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"The Re-covery Model" – An integrative developmental stress–vulnerability–strengths approach to mental health

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This paper describes the "Re-covery Model", an innovative approach to facilitating recovery in people with enduring symptoms of psychosis and other extreme states. This model has been developed by experience-based experts (EBEs), and mental health professionals, some of whom are also EBEs. It provides a shared understanding of the "human condition" in the bio-socio-psycho-cultural and spiritual developmental context in which resilience and vulnerabilities shape the person. It is easily understood and helps service clients, clinicians, and significant others to come to a shared identification of the patterns that create vicious cycles of stigma and deteriorating function. It offers a hope-inducing pathway towards victorious cycles of building resilience and manifesting a life worth living, and integrates intervention strategies from a variety of evidence based therapies to facilitate recovery. The approach and its implementation are discussed in detail.

Keywords: cognitive behaviour therapy; families; hearing voices; integrative approaches; stigma; user-led services

Introduction

The concept of recovery in mental health connotes achieving a meaningful life in the midst (or absence) of illness, and encompasses the notions of meaning and purpose, taking responsibility, having a renewed sense of hope and destiny, having meaningful relationships and activities, and making decisions about one's own treatment and life. Recovery is a lived process that is unique for each individual, but which involves commonalties in its objectives, values, and tasks. Deegan (1996) described the goal as "to become the unique, awesome, never to be repeated human being that we are called to be." The core values of recovery-focused interventions include: the understanding that personal meaning to the individual is paramount (Geekie & Read, 2009); respect for, and belief in, the person; the hope and belief that recovery (as defined above) is possible for all people given the right understanding, approach and support; and that "radical acceptance" (Linehan, 1993) of the person is often required for change to

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occur. Ridgeway (2001) identified key tasks for recovery in mental health as: the reawakening of hope after despair; breaking through denial and achieving understanding and acceptance; moving from withdrawal to engagement and active participation; and active coping rather than passive adjustment.

Many services strive to practice in a way consistent with a recovery approach. Achieving recovery-focused practice is a subtle but significant shift from standard practice and is not synonymous with even the best-intentioned standard practice. The training of most current mental health professionals does not completely prepare them for the challenge of reconciling the expectations of a risk-averse society with those of service clients for autonomy, and may lead to service that is either harmfully paternalistic, or harmfully neglectful. Although conventional treatment approaches can be made more consistent with a recovery philosophy, truly effective adoption of a recovery approach is made possible by use of a different style of therapeutic intervention. Well-defined interventions that embody the principles and philosophy of recovery in a clear and socially responsible way and that can be implemented by a wide range of mental health staff are needed. The "Re-covery Model", outlined in this paper, was developed as such an approach.

Overview of the Re-covery Model

The Re-covery Model provides a pathway for shared understanding and action between clients, clinicians, and, as appropriate, significant others. It is based on many principles of recovery outlined above. The core concepts of the Re-covery Model, and the therapeutic framework and multimodal skills training approach that derives from it, can be summarised in four diagrams, three of which are presented below. The same diagrams are used to teach these concepts to mental health professionals of all disciplines, mental health clients, and significant others. These diagrams are included in animated PowerPoint presentations, and in workbooks and posters that are provided for all service clients and staff who participate in this training. The explanations below are shared with all participants. All aspects of the model are presented repeatedly, and participants are given many opportunities to practise applying the concepts to their own personal (and professional) lives, and talking about this in groups and individually. The following sections describe these core concepts with reference to the relevant diagrams.

The "Map of the Journey of Re-covery"

The Re-covery Model is a model of *life* rather than an illness model. It presents the normalising and validating notion that we all as human beings are on a bio-socio-psycho-cultural-spiritual journey of "Re-covery" (a play on the word "recovery" that is explained below). All humans are on this journey irrespective of whether they are described as having mental health issues or not, putting us "all on the same page" metaphorically.

The "Map of the Journey of Re-covery" (Figure 1) depicts a three-dimensional spiral model of individual development. Our development is represented by movement along the spiral, starting before birth (signified by the foetus at the beginning of the spiral). The Re-covery journey continues throughout life as we experience different stressors and traumas, and respond to these depending on our own mix of temperament, physiological, and social/cultural/spiritual factors. Intra- and interpersonal

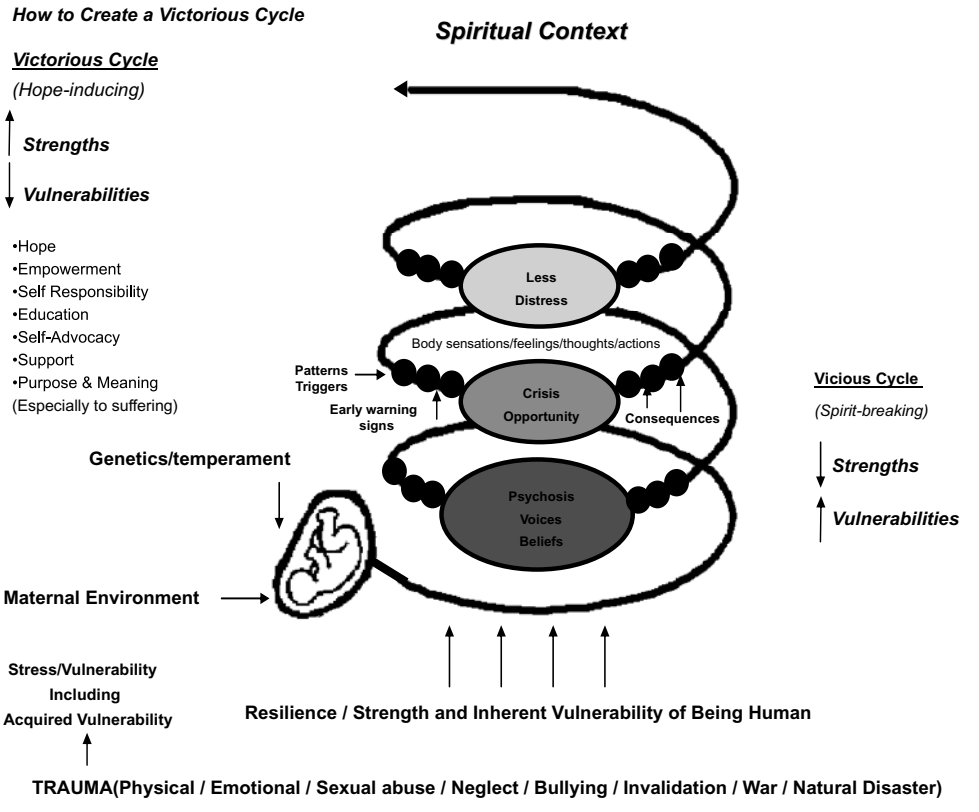

Figure 1. The Map of the Journey of Re-covery that forms a basis for explaining the Re-covery programme.

developmental challenges, such as problematic attachment patterns, require our response. We are all born with resilience and vulnerability. Importantly, our responses to these situations can change over time.

A three-dimensional spiral has two components: its circularity in two dimensions and its "movement" in a third dimension. The circularity of the spiral signifies that similar situations may re-occur (or be "re-covered") throughout life. Anniversary phenomena are an example of this, but many other situations also evoke similar patterns of response to more-or-less similar situations experienced previously. The movement in the third dimension signifies that when we "come round" to that similar situation we do not necessarily come back to the same place because our own development, experiences, expectations, etc., can affect and alter the situation and its impact on us either negatively or positively, producing either vicious or victorious cycles. Thus, we tend to re-cover the same old ground in our attempts to deal with the various challenges and traumas we experience. We encounter situations (crisis/opportunities) that trigger or "remind" us physiologically and emotionally of situations we have experienced in the past, but have not yet resolved. This "reminding" can happen on a somatic level, or be acted out behaviourally, without apparent awareness of the pattern. At each repetition of similarly triggering experiences (e.g. environmental insult, the trauma of loss and separation, sexual, physical, or psychological abuse,

invalidation, bullying, etc.) we may experience being re-traumatised and further harmed, thus *decreasing our strengths and increasing our vulnerabilities (the vicious cycle)*. This type of experience can be seen as "spirit breaking" (Deegan, 1996). This process can be mirrored in mental health settings where diagnosis and treatment can sometimes be experienced as coercive, disempowering and invalidating.

The result of acute or enduring challenges to resilience varies for different people. For some it may contribute to physical health problems or behavioural problems. Some with a particular bio-physiological and psychological make up, may, under some circumstances, experience psychosis or mood-related disorders as a consequence of their/our combination of stress and vulnerability (Read, Van Os, Morrison, & Ross, 2005). Trauma (Moskowitz, Schafer & Dorahy, 2008), and other factors can increase vulnerability to these experiences in some people. Others will develop severe problems with emotion regulation and distress tolerance, and may be viewed as having a "personality disorder" (Linehan, 1993).

On the other hand, with each new crisis situation we have the *opportunity* instead *to increase our strengths/resilience and decrease our vulnerabilities, thus creating a victorious, hope-inducing cycle*. We do this by learning to recognise our patterns – identifying the triggers and early warning signs of distress, and developing new skills to cope with life difficulties (see Figure 2). The Re-covery model aims to familiarise clients and clinicians with the possibility of enhancing their potential by moving from repeating the same old cycles to re-covering old ground in new ways.

This spiral journey is depicted as occurring in a "Spiritual Context". The concept of spirituality is increasingly regarded as an important component of mental health and recovery (Randal & Argyle, 2005). The term "Spiritual Context" will be diversely understood in different cultures (Randal, Geekie, Lambrecht, & Taitimu) and by different people (Geekie & Read). However, for many it will fall on a continuum from having an active relationship with a Divine creator which in part defines their relationship with the world, through to the other end of the continuum, which involves a personal sense of a meaningful, if not necessarily harmonious, relationship with their world. A frequent concomitant of mental health difficulties is to experience a rupture or other distortion in these relationships, and re-establishing a sense of connectedness may be an important priority.

Applying this model, an episode identified as mental illness such as psychosis or mood disorder, or an extreme behaviour such as a self-harm attempt, can be reframed as an opportunity to increase self-understanding, learning as a result how to change our patterns by taking better care of ourselves, enhancing existing coping skills, and learning new skills. For many people, being able to reframe suffering this way provides a sense of enhanced meaning and purpose in life. This can in turn equip us to make a greater contribution to others by using our experience-based learning.

This model thus provides a transformational framework of understanding and education which is supportive, empowering, nurtures self-responsibility and self-advocacy, and can help to foster a sense of purpose and meaning for all who use the approach: clinician, client, or significant other. By putting us "all on the same page", it reduces stigma, and helps to engender hope.

"Building a Bridge of Trust – Being With"

A second key aspect of the Re-covery Model is the concept of "Building a Bridge of Trust – Being With". Figure 3 (showing the actual graphic used in teaching) depicts

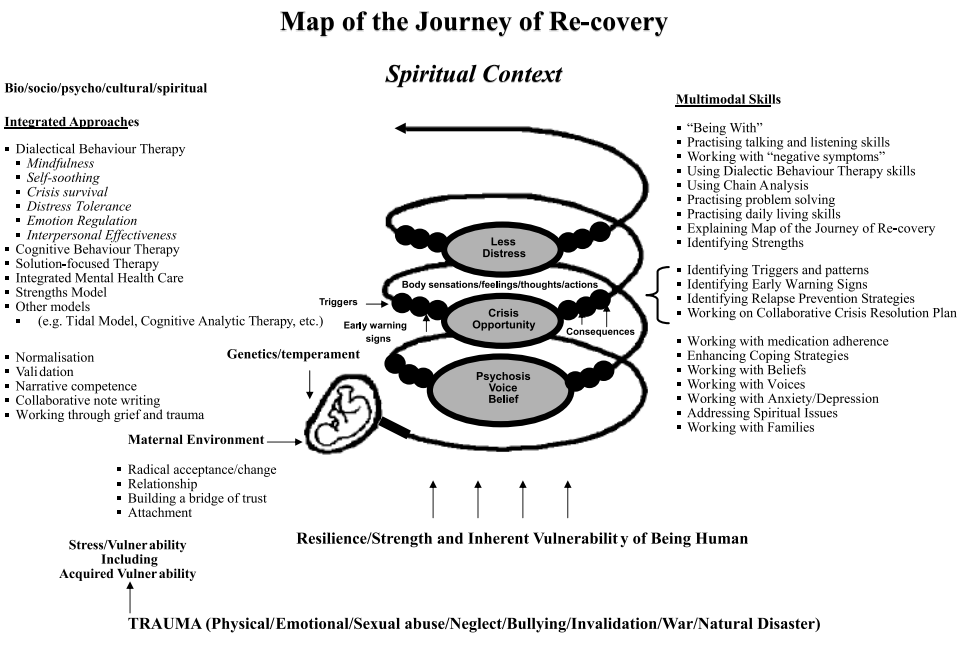

Figure 2. The relationship of multiple relevant interventions and models integrated into the Map of the Journey of Re-covery.

that we all have our own attitudes, values, beliefs, experiences, thoughts, feelings and memories that we bring into any relationship as we begin to build trust. These dimensions arise out of our own re-covery journeys and create the meaning-making context of our lives. The metaphor of the bridge emphasises that as clinicians we need to be aware of our own attitudes, beliefs, etc., including our own "professionally learned" explanatory models, and we need to attempt to cross the "bridge of trust" into the other person's reality, without judgement and with radical acceptance (Linehan, 1993), creating a safe context for the other person to share important aspects of themselves. It has been argued that it is the quality of the therapeutic alliance that allows this to occur irrespective of what therapeutic model and techniques are used (Krupnick et al., 1996). The highly intuitive and skilful act of "Being With" is required, and may be the primary intervention needed to facilitate the recovery journey (Borg & Kristiansen, 2004).

The "Bridge of Trust" metaphor allows clinicians of different disciplines to view the situation from the person's perspective. This metaphor also counteracts the "clash of perception" (Deegan, 1996) that so often remains unspoken and unacknowledged between the clinician and the client, and that can accentuate a power imbalance that leads to vicious cycles. The "Bridge of Trust" metaphor is also helpful within teams of clinicians from different disciplines and/or with different models of practice, to help build trust within the team. It also allows the client and their family members to listen to, accept, and validate one another's perspectives without having to agree on everything. In group settings and family work, the diagram is utilised to help facilitate brainstorming and sharing about what each person needs for trust to increase in the room.

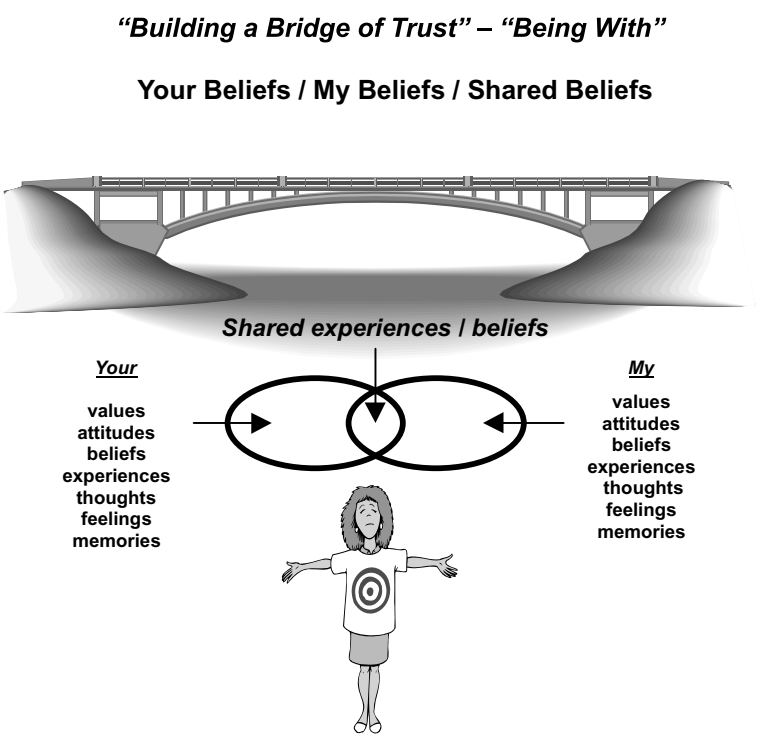

Figure 3. Figure for explaining the "Building the Bridge of Trust" concept to clients, significant others, family members, and clinicians.

"Mapping our Patterns, Triggers and Early Warning Signs"

A third major aspect of the Re-covery Model focuses on stopping vicious cycles through "Mapping our Patterns, Triggers, and Early Warning Signs". This is achieved by using the five-part model from Cognitive Behaviour Therapy (Padesky & Greenberger, 1995), and the DBT technique of chain analysis (Linehan, 1993) in the context of the Re-covery model. In Figure 1, the sequence of black dots in the middle of the spiral represent thoughts, feelings, body sensations and behaviours that lead to the "crisis/opportunity" and its consequences. These techniques are used to understand the chain of events that lead to or exacerbate the crises in our lives and also the patterns of our "re-covery" cycles. This knowledge can then be used to identify strategies to change from perpetuating vicious cycles to creating victorious cycles.

A chain analysis (Linehan, 1993) involves getting a clear narrative in chronological order of the situations, thoughts, feelings, body sensations and actions that lead from a triggering event (internal or external) to a particular outcome or situation (positive or negative). This narrative is used to explore how these factors interact to perpetuate vicious cycles in our lives, often through their consequences on ourselves and others. We improve our understanding of what makes us vulnerable, such as inadequate self-mastery and emotion regulation, imbalances in physical states (e.g. illness, sleep, exercise, and nutrition), and the use of substances (Linehan, 1993). We use this to develop and enhance our specific coping skills to manage troublesome emotions, body sensations, and thoughts/experiences. Learning to practice mindfulness (Segal, Williams, & Teasdale, 2002) can be important in this development. Becoming more

aware of the triggers that initiate chains, and finding ways of avoiding or modifying these, is important. This can occur as we begin to tell our stories and to develop "narrative competence" (Charon, 2001).

"Early warning signs" are explained as changes in body sensations, feelings, thoughts, and actions that are mapped out using prompt cards. Early warning signs are often subtle and highly individualised, thereby needing a flexible approach for identification. Prompt cards are individualised to reflect the individual's pattern of warning signs, and also to help identify strength behaviours, triggers, vulnerabilities, and risk behaviours. This increases awareness of potential risk situations, and allows development of action plans to be used early in the development of a vicious cycle to prevent an exacerbation leading to intense and potentially harmful or distressing experiences or actions. A similar set of prompt cards are used to identify the effects of medication on body sensations, feelings, thinking and actions, to enhance understanding of this, and guide strategies for mitigating these effects. These are utilised repeatedly so that people can practice identifying patterns in everyday life, and gradually formulate a collaborative crisis resolution plan. The cards are particularly useful for clients who find talking difficult, and were created in collaboration with a group of service clients.

Other important components in the Re-covery Model

The normalising component of the Re-covery Model posits that the challenges of recovery from mental health issues are very similar to the challenges of growth towards fulfilment for any human being, and many aspects of the journey for the client are similar to the journey for the clinicians they work with. The explicit optimism of recovery is partly operationalised in the Re-covery Model by this normalising approach and role modelled by clinicians who share personal experience of their own re-covery journeys. This helps promote hope, belief and expectation that recovery from mental illness is possible, and that one's own actions influence one's wellness and achievement of life goals.

Respect for the person and their role in their own recovery permeates the entire programme. It starts with respect for their own experience and learning, and flows through respect for their solutions and their power to create solutions. It also conveys respect through a slightly different relationship between clinician and client which, while not compromising ethical or professional practice standards or boundaries, strives to create more of a sense of equalness and collaborative exploration. The Model also facilitates a similar transformational learning process in staff, and potentially family members.

The Re-covery Model is an apparently simple model, yet it encompasses a high level of complexity. It escapes the linearity and unidirectionality of many models of mental health and intervention that can be misleading and unnecessarily limit understanding of the complexity and potency of change processes. Paradoxically, aspects of conventional care, including the thinking behind medical prescribing practice, have contributed to the vicious cycles. For many people, reliance on medication, and seeing "a chemical imbalance" as the *real* problem, is ultimately disempowering and can itself be stigmatising. Similarly, risk-averse conventional care practices, often at the expense of the therapeutic relationship (Sawyer, 2005), have paradoxically contributed to the increase in psychological risk for the person (by the disempowering and spirit-breaking nature of coercion). This style of care-taking has inadvertently promoted vicious cycles.

Additional to providing a framework for integrating therapeutic techniques, the Re-covery Model addresses the issue of stigma. Probably the most stigmatising and discriminatory aspect of mental illness diagnosis is the experience of being regarded as "other" – as "them", rather than "us". The World Health Organisation global anti-stigma campaign has identified separate but interacting vicious cycles for the individual, the family, and the mental health services, that engender and perpetuate stigma (Sartorius & Schulze, 2005). This exacerbates and perpetuates disability and disadvantage for the client, stress and difficulties for the family, and worsening performance and conditions for the mental health service. It is likely to continue unless actively interrupted (Sartorius & Schulze, 2005). The Re-covery Model addresses stigma through its normalising approach that emphasises the spectrum-like nature of the mental illness experience, and that, under some circumstances, anyone might experience psychosis or other extreme states.

How training in the Re-covery Model is delivered

As part of training, all participants, whether clients, clinicians, experience-based experts, or significant others, are encouraged to reflect on their own "Journeys of Re-covery". At least one facilitator in training groups using the Re-covery Model is an experience-based expert (EBE) (who may be a clinician) with lived experience of a serious mental illness diagnosis.

Staff training in the Model and the skills that support it has been delivered in groups of up to 24 participants, either as 3-hour weekly sessions over 12 weeks, or as 4 full-day sessions. The Model is presented repeatedly at different levels of complexity, gradually re-covering the material as new skills are built in to the training. Training utilises several methods, including didactic teaching, brainstorming, role play, personal reflection, and in vivo practise with modelling and coaching. Teaching includes a strong emphasis on supportive "Being With" skills, and skills such as working with negative symptoms, identifying strengths, talking and listening skills, explaining the Re-covery Model, using CBT and DBT skills, collaboratively identifying triggers, early warning signs, risk behaviours, and coping strategies, and crisis resolution planning. The model synthesises many internationally recognised evidence-based models (e.g. www.nice.org.uk) (see Figure 2). This synthesis reduces reliance on single model approaches while providing a strong theoretical structure on which multiple approaches can be combined coherently without descending into an uncoordinated and unhelpful eclecticism. Skills are taught for working with distressing beliefs, voices, anxiety/depression, addressing spiritual issues, and working with families. Practising new skills is a large component of training and skill acquisition is supervised and evaluated as an outcome of training.

The approach is used with Hearing Voices Groups and Beliefs Groups (1–2 hours a week for up to 10 weeks, repeated if necessary, including several staff participants as well as clients) and also in individual settings. The Model has been presented to groups of family members, as well as to individual families.

Current applications of the Re-covery Model, and evidence of success

The Re-covery Model has been embedded within practice at an inpatient mental health rehabilitation centre with 40 residents with enduring complex needs usually including psychosis. It is taught to staff, residents, and family members. Feedback

from participants indicated that it provided an optimistic and credible framework that counteracts the pessimistic perspective people have often received previously. This was seen as helping people to maintain their wellness and achieve personal life dreams and aspirations. Feedback from both staff and residents indicated enhancement of the residents' skills, leading to better distress tolerance, emotion regulation, interpersonal effectiveness, and problem solving ability. Residents reported greater capacity to identify strengths, cope with distressing behaviours, moods, voices and beliefs, and to manage crises effectively. They reported being better able to reframe crises as opportunities to increase personal learning and to reduce catastrophic responses. The Re-covery Model was also used in a forensic unit to successfully facilitate change in clinical situations that had previously been demoralising for all involved.

The Model underpins Key Worker Training and provides a philosophical foundation for the Acute Home-Based Treatment Service in a community public health system. It also underpins the Hearing Voices Groups and Beliefs Group run in local community services. It is being taught to both undergraduate and postgraduate nurses and to psychiatry registrars and psychiatrists. The Model has been taught to peer support workers in the NGO sector. It has also been taught to chaplains as a tool to facilitate understanding of mental health, spirituality and recovery. The possibility of incorporating the model into teaching in local churches suggests potential applications beyond the mental health system. The Model has received positive feedback in presentations at several national and international conferences. It is planned to implement the Model in other settings and to evaluate its effectiveness in improving recovery outcomes and changing staff attitudes and behaviours.

Clinical example

Mr Smith (not his real name) was a 46-year-old university graduate with a diagnosis of refractory schizophrenia despite treatment with clozapine. He was admitted to a rehabilitation unit because of an inability to care for himself. He previously had a high-paying occupation, but had not worked for 12 years. He denied having an illness. He expressed the belief that he had invented a cure for cancer and that his parents were not really his parents. He also believed that another service client had been shot by police after having been removed from the unit for damaging property and intimidating other residents. He had a history of childhood bullying.

Mr Smith regularly attended Beliefs groups, and engaged in learning the model. He established a strong alliance with the clinician/facilitators, one of whom had experience of psychosis and who shared examples of her own re-covery journey. The Bridge of Trust helped him recognise that, although his belief about the shot client was not shared by others, there was enough shared trust for him to seek alternative explanations. He discovered that the person he thought had been shot was at another hospital, and could see his belief was mistaken. He applied the Re-covery Model to reflect on the chain of events that led to his involvement with mental health services 15 years previously. He began to recognise the role of stressors (being fired from his work, and a relationship breakdown), and how this had affected his sleep, then his feelings, body sensations, thinking and actions. He recognised the vicious cycle that had ensued (including beliefs that he had been publicly targeted by his firm). Following this use of the Re-covery approach his self-care, physical health, and sense of wellbeing improved. He is making progress in seeking a job. He has enthusiastically shared his new understanding with his family, who were introduced to the Re-covery

Model at an evening session with other families, and, now, with readers of this paper, who he hopes will be inspired to use the model.

The Re-covery Model as a shared illness/wellness model

To make sense out of the experience of mental health difficulties and to develop paths to recovery, clients, their significant others, and clinicians construct explanatory models by which they understand the experience from their various viewpoints. These illness or wellness models (Lobban, Barrowclough, & Jones, 2003) serve to organise the beliefs and lived experience of the different stakeholders (e.g. service clients: Leventhal et al., 1997; significant others, and clinicians: Lobban et al., 2003) and guide their actions in response to the health difficulty. These models form the basis on which the different stakeholders develop strategies and responses (including emotional responses) to address the health issue (Leventhal et al., 1997). It is also notable that different clinicians within a team or organisation may have considerably different illness and wellness models, and these can lead to very different conceptualisations of the aetiology and nature of difficulties, different views of the value of various treatments, and different patterns of interaction with clients.

However, in the complex businesses of clinical interaction and striving for recovery, two aspects of the illness and wellness models may be of particular importance.

(1) Echoing Zubin and Spring (1977), are the illness/wellness models (individually and jointly) useful?
(2) How consistent and/or compatible are the illness/wellness models held by the main stakeholders?

A model that provides a usefully broad perspective and is relatively consistent between the main stakeholders can lead to a shared formulation that is sufficiently broad to indicate a range of intervention strategies that can address the range of issues facing the clients. Such strategies may include self-help and health-promoting activities, utilising social support, medication, etc. Finally, a useful model should not create a sense of undue distress or disadvantage for the person. The rise of the recovery approach (and the choice of its name) was partly a response against the dominant model of schizophrenia as a "chronic, progressively debilitating disorder", because this model was seen as less useful due to its potential for engendering unnecessary hopelessness, demoralisation (for both the client and clinicians), and distress (Ridgeway, 2001).

The agreement between the models of the clinician, client, and significant others may be more important than the model held by any one (Lobban et al., 2003). However, there is no guarantee that there will be a strong concordance between the models of the different stakeholders (Deegan, 1996), and there is frequently a poor fit between professionals' models, the models of clients, and their significant others' models. Different clinicians (particularly from different disciplines) may also hold different explanatory models.

To achieve optimal recovery it is important to be aware of the illness/wellness or explanatory models of the clients, the clinicians, and, as appropriate, significant others, and work to align these as much as possible. This at least in part involves negotiating a shared explanatory model that as far as possible exhibits the following characteristics: it is explicit enough that all parties who use it (i.e. clients, carers and

professionals) can reliably develop a shared understanding of it; it can be used consistently between parties, even if the depth of understanding of the elements will be different for each party; it is face-valid enough for each party – i.e. it makes sense to each from their perspective; it fits the "facts" (e.g. aetiological, experiential and clinical evidence) well enough; it is realistically optimistic, and it guides the choice of strategies for bringing about recovery. The Re-covery Model appears to meet these criteria, indicating that it provides an appropriate shared developmental illness/wellness life model for supporting collaboration and recovery.

Summary

This paper has presented the Re-covery Model as a framework for recovery-focused intervention that has high acceptability and utility for mental health clients, their significant others, and clinicians alike. The model is easily embraced by most clinicians as consistent with their beliefs and values as health practitioners and as human beings. It is also easily embraced by clients and significant others. It creates a useful resource for helping to align the illness/wellness perceptions of clients, significant others, and clinicians. This can facilitate a more collaborative mode of working, with higher levels of mutual understanding and more shared commitment to courses of action, potentially reducing psychological and physical risk. It provides a framework that assists mental health clinicians to utilise both the specific and non-specific aspects of therapy in a coherent but flexible approach that is highly consistent with recovery principles.

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Competing financial interests

The authors declare they have no competing financial or non-financial interests associated with this paper.

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