody would do that; I didn’t think I was worth it. She gave me a start to feeling better. It was a good start.”

When her psychologist left to start a family, Michaela was despondent. There was no time to transition out of the relationship and she felt horrible. They had a brief opportunity to discuss the termination of their relationship and she got through it. She got through it because she saw herself a survivor.

“I’ve started over more times than anyone I know from scratch.”

Michaela showed amazing resilience throughout her half-century crusade with mental illness. With few trustworthy people in her life and severe symptoms of mental illness, she successfully picked herself up over and over again, when her mood fell due to loss of trust in herself or others. Also, when she lost the few relationships that gave her hope for the future, she got through it and took the risk to open herself to another connection.
An additional relationship that was instrumental in Michaela’s healing was with her current psychologist. She said they have a solid, warm relationship. Also, Michaela saw her therapist as truthful and direct, being brutally honest at times.

“I told her I wanted to go back to school again and she said she did not agree that this was a good idea. It is very hard to explain, but she’s got a handle on it. She’s seen me go through all this many times. I’ve gotten so many degrees and I’m never satisfied with anything. I just keep going and going and going and I am never satisfied who I am or where I’m at.”

Even though Michaela perceived her therapist’s position on her wanting to go back to school as brutal she claimed that she appreciated her truthfulness and believed she was right. She would have to take at least three courses for vocational rehabilitation to pay her tuition. Michaela said she physically could not handle this kind of schedule and would crash. The therapist told her that she earned a masters degree and pointed out that she crashed while doing it. Also, she got her to see that when she tried to be a nurses’ assistant that she could not complete this process. She encourages Michaela to pursue her photography business, adding that she could make this a success right now. Also, because of her seven-year relationship with this therapist and her newer medications, Michaela stated that she has had fewer hospitalizations than since the beginning of her illness. So, she had a successful history with the therapist and thought she probably was right about not returning to college. However, when her psychologist did not support Michaela returning to college, she was angry with her. But, on reflection she realized her therapist was right, and then she was angry with herself for not being satisfied with where she is and who she is, now.
“She agreed to help me learn to be satisfied with myself. It makes me mad that I can’t accept myself. It’s a flaw in me. Sometimes I get very sad and I think I’m physically going to run out of time to finish this.”

According to Michaela, her dream was to meet someone and have a nice relationship. Also, to be comfortable enough with her to make a success of her photography business and establishing a life beyond financially scrambling to meet basic needs. Also, she dreamt of getting out of the social benefit system, having friends and starting a photography group with children who have a diagnosis of mental illness.

A strength that Michaela has always had was her talent for the arts, primarily poetry and photography.

“Lots of times by best work comes in times of crisis, except my photography that expresses the beauties in life, which is kind of new to me. In my poetry, I was trying to get the hurt out of me. When I was in crisis I tried to get the pain and hurt out of my soul.”

An excellent example of her poetry that poignantly expressed her pain was Longings. Michaela wrote this poem after she broke off her engagement. She was living in an inner city apartment and she had the curtains drawn, trying to shut out the world.

“I kept my curtains drawn and the doors shut, but I could hear the children playing outside and that’s what inspired me to write this poem. I loved children. I had taught school.”

Even though she verbalized her pain and loss in this poem the hope that she has always had came through. The children outside her shell connected her to the world and symbolized hope. Also,
Michaela thought that this poem was written to tell her psychologist to be gentle in getting her to
open up about her childhood. She stated this therapist that helped her out of the shell she was
trapped inside. Michaela thought she might have been telling her to be gentle with her life and
mind and not to open her too quickly, so what’s inside the shell would not get torn apart.

When she wrote *Longings*, she felt lost, hopeless and did not see a chance for a normal
life again. She felt lonely and thought she would never realize her longings. But, her love of
children and spark of hope could not be shut out.

“No matter how many blankets I put over the windows, the
children laughing would be there. I kind of filleted my soul
and put it right out there on the sidewalk for someone to see.”

She started writing poetry in college before her attempted suicide. She was going to open
up to the psychiatrist treating her by showing him her poetry and when he took it out of his
briefcase, she was devastated. Thereafter, she did not write for many years, until she was
encouraged in group therapy to start journaling.

A lot of her poetry was written while Michaela was hospitalized. Several years ago she
wrote a book of poems, *Through My Eyes*, and had it published as a teaching tool to increase
public awareness about mental illness and to fight stigma. She described her emotional journey
during a hospitalization and shared it with others.

“That’s what this whole thing is about is how I felt and how I was
made to feel, and then it jumps to the shoot’em up mood. When her
writing and cat pictures were taken away from her in the hospital, she
got very angry and let it out. “I threw water at them and I screamed.”
So, in her book of poems Michaela put her emotional rollercoaster ride out there for all to see. She went from depression to rage, through hallucinations and back to reality. Michaela said that she was integrating her soul and whatever else was inside her shell.

*I wasn’t sure what would be left. Would it be better than it was before? Maybe that was good or would it be worse than it was before or would there be anything left?*

Summary

Advice she would give to those who tried to help consumers recover from severe mental illness included: be honest, listen to where the person is at, be consistent and don’t promise what cannot be delivered.

“Try to be consistent and don’t promise what you can’t give because there is nothing worse than to be committed to and then to lose that commitment. In some of the centers personnel just come and go, come and go and you know and it’s hard for a person who is ill. It’s very, very hard.”

Also, she stated that it is important to look at her or anyone who is mentally ill as a person and not a mental illness. She was not a bipolar; she had a bipolar illness. She did not ask for this disease. She articulated that it is important to try to understand that she has a mental illness and to accept her as a person who is not to blame for having it, just like a person is not to blame for having an illness like asthma.

Michaela described recovery as an ongoing process. She stated that to her recovery is being the best she can be and doing the best she can do. She really believed she had come a long way in her recovery. Micahela was very introspective and crisis oriented, initially.
“Medication and therapy have helped to move me out of myself. Medications have had a big part of getting me out of day-to-day crises. I was able to think more clearly on the medication.”

For her, medication was a key part of the structures that along with therapy with her helping partners facilitated her recovery over time. Also, for her the phases of recovery blended together. Learning and insight helped her to move slowly from one phase to another. Like when she realized her mother enabled her abuse, she could start to move forward in her treatment.

Finally, she recommended that artistic activities and occupational therapies be part of everyone’s recovery, stating that these activities were important to build self-esteem. Also, she felt they were a great form of expression that was necessary to understand mental illness.

“Artistic activities are fun, too. They should be included with cognitive therapies to make the most of treatment.”

Through Michaela’s incredibly long and painful journey through combating mental illness, her creativity, resilience and love of innocent children and animals have kept her alive. She had a few helping partnerships that enabled her to trust and open herself to others, and these provided the structures for her to learn and get some relief from her symptoms. Her recovery has gradually evolved over many years and she used what she experienced and discovered about it to help others on their journeys. Her poetry and photography have been exceptional gifts to those who want to see inside and beyond mental illness.
CHAPTER XII. BETH

“It was the first time anybody ever said it to me. It was not like I was waiting for… well, I have been waiting for someone to do something like tell me how my hallucinations work. And my case manager did.”

(Beth)

Introduction

Beth is a 58-year-old widow and mother of one daughter who has a diagnosis of schizophrenia. She scored 65 on the MHRM and is in the early stage of recovery. She is Caucasian and graduated from high school, having two years of college.

When I contacted her about participating in the study, she said she had the flu and did not feel good enough to take part at that time. She said I could call her in a week or two and agreed at that time to be interviewed. She was very pleasant and tentative about being tape recorded in the meeting. However, she agreed and opened up later in the interview. We had a good connection, and she was never able to really relax due to the tape recorder.

Experiences

Beth was diagnosed with paranoid schizophrenia at 23 years of age. About eight months after the birth of her daughter, Beth experienced a severe depression and her husband took her to see a psychiatrist after several months when she had no relief.

“My mental illness is like living on drugs, really. I’m hallucinating and hearing things. I don’t see things, but I’m hearing things that I know aren’t true, but boy, they certainly seem real to me. The voices say they are going to kill me, and it is terrifying. My life isn’t really my own.”

Initially, Beth felt some relief when she was diagnosed with paranoid schizophrenia.

“Well at first I said to the psychiatrist at least it’s something you know At least I have something that
Before seeing the psychiatrist, Beth was screened at a psychiatric hospital, her diagnosis was made and she was referred to a doctor for treatment. She reported that the psychiatrist gave her pills (Thorazine), which did terrible things to her. She was heavily sedated and sat around like a “zombie.” He talked with her, and blamed her mother for her illness. She did not experience her relationship with him as helpful.

Over three decades ago, her experience with psychiatry was primarily negative. She was given a medication with side effects that made her feel like a zombie and offered psychotherapy. Beth experienced that she could not get any of her questions or concerns addressed in this kind of therapy, and she did not perceive that she got much relief from her illness. Recovery from severe mental illness was not conceptualized at that time. Psychotherapists, influenced by the psychoanalytic movement (Braunstein, 2005), largely practiced with the principle that it was not therapeutic to use a teaching approach or to directly answer questions from patients, because doing so diminished the patient’s self-discovery and growth. Beth felt she did not benefit from psychotherapy and experienced further alienation and paranoia from her doctor.

Because she did not significantly improve, Beth was admitted to a psychiatric hospital for 47 days. There she saw a psychiatrist who she perceived as helpful in dealing with her illness.

“He was a great psychiatrist and dealt with my problems.”

She was able to take care of her husband and daughter after this hospitalization, but was not free of psychotic thinking.

Then, her husband was killed in a car accident a few years later, and Beth had her second admission to a psychiatric hospital for three months. Her parents took care of her daughter while
she was in the hospital. Then, she moved to the town where her parents lived because she needed their support to manage her illness and raise her daughter.

Coping with her hallucinations and delusions was a continual battle because she did not find consistent relief from her symptoms.

“I just keep trying to tell myself that it is just the illness, when I hear voices and have paranoid thoughts. My case manager, who is wonderful, helped me see that it’s all mostly the delusions of my illness.”

Beth said she takes her medication, sees her case manager and doctor regularly and attends therapy groups three times per week.

“I’m getting a little bit better, and sometimes I can tell if it is anxiety, but a lot of times, I still can’t tell if it is anxiety or delusions. It is very scary.”

Sometimes, Beth tried reading about her illness to learn more about it, but mostly she learned from doctors, case managers and peers. When she read about it, she felt worse because she saw it as a terrible illness. So, instead of relieving her stress, learning about her illness on her own increased her anxiety. Also, Beth stated that she had to “veg out” at times to calm her mind. Having no mental focus helped her to calm and slow her thoughts. Beth reported that she lives alone in her home and likes it that way because she doesn’t have to worry about overhearing someone and mistaking their voices for hallucinations. In addition, living alone meant that she was in control of what she does.

“Living alone is a good thing. I can do whatever I want whenever I want.”

Medications helped Beth to manage her symptoms, somewhat. She was on various conventional anti psychotic medications throughout her illness. She learned about some of the
new atypical antipsychotic medications from peers in group, and thought about approaching her doctor for a potential change. However, she had a lot of anxiety about making her symptoms worse or not being able to tolerate a new medicine. She expressed hope and doubts about changing medications.

Beth identified that her case manager had the most important role in her healing process. They had a five-year relationship. She said they were able to talk freely about her mental illness.

“She tells me things that even the psychiatrist has not told me.

She told me when I’m trying to hear the television and the voices start that it is my brain that makes the connection with the TV, and not the TV that is causing the hallucinations. I never thought of it that way and I really connected with that idea. I never knew how voices worked, before.”

Also, she stated that her case manager helped her set goals, like getting a part-time job. Beth claimed that the case manager taught her more about her illness than anyone else. She described her as down to earth, smart and caring. Beth felt that she genuinely wanted to help her and noticed that her case manager always smiled and was happy to see her.

Since she was diagnosed, Beth had a difficult time associating with people, but she connected with her case manager more deeply than with others.

“It’s as deep as I get. I have a very hard time connecting with people, I think. I am very hard to get to know. I just don’t have anything to talk about but the illness and that’s all I think about. My case manager said we’ve got to get you thinking that here’s the illness and there is you. Another thing I learned from her, but I kind of learned on my own is that
all these thoughts that I have is the illness over there, the dirty yucky stuff

and then I’m here, like the girl next door kind of person.”

The connection between Beth and her case manager took a “little while.” When Beth realized she really listened to her concerns, she felt relief.

“I felt the tension just leaving me. I was thinking thank goodness she came into my life. At least I don’t have to deal with psychiatrists who make you figure everything out on your own.”

Because of her case manager, Beth stated she believes she has a better understanding of her mental illness. She stated that she thinks she is a bit better about knowing what’s going on in her head because of her case manager. Beth added that she doesn’t try to keep it a secret from her like the psychiatrists.

Beth’s case manager taught her about hallucinations and delusions. In this relationship, Beth’s understanding of her mental illness grew and she began to see that her illness did not have to define her. For many years, hallucinations and delusions and the thought of them filled her with anxiety and trepidation. Therefore, she never really had any consistent relief from them. So, after 34 years she glimpsed the idea that she could have an identity and life beyond mental illness.

Beth believed she was able to connect with her case manager because she was actively engaged with her. She did not experience this kind of link with other mental health professionals. Her understanding of the timing of this linkage had to do with the case manager’s ability to balance giving information and listening in their relationship. The communication was two ways and made Beth feel safer to open up. Also, she said as well as was heard more in this partnership.
than in any previous relationship. So, the new balance in their relationship was the structure that
allowed their partnership to develop into one that facilitated her recovery.

“It was the first time anybody ever said it to me. It’s not like I have
been waiting and you know... well I’ve been waiting for someone
to do something like explaining how hallucinations happen.”

So, Beth found in her case manager a person who explained her illness and helped her sort out
what she was experiencing and how to deal with it. Also, she shared some of herself in the
relationship, which brought a new dimension to a therapeutic relationship for Beth.

Another significant partner in Beth’s healing process was her therapist of about eight
years. “She was a wonderful therapist and helped me by letting me talk
and we would laugh...I don’t know, she made me feel relaxed when
I was with her. We talked about my crazy thoughts.”

The therapist helped her from the beginning of their relationship, and she retired a year ago.

“She had tiny little sprits of fire. She was tiny and energetic.
She was Finnish like me, so we had a common ground.”

Her therapist helped Beth to feel comfortable and to move forward somewhat in her
recovery. She felt great every time she took a few steps forward, and felt like she wanted to
conquer this illness and get on with it. She just wanted to take her medications, and then be a part
of life. Also, in her treatment with the therapist, Beth had days when she felt good and some
when she felt bad.

“Some days I felt down the pipe and other days I felt
oh gee I do have this illness but I don’t know...”
Beth was unhappy about losing the relationship with her therapist, but was seeing her case manager at the time and had a more open relationship with her. Her understanding about the difference in her relationship with her therapist and case manager had to do with her comfort level with opening up to another person. She stated it might be related to her being further along in her recovery in recent times compared to eight years ago when she started to see the therapist.

“We didn’t open up as much with each other. I mean she was open with me, but I was you know. I wanted to know the answer now, take the medications, that kind of thing. We talked in detail, but not as much as with my case manager.”

The psychiatrist that Beth saw for the last ten years was a positive helping partner in her healing. She said the doctor gives good advice. Beth described her as kind and caring. Even though Beth saw her infrequently, the doctor managed her medications including her in the process. Also, Beth always felt safe to ask her questions about medications and got answers.

Beth was thinking about wanting to try taking a new anti psychotic medication and expressed that her doctor would be open to discussing a switch in medications. In the past when Beth and her doctor discussed medication changes, the doctor said she wanted her to be in a half way house while the changes were made. Beth stated she was reluctant to leave her responsibilities with her mother for that long.

“She wants me to go to the half way house for a minimum of two weeks to switch my medications and I have to take care of my mom and stay in touch with my daughter.”
Also, Beth said that she was afraid to change medications because she had negative experiences with some of them. Some of her initial drugs were sedating and she said she never wants to go back to that experience.

Over the years, Beth learned to test out her invasive thoughts with those she trusts. For example, when she was with her case manager, and she heard voices say,

“I hate you, I don’t want to be here, you’re too fat,”

Beth checked out what she was hearing with her case manager. She asked the case manager if she said these negative remarks and found out of course she did not say them. Additionally, she learned to turn off the television when watching it triggered her hallucinations and paranoid delusions.

Before Beth was diagnosed with paranoid schizophrenia, she attended college and worked as a transcriptionist. She said she would like to have a part time job, but she has not been able to keep a job for more than a month or two. The last work she had was in food service in the kitchen of a nursing home. She helped in the kitchen and served dinner to the residents.

“Every time I get a job, I’m only there for 4 or 5 weeks and then boom, they fire me. The last job that I really enjoyed was in a nursing home. You know I really don’t know why I lost the job.”

Also, a hobby that became an excellent coping mechanism for Beth was crewel embroidery. She identified that crewelwork really relaxed her and helped stop her hallucinations and intrusive thoughts. She started doing crewel in college and continued it. Beth stated that she loved the crewel embroidery. However, she only allowed herself to do it when all her work was
done in the house and then she could sit down and do it for a while; two or three hours. She felt inspired to continue the crewel because of the creative process and the relaxation she experienced.

“For a time it gives me relief from my illness, so that’s why I do it.

I’ve got one for my granddaughter that I’m working on kind of right now. For me it’s like painting you know only with threads.”

Therapy groups with peers helped her to learn about mental illnesses and how medications work in the body.

“The groups help me to get out of the house and you know to be able to talk to other people or listen to how they’re dealing with their illnesses and everything. It helps a lot for me to get out like that.”

Beth stated that she gets help in the groups, but was not been able to help others. She very seldom gave advice in the group; because she believed she was not capable of helping others. She saw what they needed to do to get better, but did not want to give them screwy advice.

In group, Beth was not able to offer support to others. She saw herself as selfish and unable to help others.

“I’m selfish. All I’m worried about is my own illness. I don’t help that many people, I can’t.”

Beth was not able to help others with a diagnosis of mental illness because she has not gotten beyond her symptoms. She used all her energy trying to control her anxiety, hallucinations and delusions. So, she has not had the energy or confidence to offer support to others.
Church had a life long and consistent part in Beth’s life. Her parents took her and her sister and brother to church every Sunday and she continued to attend every week. Beth said that she takes her mother to church every Sunday and then spends the day with her.

“I attend but I’m not active in the church. Being active is volunteering to do things on my own or helping out. Before I got sick I was active in the church, but since my mental illness, I haven’t been active at all. My family doesn’t want the people in church to find out how awful I am. How do you describe mental illness? It would upset me if they knew, too.”

The stigma of mental illness was a heavy burden for Beth over the years. Only two friends and her family outside the mental health system knew she had a diagnosis of mental illness. She expressed that she saw it as a terrible illness and experienced her hallucinations and paranoid thoughts as largely unspeakable. She never spoke to anyone at church about her illness. Even though her friends accepted her in spite of her illness, Beth stated that she didn’t want others to know how confused and disturbed she really was with her hallucinations and delusions.

Her parents helped to take care of Beth’s daughter when she was hospitalized, and they were in close contact with her, after her husband was killed. Her father died about a year ago, and Beth took on a caretaker role with her mother. Beth reported that her relationship with her mother was stressful and contact with her often triggered her hallucinations.

“She doesn’t know it and I don’t want to tell her, but when she yells or is nasty to me she triggers my illness a lot. She’s blind and has a lot of back pain and complains to me a lot.

When she and my sister are together I have chaos in my mind.
I don’t have the mother daughter bond like my sister and she have.”

Her daughter was perceived as a blessing.

“Boy, she’s a sweetheart. I don’t know what I did to have her, but she was really a blessing. She’s an adult now and living in a near by city with her daughter and husband. There are days when I wish she could be here, but she doesn’t want to be any closer than they are, about 45 minutes away. I talk with her about 3-4 times a week and they come to visit.”

Recently, her daughter and family were incorporated into Beth’s delusional system and she expressed being worried about it. Subsequently, she began thinking that perhaps she needed a medication change.

“My daughter started getting upset saying I was calling her everyday for three weeks. Even though I was not calling her everyday, I knew I needed to get myself together again.”

Beth stated that her daughter and granddaughter are very precious to her and she doesn’t want to push them away with her delusions.

Summary

When it came to offering advice to those trying to help other people facilitate recovery from severe mental illness, Beth said she did not know. However, she was able to identify several ways others can help her get better and ways she could help someone else.

“I would just tell them that it is delusional thinking and maybe you have to turn off the television set.
This is what they are telling me to do, turn
off the TV set and get to work.

As far as helping her, Beth wants to be heard and told the truth.

“Just listen to me and give me good advice. Tell me the truth,
that’s really what I want. I want honesty in large doses.”

Describing recovery was difficult for Beth. She would love to go a whole week with
mixed up ideas.

“I don’t think I’ve experienced recovery, yet. I think it is being
free of disturbing thoughts or the ability to make the thoughts gel
in my mind. I think it is making my mind just smooth and easy.

She expressed that she just want to live in the here and now and not the there and then. Beth
stated she believes she is a good person, but that her mental illness keeps her from being the best
person she can be.

However, Beth made some gains in healing from her mental illness. She had several long
term, meaningful therapeutic relationships with her case manager and therapist, learned to
identify what triggered her hallucinations and invasive thoughts and learned to decrease or stop
the stimulus. She was willing to take different medications to treat her psychosis, lived
independently and in the face of severe and persistent mental illness, and had only 3 psychiatric
hospitalizations in 34 years.

Conversely, she expressed feeling like she has not experienced recovery, yet. Beth
articulated the basic concept of recovery several times throughout the research interviews. For
example, she said she can see a life for herself beyond mental illness, but she was not able to get
there. Beth added that she could understand she was separate from her diagnosis of paranoid schizophrenia, but was not able to actualize this understanding in her life.

Participating in this research process took a great deal of courage for Beth. She struggled with the audiotaping that was so difficult, given her feelings of paranoia. She claimed she was never interviewed about her illness and recovery, and hoped that is was helpful information. She expressed that it went OK from her perspective and that she experienced feeling courage and hope, during the interviews.
CHAPTER XIII. DAVID

“The best thing in my recovery is going to groups. I am a big advocate of groups because I don’t think I would be here today, if it wasn’t for some of the things I heard in group therapy and how some of the people got through it.”

(David)

Introduction

David is a 49-year-old single man with a diagnosis of major depression. He scored 60 on the MHRM, which places him in early recovery. He is Caucasian and has a high school education.

When I contacted David for the interviews he was receptive. Because he had so many groups scheduled during the week, we had to negotiate a time that did not conflict with his group meetings. He was polite and a bit guarded when we met face to face, and he relaxed about 15 minutes into the first interview. He told me later that the first meeting seemed a little long, but the second one was OK.

Experiences

At age 35, David was diagnosed with major depression. He was employed after he graduated from high school and worked in a factory at the time he started experiencing symptoms of depression.

“I think I had depression for a long time. It runs in our family.

My mother had it and out of 7 sisters and 3 brothers there was schizophrenia, bipolar and major depression. And there was major depression in my Dad’s family. I think I inherited it.”

David was laid off from his job for almost a year and when he returned to work he began having difficulty concentrating, sweating at work and increasing sleepiness. He couldn’t think very well and had trouble keeping up with his work. He stated he was sleeping all the time,
having night sweats. Also, he was sweating excessively at work and it became impossible for him to do his job.

He ended up losing his job and stated he was a victim of stigma against people with a diagnosis of mental illness. David told his co-workers that he was suffering from depression because he thought they needed to know why he was struggling to keep up with his work. He thought they would be relieved to know what was happening to him; after all he worked there for eight years.

“Certain people would say I really didn’t belong in the workplace. I should stay home and some would say that…they’d say these things loud enough so I could hear them. They’d say this isn’t a mental institution you know he shouldn’t be here. I had one guy I was working with say don’t put your depression on me. I wasn’t even talking with him and he said don’t put your depression on me. See, I had admitted that I had depression whereas I’m not sure that was a good idea.”

Stigma had a role in David losing his job and it had a role in him getting access to treatment, initially. The first professional that he saw was a social worker and David told him he needed to see a psychiatrist. The social worker said he would not recommend him to see a psychiatrist, so he just struggled on with his life trying to cope with his symptoms.

“I went in and told him I thought I needed to see a psychiatrist and he said he didn’t think that I did need to see one, and I just went on until finally the depression just stopped me in my tracks and I couldn’t go any further.”
It was a relief for David when he saw a medical doctor and was told he had a diagnosis of major depression. He did not know what was wrong. He thought he had an incurable disease and was afraid to go to the doctor. David thought perhaps he had cancer and was actually relieved when he was told he had a diagnosis of major depression.

“When the doctor said it was major depression. I was kind of relieved. Then he said he had medication for it and I was kind of relieved there too because you know I knew there was help.”

After he felt better, David stopped taking his anti depressant in about a year. He was back to work and believed he could do without them. Shortly, he relapsed back into depression and he was put on a new anti depressant. Then, about two years later, he stopped taking his medication again.

“I felt so good I didn’t think I needed to take it any more. I went into a deeper depression that I didn’t know anything about. I didn’t think you could do that and I developed psychosis. I was always thinking about dead people and kept thinking that there were graves around me all the time and skeletons and things like that talking to me.”

Following his fifth relapse David was hospitalized again. When he was discharged, he saw a psychiatrist and participated in multiple treatment modalities. Being treated with medication by a medical practitioner was not effective for David, and it took several episodes of major depression, development of psychosis, loss of his long-term employment and five hospitalizations for him and his healthcare providers to identify how severe his mental illness was and what treatment he needed. Stigma and lack of knowledge in the healthcare system contributed to the increasing severity of his illness and the delay in treatment in the mental health
system. David told his medical doctor that he needed to see a psychiatrist and the doctor told him it was up to him to do this. David hesitated because he was fearful that he would be committed to a psychiatric hospital. However, he never was committed. Each time David had a relapse he voluntarily agreed to be hospitalized. David has not relapsed or been hospitalized in 10 years with mental health follow up.

David learned to cope with his diagnosis of major depression by taking his medications as prescribed, instead of adjusting them according to how he felt at any given time. He tried to stay active by walking, riding his bicycle, playing pool, playing cards and attending treatment groups. He had a Monday through Friday group schedule. In addition, he maintained his apartment, visited with his parents and others as much as he could to stay connected to others.

Over the last 10 years, David had numerous case managers that had a major role in his healing process. He saw his first case manager for several years. He was a true partner in facilitating David’s recovery.

“He had a lot of experience with people. He was an advocate for me and pushed me along. He advocated for me to go back to school and to find things to get me motivated. He knew how to do that. He got me to take that first step for that long journey out of depression.”

The first case manager was depicted by David as a big brother who understood mental illness. He came to David’s apartment and talked with him. If he had problems, he called the case manager and he provided guidance and support in solving problems. He had his phone number and could use it at anytime.

Another critical function that his case manager performed was connecting him to resources in David’s recovery process. He helped right away by linking him to financial, medical
and group resources. He assisted David in applying for vocational rehabilitation and college classes and then in finding jobs. Also, he provided transportation to appointments before David was able to drive his own car.

"He was a good communicator and helped me a great deal when I was really down and out. When I could hardly pick up a phone to call people he would dial and I would talk."

In looking closely at when he realized his case manager was helping him, David said that he knew the clinical manager was helping him when he presented things he didn’t think he could do because of the depression in such a way that they looked like good ideas. And he would do them and started feeling better.

"I am less anxious and steadier than I was before meeting him. I think I was able to step out of that circle of safety and take steps forward in getting better because of him."

Subsequently, David had a series of four case managers over the next few years. He reported that they did a lot of the things his first one did. Then, he had another case manager for several years with whom he developed a close bond. He worked with her for about two years and he described her as understanding and informational. David claimed that anything you wanted to know about mental illness she seemed to know what to do or if he got short off medication she would get it for him.

"She was available any time and connected me with the people I needed to see. I felt good that I could depend on her."

David thought the biggest difference between her and his first case manager was that she was less pushy. She took the position that when he was ready they would work together to act. He
stated he believed her approach of letting him move at his own pace was the most appropriate method for him at that time.

David identified group therapy as the most effective type of treatment he received.

“Well, it took a long time for me... I lost all my self-esteem and it took a long time...and stuff from the groups to hear in groups to get that back to even think that I even belonged here on earth. It took a real long time for that and I learned that in group, from the group.”

David had suicidal thoughts during his relapse of depression with psychosis and it took the support of others who had experienced mental illness to guide him back to his life.

Over time, the connection to consumers who had severe mental illness in a facilitated group setting was the structure that led to group being David’s most powerful partner in facilitating his recovery.

“The best thing in my recovery is going to groups. I am a big advocate of groups, because I don’t think I’d be here today if I didn’t hear some of the things that I heard in group therapy and how some of the people got through it. I’d see people who were depressed like I was but they didn’t seem to...they didn’t seem to not want to be here on earth like I did. I just felt like I was hopeless and I felt that I was just a burden on my family and I didn’t belong here and I didn’t hear that from other people in the groups.”

For the last two years, David learned a great deal about mental illness and himself in coping skills groups at his local consumer advocacy organization. His case manager referred him to the group, which was facilitated by case managers. Different topics about mental illness were
discussed. Sometimes the groups of 20-25 consumers were like a class and sometimes they were
discussion oriented. He described the group structure as starting with members giving a report of
their activities for the week and giving a positive report of what they accomplished. Members
could ask for help and or gave feedback to others.

“Group is the main thing that has helped me because you get other
peoples’ ideas, mostly. How they’ve done things and you say ahhh
I’ve done that and I couldn’t deal with it and then they tell you how
they dealt with it and if you didn’t hear that you might be going on
the run in the wrong direction.”

Interacting with and learning from peers who experienced mental illness was a powerful
facilitator of David’s recovery.

“They’ve walked through it. At first I was scared to death
to talk in front of people. I would just sit there and listen
to everybody because I was afraid to talk with anybody.
Then I started to see you know it started to dawn on me
that these people are like me. I don’t have to be afraid plus
they were giving me ideas that I want to hear to survive.”

He described that his self-esteem started to increase whereas before he felt worthless and
hopeless. He heard peers saying that they felt good and enjoyed being in the group and even
though David said he didn’t feel that way he learned that by starting to say he felt good he started
to feel better.

In addition, as David felt safer in the group he started to express himself there.
“I started to feel better because I felt what they felt, but never told
anybody. I always kept it inside. I didn’t think it was something that
you could talk about. And come to find out it’s like this person’s really
saying this and you know it’s true and you can say it and not get in
trouble or nothing bad happens to you.”

While listening to peers in group talk about the new medications, David began to think he
might be on the wrong medication. He decided to talk with his psychiatrist about a change.

“I didn’t know you could do that and I’m hearing these people saying
you know I went to my doctor and we did a medication change and
now I feel better or in some cases I feel worse. Then, I decided to do that.”

David transitioned to a partnership with his doctor when he learned that others had a
collaborative relationship with their doctors. So, David and the psychiatrist talked about it and
decided to change his medications. As a result he felt improved on the new medication.

Finally, he described the vast amount of educational content he was exposed to in-group.
He thought the Wellness Recovery Action Plan (WRAP) was almost like a Bible to mental
illness on how to deal with mental illness. These classes went on in the group for weeks with
written material and homework, and he stated they were instrumental in understanding mental
illness and what to do about it. David identified that his next step in recovery was to become
employed, but that he intended to always find time to attend group because it helped him recover
more than any single person and he learned something everyday.

Spirituality was another significant contributor to David’s healing. He has gotten beyond
feelings of worthlessness and hopelessness, and felt that God put him on earth for a reason. He
believed that he belonged here as much anybody else.
"Spirituality played a big part in my recovery having a higher power to guide me along and to talk to and going to church. I started going back to church, when I started feeling better, and taking the oath of the church made me feel like a better person to help other people."

His belief in God helped him deal with his mental illness. Also, David said his mother prayed for him to recover. She had a serious depression in the past and even though she saw he was in a grave situation she was unable to give him any guidance about getting treatment. He believed she was in denial about his having a mental illness because she hoped he was one family member that would be spared this suffering. In addition, God helped David in his recovery by the feeling of love and forgiving other people and forgiving himself. God helped him find his way back to the church community, which he found to be very important to his recovery.

Also, David felt God in the groups he attended. In Substance Abuse and Mental Illness (SAMI) groups the higher power was often brought up. He attended the SAMI groups because he used marijuana to relieve anxiety much of his life. In the mental health groups he felt the higher power, too.

"Everybody has their own higher power. Mine is God, Jesus and for others it maybe something else. It might be God, the group, a case manager or doctor, but most people have a higher power."

He believed having faith in a higher power helped him and others to have the strength to heal from their mental illness.
Summary

Giving advice to those helping others recover from severe mental illness came pretty easily for David. He helped several people get connected to treatment. He stated that he ran into a man who was agitated, convinced that someone was trying to poison him and that he was being followed. David allied with him and told the man he knew a place where people talk about his kind of problems.

“I didn’t want to scare him off and I knew right away …because my uncle has schizophrenia and I just said they talk about things you’re talking about. I did not tell him they’re professionals, just told him where they were and when they would be there. I told him he probably needed to talk with someone. He went to the mental health agency and I saw him there several times. He waved at me.”

So, David advised that helpers refer those needing assistance without challenging their beliefs. He related that in another instance he called a person’s family doctor to let him know what was happening. He saw the man was agitated carrying a gun and talking about killing people. David could see it whereas other people did not see what was going on with him. He thought this was because through learning about and going through the classes about different mental illnesses and their symptoms, he could see it.

“So instead of him or a bunch of people getting killed or hurt, I felt I had a responsibility to do something. I don’t know the outcome, but I saw him around, and he looked better.”

Learning was identified by David as the key to helping consumers understand their mental illness and the need for medications. Therefore, people who are trying to help others
recover from severe mental illness have to find a way to teach about the illness and the medications. David said he couldn’t overstate the importance of teaching and learning in recovery through enabling helpers to connect with consumers by shedding light on what was happening, why it was occurring and what to do about it. Understanding achieved by learning with helpers was an important structure in the development of a partnership that facilitated recovery, from David’s perspective.

The most important thing for helping David get beyond his mental illness was moving into employment. He expressed some doubt about ever really getting beyond his depression because it is something he has had to deal with every day.

“I have to become employed and have a steady job for people to understand that I’ve gotten over my mental illness.” He added that it was very important for others to know that I have an illness like any other illness and it is not just something I do because I want to. It is an illness that I inherited and is not my fault and I am doing everything I can do to recover. Yeah and they don’t have to be scared of me and they can talk with me just like anyone else.”

David’s description of recovery meant going back to work, getting better, belonging to the community and socializing with other people. He added that living independently, but being interdependent with others was important in recovery. He thought trying to be independent from others could make mental illness worse because he did not believe that people could recover from severe mental illness on their own.

David identified the process of recovery in several stages. The beginning stage was when consumers recognized they had a mental illness and started treatment: medications and therapy.
When consumers go through the treatment stage the middle stage is peer counseling. Being able to be part of the community and being employed was the later stage of recovery according to him. David expressed that he was moving from the middle stage to the last stage, but that he saw the connection with peers as a necessary component of recovery for him throughout this life long process.

David had to struggle to get into the mental health system for treatment of his depression. He met resistance from health care providers who out of lack of knowledge and/or stigma did not believe he needed the psychiatric/mental health level of care. David’s will to live and support from his higher power prevailed and he accessed the services he needed to recover from major depression. He entered a mental health system that had a recovery focus and learned how to understand his illness and how to heal. He had a dream of being employed again and starting his own business. Through the telling of his remarkable journey, David demonstrated he has the drive to realize his vision.
“I realized my doctor was helping me when we talked about what we were going to do about my depression. Not what he was going to do about it. We made decisions together which I thought was refreshing.”

(Harry)

Introduction

Harry is a 50-year-old married father and has a diagnosis of major depression. He scored 49 on the MHRM, the lowest score of the co-researchers, and is in the early stage of recovery. He is Caucasian and has a Bachelor of Arts degree.

I called Harry to set up an appointment for an interview and he agreed to participate. He was on time for the interview and was polite as well as somewhat withdrawn. I did not feel a solid connection with him during the interview. Harry said the experience was good for him and it did not make him anxious. However, the day before our second meeting he cancelled the interview and said he did not want to continue the project.

Experiences

Harry was diagnosed with major depression at age 23 after attempting suicide. A few years later he was diagnosed with bipolar disorder.

“It’s very different from the time I get up in the morning to the time I go to bed. Each day it’s a little different from the day before. Some days are a day of crisis from the beginning to end and some days I just do it pretty smoothly. For instance, Monday was a day of crisis for me. By 10 AM, I was taking anti anxiety drugs because I just couldn’t cope.”

After Harry and his wife lost their jobs, it was an overwhelming time for him. He was trying to start a small business that did not work out, found out his wife was pregnant with their third child and it was Christmas time, so he could not cope.
“A lot of factors came together at the same time. I was thinking I just couldn’t take care of my family anymore and I wasn’t worth anything and I just couldn’t see any reason for going on.”

Then, he overdosed, was unexpectedly discovered by his wife and was hospitalized.

For quite a few years before he overdosed, Harry thought there was something wrong with him. He was not surprised to be diagnosed with major depression because he had thought of killing himself before he acted upon it. He did not find help with recovering from depression early in his treatment.

“When I was at one hospital it was like being on vacation. If you were a good boy you got to go bowling or you got to go to the mall. At other hospitals in the area it was the same. No one wanted to deal with my mental illness. There was no group therapy and no individual therapy. It was ridiculous.”

Medications did not help alleviate his symptoms early in his treatment, either. Just a few weeks later he made another suicide attempt by standing in the road and waiting for a truck to hit him. Harry was rehospitalized and placed in a safe environment, but he did not feel any better. After this hospitalization he saw a psychiatrist and took medications.

“I took up seeing a psychiatrist, but the one I was seeing just kept me fried on medication. I worked as an orderly on a psychiatric unit for a while and I used to stand in front of the mirror and I’d say, who are you. That’s how fried I was.”

The first several hospitalizations that Harry had were not perceived as helpful to him. He did not feel better nor did he make a therapeutic connection with any of the doctors who saw
him. Reportedly, he received no therapy, either. Even the medications he was given were not effective in providing a respite for how badly he felt. Subsequently, his symptoms of depression were not relieved and he continued to be suicidal. Up to this point, the treatment he was offered did not meet his expectations of therapy.

Finally, Harry felt he got a psychiatrist who was able to help him when he was admitted to a hospital near his new home. He attempted suicide again and met the doctor that he saw since then.

“I really started getting relief and really started feeling better when I had my first stay at the new unit. When we moved over here I had another episode and stayed two weeks out here. That’s how I met my current doctor. He and the staff actually worked on my problems. They had group and individual therapy.”

Working with his psychiatrist allowed Harry to stabilize and get on with his life for a long time. Up until several years ago, he worked at a job he loved. He was a sales manager for a food broker and had eight salesmen reporting to him. He was on the road about two nights a week and he had a lot of energy. During this period of time, he saw his psychiatrist for medication follow up and did not see a therapist for three to four years of that 15-year timeframe. Also, he was very active in the community. Harry was on the local school board and sang in his church choir.

“I felt better about myself and in fact was on the school board. The stress of my job did not bother me because I was good at it.”
Then, suddenly Harry relapsed, and was not able to stabilize.

“All at once things just...my mind...wires just started crossing each other. I got two traffic tickets in one day. I had two car accidents. I’d fall asleep at the wheel.”

He just stopped functioning and that was about the time he was diagnosed with bipolar disorder.

Coping with his bipolar disorder was a challenge for Harry.

“I feel like I live from crisis to crisis. Just leaving town to visit my daughter and her husband becomes a crisis. I am most comfortable staying at home, watching TV, eating and sleeping.”

He reported that the medications he took were not working very well. He was not able to work for 6 years and said he received Social Security Disability. Harry stated his doctor thinks he should have a goal of going back to work, but he expressed that he couldn’t imagine working a job the way he feels.

Involvement in his church was identified as an additional way that Harry coped with the stress of life and his mental illness. Sometimes he went to his church to work in the food pantry. He took care of the food pantry at church. Also, he would go out to lunch with his minister. In addition, he said he still went to church every Sunday, but does not sing in the choir any longer.

Harry acknowledged that his psychiatrist of 18 years had the most important role in his healing process. The doctor talked with him and prescribed medications for him. Harry depicted him as quiet, considerate and caring. He strongly believed the doctor made a commitment to him long ago.

“I can tell by the way he talks and looks that he cares about me. Like I said he’s already called the house to see how I’m
doing. Not many doctors do that, obviously. And he always says if you ever need anything just come on up to the office.”

The doctor and Harry hit it off right at the beginning of their relationship. He was quiet and respectful. Also, Harry said he really listened to him and had a dry sense of humor to match his own. He could make Harry laugh. The first time he realized the doctor was helping him was when he discussed what they were going to do about his depression.

“Not what he was going to do about it, but what we were going to do about it? We made decisions together which was refreshing.”

There was two-way communication between Harry and his doctor that made him feel comfortable telling what he really felt.

“If there was a medication I was on and I told him it wasn’t doing any good or I needed more of it or less of it or something like that he would automatically take my feelings into consideration. We could communicate with each other and like I said he took my thoughts and desires into consideration. It seemed like I started getting better from the conversations that we had and the therapy sessions that we had.”

Also, Harry felt greatly relieved that he finally was getting somewhere in his treatment.

“That was the first time that I really felt like I was getting some help for the very first time and that somebody cared. I finally found… a person and hospital that cared. I felt like I had a whole circle of help.”

So, for the first time in his treatment of depression, Harry made a therapeutic connection with his doctor. The two-way communication and respectful nature of their relationship quickly forged into a helping partnership that started his recovery.
Because of his relationship with his doctor Harry stated that he could function a lot better even though right now he feels like he is going through a rough period in his life.

“I can still get up and go to church in the morning and I can still go out to Wal-Mart and shop if I want to and do things. I don’t have to stay isolated if I don’t want to. I can get up like tonight we’re supposed to go out to shop for a couple of gifts for people and I can do that without any problem and go out to eat, socialize. Like yesterday, I called my pastor and made a date to go to lunch with him. I used to hibernate and never initiate anything when I was depressed.”

In addition, Harry identified that his new therapist of three months had a helping role in his recovery. He asked for a therapist change because his former therapist and he went as far as they could go.

“I like him real well. He listens and we can talk about things... we can talk about anything. The new therapist was described as soft spoken, caring and considerate. He’s real talented and we have a good repertoire back and forth with our conversations.”

They work on mutually established goals. Also, they talk about things that Harry feels he has to do that he does not want to do.

“*He helps me have a positive attitude. I know I have to do it but I need to have a positive attitude about doing it and he helps me see that.*”

Also, Harry felt that the therapist was there for him when he needed him. He felt the therapist was helping him from the first time they met. Harry expressed that he believed they
were going to get somewhere. He described the therapist as calm, real quiet and serene. Harry felt a sense of hope with him right away. His mannerisms, listening skills and questions that he asked made Harry feel relaxed and open.

“I think I am on a better road to recovery. He seems to build up my self-esteem and my self-confidence and makes me feel like I can do things that I couldn’t do before.”

The therapist facilitated Harry identifying expectations of him and how he wanted to get through each day. Additionally, they discussed his expectations of what he wants to get out of each day. Therefore, instead of focusing on what he thinks he should be doing and what others expect of him, they started focusing on his expectations. This approach to therapy was somewhat similar to his doctor’s approach as well as including his needs and expectations in the relationship. Hence, the structures that enabled Harry’s helping relationships to facilitate his recovery were inclusive, partner-oriented interpersonal approaches. These approaches motivated Harry, while previously the doctor being in charge and prescribing medications approach increased his resistance to treatment.

At the conclusion of the first interview, Harry said it went good for him. He agreed to the second interview in two weeks. However, several days before the interview, Harry called to say could not make the second interview. He added that he did not think he was benefiting from the research project, so did not want to continue. The researcher called Harry to discuss his termination from the study, but he did not return the contact.

Summary

After the first interview there was no overt sign that Harry was distressed. However, he said that he was going through a “rough time” and in general did not feel good about where he
was in his recovery process. He expressed hope that his doctor and therapist could help him move forward, but felt he was fighting day to day to leave his home and engage in the community. The focus on healing from mental illness was likely uncomfortable for him given that he wasn’t feeling positive about where he was in the process. Of all 10 co-researchers, Harry was the only one that the researcher did not sense a connection with during the first interview. And he was the only co-researcher who did not complete the interview procedure.

Finally, Harry had the lowest score on the Mental Health Recovery Measure. The score indicated that he was in the early stage of recovery and this result was consistent with his perception of where he was in the process after his last relapse. Therefore, living in a day-to-day struggle with his illness and the absence of an interpersonal connection to the researcher most likely had a negative impact on completion of the second interview.
CHAPTER XV: SUMMARY AND CONCLUSIONS

Introduction

The experience of helping partnerships that facilitate recovery is a unique and powerful interpersonal connection. Even though none of the co-researchers had the exact same experience, there are many similarities in their quality, meaning and essence to guide helpers to this special place with individuals that have a diagnosis of severe mental illness. First of all, there is a complexity and essence of these relationships that confounds the mind. But, by carefully mapping them out, the researcher can see what it looks like and how to get there. However, the partnerships are dynamic and what is the essence today will look different tomorrow. It is like trying to hold a particular shade of sunshine in your mind, while the sun keeps moving and its shades are perpetually changing.

Composite Experiences

The participants reach out to a potential helping partner with angst and fear. Their cognition and emotions are distorted by profound mental illnesses. On some level, it may not be conscious; they realize that they need help to deal with these illnesses. It means taking a big risk to reach out for help when they are so vulnerable and no one but the co-researchers know just how great a risk and how much courage it takes to do it, much like Schiller (1994) experienced.

Edinger (2002) described Jung’s theory (1960) about the human mind, including the collective unconscious, which these participants experienced related to their “dark times” in depression and psychosis. All the participants had images of darkness associated with their most difficult experiences of their mental illness. For example, Al felt the dark cloud that did not lift until he took antipsychotic medication, David had images of graves and death, Michaela had hallucinations of ancient people calling her to join them in death and Beth still experiences
hallucinations with dark messages to her about death and her family. Even James, who had humorous hallucinations at first, experienced a shift to the dark side of psychosis that lead to a violent encounter and arrest. According to Jung, these are the universal, primitive images developed from the deepest layer of the unconscious mind. Also, consistent with Jung’s theory, 8 of the 10 co-researchers experienced the archetype of transformation that was associated with their emotional and spiritual growth that developed out of the profound stress of their mental illness. Finally, half of the participants used creative arts to augment their growth and development of their minds, which is consistent with Jung’s theory.

Michaela, after being betrayed by her father, mother, first psychiatrist and fiancé, was incredibly brave to endanger herself by opening up to a psychologist about her mother’s role in her abuse. How can Michaela reaching out in the face of such lack of trust be understood? She tells us she was desperate and on an emotional rollercoaster at this point. So, she needed something to hold onto or someone to trust if she was going to get off the rollercoaster and live. Also, she says she had a wonderful loving grandmother whom she trusted without reservation. Michaela is a quick learner and perhaps she was able to learn that some one can be trusted after all based on the relationship with her grandmother. The human need for connection is very strong, and as Michaela says she died and came back, so she was frantically in need of a lifeline.

From this study the kind of relationships that develop into significant helping partnerships in the recovery process have numerous consistent characteristics. The relationships start out with contact over time and include a caring, knowledgeable helper whose intent is to help the participant. All of the co-researchers can tell when a helper is genuinely concerned and truly listening to them. The helper smiles, which inspires hope, and carefully listens to who the participants are and what they need as well as what they want. There is two-way communication
between them and the participants expect the helper to tell the truth and provide honest information and feedback about their mental illness and behaviors. The co-researchers are exquisitely sensitive individuals and can tell by tone of voice, eye contact and by listening to the helper talk if they are being heard and respected. James says that his doctor respectively waits until he finishes speaking before she responds. Harry says that he knew he was going to have a helping partner with his doctor when the psychiatrist said, “Well what are we going to do about your depression?” No one up until that point had included him in his treatment planning.

Making connections to important resources is characteristic of professional and non-professional helping partnerships. Bree depends on her friend to link her to resources that will help her grow in her recovery. Her friend can often make mental connections for her that she cannot see. Her friend knows her so well that she can sense when the time is right for Bree to see herself in a new way. Also, Carlos’ mother linked him to psychosocial rehabilitation that was a crucial movement forward for him in recovery. This link led to connections with peer friends, a case manager and vocational rehabilitation. In addition, Carlos’ case manager linked him to a parapsychology group that he participated in for 15 years. Similarly, David’s case manager referred him to group therapy that is his most important partner in recovery. It is apparent from these experiences that helping partners are instrumental in creating connections that comprise a complex network of helping relationships and partnerships that facilitate recovery.

Also, partners validate participants as individuals even when they have different opinions about an issue or action. This kind of validation takes faith in the participants and respect for where they are in the process of recovery. Likewise, being able to bond with these participants is contingent on respect for what phase of recovery they are in and consistently staying connected
with them. When Carlos is attempting to form a partnership with his clients and they are not ready to trust him yet, he keeps contact, is polite and respectful. He stated,

“Finding a common ground for communication and establishing a connection is essential to begin a helping partnership.”

Nine of the 10 co-researchers have an awareness of different stages of recovery and believe that they have to be accepted where they are in the process by a helper for there to be a real partnership. The acceptance is linked to staying power and anticipation that the participants are going to move through the process in their time.

Another characteristic of helping partners that is connected to staying power is patience. It is identified as an important component of a helping partnership, because some participants, like James, say that there is a lot to learn about managing mental illness and he knows he can’t learn it all at once. Also, 8 of the 10 co-researchers struggled with medication conformity and were able to get through multiple related relapses because their doctors and families were very patient and always tried to find out what happened, when they stopped taking medications. Similar to the findings of Mueser et al. (2002), the co-researchers in this study identified that incorporating recovery values into mental health care supports medication adherence. But, these participants emphasized the teaching and learning process within the context of multiple helping partnerships that helped them accept their diagnosis and the need for medications as the key to medication adherence. All of the co-researchers are self-powered or starting to be self-powered because of partners that endured the struggle of recovery with them over time.

There is an interactive character of helping partnerships that is related to patience and ongoing connection that work together with the co-researchers readiness to accept help. For some of the participants the connection with the partner is almost instantaneous; the participants
were ready to accept help and the partner with the “right chemistry” was there, so they clicked. With other co-researchers, the potential partner is patient, stays connected to the individual and when a crisis occurs or a perceptual window is opened the participant and partner start working together.

Expectations of professional helper relationships are focused on receiving knowledgeable information about mental illness and treatment that in all cases for these participants includes psychotropic medications. So, the co-researchers validated (Mueser et al. 2002) the concept of evidenced-based practice that includes medications and 8 of 10 claimed medication in combination with therapy work best for the achievement of symptom stability. These relationships develop into partnerships when co-researchers trust that the helper is working with them instead of on them. Mutuality of purpose and respect for each other is an important quality of helping partnerships, which is consistent with Horvath and Luborsky (1993). When a professional helper can be open to learning from the participants as well as presenting information, it is then clear to the participants that a partnership is being forged. Harry says that he knows that his doctor is his partner because he listens carefully to how his medications affect him and to his perception that he needs more, less or a different medication to alleviate his symptoms. Also, connection to necessary resources is another vital function of these partnerships that coincides with Schiller’s (Schiller and Bennett, 1994) experience. All participants need or needed financial, medical, housing, social and vocational rehabilitation links to establish stability in their lives. Case managers are particularly helpful partners with these basic living resources. James was convinced that his second case manager was working with him when she assisted his link to vocational rehabilitation. His next big step is getting back to school and she made a
special connection with him that turned into a true partnership when she took his college goal seriously and acted on it with him, which is consistent with the theories of Anthony et al. (2003).

A significant number of participants (7) developed intense helping partnerships with peer/friends and groups of peers. David feels that his groups are the most valuable component of his recovery. It took him a while to feel safe in the meetings that were facilitated by case managers, but he says that it dawned on him that he did not need to be afraid of the members because they were looking for help, just like him. Peers have a special connection to the co-researchers because they experience mental illness as pointed out by Bentley (2000), Segal et al. (1993) and Rappaport (1985). When group members tell their stories there is a powerful resonance with David, Bree, Al, Anzel, Michaela, James and Carlos. They learn about their illnesses and strategies to stabilize and make their lives richer. Also, David learned about the new medications in the groups and decided he might need a change. David discussed a medication change with his doctor and feels much better on the new ones. He trusted the group, himself and the doctor and transitioned to a partnership with his psychiatrist as a result of this negotiation for new medications.

In peer and family partnerships there is an interdependency quality that became visible from participants’ interviews. Being helped and helping others has a compelling effect on helper and helpee. Anzel described the ego as problematic for mankind and its need to be disciplined. When he had the “Sampson Syndrome” he was determined to deal with his mental illness alone. Well, that did not work and he learned he had to accept help from professionals, family and peers to move forward in his healing. Also, he found that when he got stronger in coping with his illness he got more strength by helping others. He learned the hard way, through almost twenty hospitalizations that he has to ask for help. In addition, he learned that by assisting others he
moved forward in recovery, thus the interdependency in his helping partnerships. Eight of the ten co-researchers experience the same benefits of helping peers with their recovery, which Mowbray and Moxley (1998) found for some Peer Support Specialists in the WINS Program.

Teachers can be significant partners in recovery as well. For Carlos and Michaela teachers were their first helping partners. So, even before they were diagnosed with mental illness, these co-researchers found caring, supportive teachers that challenged them to be their best. Both were in a lot of emotional pain and the teachers were sensitive to their pain. They perceived the teachers as role models that used a learning approach to assist them in feeling good about themselves and having growth experiences in the school environment. For Bree, her college professors provided a clear set of expectations that allowed her to be successful and build her self-esteem. These teachers had such a powerful impact on them that they all are life long learners, who credit their learning drive to the teachers. Finally, Al feels strongly that teachers need to watch Zoloft commercials because there are a lot of depressed kids headed toward suicide, if they don’t get help. As Al said,

“Teachers and parents will say, hey, maybe my son has depression and they’ll get him help before he tries to kill himself because depression can lead to suicide.”

The teaching/learning process has a great deal to do with emergent helping partnerships. All co-researchers feel that the understanding that comes from the learning process with a helper moves the relationship toward a true partnership. Even though partnership and relationship are used interchangeably in this study, I learned from the participants that a relationship does not equal a partnership. In the helping partnership, there is a deep level of commitment to the participants over time. The contact does not have to be of a specific frequency, but the quality of
the contact is critical. For each relationship that developed into a partnership the participants’

experienced a profound sense of relief that the helper came into their lives. As Beth put it,

“I felt the tension just leaving me. I was thinking thank

   goodness she came into my life. At least I don’t have to

   deal with this alone, anymore.”

Beth was 30 years into her treatment when she met her case manager who has the most impact
on moving her toward recovery. What sets this partnership apart from others in her life is the
balance between information her case manager gives and real communication from Beth. Also,
she gives some of herself along with educational and resource information and her openness
makes Beth feel safer and closer to her than to any other helper in 35 years. The mutual sharing
of self and the depth of teaching and learning that led to new insight facilitated the evolution of
their relationship to a partnership for Beth. James agrees with Beth about the teaching and
learning that has to occur for him to know enough about schizophrenia to be able to be a partner
with his doctor in his recovery. As James says it,

   “Knowledge is power, and I have to have the

   facts to know what I have to do to get better.”

The significant helping partnerships give the participants a clear sense of hope for the
future, which numerous theorists and consumers support Anthony (1991), Schiller and Bennett
(1994) and Deegan (1993). Making these powerful connections, in the face of mental illnesses
and all the pain that is associated with these illnesses, the co-researchers feel hope for the future,
their futures. It appears to be that when partners believe in the co-researchers’ ability to change
and grow long enough, they start believing it themselves. As Bree puts it,
“When a whole lot of my peers believe in me when
I don’t believe in myself and convince me that I
 can, this is very powerful learning and support.”

The partnerships inspire them to go forward in recovery and take risks with trying out their fragile sense of self-power, which other theorists described as empowerment (Anthony 1991, 1993; Anthony et al., 2003; Smith 2000 and Young and Bullock, 2003). As they succeed they are encouraged to go further in the process to reach their dreams of career, family, home and community. All participants experienced support from their helping partners to use their creativity and drive to progress in their growth. Carlos used his artwork to express feelings he could not verbalize, Michaela uses her photography to share the beauty of life with others and Anzel uses his spiritual writings to teach children about God consistent with the findings of Ralph (2000). Also, DuPage County National Alliance for the Mentally Ill. (2003) identified and established a program to empower individuals through art, recognizing the value of artistic expression in healing.

When the co-researchers relapse, their partners help pick them up and continue to move toward their dreams. Like Kim’s mother, who picked her up off the kitchen floor when she took a lot of pills and fell down, they are there at times of need. The co-researchers are never alone with their illnesses when they have helping partnerships. True partnerships and the hopeful anticipation for the future that they engender into the lives of the co-researchers become incorporated into their internal strength and self-esteem. So, as the participants grow stronger and become more autonomous they have the endurance to meet the challenges of life.

Like most resources, helping partnerships are best when they exist in numbers. Having partnership options is experienced as important for the participants because no one partner can
always be there for them. Having networks of partners and helping relationships is the safest and most reliable system of support for these participants. Some co-researchers have time-limited contact with their partners and they are needed only under specific circumstances. For instance, doctors, therapists and case managers are most needed by the co-researchers early in treatment or when changes need to be made in medications or services. Family members are part of their lives throughout, but these participants found them most valuable partners early in recovery and in fact family members were often the first link between them and mental health professionals. Spouses and peers/friends are in for the long hall and these helping partnerships may be operational for a lifetime. Also, consumer advocacy groups and peer support groups provide long-term partnerships, which coincide with Frese et al. (2001) who stated that consumers need different support from different sources, depending on their stage of recovery. Only 3 of 10 participants say they can see that in the future their helping partnerships will be less needed as they become more incorporated into the community and get on with their life goals.

All co-researchers say that they have a higher power in their lives that helps them to recover. The higher power for some is God, Jesus or Buddha. Others believe their higher power is their peer or advocacy group. For everyone, the higher power becomes incorporated into their inner selves and facilitates strength and hope from within when they are alone. In fact, Al, James, Anzel, David and Carlos say they are never alone because their higher power is within them. Five participants believe that their higher power inspires them to use creative talents to express, learn and communicate about their illnesses that they have not been able to articulate other than in an art form. James, our youngest co-researcher says that recovery occurs on three levels: spiritually, physically and mentally. In his point of view, spiritual recovery has to occur before physical and mental recovery can take place. Other consumers (House, 2005) and researchers
(DeMasi et al., 1996) agree that recovery can never be complete without spiritual development and that the authentic spiritual struggle of mental illness offers fertile ground for growth of deep and healing faith.

Anzel agrees with James and believes that only with his helping partners that include the Lord can he recover from his mental illness. He describes recovery as occurring in phases: acceptance, compliance, the wilderness, recovery and mental health. Acceptance is when he accepted his diagnosis and compliance is when he followed the treatment prescribed by his doctor. The wilderness was when he struggled from day to day for stability and he believes that his higher power enabled him to move out of the wilderness and into recovery. The next step for him is mental health where his illness moves into the background of his life and he starts his own helping business like feeding the homeless. Nine of the 10 participants described stages of recovery that they learned from helping partners or their own research. The stages included concepts of acceptance, adherence with medication and therapy, peer support and community roles.

**Composite Summary**

Universal themes are evolving from the composite of all the co-researchers’ experiences of helping partnerships that facilitate recovery. The participants have to be ready to accept help in their healing process, so time is a consistent element of their recovery. Authentic, knowledgeable helpers have to be accessible when they are ready and the relationships that develop into partnerships are characterized by: respect, acceptance, two-way communication and commitment, consistent focus on learning and growth. In addition, partners in recovery make important connections with other helpers that build flexible social networks. Growing helping networks provide resilient support systems in the face of stress and change. Finally, mutuality of
purpose, respect, trust, growth and commitment over time is at the heart of the helping partnership. As depicted by the participants, the partnerships are with family members and mental health professionals for some, peers and teachers for others, the mental health system for a few and their higher power for all. James said it very well,

“Different people come into your life at different times and under different circumstances, and they are there to assist my recovery.”

James suggests that inspired energy from co-researchers and their partners drives the partnership process and its outcome. The dynamic nature and uniqueness of the co-researchers means they need diverse options for healing and getting on with their lives at various points in time and recovery. And universally they need hope, creativity and resoluteness in their partnerships to realize the dreams in their futures. See Figure 2.

*Figure 2. Composite: Helping Partnerships That Facilitate Recovery*
Emerging Themes

Introduction

The themes that were visible in all the transcripts for the 10 co-researchers were (a) networks of helping partnerships, (b) medication, (c) teaching and learning, (d) spirituality/higher power, (e) creative drive and (f) time. Each theme interacts with others and together they constitute meaningful components of universal experiences of helping partnerships for the group of participants. The richness and complexity of the experiences in this study can be described from numerous perspectives. Using these themes along with the universal description of the group is an evocative way to get a handle on these research findings that have some similar and different outcomes from other related studies. In addition to the text descriptions of the emerging themes below, refer to Figure 4 for a visual integration of these themes.

Networks of Helping Partnerships

The participants in this study had a network of helping partnerships that were instrumental at various times in their recovery. Helping options were present at all times from point of diagnosis to the present, which was from 3 to 35 years. For some participants, the network was made up of family, mental health professionals, friends, peers, spiritual guides and groups. Most participants had some of each of these helper groups and several have less categories of helping partnerships. In order of frequencies the following categories of helping partnerships are evident in this sample of co-researchers. See Figure 3.
Table 3. Helping Partnership Frequencies

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<th>Helping Partnerships</th>
<th>Frequencies</th>
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<tbody>
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<td>Mental Health Professionals</td>
<td>10</td>
</tr>
<tr>
<td>Therapists</td>
<td>4</td>
</tr>
<tr>
<td>Case Managers</td>
<td>4</td>
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<td>Psychiatrists</td>
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<td>Mental Health System</td>
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<td>Psychiatric Nurses</td>
<td>2</td>
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<tr>
<td>Peers/Friends</td>
<td>9</td>
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<td>Peer Groups</td>
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<tr>
<td>Family Members</td>
<td>8</td>
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<td>Teachers/Professors</td>
<td>3</td>
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In the individual and composite descriptions each category of helping partnership is delineated along with distinguishing characteristics. The network theme that goes beyond any category of partner includes all of them. Partners of the participants connected them to other helpers and some of these relationships evolved into partnerships. Then these helpers linked the co-researchers to other helpers. Carlos’ doctor referred him to a case manager who in turn connected him to a parapsychology group that became a partnership for him over 15 years. The more connections that are made by the partner or co-researcher the larger the network becomes.

Barabasi (2002) said there are universal laws that all networks follow in their development. Some of them include that networks have a scale free topography, meaning they are not dominated by anyone entity. They grow as links are made and consist of well-connected hubs, or in our context partners, that are instrumental in making contacts and stimulating the growth of the network. The participants experience their network of helping partners as a resourceful and flexible system of opportunities to receive assistance and to assist others in the process of recovery. They move toward and away from helpers in their systems, depending on their need and the needs of others. Having these networks provides a multidimensional resource
in the face of their rapidly changing environments and resources. David and Beth detailed the fast turnover of therapists and case managers, but these participants and others were not devastated by the changes because they have other helping partners in their system.

Also, when the system includes multiple family and consumer advocacy groups, such as the National Alliance for the Mentally Ill and local as well as national consumer groups, which it does for 8 of the 10 co-researchers, it is a powerful network pushing change in our society. Four of the 10 participants are active leaders in consumer agencies that bring hundreds of contacts to their social milieu and provide an environment to make a significant improvement in their lives and thousands of others touched by the network.

In this study, the dynamic interplay of partners and helpers in the networks of these co-researchers is captured and explained. The knowledge of how they work for these participants can be used to nurture the growth of helping systems for many consumers. Community support systems for individuals with severe mental illness are not a novel concept (Anthony, 1991 and Cohen et al. 1990), but identifying the components that include all helpers as identified by the co-researchers and showing how they interact for recovery is fresh information. Knowing how to maximize the growth and use of resources in our struggling economy can have vast and positive implications for those with severe mental illness and the stockholders of mental health services and may go along way toward accomplishing a key goal of the President’s New Freedom Commission (2003): a transformed mental health system that provides access to evidenced-based services for all individuals with mental illness and the elimination of stigma.

**Medication**

All participants identify the consistent use of psychotropic medications as critical to their stabilization of symptoms of mental illness. Without the medications each co-researcher
experienced relapse of active symptoms that significantly interfered with daily living activities and roles in families as well as communities. Eight of the participants struggled through multiple relapses before learning that they needed the medications to control symptoms and to move forward in the healing process, which is supported by Smith (2002). Without exception, the participants say they cannot consistently access treatment and its benefits unless they take their medications, regularly.

An important aspect of information from this study about medications is when the co-researchers decided to be adherent to the medication plan. This decision came about in the context of the helping partnerships when partners informed participants about medication options and included them in choosing what medication to use, the route and the dosage. James says he couldn’t choose to take medications consistently until he accepted his diagnosis and understood how the medications impacted his mind and body.

Four of the participants take conventional anti-psychotics or in other words the first generation of anti-psychotic medication, while six participants take the new generation of anti-psychotic and anti-depressant medications. Those taking the older medications, known for side effects that can inhibit optimal cognition and energy levels, have heard of the newer medications from peers or case managers. Four of 4 of these consumers intend to discuss a potential medication change with their psychiatrists.

One co-researcher found out about the new medications in a recovery class. He decided to talk it over with his doctor and she changed his prescription to a second-generation antidepressant. He says it is working well for him and that this is an example of how much he learns from his groups with peers.
Teaching and Learning

All participants identified the process of teaching and learning as a cornerstone in their recovery. Several clearly articulate the importance of information about their mental illness and treatments as critical to giving consent to treatment consistent with Mueser et al. (2002). Without understanding of their illness and recommended treatment, 8 of the 10 consumers were unwilling to take or stay on their medication and participate in treatment in the early phase of their treatment.

A characteristic of the significant helping partners that facilitate recovery was knowledge about severe mental illness. In partnerships there is a give and take and in the co-researchers’ helping partnerships this held true and this coincides with Diorio’s (2001) findings that when consumers and service providers partner together recovery outcomes improved. In this study, co-researchers say that a two-way communication between knowledgeable partners was the foundation of the teaching/learning process. For example, a psychiatrist who has knowledge about mental illness has to be open to the experience that the participants bring to the table about their mental illness to be able to engage them in the teaching/learning process. And since learning cannot be transported from one person to another, the participants have to be motivated and feel safe enough to learn what the psychiatrist or helper is teaching.

Also, with peers, 8 of 10 co-researchers feel that learning from them is the most powerful method of learning about mental illness and strategies to manage it. The understanding that comes from having been or being there in the struggle is very influential to the peer learner because the issue of fear of control by someone else is largely removed from the teaching/learning situation. In addition, it is non-threatening for the participants to listen to the
stories of peers, and they can try out coping strategies without committing themselves to a
treatment goal before they feel ready to do so.

**Spirituality/Higher Power**

All of the co-researchers describe a higher power in their battle with mental illness. Most identified God, some identify groups of peers and several describe church fellowship as their higher power. One says that Jesus and Buddha are his role models for living a productive, caring life focused on growth and helping others. However, the higher power is defined; it is present in every participant’s healing process.

For three of the co-researchers their faith in God kept them alive through sinister times, and is their primary helping partner that helped them to decide to live. Seven of the co-researchers consistently nurture and develop their spirituality by praying, writing, congregating with others, reading, reflecting and meditating. The strength of faith that they developed in their higher power increases their resilience to cope with day-to-day stressors. It appears to work like Bree’s example of her higher power of peer groups that believe in her over time and then she can believe in herself, too. There is almost a palpable energy present as Anzel described how he used to have God in a little box and he would bring him out and dialogue with him when he felt the need, while his illness was in the center of his being. And now, after years of work with his helping partners, his illness is in the box and God is in the center of his being.

Moore (2004) linked emotional turmoil, spirituality and creativity in his writings about the dark nights of the soul. He said that strength of spirit comes out of going through the dark times because experiencing tragedy sensitizes us to the true meanings in life and helps us to transition to new outlooks and growth. Also, House (2005) concurs with Moore’s theory.
In addition, I saw a similar connection in the stories of the co-researchers. They all worked through their dark times with mental illness and as a result gained strength of spirit as well as focus of their creative energies toward new meanings and purposes in their lives. Their mental illnesses started the co-researchers’ spiritual journeys that stimulated the use of their creativity and transformed their lives. Anzel shows us how his illness, spirituality and creative drive worked together to transform his life and purpose.

“I had some real dark moments with this illness. I said Lord this thing is pretty bad isn’t it? It’s not just bipolar, there’s some psychotic stuff kicked in there that’s really making me fade bad, and so as I began to accept myself and started meditating a little bit, I’d say you know it Lord you probably allowed my life to shatter and you’ll probably will give me another life, a life of meditation, more of a spiritual life that takes its place. So, I’m evolving into a different kind of person than I was before. I’m much more sensitive and I like myself more this way. The Lord just chose me...you may not get back where you were before in some parts of your mind, your brain, your soul, but, the spirit that’s in you can give you something else to guide you.”

Faith in a power that is greater than the power within individuals is at the core of healing, according to these co-researchers. It drives them forward in their recovery and moves them closer to others in need. The higher power is alive and well in their helping networks, as the more individuals who get help in the networks and the more they give help to others creates more energy and links that keep the system growing and working toward a recovery oriented approach to healing from mental illness.
Creative Drive

All the co-researchers have a creative, productive drive that moves them forward in their lives and in their recovery from severe mental illness. Ralph (2000) found that recovery is understood in the writings and creative expressions of consumers, also. With some the drive is internal, God given, and with others it is inspired by family values and behaviors of role models. The majority of the participants have an artistic talent that was used throughout their illnesses as a refuge from symptoms, a form of expression, focus of reflection, learning about self and as a way to connect with others.

The artists and poets in the study use their ability to learn about themselves and to express emotions that are not easily verbalized. Also, they use their creativity to teach the public about mental illness and recovery. Stigma, which is a barrier to participants achieving their full potential (Surgeon General’s Report on Mental Health, 1999), was experienced by most of the participants and they use whatever means they have available to them to help others understand the nature of mental illness and its treatments. The artists use their artwork and the others use their gift of spirit to help others to recover in their own ways.

Coping with mental illness takes a lot of creativity. Partners, who have been instrumental in the co-researchers’ recovery, use creative teaching, communication, linkages and story telling. The participants use all kinds of creative coping skills, like Beth using crewelwork to stop her hallucinations and Al using his poetry to change a frightening experience into a humorous poem.

The co-researchers that do not have a specific talent for the arts are no less driven to learn, teach and be productive in their lives. Some are becoming professional mental health providers, some teach children and all help other consumers in some way. Even Beth, who thinks she is too focused on her own mental illness, can see what will help others in her groups and at
times will offer them ideas. The creative drive was strong in this group of participants and they all know how to replenish their drive, which demonstrates their self-power in their recovery. Anzel knows he has to sleep and be with other consumers, Beth knows she has to have her alone, veg time and Bree knows she has to balance her taking care of herself time with helping others take care of themselves. There seems to be no end of creative drive in this group of co-researchers.

Jung (1970) called the creative drive “daimon” and described it as a strong force that drives a person to action and identified that it could be in the individual and in the world. Moore (2004) theorized that daimon is our ultimate creative power that urges individuals to take major turns in their lives. The co-researchers showed their creative power when they discovered unexpected strength and deep passion in their struggles with mental illness and worked with partners toward new meaning in their lives. Some of them write vivid poetry and create graphic pictures of their recovery processes. Other participants are pursuing their education and taking on helper roles with individuals suffering from mental illness. But, all the co-researchers have a strong creative drive that urges them on toward changes and their destinies.

_Time_

Time is part of all participants’ helping partnerships. Relationships move in and out of their lives at different phases of their healing. Recovery is described as a life long process by 10 of the 10 participants. Over their lifetimes, they have varying needs for helpers. Early in treatment, their higher power, family members and mental health professionals are important in the process. Later as they stabilize, peers, advocacy groups and classes take on greater importance and family and mental health professionals decrease in their facilitator roles. For three participants, teachers in grade school, high school and/or college had a large part in setting
the stage for recovery and helped in coping with pre diagnosis problems. The teachers and professors primarily have a role modeling and caring connection to these participants, and they set the bar for life long learning that is directly related to recovery for them.

Limited time as a dimension of reality that all humanity shares is a theme that kept appearing throughout the interviews and analysis. Time as it relates to past, present and future is significant to the co-researchers because all but one of them was diagnosed with a mental illness in the past that did not focus on recovery of mental illness. James, the youngest participant, was diagnosed at the turn of this century and received services in a network of agencies that has a recovery focus in their treatment. He progressed quickly in a system that used education about mental illness and medications as well as recovery classes. It is no accident that he learned the importance of medication in the treatment of schizophrenia and had access to case managers, nurses, doctors and hospitals that are well versed in recovery concepts. Even the police, were able to recognize that James needed treatment, not incarceration.

On the other hand, the participants who were diagnosed in the past, 3-4 decades ago have a much different experience of early treatment, many of which were negative. Bree, Beth, Michaela and Harry experienced sedating drugs, talk therapy or no therapy. In addition, Beth, Harry, David and Kim did not perceive that they improved significantly until they started receiving treatment from agencies and professionals using recovery principles. They took classes about mental illness, medications and the process of recovery. They learned how to have a partnership with their doctors, therapists and case managers and started taking an active role in negotiating their treatment. Beth and Kim are not quite at the negotiation phase about their medications, but they are thinking about it.
Another dimension of time, timing, is relevant to when the co-researchers accept treatment and the point in time when they realize that a relationship with a helper moves into a partnership. Anzel had that critical point in time when his first child was born and he made the decision not to go back to the state hospital. This was an awakening or moment of insight when he realized he was going to have to be responsible for another person’s life and he wanted to be sane and present for her. Similarly, Bree had a critical point in time when she realized she had to support herself and decided she needed to go back to school to prepare for her self-sufficiency. Also, when her friend was afraid to be in her home while she was on drugs, she suddenly made the connection that her drug use was not normal and decided to go into drug rehabilitation. Another manifestation of critical timing was when Michaela’s psychologist came to visit her in the hospital and she realized that a partnership commitment was being offered to her. In Bree and Michaela’s case, their helping partners got through their resistance by timing a critical intervention when Bree and Michaela were most receptive to their message. Hence, a breakthrough in their progress forward in healing, related to the timing of a symbolically critical intervention by a partner, is a final aspect of timing that is visible in this research. When co-researchers have a crisis, patterns of their thinking and behaviors unfreeze and they have an opportunity for insight and change. So, crises that occur are openings for growth spurts that can be facilitated by helping partners, which is consistent with classic crisis theory (Parad, 1974 and Lazarus, 1966).

Finally, having limited time to work in recovery, taking care of the self and realizing life visions is a concern for some of the participants. Michaela expresses sadness about potentially running out of time to have an intimate relationship and develop her photography business.
“Sometimes I get very sad and I think I’m going to run out of time. Physically run out of time to finish with treatment and be free of the mental health system, have a nice relationship, have friends and a successful business.”

Heidegger’s (1996) theory of temporality of understanding comes to mind in Michaela’s struggles to gain acceptance and peace with her essence of self, before she runs out of time to realize her dreams. He conceptualized that true understanding means: “to be projecting toward a potentiality-of-being for the sake of which the essence of inner self always exists.” Michaela is worried that physical time will end for her before she reaches her potentiality of being. However, Michaela’s inner resoluteness in recovery and creativity are moving her toward her authentic future, regardless of dimensions of external time.
Figure 4. Interaction of Research Themes Leading to Transformation
Research Questions

Research Question 1. What are the consumers’ experiences of recovery from severe mental illness?

All participants experience recovery as an ongoing process that starts with acceptance of their diagnosis (Anthony 1993, Borkin 2000 and Ralph 2000) and coherence with prescribed treatment that leads to stabilization of their disturbing symptoms. In this study, the participants say they had to consistently take medications to stabilize their illness and 8 of 10 of them feel that therapy along with medications is necessary to truly get beyond their symptoms. Also, all co-researchers struggle with the relapse and re-stabilization process. They universally believe that learning about their diagnosis and treatments is critical to understanding the need for specific treatments and to prepare them for what they will need to get on with their lives. In addition, they have knowledge of stages of recovery and where they are in the process. For instance, Kim said,

“I’m not normal, but I am getting better.”

And James said,

“I’m at the stage where I plan to get back to school.

I’m stable and working with vocational rehabilitation.”

In addition, all co-researchers have a higher power that gives them hope for the future and the strength to keep up the work of their recovery, consistent with DeMasi et al. (1996) and House (2005). The nature of the higher power varied from God to groups of peers, and the function of the higher power was similar. Also, the co-researchers say they need a variety of helpers and supporters to progress in the recovery process. And finally, 8 of 10 get stronger and build confidence by helping other consumers to cope with their illnesses.
Research Question 2. How do consumers describe the experience of their helping partnerships that facilitate recovery?

There is a strong consistency in the qualities of the helping partners and how these partnerships are experienced. The descriptions of their helping partnerships included: respect, long term commitment, two-way communication and teaching/learning, dependability, honesty and caring. Some of the partnerships were made right away on an intuitive level and most took time to develop with consistent experiences of respect and validation. The partnerships are perceived as safe interpersonal relationships that depend on a deep level of trust where they can talk about the darkness of their illness and not fear being judged. Finally, self-control and power are nurtured in these partnerships. As the co-researchers got more stable they were encouraged to take more responsibility and risks in their recovery, also described by Frese et al. (2003).

However, the categories of helping partners varied. And with all participants there is more than one partnership. Furthermore, in all but one case there is a network of helping partners. Everyone had professional partners that consisted of doctors, nurses, case managers and therapists and the mental health system as a whole. Family members tend to be early partners who got the co-researchers connected to treatment, and then became less involved in the process over time. However, some participants had families that increased or triggered their symptoms, and were not perceived as helping partners at all, due to lack of knowledge about SMI. Peers and peer groups are strong helping partners for this group of participants because of the experience they have with mental illness that coincides with Segal et al. (1993) and Rappaport et al. (1985). They experience peer partnerships as non-threatening and able to generate a lot of practical strategies to deal with their illness and stigma. A great deal of learning occurs in the context of these partnerships, no matter who is the partner(s).
Helping partnerships are developed by partners and participants engaged in two-way learning and communication. In the process of these interactions, partners have to be willing to know and enter the experiences of the participants. There were more peer partners than professional partners identified as major helping partners in this study. This may be because professional helping partners have more rigid boundaries than peer helpers that prevent them from entering the experience of the co-researchers. In my practice of being a professional therapist, it was frowned upon by nursing, psychiatry and psychology to permit the interpersonal boundary to be flexible, so that the therapist can engage as a person with the consumer. As a consequence, professional helpers may not be able to enter the helping network of the consumers and have as meaningful an impact as possible on their recovery process.

Professional helping partners who created partnerships with the co-researchers went the extra mile with them by making a follow up telephone call during a time of crisis, spending time after their shift to provide education or support, visiting them in the hospital or providing referrals that opened up support opportunities. Having dynamic interpersonal boundaries with the participants, which allow the partners to enter the crisis or personal experiences of the participants, makes a profound connection between helper and consumer. This level of connection is clearly associated with partnerships for the co-researchers that facilitate recovery.

Research Question 3. What are the underlying themes and contexts that account for the experience of partnerships that facilitate recovery?

The themes from the data that account for the experience of the helping partnerships were: networks of helping partnerships, consistent medications, the teaching and learning process, spirituality and identification of a higher power, creative drive and the dimension of time. All co-researchers have multiple helping partners and all but one have a whole network of partners.
Partnerships are developed out of a specific need or needs at a point in time, often in a crisis, and maintained over time. At the beginning of the recovery process, when participants were struggling to accept their diagnosis and treatment, the mental health professional partnerships are developed. With the majority of the participants their family members brought them to the professional helper for treatment because of symptoms. In all instances, participants were not able to stabilize their symptoms and take part in therapy without taking psychotropic medications on a consistent basis. For 8 of 10 co-researchers, multiple relapses occurred before they were able to accept that they truly had a diagnosis of mental illness and needed medications.

The teaching and learning process was critical with all the participants in being able to accept their diagnosis and treatment. It was most frequently in the context of learning with a helping partner that the acceptance occurred, and it was almost as frequent that the partnership became recognized by the co-researchers during the two-way teaching and learning process.

Also, all participants attribute strength and fortitude of staying with the recovery process due to a higher power or their spirituality. Higher power was experienced mostly as God and in some cases as groups of peers and church connections. And creative drive, often stimulated by the participants’ higher power kept them moving forward, coming back to doctors, therapists and groups to work on staying stable and creating new meanings and purpose to life. Spirituality and creative drive, together (Moore 2004), is a consistent theme in motivating co-researchers to continue their education, help other consumers, work toward new careers and create art and poetry to decrease stigma of mental illness as well as inspire themselves and others to transform their lives. The travesty of mental illness seems to increase the participants’ sensitivity to the limits of time, energy and importance of achieving meaning in life.
Finally, stigma was strongly present in the experiences of half of the participants. Kim, Beth and James did not want the church members in their parish to know that they had a diagnosis of severe mental illness. For Kim and Beth, it was a major concern for their family members that knowledge of their illness not be public. James did not want church members to know about his illness of schizophrenia, because he chose to have interactions with others outside the mental health system that were not focused on mental illness. Anzel’s family would not come to visit him at the hospital, even though they were supportive of him and his recovery. He understood that stigma and fear about his illness and coming to the public mental hospital was intolerable for them, even though they cared about him and wanted him to get better. Three of these 4 participants are African American, and keeping information about mental illness private in this culture may be the norm related to stigma.

Also, David told his co-workers that he had depression and believed it was related to his termination. He overheard negative remarks about people with depression not belonging in the workplace and several people confronted him with keeping his depression to himself. David was discredited in the workplace and co-workers were uncomfortable and cruel to him at times. Even his social worker and medical doctor believed he did not need psychiatric help and refused or passively obstructed his referral to the mental health system, until he had a psychotic depressive episode. Also, his mother could not discuss his depression with him even though she had episodes of depression.

Stigma and shame are associated with having a severe mental illness for family members of 5 of the 10 participants. The participants believe that fear of others finding out that they have mental illness, keeps their family members separated from support. Also, it prevents them from being able to really know and support the participants. Two of the 3 African American co-
researchers felt this stigma intensely and perceived they were cut off from receiving help in the family at times because of it.

**Research Question 4. Where in the recovery process do these partnerships form?**

The partnerships form at different times in the process, depending on the need of the participants and the skills and abilities of the helper. Early in recovery, most of these co-researchers formed partnerships with mental health professionals because they needed hospitalization, medications and therapy. Later in the process, they tended to need less contact with professionals and move to helping partnerships with peers and peer groups, which was similar to Frese et al. (2001) recommending that evidenced-based practices and the recovery model be integrated. Once stabilized, peers provide wonderful ideas and strategies about recovery. Nine of 10 co-researchers feel that stories from other consumers hold powerful knowledge for them to understand and test out.

Also, helping peers signals a progression in the stage of recovery for the participants. When they are no longer struggling day to day with disturbing mood swings and hallucinations or immobilizing depression they are able to reach out to others that are still in the day-to-day stress of symptom management and by doing so increase their self-esteem. Frequently, participants receive positive feedback for their helping efforts and it makes them feel good about themselves, which energizes their recovery process. Four of the participants, two in the advanced stage and two in middle stage, give speeches and testimonials to groups of peers and the public about mental illness and its stigma. In doing so, they keep their recovery energized and moving.

Windows of opportunity occur for helping partnerships to form in times of crisis when participants’ coping mechanisms are not sufficient to deal with the situation that corresponds with classic crisis theory (Parad, 1974). For example, when James was arrested for a scuffle in a
restaurant, he quickly experienced a change in his perception of his mother’s role in getting him help for his hallucinations and confusion. Then he understood she was trying to help him instead of being intrusive in his life, and formed a helping partnership with her. Without the crisis of being arrested and jailed, he was not able to see what she was trying to do, realistically.

Researcher Transformation

This is the last section of the dissertation that I am actually writing because I wanted to look at all findings, figure out what they say to me, their implications and what I want to recommend from here before going back to my description of bias about recovery and helping partnerships. Well, I have to laugh because my bracketing of perception and bias is so far removed from the findings of this research that it feels like a different person wrote about them.

First of all, it is not that my description of how I understood recovery from severe mental was so off the mark from what I learned from the co-researchers, but is very much off the mark regarding depth of understanding recovery and its stages. I just described the beginning of the process and completely left out the middle and advanced stages: what they are, how they are manifested and the nature of the challenges at these stages.

Regarding helping partnerships, it is clear to me that I was looking at these partnerships from the perspective of the mental health professional and the consumer and giving little consideration to the myriad of other helping partnerships that are essential aspects of successful recovery. So, what I have learned about recovery and helping partnerships from this study could come close to filling the Grand Canyon, and I can safely say to myself and my committee that I did not skew the results of the study with my previous biases.

First, I believe after spending hours with the researchers and months with their data that transformation from severe mental illness is a more accurate concept to use than recovery from
severe mental illness. Anzel, Bree, David, Carlos, Michaela and Al have transformed their lives in comparison to their existence with mental illness in their early recovery. They have not gone back to a pre diagnosis state or just carried on their lives in spite of mental illness. They have become different people with different values and new meanings to their lives. They have gone through stages of recovery and struggled with many relapses and out of these experiences have become new individuals with new faith and purpose, which is coherent with Jung’s (1960 and 1964) theory and Edinger’s (2002) interpretation of his theory. All co-researchers describe their dark journeys such as through the black pit, dark cloud, dark dungeon or death that is consistent with Jung’s archetype of transformation in the collective unconscious. Having come through these dark experiences they are sensitized to the meaning of life and the struggles of others. They are focused on others as much as themselves and teach, support, and guide the public and peers in understanding healing from these incurable illnesses. I believe this is a transformation process that is broader than recovery as I understand it. Anzel says it well

“Now my mental illness is in a little box off to the side of my life instead of being in my center, and my spirituality is in my center instead of being in a little box off to the side.”

The role of spirituality in healing became very clear to me from this data as well. I always believed it was important for some consumers and did not understand how integral a higher power is to the process until I entered the participants’ stories. All participants identified that their higher power gave them strength and hope to keep working with their helpers toward recovery. Also, 9 of 10 participants agreed or strongly agreed on the MHRM that spirituality has a major role in their healing.

Next, I learned that a partnership and relationship are not interchangeable. At the start of this research I used these concepts as one and the same. This probably comes from years of
working in therapeutic relationships with mental health consumers. Now, I do not see them as interchangeable, only related. The critical differences have to do with level of commitment, sharing of power and two-way teaching and learning. A helping relationship may develop into a partnership because the behaviors of the helper in these different relations are similar: being respectful, listening, and trying to help consumers manage symptoms of mental illness, being consistent and caring. However, some of the issues that differentiate the partner from the helper are: personal values and insight, sharing responsibility, making linkages to critical resources and motivation to transition to a partnership, which often includes making a longer term and deeper commitment. Also, the helping partner has an almost artistic ability to move through or around the co-researchers’ defenses. Hence, imaginative and scientific skills work together to create helping partnerships.

Another aspect of partnerships that I learned from the co-researchers is that it does not have to take a certain length of time to develop a helping partnership. Some of the most powerful partnerships are created very quickly with acts that make a profound connection with the participants. When Anzel’s future wife came to see him in the hospital and when Michaela’s therapist came to see her in the hospital they knew right away that this was going to be a new kind of relationship for them.

Even though I understood the value of community support systems in recovery, I did not think that networks of multiple helping partnerships were going to be the biggest category of helping partnerships. Learning that there are multiple concurrent partnerships in the participants’ system of recovery relationships was new information. Peer, professional, family, teacher and group partnerships create a dynamic resource for participants that are resilient in the face of rapid
changes because there are numerous options for support and guidance. Also, the movement from partnership to partnership and the dynamics of these movements became visible in the study.

I was energized and enlightened by the stories of mental illness and partnerships in recovery from the co-researchers. As I was hearing about changes and learning what they experienced, I was going through some similar changes and learning that lead to my transformation. There was a parallel process that emerged between the co-researcher experiences and mine during the study. The emotional struggle with acceptance about the diagnosis of mental illness that the co-researchers had was similar to my emotional efforts to process the perceptions, emotions and essences of their stories. And the relief and joy that they felt when connection was made with helping partners was related to my liberation and elation when I was able to understand the co-researchers perception and understanding of helping partnerships. So, as the co-researchers moved through their stories and experiences in recovery, I moved in my understanding of their partnerships that facilitated recovery.

Finally, 9 of ten participants reviewed and validated the analysis and descriptions of their interviews. Five of the 9 participants said they benefited from the interviews by looking at the process of their recovery. They claimed that they learned new perspectives on what happened in the course of their illness and healing. So, the interaction with me and the review and memories of their helping partnerships stimulated a new depth in their understanding of the participants’ recovery process. Hence, half of the co-researchers moved forward in their learning process as a result of participation in the study, as I transformed my knowledge of recovery from severe mental illness.

So, I learned a great deal of new information about recovery and helping partnerships from the co-researchers. These are some of the biggest differences from my pre study biases.
This was a profound learning experience for me, and it will nurture and inform my leadership in the mental health system for the rest of my career and beyond.

Limitations

Being a qualitative study the small number of participants is a reality that means results cannot be generalized to large numbers of consumers. In addition, in trying to achieve diversity and at the same using six variables, it was difficult to get as much variance in the sample as I wanted. For example, I chose another co-researcher in his twenties of Latino decent, who was not available to participate. In choosing a replacement individual to take part, I was unable to find another person of Latino decent with the age range and diagnosis I needed to complete the sample. So, the readers have to evaluate the merit of the data in looking at consumers they are trying to help through the recovery process. I believe there is enough depth to the data for the analysis and conclusions to resonate with mental health clinicians and consumers.

Also, there appears to be an inconsistency in the MHRM score of one of the co-researchers, Kim, and the qualitative data. She scores 111 out of a possible 120 score that put her at the top of the sample. However, from her experiences of her mother and her sisters taking care of her appointments, finances and medications, I have some doubt about her being in the advanced stage of recovery, as I understand it.

Finally, I think I achieved validity of the data analysis and realize that some researchers do not believe that validity can be reached in qualitative research. In most of the qualitative studies I have reviewed the researcher strives for trustworthiness of the data and analysis. Using the Moutakas (1996) revised method of phenomenological analysis, member checking, triangulation, multiple interviews and expert review reached the level of validity in my opinion supported by Morse et al. (2002). Also, having methodological coherence between the research
questions and method of data collection and analysis as well as saturation of data supports validity. In conclusion, the interaction of these processes works toward the soundness of the data and analysis.

**Implications and Recommendations**

In this research, all co-researchers experienced helping partnerships that facilitate their recovery. Most of the partnerships evolved over time out of helping relationships that were characterized by: respect, deep commitment, two-way communication and action as well as strong focus on the teaching/learning process. For the co-researchers in this study, outcomes of these partnerships were: acceptance of their mental illness, stabilization of symptoms, growth of self-esteem, self-power and hope. Another significant outcome was the transformation to new meanings and life goals.

In this study, the recovery literature of Anthony (1991, 1993) Anthony et al. (2003), Mueser et al. (2002) and Smith (2000) is supported as to the process being individual, ongoing and inspired by hope from peers and mental health professionals. Also, the findings from the co-researchers in this study support the consumer literature, Schiller and Bennet (1994), Fox, (2000), Holst (2000) and Thomas (2000) in regards to recovery beginning at the point of acceptance of diagnosis and treatment. In addition, this study is consistent with evidence-based practice literature, Smith (2002) and Ralph et al. (2002) that medications and therapy lead to stabilization for individuals with severe mental illness. Finally, results show that integrating mental health services with recovery principles (Frese, 2001) leads to positive outcomes for consumers. All participants in this study experienced stability of symptoms through medications and recovery oriented mental health providers. The co-researchers who had non recovery
oriented services received their treatment several decades ago before recovery principles were applied to services for consumers with severe mental illness.

Contributions from this research to the recovery literature include several key areas: networks of helping partnerships and some of their dynamics that facilitate recovery, description of characteristics of helping partnerships that foster recovery and data about the process of how they function and the role of time, creativity and spirituality in the context of helping partnerships that facilitate recovery. Also, there is data that supports Jung’s (1960) theory of collective unconsciousness associated with major depression and the psychotic process.

This study described helping partnerships and how they facilitate recovery as Anthony et al. (2003) suggested needed to be done. As Frese et al. (2001) pointed out; the initial helping partners are often mental healthcare providers, using recovery principles. The timing when these partnerships most often occur is during a crisis or emotional upheaval that is taking place, which coincides with traditional crisis theory (Parad, 1974; Lazarus, 1966). Then, when stabilization of symptoms is accomplished the participants start moving toward peer and peer group partnerships. Providers are often the link between the peers and peer groups, and as the numbers of partnerships and helping relationships grow they create a network that emanates advocacy and healing energy. Also, the process of the participants helping others in recovery generates movement toward their own recovery goals. Teaching and learning, development of creativity and spirituality are integral elements of the helping partnerships experienced by these co-researchers. Creation of new meaning in their lives from the struggle with mental illness is leading to a transformation for 9 of the 10 participants from this study. I was particularly struck by the combination of spirituality and creativity and their impact on recovery. The depth of sensitivity, imagination and faith that is generated in the process of the participants’
transformation was inspiring as the depth of pain and torment in their minds during active depression and psychosis was disturbing.

Many suggestions related to this study are generated to increase understanding of helping networks for elimination of stigma and advancement of recovery. The recommendations are organized according to the themes that emerged from the participants’ composite description and the data analysis.

*Networks of Helping Partnerships*

All co-researchers have multiple helping partners, and 9 of 10 have a network of helping partners and relationships. As previously presented, these networks include a variety of partners: peers/friends, peer groups, mental health professionals and systems, family members and teachers. The networks provide participants with support options and they grow related to increased connections and links with dynamic information, also. Another very important outcome of these networks is they are a system that encourages two-way supports on multiple dimensions that increases the creative power of the network to move individuals and groups of individuals forward in recovery. So, recommendations about the networks are as follows:

1. Include network models (Barabasi, 2002) in treatment processes. To some extent they are included or the results of this study would be very different than the actual findings. However, peers, the most frequent helping partners with the co-researchers can be a much larger part of the network and engaged in the process sooner.

2. Support coordinating the sub groups of the networks to increase efficiency and efficacy of their combined efforts to move individuals and groups forward in the understanding of recovery and to counter act stigma. The President’s New Freedom Commission (2003) recommended that mental health agencies and advocacy groups join forces to educate,
provide access to proven treatments and community living for everyone with severe mental illness. Using the new science of networks (Barabasi, 2002) is a way to approach these daunting goals using recovery networks in the face of our struggling economy to unite and coordinate fragmented services and systems.

3. Study the new science of networks and recovery. Use Barabasi’s research on networks and recovery research to identify ways to combine forces of existing mental health systems and consumer advocacy groups to accomplish the goals of the New Freedom Commission.

4. Educate mental health professionals about key elements of developing helping partnerships and dynamic boundaries as an integral part of the recovery process that is critical to engaging the consumer in active treatment.

5. Use peer coaches/specialists (Mowbray and Moxley, 1998), to reach consumers when they are in crisis to help engage them in the stabilization process of recovery. Partnering of peers in advanced recovery, mental health professionals and families to connect with individuals in crisis is a promising new direction for increased engagement in recovery at a time of great need and opportunity for consumers with a diagnosis of severe mental illness.

Medications

All co-researchers say they had to get on consistent medications to stabilize their symptoms of mental illness. Before they could accept the medications, they had to accept their diagnosis. Education at the right time delivered in the context of a trusting partnership is how these participants were able to accept their diagnosis and treatment. Also, 8 of 10 participants say
medications and therapy together lead to stability. So, this study supports the evidenced-based research that says medications and therapy work together to effectively treat SMI (Ralph et al. 2002). Therefore, recommendations about medications are as follows.

1. Educate consumers and their support systems about medications in the context of mental illness and its symptoms and provide consumers written data to reinforce teaching.

2. Include recovery in education of mental health professionals, health professionals and clergy to increase awareness and use of recovery theory, research and approaches.

3. Address cultural competence in professional education to ensure providers can identify and incorporate consumer values in mental healthcare education.

4. Teach benefits and risks of treatment as well as risks of lack of treatment to consumers, to encourage understanding of multiple aspects of treatment for informed consent.

5. Partner peer advocates/coaches with mental health professionals to foster the impact of education about mental illness and medications.

6. Promote self-directed learning about mental illness and related treatments.

7. Promote choice in consenting for treatment. When individuals are experiencing confusion and fear associated with mental illness, they are fighting for self-control, so it is critical that partners and helpers avoid power struggles about taking medications. Getting input and offering choices of medication, route, doses and times of administration can help individuals feel they have some control and increase their willingness to choose to take medications. Side effects, stigma or decrease in symptoms were the most frequent reasons this group of participants stopped taking medications, so these issues have to be addressed with consumers up front.
Teaching and Learning

All participants experienced that learning about their mental illness, treatments, and resources for recovery was critical in their healing. It seems almost too simple to say that without learning there is no opportunity to understand mental illness and be a partner in recovery, but this is what the majority of the co-researchers experienced. Recommendations about teaching/learning are as follows.

1. Involve peers in education about mental illness and recovery in hospitals, mental health agencies and boards. Peers were the most powerful helping partners for the majority of the participants in this study. The understanding that individuals who have a mental illness and are progressing in their recovery brings to the learning environment is compelling.

2. Individualize teaching style and methods to accommodate the learner. Teaching is an art and learning depends on individuals’ receptivity and understanding of information. So, here again the concept of partnership emerges. There has to be a meeting of the minds for the education process to be successful, so the teacher and learner need to negotiate how and when the information is to be shared.

3. Use multi methods and recovery research to develop learning tools for consumers and the public.

4. Partner mental health and consumer agencies with churches and primary healthcare providers to educate the public about severe mental illness for the purpose of decreasing the related fear and stigma.

5. Bust stigma with education, preferably by consumers with a unified learning plan by consumers, mental health agencies and consumer advocacy agencies.
Spirituality

All participants have a higher power that provides support, hope and internal strength to keep up the recovery process in the face of severe and persistent mental illness. The definitions of higher power are different for individual co-researchers and they all feel passionate about the positive impact their higher power has on healing. Recommendations about spirituality follow.

1. Incorporate spirituality into mental health treatment. For many years, mental health providers avoided dialogue about religion and spirituality with consumers. I can recall many instances when individuals wanted to discuss God and co-workers shied away from the topic. I think it went back to the psychoanalytic roots of mental health services that Braunstein (2005) described. Therapists could not contaminate the therapeutic relationship by discussing spiritual issues because they might influence a vulnerable patient to take on religious beliefs or delusions. I think it is time to facilitate exploration of consumers’ spirituality because as this study shows, a higher power inspires hope and strength in the face of pain and suffering.

2. Conduct research on the role of spirituality in recovery from severe mental illness. This study suggests that spirituality is an important part of all the participants’ healing and that it is developed through art, journaling, meditation, participation in therapy and church groups. Moore (2004) said that pain and suffering work to strengthen spirituality and creativity, and it would be very useful to learn just how this works for individuals with mental illness.

3. Include spirituality in the curriculums of mental health professionals. Unless professionals are knowledgeable about spirituality, comfortable with it and its impact on recovery, this dimension of healing will not be consistently present at the practice level.
**Creative Drive**

The drive for a purposeful and meaningful life is present with all the co-researchers. Some of the participants felt strongly that the occupational therapies of past mental health services have disappeared and believe they need to be restored. They say that learning ways to use time creatively and have a product such as a ceramic piece or other craft item, builds skill, self-esteem and personal satisfaction. Recommendations for creative drive are as follows.

1. Identify and nurture creative drive in consumers by including alternative treatment modalities in mental health and consumer advocacy agencies.

2. Encourage use of creativity in recovery strategies with consumers, families, mental health professionals and advocacy agencies.

3. Research the connection between creativity, spirituality and severe mental illness to potentially open up new avenues of recovery.

4. Include the use of the creative drive in mental health curriculums to teach professionals to identify, use and nurture it.

**Time**

Time is a valuable resource that is limited. It kept coming up in all the co-researchers’ recovery stories in a variety of contexts. Suggestions about time from this study are as follows.

1. Educate consumers and helpers about the opportunities that emerge in the dimension of time. Critical events that are positive or negative can precipitate opportunities to make significant changes. Birth, death, incarceration and marital separation are a couple of the events that triggered insight, acceptance of diagnosis, commitment to change such as pursuing an education for the co-researchers. These events stimulated a crisis that
required new attitudes and behaviors. So, the participants became available to
counters with helping partners and new approaches to their illnesses.

2. Promote understanding of various perceptions of time in recovery. Time is a relative
concept and in our fast paced world individuals with an altered sense of time can be
invalidated.

Summary
Interaction of these themes from the study creates some new perspectives of recovery and
helping partnerships. Also, understanding these themes and how they build upon each other can
potentially benefit state and national initiatives to reduce stigma about mental illness, promote
access to services for those that need it and coordinate many resources needed to help
consumers’ and their families’ recovery from severe mental illness. Use of networks of helping
relationships and partnerships that include peer systems can add a lot of resources to facilitate
recovery in the face of threatened governmental funding. Nurturing creativity and spirituality in
these helping networks can add a great deal of energy to the recovery movement, and stimulate
political changes against discrimination of individuals with a diagnosis of mental illness. Finally,
education about recovery and stimulating new knowledge through including consumers in
research will greatly enhance efforts to expand healing and eliminate stigma.
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**APPENDIX A.**

**Mental Health Recovery Measure**  
Young and Bullock, 2003

Client’s Name: ____________________________  
Client UCI Number  
Survey Date

The goal of this questionnaire is to find how you view your mental health recovery process. There is no right or wrong answers. Please read each statement carefully and indicate how much you agree or disagree with each item by filling in the appropriate circle.

<table>
<thead>
<tr>
<th>SD=Strongly Agree</th>
<th>D=Disagree</th>
<th>NS= Not Sure</th>
<th>A=Agree</th>
<th>SA Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
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</table>

1. I work hard towards my mental health recovery.

2. Even though there are hard days, things are improving for me.

3. I ask for help when I am not feeling well.

4. I take risks to move forward with my recovery.

5. I believe in myself.

6. I have control over my mental health problems.

7. I am in control of my life.

8. I socialize and make friends.

9. Everyday is a new opportunity for learning.

10. I still grow and change in positive ways despite my mental health problems.

11. Even though I may still have problems, I value myself as a person.

12. I understand myself and have a good sense of who I am.

13. I eat nutritious meals everyday.
SD=Strongly Agree   D=Disagree   NS=Not Sure   A=Agree   SA=Strongly Agree

14. I go out and participate in enjoyable activities every week.  O    O    O    O    O    O
15. I make the effort to get to know other people.                  O    O    O    O    O    O
16. I am comfortable with my use of prescribed medications.     O    O    O    O    O    O
17. I feel good about myself.                                    O    O    O    O    O    O
18. The way I think about things helps me to achieve my goals.   O    O    O    O    O    O
19. My life is pretty normal.                                    O    O    O    O    O    O
20. I feel at peace with myself.                                 O    O    O    O    O    O
21. I maintain a positive attitude for weeks at a time.          O    O    O    O    O    O
22. My quality of life will get better in the future.            O    O    O    O    O    O
23. Every day that I get up, I do something productive.           O    O    O    O    O    O
24. I am making progress toward my goals.                        O    O    O    O    O    O
25. When I am feeling low, my religious faith or spirituality helps me to feel better.  O    O    O    O    O    O
26. My religious faith or spirituality supports my recovery.     O    O    O    O    O    O
27. I advocate for the rights of myself and others with mental health problems.  O    O    O    O    O    O
28. I engage in work or other activities that enrich myself and the world around me.  O    O    O    O    O    O
29. I cope effectively with stigma associated with having a mental health problem.  O    O    O    O    O    O
30. I have enough money to spend on extra things or activities   O    O    O    O    O    O

Thank you for completing this measure.
The MHRM was developed with the help of mental health consumers by researchers at the University of Toledo. This research was supported through a grant from the Ohio Department of Mental Health, Office of Program Evaluation and research. For further information, please contact Wesley Bullock, Ph.D. at (419) 530-2721 or email:
Wesley.bullock@utoledo.edu
APPENDIX B

RECOVERY PARTNERSHIP INTERVIEW TOOL

Introduction: The following questions were designed to begin a discussion about helper relationships that have assisted you in your recovery from mental illness. The purpose of the questions is to get the best picture of what these relationships look like and how they have facilitated your healing. Additional questions may come up during the interview to better understand your view of helping partnerships and recovery.

Thank you for agreeing to the interview.

1. Please describe what it is like to live with a mental illness.
   a. When were you diagnosed with a SMI?
   b. What was being diagnosed like?
   c. What were your early treatment/experiences?

2. In what ways have you learned to deal with your mental illness and get on with your life?

3. How are you still working on managing your illness? Writing, Music, Art?

4. What do you do on a day-to-day basis to cope with your illness?

5. Who has had a major role in helping you to heal?
   a. When did you meet?
   b. How long did the relationship last?

6. In what ways has he/she helped your ability to cope with your mental illness?

7. What characteristics describe this helper?

8. When did you realize your partner was helping you to deal effectively with your illness?

9. What was he/she doing to help when you realized your partner was helping?
10. Recapture what was happening in your relationship at this time, when you realized he/she was helping you to heal.
   a. What were you feeling?
   b. What were you thinking?
   c. What was happening?
   d. What else?
   e. Where are you because of the helper relationship?

11. What advice do you have to give to someone interested in helping a person with a diagnosis of severe mental illness?

12. What do you think is most important for people to understand about helping you get beyond your mental illness?

13. How do you describe recovery from severe mental illness?

7/04 ka
Recovery Research Demographic Questionnaire
Kathleen Anthony RN, MS

Dear Consumer,

If you choose to complete the MHRM questionnaire, and are interested in being interviewed as part of my study, please answer the following questions. Your answers will be used to select a group of consumers that represent different stages of recovery.

No one but, my educational supervisor and I will know that you answered these questions. When the study is finished, this letter will be destroyed to protect your privacy.

Name: _________________________________  Age: _______________
Telephone Number: _____________________  Sex: _______________
Diagnosis: _____________________________

Race: Choose One

African American   _______________________
Native American     _______________________
Latino/Hispanic      _______________________
Asian                      _______________________  
White/Caucasian    _________________________
Other (Describe)    ________________________

Education: Choose One

Finished 6th Grade _______________________
High School           _________________________
College, BS or BA __________________________
Masters Degree    __________________________
Other (Describe) __________________________

Thank you for showing an interest in recovery research. If you are chosen to be interviewed, you will receive $20 per interview, and you will be interviewed 2-3 times in the next couple of months. I will notify you in about two weeks, if you have been selected to be interviewed.
Dear Co-Researcher,

As we discussed, please review my description of your helping partnerships that facilitate your recovery. Write on the document anything important I have left out or changes that need to be made to make it accurate.

My goal in writing this description is to describe your experience of recovery and how it happened, including the key people who helped you along the way. I want it to be as true to your experience as possible, so that is why your feedback is so important.

After reading it over and making your comments, please send it back to me in the self-addressed envelope. Try to get it back to me in a week, by August 19, if possible.

Also, I want to use your exact words and some of your poetry in the write up, but I don’t want anyone to be able to identify you. Since I want to protect your privacy, I think using a fictitious name for you would be the best way to express what you feel without anyone knowing it is you that said it. What first name would you like me to use, instead of using ____________?

Thanks for you help in this research! Call me at 419 350-3237, if you have any questions about sending me your feedback.

Sincerely,

Kathy Anthony
3555 Island Avenue
Toledo, Ohio 43614
APPENDIX E.

Recovery Partnership Recruitment Flyer

YOUR HELP IS REQUESTED IN A RECOVERY STUDY!

Study Topic: **Partnerships that Facilitate Recovery from Severe Mental Illness**

**Title of Study:** Exploring Helper and Consumer Partnerships that Facilitate Recovery from Severe Mental Illness

**Study Investigator:** Kathleen Anthony, RN, MS, CNS

**Description:** You have the chance to take part in a research study about helper relationships that facilitate recovery from severe mental illness (SMI). The researcher is a doctoral student in the School of Leadership and Policy Studies at Bowling Green State University.

The purpose of this study is to increase understanding of what partnerships help consumers to recover from mental illness, and how these relationships promote recovery. This study has several steps and involves:

1) Completing a questionnaire, *Mental Health Recovery Measurement* tool, that measures what you think and do about your recovery (10 minutes),

2) Filling out a brief *Recovery Partnership Demographic Questionnaire* (3 min.), **if you are interested in being interviewed two to three times**.

3) Participating in 2-3 face-to-face audiotaped interviews over 3-4 weeks and receiving $20 per hour after completing each interview.

**Information you provide will be confidential. Your participation in this study is strictly voluntary.**

**Who Participates:** To participate in this study you must:
   1) Have a severe mental illness diagnosis: schizophrenia, bipolar disorder or major depression.
   2) Have or had a relationship with someone who has helped in your recovery.

**When/Where is the Study:** The researcher will come to your Community Mental Health Agency or Consumer Advocate Group:

on Wednesday, **2/23/05** at 2:30 PM, and will explain more about the study and protection of your privacy.

**Questions:** You can contact the researcher, Kathleen Anthony at (419) 350-3237 if you have questions about the study and how it works.
APPENDIX F.

Bowling Green State University

INFORMED CONSENT TO PARTICIPATE

Partnerships that Facilitate Recovery from Severe Mental Illness

Title of Project: Exploring Helper and Consumer Partnerships that Facilitate Recovery from Severe Mental Illness

Project Investigator: Kathleen Anthony, RN, MS, CNS

Telephone Number: 419 350-3237

You have the chance to take part in a research study about helper relationships that facilitate recovery from severe mental illness (SMI). I am a doctoral student in the School of Leadership and Policy Studies in the Education Program at Bowling Green State University. Also, I am a Clinical Nurse Specialist in Psychiatric/Mental Health Nursing and have worked with people recovering from severe mental illnesses for over 25 years.

I am conducting a study for my doctoral dissertation. The purpose of this study is to increase understanding of what partnerships help consumers to recover from mental illness, and how these relationships promote recovery. This study has several steps and involves:

3) Completing a questionnaire, Mental Health Recovery Measurement tool, that measures what you think and do about your recovery (10 minutes).
4) Filling out a brief Recovery Partnership Demographic Questionnaire (3 minutes)
   If you are interested in being interviewed two to three times.
5) Participating in 2-3 face-to-face audiotaped interviews for 1-1.5 hr. and receiving $20 per interview within the next 3-4 weeks.
4) Giving feedback to the researcher about your interviews to make sure you were understood (15-30 min.), several weeks after each interview.

To participate in this study you must;
3) Have a severe mental illness diagnosis: schizophrenia, bipolar disorder or major depression.
4) Have or had a relationship with someone who has helped in your recovery.
5) Be willing to consent to participate.

There is a small risk that you may get anxious or nervous talking about your recovery. However, it is not expected that you be at any greater risk of this than of general nervousness encountered in your daily life.
The benefits to you of taking part in the study are: you will have an opportunity to review what has helped you in recovery, you may help increase knowledge about how recovery works and you will be reimbursed $20 for each interview.

Information you provide will be confidential, and no one will know what you answered on the questionnaires or what you said in any of the interviews, except the researcher and her supervisor. When results are reported, only group information will be published, so your statements will never be published.

The audiotapes of your interviews will be kept in a locked cabinet in the researcher’s locked office, and they will be erased after the study, approximately summer 2005. Also, after the research is completed, any connection between you and your written information will be destroyed.

Your participation in this study is strictly voluntary. This means you decide if you want to take part or not and there are no negative results of you deciding either way. You can decide not to answer any of the questions or withdraw consent at any time in this study. By completing this consent form you are agreeing to fill out the Mental Health Recovery Measure tool, and by completing the Recovery Partnership Demographic Questionnaire and putting your name on it, you are agreeing to participate in the 2-3 audiotaped interviews.

If you have any questions or comments about this study, you are free to contact me at 419 350-3237 or by e-mail at anthonyk@mhmail.mh.state.oh.us. Or you may contact the researcher’s supervisor at 419 372-7313 or by e-mail at jalston@bgnet.bgsu.edu.

For concerns or questions about participating in a research study, you can contact the Chair of Human Subjects Review Board at Bowling Green State University at 419 372-7716.

The study describe above has been explained to me and I voluntarily choose to participate in this research. Please sign two copies, one for you to keep and one copy for the researcher.

Signature: ___________________________ Date: ______________

Printed Name: ___________________________

Code # ________________________________
APPENDIX G.

Recovery Partnership Artifact Questionnaire

1. How does artwork (writing, photography) affect your recovery?
2. When did you start your artwork?
3. Who encouraged your artwork?
4. What does your artwork say about your healing process?
5. When do you draw/write/photograph?
6. Where do you draw/write/photograph?
7. How do you go about it?
8. What inspires you to draw/paint, write, and photograph?
9. How do you share your work with others?
10. How does your artwork relate to partners that have helped to facilitate your recovery?

Specific artwork, writing or photography –

1) What are you saying with this work?
2) What is it about?
3) What inspired you to do this?
4) What were you feeling, sensing, and thinking as you did it?
5) What else was going on?

7/5/05 ka