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Introduction

1.1 What is the recovery movement in psychiatry?

In 1999, the Surgeon General of the United States – the top physician for the country – issued a first-ever *Report on Mental Health* (Department of Health and Human Services, 1999). This 458-page tome included much important information and many surprises, but to those of us who consider ourselves part of the recovery movement, its most prominent feature came near the very end of the book with the simple assertion that all mental health care should be ‘consumer oriented and focused on promoting recovery’ (Department of Health and Human Services, 1999, p. 455). To naïve readers, this statement may appear simply to be asserting the obvious, that is if mental health services were not focused on promoting recovery, what else might they be for? Or perhaps some readers will see this statement as indicating that mental health care should just become more like general medical care, assuming more of the ‘customer service’ philosophy that has been spreading throughout medicine for the last decade under the rubric of ‘patient-centred’ or ‘person-centred’ care (O’Brien, 1987; O’Brien and Lovett, 1992; Laine and Davidoff, 1996; Marrone, Hoff and Helm, 1997; O’Brien and O’Brien, 2000; O’Brien, 2002; Tondora *et al.*, 2005; McCormack and McCance, 2006). The matter-of-fact tone with which this statement was made could certainly support either of these interpretations.

But for those readers who are more familiar with the history of psychiatry, and who are aware, in particular, of the history of the use of the term ‘consumer’ within psychiatry, this statement means something entirely different. Its appearance in a Surgeon General’s report on mental health in fact heralded the beginning of a new era in psychiatry, an era in which radical reforms are to be made in how we understand and treat mental illnesses and, equally importantly, how we understand and treat individuals living with mental illnesses. To those individuals who considered themselves mental health ‘consumers’, and to those other advocates of ‘recovery’ – a term we define below – who had been fighting a battle of values, principles and ideas for over 30 years, this statement indicated that we had, at last,

won a prolonged – if relatively bloodless – war. One of the many surprising things about this statement appearing in an official federal report in 1999, though, was that it was not at all clear yet what war precisely it was that we had won.

The following book represents one more attempt to help to define the nature of the war and the implications of its having been won for individuals with mental illnesses, their loved ones and the mental health practitioners, programme managers and system leaders who have the privilege of serving and supporting them. Perhaps it is not unusual for wars to be won before either party realizes all of what has been at stake and what exactly is to result from victory. The current wars in Iraq and Afghanistan certainly confirm this, but so do the American and French revolutions. So perhaps it is perfectly understandable that we now are in a position of having to establish, clarify and defend what it is that has been won in the process. Unlike the American and French revolutions, and the wars in Iraq and Afghanistan, however, this was a war that the vast majority of the public, including that segment of the public involved directly in mental health care, did not even know was being waged. It was for perhaps this reason in particular that the war's having already been won in 1999 came as such a surprise, at least to those of us who were not serving on the front line at the time.

Some readers will undoubtedly object to our use of the term 'war', as the mental health consumer and broader recovery movements have never involved use of force or other violent means. They have not even involved labor or hunger strikes, sit-ins, large-scale political rallies or other non-violent acts of resistance, although there have been occasional marches and the creation and dissemination of protest songs, folk ballads, inspirational poetry and manifestos. On the other hand, though, it is important to recognize that these movements were indeed in response to centuries of violence and bloodshed in which people with mental illnesses were stoned, burned at the stake, locked in cages, chained to posts and walls, confined to squalid and inhumane living conditions, insulin-shocked, hydro-shocked, electro-shocked and lobotomized.

Lest the reader think that these atrocities are all only in the distant past, or only continue to occur in the developing world, a recent report released by the US Medical Directors Council of the National Association of State Mental Health Program Directors suggests otherwise. Since the mid-1980s, there has been an increase, rather than a decrease, in the discrepancy in average lifespan between those with and those without a serious mental illness. While the discrepancy in lifespan was a 'mere' 12 years in 1986, it more than doubled to 25 years by 2006 (McCarrick *et al.*, 1986; Colton and Manderscheid, 2006). That means that in 2006 in the United States people with serious mental illnesses died on average 25 years younger than their peers. This loss of one-third of their lifespan is due to a combination of factors, including higher rates of suicide and substance use; a lack of access to and/or inadequate treatment of medical conditions like diabetes, heart and respiratory diseases; and higher rates of preventable and modifiable risk factors, such as obesity, poor nutrition and lack of exercise. It is hard to imagine that a prosperous society would tolerate a loss of one-third of the expected lifespan in any other population

of its own citizens, providing at least one clear and unequivocal indicator of the fact that stigma and discrimination continue to exist against individuals with mental illnesses – with concrete, tangible and appalling results.

The stigma experienced by and the discrimination against individuals with mental illnesses – while not carried out (any longer) through burnings at the stake, lobotomies or other violent means – thus remain nonetheless serious, life-or-death, matters. Add to this recognition of the huge numbers of individuals with serious mental illnesses currently being held in jails across the country for non-violent and petty crimes and one can begin to appreciate the need for radical reform. How did the Surgeon General's assertion that mental health care should be 'consumer oriented and focused on promoting recovery' intend to change this picture? What kind of transformation is required in mental health care – 'transformation' being the term chosen by the subsequent US President's New Freedom Commission on Mental Health to capture the degree of deep and substantive change required (Department of Health and Human Services, 2003) – and how is it to be achieved? To return to our metaphor, what war precisely is it that we have won and, perhaps even more importantly, what will we now need to do to establish and keep the peace?

We return briefly to the Surgeon General's landmark report. The sentence which follows the assertion quoted above reads: 'That is, the goal of services must not be limited to symptom reduction but should strive for restoration of a meaningful and productive life' (Department of Health and Human Services, 1999, p. 455). 'Recovery' for the person with the illness (the 'consumer') is thus defined as restoration of a meaningful and productive life. This is what the mental health consumer/survivor/ex-patient movement advocated, and this has been the overarching aim of the recovery movement: to afford people with serious mental illnesses the rights, opportunities and resources needed to lead meaningful and productive lives. The New Freedom Commission's final report which followed four years after release of the Surgeon General's report went several steps further, defining this life as involving living, learning, working (a somewhat puritanical list to which we have added the terms 'loving' and 'playing') and participating fully in community life, having as its vision 'a life in the community for everyone' (Department of Health and Human Services, 2003, p. 1).

At a minimum, this vision would suggest that individuals with serious mental illnesses should no longer be confined to hospitals or other institutional settings but should be free and enabled to live in the community alongside their non-disabled peers (Davidson, 2007a). The New Freedom Commission, and the Supreme Court's *Olmstead Decision* which was issued at almost the same time, stressed that this was a vision that should be accessible to everyone with a serious mental illness, no matter how disabled they may be or the nature of the supports they may require in order to live as independently as possible. It is rather an issue of (i) assisting the person in learning how to live with and manage his or her condition and (ii) identifying the services and supports needed to enable him or her to do so. The field of psychiatric rehabilitation will take on these related challenges and will

develop approaches and strategies for instilling hope and encouraging the person to mobilize his or her remaining strengths and resources in order to gain mastery over the illness; identify, set, pursue and accomplish personal goals; and, in general, live a meaningful and satisfying life in the face of an ongoing, if not necessarily life-long, condition (Corrigan *et al.*, 2008).

Two major obstacles to adopting a disability model and addressing these challenges in relation to serious mental illnesses are recognition of the fact that we do not currently have a cure for these disorders (even though many people recover fully from them nonetheless; Davidson, Harding and Spaniol, 2005) and the need to move from an acute care to a disease, or recovery, management model. Although we may already tell people with serious mental illnesses that they have ‘chronic’ diseases for which they may have to take medication for the remainder of their lives – just as people with diabetes have to take insulin – we have not taken this model very seriously ourselves. We have not fully accepted that there currently is no cure for psychosis, and that there does not yet appear to be promise of one any time soon. Instead, we insist that people adhere to prescribed treatments, including medications which have limited effectiveness (i.e. not nearly as effective as insulin), and expect them to wait until their illness abates before they resume their lives, as if they are suffering from an acute illness. We do not expect people with diabetes to put their lives on hold until the illness resolves, because we know that as of today we have no way to resolve the illness. They are thus encouraged to pursue their own hopes, dreams and aspirations – learn how to play football, drive a car, go on dates and marry – managing their illness within the context of this life as best they can. This is the meaning of the term ‘recovery’ in relation to serious mental illnesses that is used in the Surgeon General’s and New Freedom Commission’s reports, and the meaning of the term articulated and promoted by the subsequent federal *Action Agenda*, in which we read that the magnitude of change that will be required to implement this vision of recovery is ‘revolutionary’ (Department of Health and Human Services, 2005, p. 18).

The following book is concerned primarily with identifying what is revolutionary about this use of the term recovery and what its transformative implications for mental health practice are. Is it possible for serious mental illnesses to be treated truly the same as other chronic medical conditions? Is it possible to imagine a world in which serious mental illnesses were as well accepted, almost invisible, a part of life as diabetes? Will it be possible to develop supports and prostheses that represent the equivalent of psychiatric wheelchairs or Braille to help people compensate for the more enduring and disabling aspects of these ‘brain diseases’? Will we be able to afford people a personally meaningful and gratifying life in the communities of their choice while they continue to experience a serious mental illness? These are some of the questions that face the recovery movement in psychiatry, some of the questions that will have to be addressed in establishing, and keeping, the peace if we are to be successful in ushering in a truly new era in mental health, an era in which despair will be replaced by hope, demoralization and helplessness will be replaced by

dedication and commitment and empty lives will be filled with both the joys and the sorrows of ordinary everydayness (Davidson *et al.*, 2005; Borg and Davidson, 2007).

While the answers to these questions remain far from certain, earnest efforts are being made every day to come up with innovative and creative solutions to the problems posed by mental illness. We consider this book one of those efforts. We hope that as a result of looking backwards we will be able to offer some useful directions for moving the recovery movement, and the broader field of psychiatry, forwards.

Because we are primarily looking backwards, a note on the language used in this book is unfortunately necessary. We believe strongly in, and adhere to, person-first language in our own work, including in our own writing in this volume. We thus refer to individuals with serious mental illnesses as people with serious mental illnesses, or people in recovery, rather than as ‘the mentally ill’ or any one of the historical epithets used to refer to such individuals (e.g. ‘mental patients’, ‘schizophrenics’, ‘manic depressives’, etc.). It is, as we will repeatedly stress, a foundation of the recovery movement to view people with serious mental illnesses as people first and foremost, and only secondarily as people who have happened to develop a mental illness. The illness or diagnosis can no longer be viewed as subsuming the person.

We cannot, however, change the past. And thus, when quoting from some of these historical figures, we have had to include their own language, despite the fact that it may very well be offensive to some readers. We agree that it is offensive. But we also think it important to include their original language rather than to purge it of these offensive terms. For one reason, it is important that we be reminded of how people with serious mental illnesses were viewed and treated in the past so that we not repeat these same mistakes. Second, it can be taken as a sign of the progress we have made thus far that we no longer refer to such individuals as ‘maniacs’, ‘lunatics’ or ‘schizophrenics’. As here, when we use these terms in the text, we set them apart using single quotation marks to denote their historical significance and to remind the reader, if necessary, that these are now outdated terms of reference.

1.2 Rationale for the book

Why did we choose to write a book on the *roots* of the recovery movement in psychiatry? Especially for a movement so early in its evolution, and whose ultimate impact on the field is so far from certain, it may seem premature to be looking backwards and trying to discern its history. This is not that kind of history, however. We use the term ‘roots’ in a conceptual sense rather than in a historical one. In other words, this book is not a historical account of how the recovery movement actually came to be. There is a very simple answer to that question, which we and others have discussed elsewhere (Chamberlin, 1990; Deegan, 1992; Davidson *et al.*, 2009). For a more thorough and complex answer, we will all have to wait for the historians to take the long view of the role of this movement as a social, political and intellectual force in psychiatry; but many more years will need to pass before we will

be able to look back on and determine that history. It will be a very different history, for example, should recovery represent no more than a temporary fad, going the way of phrenology in the nineteenth century or problems in living in the 1970s, as opposed to bringing about the transformation of care that it currently promises to achieve (Department of Health and Human Services, 2003; Department of Health and Human Services, 2005). We will leave that determination for others.

What, then, do we mean by the ‘roots of recovery’, and why are we interested in them? The answer to this question is not nearly as simple as the historical one, but it is one that we think cannot wait until the movement has come to its natural conclusion. In fact, we think that the answer to this question – if given clearly, persuasively and with ample illustrations of its concrete implications – may be able to contribute to the eventual success of this movement, and it is for this reason that we are offering this book now rather than waiting until the movement has attained greater maturity. Briefly stated, many of our presentations, workshops and trainings on recovery and recovery-oriented practice have been met with the response: ‘But we are doing this already.’ Granted, this response only comes from a select few participants each time; it typically comes from those participants who have the most invested in the current system and who hold considerable power and authority over any possible changes that might be made in the future. They are, more often than not, those individuals we are most concerned about reaching in a given system, those individuals who most need to grasp and appreciate the scope and magnitude of the transformation that is involved in re-orienting mental health services to promote resilience and recovery.

As we noted above, according to the President’s New Freedom Commission on Mental Health, we are being called upon to ‘fundamentally refashion’ mental health care (Department of Health and Human Services, 2003, p. 5). According to the subsequent American federal *Action Agenda* that provides the blueprint for implementing the recommendations of the Commission:

Mere reforms to the existing mental health system are insufficient . . . Applied to the task at hand, transformation represents a bold vision to change the very form and function of the mental health service delivery system . . . It implies profound change – not at the margins of a system, but at its very core . . . (Department of Health and Human Services, 2005, p. 5)

Parallel documents in Canada (Standing Senate Committee on Social Affairs, Science and Technology, 2006), New Zealand (Mental Health Commission, 1998) and the United Kingdom (Care Services Improvement Partnership, 2006) reflect similar sentiments. Clearly, the organizations and institutions endorsing the recovery vision and recommending that all mental health services be re-oriented to promote resilience and recovery do not think that we are ‘doing it already’.

It is on this gap between a revolutionary vision for the future of mental health care and the current realities of everyday clinical and rehabilitative practice that

this book will focus. When we have asked our sceptics in what ways they are already offering recovery-oriented mental health care or practising in ways that promote resilience and recovery, their responses usually land in one of several camps. They may, for example suggest that recovery is simply a throw back to the days of ‘moral treatment’, in which humane staff used gentle, supportive and primarily educational interventions to help the residents of their asylums get back on their feet and resume their normal routines and responsibilities, a time during which ‘recovery’ rates were estimated to be as high as 90%. Or they may suggest that being recovery-oriented refers to the active listening and other efforts that psychoanalytically oriented practitioners made to explore and understand the subjective experiences, or inner lives, of their patients in psychodynamic treatment within the context of long-term hospitalization. Here much attention was paid to developing respectful relationships in which the practitioner helped the person to identify and pursue his or her own goals, with adherents of this approach claiming also to have seen the successful resolution of many cases (Karon, 2008). In both of these examples, of course, what appears to be overlooked is that the care provided was institution-based and that it was extremely difficult to establish and lead ‘a life in the community’ – the vision of recovery put forth by the New Freedom Commission – when confined to a psychiatric hospital. This point is also ignored by people who point to the heyday of the large state hospitals as evidence of a time when people with serious mental illnesses were put to work as part of self-sustaining farms, work for which they, unfortunately, were never paid.

At the opposite end of the spectrum, others will suggest that we already treat people with serious mental illnesses the same way we treat people with other chronic medical illnesses, such as asthma or diabetes. They agree with the sentiments that mental illnesses are illnesses like any other, that they are treatable and that people can live meaningful lives in the face of them. Others will argue that we have been ‘doing recovery’ at least since 1976, with the emergence of the community support movement. This was the movement that introduced such advances in practice as assertive community treatment, self-help and peer support, family education and support and psychiatric rehabilitation. It is true, of course, that use of the term ‘recovery’ in relation to serious mental illnesses did develop in its contemporary form (i.e. as opposed to during the moral treatment era) within the context of this movement. In these two cases, though, what appears to be lost is the important if subtle distinction between recovery, which refers to what the person with the mental illness does, and recovery-oriented care, which refers to what practitioners provide in support of the person’s recovery (Davidson *et al.*, 2007). We will argue in the following that the recovery movement is first and foremost a civil rights movement by and for people with serious mental illnesses (Davidson, 2006; Davidson *et al.*, 2006). It is only secondarily a movement which has implications for the way mental health practitioners practise. To the degree to which people associate recovery solely with how practitioners practise, they miss the critical and central role played by the person him- or herself. In this case, even if *we* (i.e. practitioners) do actually ‘do it

already’, this is of little consolation if people with serious mental illnesses have yet to reclaim their lives as citizens of their community.

In the end, however, we are not as much interested in refuting these examples as we are in learning from them. It is not helpful simply to point out how people offering up these examples have missed important aspects of recovery-oriented care, such as the desire to live in the community rather than in the hospital or the right to be paid a decent wage for one’s labor. What is more interesting is the way in which these examples were right about certain aspects of care, and what we can learn from these prior efforts. We could argue, for instance, that one thing that was common to all of these efforts was the recognition – as partial as it might have been – that people with serious mental illnesses remained people who had certain interests and capacities. If we agree with Patricia Deegan, an international leader of the recovery movement, that ‘The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with a mental illness are human beings’ (Deegan, 1993, p. 8), then this insight was a core element of these earlier approaches that is shared by the contemporary notions of recovery and recovery-oriented care. Rather than argue that we are not proposing a return to moral treatment or to exploratory psychoanalytic treatment, it is useful to acknowledge that the recovery movement does share certain values, principles and perhaps even strategies with some of these approaches. We certainly understand that this is not the first time in the history of psychiatry that we have attempted to treat people with serious mental illnesses *as* people. What we take up in the following volume is what lessons have been learned by these previous attempts, and how these lessons can help us in our current efforts to get it right this time round.

It is useful to note, for example, that people with serious mental illnesses participated actively in music, art, exercise and educational activities when offered such opportunities within well-staffed and therapeutically oriented hospitals. It is also useful to note that even within largely custodial institutions people with serious mental illnesses were able to work with little, if any, support. It is equally useful to know that many more people can work with supports, and that work has an ameliorative effect on symptoms (Drake *et al.*, 1994; Drake *et al.*, 1999). Each of these camps thus has important information and experience to offer us as we continue to push the notions of recovery and recovery-oriented practice further. By ‘roots’, then, we mean to refer to those prior efforts that have been made within psychiatry to treat people with serious mental illnesses as people and to afford them the opportunity to lead decent and gratifying everyday lives, either in the absence or in the ongoing presence of the symptoms of the illness. We will point out along the way some of what might have been missed in the earlier efforts, and in this way hope to persuade our sceptics that there is still much work to do in ‘achieving the promise’ (Department of Health and Human Services, 2003) of recovery-oriented care. Our primary focus, though, will be on what was learned through these efforts that was effective and helpful, hoping in this way to add flesh and bones to what remains a largely skeletal framework for recovery-oriented practice (Davidson *et al.*, 2009).

As we see it, the primary challenge for recovery-oriented practice is how to educate, encourage and support people with serious mental illnesses as they go about trying to figure out how to live a meaningful life with, compensate for and perhaps eventually overcome a serious mental illness. While there remains much for us to figure out in terms of the nature of the illness, its impact on everyday life and what we can do to educate and encourage people, there may also be much to learn from previous efforts to support people in having a life. We will begin to unpack in the following some of those lessons and their implications for ways to transform current practice. The remainder of this chapter provides a brief introduction to and overview of the various areas in which some of these efforts have been made.

1.3 From *traitement moral* to moral treatment

As we mentioned above, some people see the recovery movement as a return to the days of moral treatment. This was roughly a 100-year period between 1790 and 1890 in which people with serious mental illnesses whose families had the financial means could send them to an asylum or ‘retreat’ for convalescence and recuperation following an episode of mental illness, and during which they were likely to be treated and cared for by a benevolent doctor and staff who would gradually restore them to, or help them to achieve for the first time, a state of mental health, maturity and satisfactory functioning. As also noted above, success or recovery rates for these institutions were estimated to be around 90% for those patients admitted within a year of the onset of their illness, attesting to the effectiveness of this re-educational approach.

In this chapter, we will expand our focus beyond the specific strategies of this period to consider the humanistic elements that led up to the development of ‘*traitement moral*’ by Philippe Pinel and the humanistic aims which this approach was then deployed to achieve. We will begin this section, therefore, with the liberation of mental patients from the chains in which they had been held during the Middle Ages. We will find, perhaps surprisingly, that recognition of the value of hiring people in recovery to provide care to others – what is currently called ‘peer support’ – can be traced back to this era, when Jean-Baptiste Pussin, the governor of the Bicêtre when Pinel arrived there and himself a former patient of the hospital, was not only the first to remove the inmates’ chains but also the first to use the strategy of hiring convalescing patients to provide *traitement moral* to the patients of the asylum.

We will then follow Pussin and Pinel’s approach as it crossed the English Channel and then eventually the Atlantic Ocean, being transformed into what has come to be known since as ‘moral treatment’ proper. We will see that some things were lost from, and others added to, Pinel’s original vision in the translation from the French, with mental illness and its care taking on a much more paternalistic and moralistic tone under the influence of the Tukes and their like-minded contemporaries in Victorian England. Where previously there had been treatment for illnesses that were most likely to affect people of extraordinary sensitivity and talent, there came

to be an educational and disciplinarian approach to promoting self-control and restraint in people who had come to be seen as ‘wayward children’. Although the precise factors that account for the transformation of *traitement moral* into moral treatment are not clear, we suggest that one possible source of explanation is the difficulty involved in managing large institutions, regardless of their stated or explicit aims. It certainly was in part the rapid growth, over-crowding and under-staffing of these moral treatment retreats which led to their rapid demise.

1.4 Reciprocity in community-based care

After discussing the changes moral treatment underwent when adapted by British and American reformers, we will then consider the Herculean efforts of Dorothea Dix to spread the promise of moral treatment to all those afflicted with mental illnesses, despite their social class or their family’s ability to pay. Dix was particularly concerned with individuals who had ended up in jails and prisons and who, therefore, were not receiving any of the benefits of the available moral treatments. Within this context, we suggest that the magnitude of the work that remains to be done is indicated, in part, by the fact that there are even more individuals with mental illness in jails and prisons now than there were when Dorothea Dix began her crusade in the 1840s.

Acknowledging her importance to the recovery movement – as representing advocates who wish to secure appropriate and effective care for all those in need – we then turn to question the central belief that Dix held in common with both Pinel and the moral treatment proponents in the United Kingdom and the United States, namely that people with serious mental illnesses needed to be extracted from their everyday and interpersonal context in order to recover. In order to offer an alternative vision of how care can be provided in a person’s home environment and community, we take up the thinking and practice of Jane Addams, founder of the settlement house movement in the United States. Perhaps more than anyone else, the work of Addams provides a counterpoint to Dix and her wish to rescue people from their everyday lives. Coming from outside of psychiatry altogether, Addams offered the first model of what a comprehensive and holistic approach can offer in a community, as opposed to institutional, setting. Rather than bringing people to care, Addams and her colleagues brought care to the people they viewed as being in need, offering them the opportunities, encouragement and support needed for them to reclaim their lives out of the ravages of illness, addiction, poverty, discrimination, oppression, immigration and disability. Addams was perhaps the first to point out how it is not enough to establish a trusting relationship with someone who is suffering or in need, but that the way in which care, compassion and resources are offered to that person can also influence the degree to which, or the ways in which, that person will then be able to make use of such gifts.

The work of Addams offers us hints as to ways in which help can be offered to people in need without locking them into a second-class status or engendering their further dependency on help-givers. By reviewing the principles and lessons

learned by the settlement house movement, this chapter considers the positive characteristics required of community-based services and supports if they are not to perpetuate segregation and chronicity. 'Care', in this sense, is not something that is given by one person to be passively received by another, but rather involves creating or expanding access to opportunities for people to take advantage of in pursuing their own hopes and dreams and in giving to others. Indeed, within this framework the notion of 'giving back', which is frequently cited by people in recovery as an important foundation for their efforts, is given a central role in re-establishing and expanding the person's sense of self and agency. These key concepts will then be taken up again in Section 1.8, when we turn to the central role of agency in recovery.

1.5 The everyday and interpersonal context of recovery

The work of Addams is complemented nicely by turning next to the work of three leading psychiatrists who specialized in serious mental illnesses and the care of individuals experiencing and recovering from them. A contemporary of Addams, Adolf Meyer, considered by some the father of modern American psychiatry, was the first person from within psychiatry to propose a community-based alternative to moral treatment and mental hospitalization. Swiss born and trained, Meyer brought with him from Switzerland intimate knowledge of European psychiatry at the turn of the century and introduced to the newly emerging discipline in America the ideas of Emil Kraepelin and Sigmund Freud, among others. In contrast to their ideas (i.e. Kraepelin's belief that psychosis was an organic and progressively deteriorating condition and Freud's that it was both organic and a pre-Oedipal developmental fixation), Meyer's own view of serious mental illnesses was perhaps closest to Pinel's. Consistent with what we will read from Pinel's *Treatise on Insanity*, Meyer was perhaps the first American psychiatrist to take seriously the ideas that mental illnesses could be illnesses like any other, that many people can recover from them and that, even when they are ill, most people with serious mental illnesses retained areas of healthy functioning relatively in tact, co-existing with the illness.

Where Meyer differed from Pinel was in terms of the nature of the treatment required by this particular form of illness. Rather than viewing the illness as internal to the person, Meyer – like Addams – believed the illness, or what he termed 'problem in living', to arise at the interface between the person and his or her immediate social environment. In this case, it made little sense to extract the person from his or her situation, as the problem did not reside within the person per se. If the problem were to disappear with the person's removal from his or her life circumstances, it would just as surely re-emerge as soon as the person was returned to these same circumstances once the treatment or cure had been effected. In this way, Meyer viewed the person's everyday life within his or her social world as the primary locus for psychiatric research and intervention. Rather than sending them off for rest, respite and recuperation, Meyer believed that people could deal with and manage their difficulties within the context of their ongoing lives, rather, that is, than waiting for the illness to abate before returning to the community and resuming

their lives. He saw that it was through the process of navigating and negotiating everyday life, rather than in escaping from it, that people were able to build on their strengths in constructing satisfying lives. Although contemporaneous with him, Meyer in this way set the stage for the Russian psychologist Lev Vygotsky, with whom we will deal in Section 1.8. Both are credited with providing the conceptual foundation for the fields of occupational science and therapy, as both understood the central role of activity and occupation in human growth and development.

Much of the material about Meyer, his work and his influence will come from the one author of this volume who was trained in the era, and in the places, where this influence was most directly and immediately felt. Following this retrospective reflection, we then have asked John Strauss, the second of the leading psychiatrists discussed in this chapter, to summarize the findings from his own groundbreaking research. Being the senior partner in the trio of authors for this book, John has served as an invaluable mentor, friend and inspiration for the other two of us (LD and JR). The papers that he began to publish with his collaborator and friend William Carpenter in the 1970s on the course and outcome of psychotic disorders marked the beginning of the recovery movement for academic psychiatry. Simultaneous with the origins and development of the consumer/survivor/ex-patient movement in the United States, Strauss and Carpenter's work provided the scientific evidence to corroborate and confirm what people in recovery were saying. This body of rigorous longitudinal research, which John describes briefly in this chapter, has been one of the key sources of inspiration and information for the recovery movement since. It paved the way for the next generation of research on recovery and recovery-oriented practice in which we and others have been engaged, and for which we owe John a debt of gratitude.

As the last component of this chapter, we then turn to the work of Harry Stack Sullivan, who, more than anyone else, pioneered the development of a psychotherapeutic approach to working with individuals with serious mental illnesses. Although typically viewed as falling within the psychoanalytic tradition, Sullivan actually was equally, if not more so, influenced by thinkers such as Meyer and his American contemporaries than by Freud and his other followers. Sullivan's major original contribution was to view interpersonal relationships as the central medium for both the development and the treatment of serious mental illnesses. Like Meyer's 'common sense' approach to psychiatry, this point may now seem to be so obvious as to be taken for granted. Prior to Sullivan, however, people with schizophrenia were viewed as impossible to understand, and therefore impossible to relate to or to engage in meaningful, reciprocal relationships. The interpersonal milieu of psychoanalysis was viewed as inappropriate for people suffering from psychosis, leaving them to fall outside the boundaries of the emerging discipline of clinical psychiatry. Sullivan broke with this position, viewing psychosis as a basically human – rather than primitive or alien – condition and showing how interpersonal relationships, particularly with skilled and caring practitioners, could be therapeutic or healing.

Sullivan's early work took place within the context of a psychiatric hospital and could, in this way, be viewed as a continuation of Pinel's *traitement moral*.

Like Pussin before him, he made a practice of hiring recovering patients to staff his inpatient unit, convinced that their own first-hand experience of psychosis and recovery prepared them especially well for the tasks involved in caring for their acutely ill peers. While Pussin, Pinel and the Tukes all placed a premium on human relationships, they gave little thought to how specifically these relationships could effect changes in the person's mental health. Despite having to invent highly idiosyncratic, off-putting, terms to express his original ideas, Sullivan was able to demonstrate through his practice and his teaching that people could be welcomed back from psychosis through the medium of human relationships. The fact that he experienced a psychotic episode himself both lends credence to his views and makes him an especially appealing and relevant figure during this era of 'peer support' in which increasing numbers of people in recovery are being trained and employed to engage with and promote the recovery of their peers.

1.6 Closing the hospital

Following on the demise of moral treatment, it then required someone, or several influential someones, to realize that recovery was more likely to occur outside of the institution, where everyday life in the community naturally unfolded, than inside of the institution, where everyday life was in the hands of, and determined by, others. We focus on two of the central conceptual figures behind de-institutionalization, one of whom, Erving Goffman, primarily documented and demonstrated the destructive influence and iatrogenic effects of the hospital and the other of whom, Franco Basaglia, understood well these effects and went the farthest in actually closing hospitals and beginning to sketch out how life in the community could be supported and sustained among individuals with the most disabling mental illnesses.

As a classic text, Goffman's indictment in *Asylums* of what he terms the 'total institution' may well be understood at an intellectual level by students of the social sciences. There is much in what Goffman wrote about the asylum and institutionalization, however, which has yet to be fully appreciated at the concrete level of practice within psychiatry. As we are beginning to learn in the recovery movement, there are ways in which the effects of stigma and institutionalization extend beyond the walls of the hospital or even take up residence in the lives of individuals who have never been hospitalized. Goffman's understanding of how the institution can be recreated within the person's own psyche or identity may be useful in contending with what is currently being referred to as 'internalized (or self) stigma', which is being reported to pose as formidable a barrier to recovery as discrimination and the illness itself.

With profound insight into the ways in which the institution not only affected its inmates but also affected the very manifestation of the illness itself, Franco Basaglia might have gone further than anyone else before him in envisioning the possibilities that could be created by closing the asylum altogether. This he did at first in Gorizia, then in Parma and Trieste, initiating what has since been called the Italian mental health reform movement. Basaglia's efforts in Italy differed from the majority of

parallel de-institutionalization efforts in the United States and elsewhere by being grounded explicitly in an appreciation of the freedom and autonomy of people with mental illnesses and by developing community-based systems of care founded on the principles of social inclusion and participatory governance. Basaglia not only succeeded in securing funds for robust systems of community-based care (unlike the United States, for example) but also recognized that many of the characteristics of his patients that were thought to be intrinsic to their mental illness per se, the vacant stares, the word salad, the perseverative movements and gestures, appeared to melt away as they left the confines of the asylum. From these observations, he concluded that we would not know what mental illnesses were, or what limitations they would intrinsically place on individuals suffering from them, until both patients and staff were liberated from the culture, attitudes and beliefs of the asylum. With poverty, social isolation, discrimination and prolonged unemployment taking the place of the hospital, we suggest in the following that for the most part we still do not know what limitations are intrinsic to the illness per se, if any.

The more innovative aspects of this legacy are now being used as a basis for policy and programme development in Western Europe, Canada, Australia and New Zealand, and have begun to offer insights into how much less disabling mental illnesses may be when they are uncoupled from these attitudes and beliefs, many of which have survived well beyond the tenure of the institutions which gave them birth.

1.7 The rights and responsibilities of citizenship

Following the work of Basaglia to its natural conclusion, we then come to appreciate that a key aim of recovery-oriented care is to enable people who had been thrust to the margins of society to reclaim their basic citizenship as free and autonomous actors. As Rowe (1999) suggests, rather than recovery being a precondition of citizenship, it is achieved actually *through* citizenship. But what is the ideal of citizenship to which such individuals aspire? What exactly is involved in exercising one's citizenship? Is citizenship merely the absence of discrimination or oppression, or do we have a positive notion of citizenship which may provide more concrete guidance to mental health services? In this chapter, we turn to two perhaps unlikely figures to help us understand what is involved in reclaiming one's rights to citizenship along with the responsibilities associated with it.

While only peripherally interested in issues of mental illness and mental health, who better than the Reverend Dr Martin Luther King, Jr to turn to for guidance on the civil rights dimension of recovery? King learned many valuable lessons about what is entailed in an oppressed minority population staking claim to and winning the battle for their basic human dignity and rights. As we noted above, the recovery movement is first and foremost a civil rights movement initiated and led by, and for the direct benefit of, individuals with serious mental illnesses. There are more parallels between the battles for civil rights among communities of color, women and lesbian/gay/bisexual/transgendered people and those with serious mental illnesses

than one would initially or ordinarily think. This chapter considers some of these parallels and what they can teach us about future challenges faced by the recovery movement.

In addition to promoting human and civil rights, both King and the French philosopher and political thinker Gilles Deleuze cautioned people not to feel obliged to adjust or adapt to the world as it currently is, but instead to contribute actively to creating a world that is more like one thinks it could or should be. King, for his part, refused to adjust ‘to lynch mobs, segregation, economic inequalities, “the madness of militarism” and self-defeating physical violence.’ ‘The salvation of the world’, he writes, ‘lies in the maladjusted’ (King, 1981, p. 23). Deleuze took this sentiment further, challenging the very notion of adjustment as a psychological construct and drawing attention to its inevitable political function within a capitalist economic system.

One of the more enigmatic facts that we appear to know about recovery from serious mental illnesses is that it is easier to recover in non-industrial, non-capitalist countries. One of the more promising theoretical explanations for this disparity is that capitalist economies insist more stringently on people ‘fitting in’ or adjusting to the requirements of the labor force. King apparently was also beginning to understand this association between oppression and capitalism late in his life, as his attention turned more towards poverty and the Vietnam war as posing even more fundamental challenges to civil rights than racism. We look to the thought of Deleuze for guidance as to how to promote civil rights and citizenship among individuals with serious mental illnesses without falling sway to the seduction of a rigid capitalist notion of ‘normalcy’. While this line of thinking is still in its early stages, we consider it important enough to preventing individuals with mental illness from trading in one form of oppression for another that we devote the remainder of this chapter to laying out these ideas in admittedly rough and unfinished form.

1.8 Agency as a basis for transformation

Given the emphasis on agency emerging first from Addams and Meyer through Basaglia to Deleuze, we then take up this important notion more fully in this chapter, turning to the thinking of a largely under-appreciated (in the English-speaking world) but influential Russian psychologist, Lev Vygotsky, and an increasingly relevant Nobel Prize-winning political economist, Amartya Sen. What these two disparate thinkers have in common is their fundamental commitment to agency as a defining characteristic of human nature and their corresponding emphasis on activity, doing and occupation as core aspects of determining a person’s quality of life. In contrast to their actual chronological order, we will begin this discussion with Sen’s work, as it provides a more accessible point of departure and clear parallels to what we have learned thus far about recovery. With that framework in place, we then turn to the thinking of Vygotsky to help us translate these lessons into their implications for recovery-oriented practice.

Sen was an economist by training. But rather than focus in determining quality of life on what people have, as has been conventional in economics (but only within the last century, as Sen points out), he emphasized ‘the *actual living* that people manage to achieve’ (Sen, 1999, p. 73). Regardless of one’s material wealth, it is the capability to act and ‘to take part in the life of the community’ that is a fundamental expression of the person’s freedom and autonomy, without which he or she cannot function as a fully human being (Sen, 1999, p. 73). At the collective level, Sen showed how the investment of resources in enabling the population of a country to become free and active participants and contributors to the economy in the end generates prosperity and capital, whereas no amount of prosperity or capital in and of itself can ensure or bring about freedom. ‘The usefulness of wealth’, according to Sen, lies only ‘in the things that it allows us to do – the substantive freedoms it helps us to achieve’ (Sen, 1999, p. 14). Based on this central commitment to the priority of agency over possession, Sen distils three useful principles for a psychiatry that is attempting to help restore to people their sense of agency and efficacy in the world. These three principles are: (i) for choice to be truly free it must be determined by each unique individual for him- or herself; (ii) free choice necessarily results in variability and diversity, as unique individuals will choose different things from each other; and, finally, (iii) we cannot insist that people wait until certain material, social or political preconditions are in place in order for them to begin to choose, as people are born active agents who are always already making choices in their lives on an everyday basis (Davidson *et al.*, in press). We will see, as we turn to Vygotsky, how these principles have direct applicability in recovery-oriented practice.

For Vygotsky, action preceded rather than followed from thought, as did language. It was through the person’s active engagement with the world and with others that he or she learned how and what to think, adopted a shared language and eventually came to reflect on him- or herself and his or her place in the world. None of these things could be acquired, not to mention mastered, first or prior to action and activity, but instead were some of its by-products, as were habits, routines, social norms and a common culture. As a developmental psychologist (among other things), Vygotsky studied how these processes unfolded in children as they learned and grew over time. As we now know, people do not stop learning and growing when they reach adulthood, and these same fundamental processes are at play in adults as well. Vygotsky’s insights have since proven to have equal relevance for learning and growth processes in adults, including adults who are learning about and trying to figure out how to manage a serious mental illness while pursuing their life goals and aspirations. We close this chapter with two in-depth examples of how these insights shed light on and help us to understand what appear to be some of the central principles of recovery, principles which may have less to do with the nature of serious mental illnesses and more to do with the nature of human beings.

1.9 Why these figures and not others?

Some reviewers of the proposal for this book were concerned that our choices were too slanted to American developments or did not include important figures or traditions from outside of the United States. Others may consider our choices highly idiosyncratic and question our inclusion of people like Jane Addams, Amartya Sen, Martin Luther King, Jr or Gilles Deleuze who have had little if anything to do with serious mental illness or recovery. We acknowledge that these are not choices that would likely be made by most other proponents of recovery, but we also think it is important that mental health not remain as insular as it has tended to be in the past. There is much valuable knowledge and guidance that can be gleaned from outside of mental health, particularly as it relates to restoring the rights and citizenship of individuals who just happen to have serious mental illnesses. We mentioned this first in the preceding paragraph in relation to Vygotsky, but it applies equally well to others. As there is much more to individuals with serious mental illnesses than the mental illnesses they happen to have, there also is much more to the knowledge we need to acquire and the care we need to offer than what is specific to mental illness per se – especially, as we noted above, as we still do not know what is specific to mental illness per se and what stems from the social conditions under which people with mental illnesses have had to live for the last three centuries.

On the other hand, there are undoubtedly additional people we could have mentioned. Why, for example, would a book that is at least in part about efforts to humanize psychiatry not include representatives of humanistic psychology, such as Carl Rogers, Viktor Frankl or Abraham Maslow? Rogers was certainly a pioneer in the pursuit of active, reflective listening, Frankl understood the importance of having a sense of meaning and purpose in life and Maslow appreciated the urgency of meeting an individual's basic needs for home, income, food, safety and companionship. Although important, these are aspects of recovery that would appear to require less conceptual justification. Perhaps as a result of its success or influence, the aspects of recovery to which this stream of the humanistic tradition speaks are more easily taken for granted or considered of obvious value than those aspects to which we devote our time and attention in this book.

Very few people will argue, for instance, about whether individuals with serious mental illnesses need to have a safe and dignified place to live, food and a sense of meaning and purpose in life. Most practitioners will agree that taking the time to listen carefully to individuals with serious mental illnesses would be a good thing to do – had they the time to do so. What people will argue about, however, is where people should live and eat (e.g. in a hospital or a home, with or without supervision), whether a sense of meaning and purpose can be supplied or given by others (as opposed to needing to be actively chosen by the person him- or herself) and what value or function listening is ultimately to serve (e.g. to identify the person's own goals for his or her life or to identify leverage and evidence that

can be used to persuade him or her to adhere to prescribed treatments). In our opinion, answers to these questions are better found in the work of the thinkers and doers we have selected to focus on in this volume than in the humanistic tradition in psychology.

How about other innovations or other innovators in psychiatry? There currently is much stock being placed, at least in certain parts of the world, on treatment advances such as assertive community treatment, cognitive-behavioral psychotherapy, cognitive remediation or re-training and the development of newer and better psychiatric medications. Why don't we discuss these here? The original theoretical impetus of assertive community treatment of *in vivo* skills training and support has since made possible many of the advances made in psychiatric rehabilitation and can be found at the core of supported employment, supported education, supported housing and supported socialization. *In vivo* skills training, unfortunately, is one of those aspects of assertive community treatment which receives the least attention in the literature and in practice, resulting in many assertive community treatment teams becoming little more than mobile crisis or intensive case management programmes which, as Floersch has aptly described, have narrowed their focus to 'meds, money and manners' (Floersch, 2002). While there are efforts underway to make assertive community treatment more recovery-oriented (Salyers and Tsemberis, 2007), these efforts are limited primarily to decreasing the amount of coercion used and increasing the degree to which care is driven by the person's own goals, failing to constitute significant advances or breakthroughs in practice.

Cognitive-behavioral psychotherapy may constitute a significant breakthrough, especially as it relates to medication-resistant positive symptoms of psychosis. The underlying framework for this approach can already be found, however, in the work of Harry Stack Sullivan and his colleagues. While they did not develop the specific technical interventions involved in cognitive-behavioral psychotherapy in any explicit way, their practice was already an effort to explore the patient's own mental processes and ways of perceiving and understanding the world within the context of a collaborative and respectful relationship. We will, for this reason, take up briefly the topic of cognitive-behavioral psychotherapy in our chapter on Meyer and Sullivan. As a highly technical intervention addressing only a very narrow swath of psychotic symptoms, however, cognitive-behavioral psychotherapy can only be considered one useful tool among many in the recovery-oriented practitioner's toolbox. As there is much more to recovery than the reduction and/or management of the positive symptoms of psychosis, there needs to be much more to the care of individuals with serious mental illnesses than cognitive-behavioral psychotherapy alone.

The same case could be made for psychiatric medications, as they traditionally have only been effective in targeting these same positive symptoms of psychosis. We can certainly hope that new and more effective medications will be developed in the future, both with a broader focus than hallucinations and delusions and with fewer potentially lethal side effects. The modest progress made since the 1950s, however – especially when contrasted to the marketing claims made by

pharmaceutical companies and zealous investigators – does not give us much hope for the near term in terms of significant breakthroughs. It is also difficult to imagine making such breakthroughs, other than through accidental discoveries, when we know so little about the nature of the serious mental illnesses we are trying to treat. As we noted above more than once, we still do not know what mental illness will look like once freed from the institution *and* from the layers of poverty, unemployment, isolation, discrimination and social disadvantage layered on top of it in contemporary society. As Strauss suggested in 1994, it will continue to be difficult to make genuine breakthroughs in developing effective medications until we have a more focused and accurate descriptive base of what serious mental illnesses look like in the person's everyday life experience, until, that is, we know what it is we are trying to treat (Strauss, 1994a). We are still a long way from having such a descriptive understanding of these disorders (Flanagan, Davidson and Strauss, 2007).

We are more hopeful that such a process is now underway in the development and testing of approaches to cognitive remediation or cognitive re-training. We know from research that the cognitive impairments that appear to be associated with serious mental illnesses are among their most disabling features (along with negative symptoms). There are many efforts currently underway to better identify, understand and begin to address these impairments, and early results have shown promise. This is a genuinely new area of research that has opened up only within the last decade or so, made possible by revolutionary new insights into the plasticity of the brain and central nervous system. Once thought to be permanent and irreversible, we are now learning that damage to the brain can be lessened, compensated for and at times even reversed through the generation of new neuronal connections. These processes of regeneration can be stimulated both by somatic interventions, including psychiatric medications, and by life experiences, including the kind of mental challenges and exercises involved in cognitive remediation or re-training. We look to this area of research for exciting new developments in ways to address, compensate for and possibly reverse some of the more disabling aspects of serious mental illness, and expect these interventions to play increasingly prominent roles in the recovery-oriented systems of the future. If so, these interventions would figure prominently within the framework we describe in Chapter 7, as part of the activity analysis and rehabilitative approach inspired by Vygotsky. At this time, however, there is not much more we can say about such interventions other than to hope and pray for their eventual success in lessening some of the least visible, but most distressing, elements of the disorder.

Finally, the humanistic(-existential)-inspired work of R.D. Laing in the 1960s and 1970s, and of Loren Mosher and others since, is worthy of comment. These have been efforts to offer humane and supportive alternatives to inpatient care and forced medication for people experiencing acute episodes of psychosis, first in democratically governed therapeutic communities inspired by the communes of the 1960s and then later in crisis respite and residential programmes staffed by tolerant and understanding people who sought to guide people gently back from the abyss to

which their emotional distress had unwittingly taken them. We have not included a fuller discussion of this area of work for three reasons.

First, despite their protestations to the contrary, these approaches have tended to romanticize psychosis as a spiritual journey of discovery or self-actualization and have, in principle, denied people access to certain interventions, such as medication, that they might have found useful in lessening their distress out of a conviction that the distress needed to be ‘worked through’. In our experience, there is very little that is romantic or spiritual about psychosis per se, which is not to deny that spirituality and faith may play a key role in the recovery process. We view psychosis primarily as a serious and potentially fatal illness (e.g. one out of 10 people with schizophrenia commit suicide) which tragically disrupts a person’s life and from which he or she seeks relief. We do not believe in insisting that people ‘work through’ their psychosis to ‘self-actualize’, but rather that they are doing their best to ‘actualize’ themselves already and are trying to recover from or, if that is not yet possible, to find a way to live a decent and meaningful life in the face of this horrendous condition.

Second, the most promising elements of this approach to providing a humane and accepting environment for people suffering from an acute episode of psychosis as an alternative to inpatient care have been developed further by Shery Mede and others (Dumont and Jones, 2002) as a peer-run respite model which eschews the more controversial and, in our opinion, unnecessary aspects of the Laing/Soteria approach. This model for respite care has been highly successful to date and is beginning to be replicated across the country as one of several peer or consumer-run programmes, and in this sense is included in Chapter 3 under this broader rubric that dates, from our historical perspective, back to the groundbreaking work of Sullivan in the 1920s. As we noted above, at that time, Sullivan – like Pussin before him – made a practice of hiring individuals who had recovered from psychosis to staff his inpatient unit as he believed that they would have an increased sensitivity towards, and acceptance of, others who were suffering from the same condition as they had themselves experienced. He also thought that their life experiences offered them valuable knowledge and expertise that they could lend to the patients in their care, foreshadowing the explosion in peer-delivered services we have seen around the world since the early 1990s.

The third and final reason is important not only for justifying our exclusion of Laing and the Soteria House model but also for the consideration of many other approaches and interventions that others may think useful in promoting recovery. This reason is that Laing’s communities and the Soteria House model are acute care settings for acute episodes. Although it is of course important that people receive compassionate and competent care when experiencing an acute episode of psychosis or other serious mental illness, and that it is true that how this episode is handled could have longer-term repercussions for that person’s life, it is also true that most people with serious mental illnesses only spend 5% of their lives in acute distress (Wexler *et al.*, 2008). This means that they spend 95% of their lives not

in acute distress. The vast majority of recovery thus happens in that 95% of the time when they are not in acute episode, thus limiting the utility or effectiveness of interventions that are only oriented towards resolution of acute episodes.

This fundamental limitation of the Laing/Soteria model applies, therefore, to a much broader range of interventions and approaches and reminds us of Goffman's characterization of institutional care as a whole. Goffman likened hospitalizing someone with a serious mental illness to taking a drowning person out of a lake, teaching the person to ride a bicycle and putting the person back into the lake. While it is important that there are safe, dignified and supportive ways to assist people who are experiencing an acute episode of distress and/or psychosis, we should strive to avoid becoming overly ambitious about what can be accomplished within a short period within the context of a long-term condition. On the one hand, crises may represent opportunities for changing long-standing beliefs or behaviors. In this case, capitalizing on the opportunities represented by acute episodes may prove to be beneficial in the long-term. On the other hand, however, we have little reason to believe that acute care for serious mental illness is any different from acute care for a heart attack, a particularly severe asthma attack or an episode of ketoacidosis for someone with diabetes. In most cases, people need to recuperate from the acute distress, come to terms with its consequences for their lives, try to understand what might have caused it and, if possible, try to prevent it from happening again in the future. It will be in the remaining 95% of the time, which is typically lived outside of institutional settings, that they will have to contend with, manage and live their lives in the face of, despite, or alongside the illness. It is for this reason that most recovery-oriented interventions address people's everyday lives within the everyday community contexts in which those lives are lived.

1.10 Conclusion

We have laid out the beginnings of a framework for identifying, exploring and learning from various aspects of the recovery movement in psychiatry. At this point, it might have become evident to the reader that there will be a few fundamental or overarching tensions that will emerge from and permeate our study of the various thinkers and doers described above. Looking back from Vygotsky and Sen to Sullivan and Meyer, for example, we can see that there may be a tension between a focus on people as free and autonomous agents and a counterbalancing focus on their needs for social relationships, resulting in a dynamic view of what we will describe as 'self in relation'. Similarly, looking backwards from Goffman and Basaglia to Pinel and Dix, we can see that there may be a tension between an emphasis on choice, creativity and self-determination on the one hand and a counterbalancing emphasis on community membership and reciprocity on the other, resulting in a dynamic of what we will describe as 'self in society'. Finally, there is a related tension between Deleuze's attention to the rights of citizenship and Addams' attention to

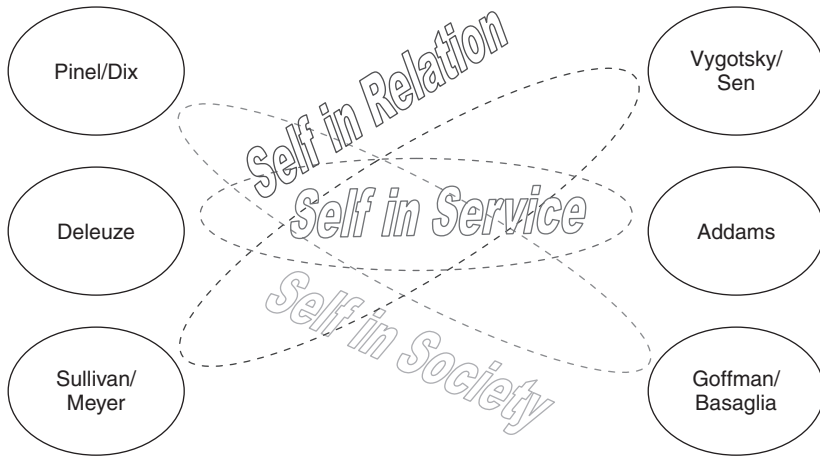


Figure 1.1 A schematic for three fundamental tensions in recovery-oriented practice.

the associated responsibilities, resulting in a dynamic of what we will describe as ‘self in service’. These various dynamics are depicted in Figure 1.1. In our concluding chapter, we will envision a dialogue between these various thinkers and doers which will help to explicate these tensions further and begin to establish a coherent conceptual framework for the development and dissemination of recovery-oriented mental health care.