Recovery Based Psychiatry (2024)

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Abstract:

Over the last several decades a Recovery Movement has developed in community mental health. It includes both a set of practices and programs (like outreach and engagement, housing first, psychosocial rehabilitation, clubhouses, Soteria model crisis response, peer support, harm reduction, shared decision making, and trauma informed care) and a set of values and principles (like meeting people where they're at, client driven, collaboration, nothing about us without us, empowerment, strengths- based, resilience ,and finding strengths in suffering). Most psychiatrists are separated from these practices and principles, unable to refer our patients, or provide recovery services in our own teams or programs, and especially not altering our own practices and prescribing to be integrated into Recovery Model treatment. To integrate ourselves we need to make three transformations (each with exemplary practices): 1) From illness-centered to person-centered (including relationship-based services, using formulations instead of check list diagnosis, quality of life goal driven medications), 2) From professionally-driven compliance to patient-driven collaboration, empowerment through education and patient choice, (shared decision making instead of informed consent, facilitating trial-and-error learning, and using patient explanations / perspectives of their conditions to avoid "lack of insight"), and 3) From deficit-based to strengths-based (building protective factors and resilience, building on their strengths, finding meaning in suffering, and deprescribing). We can develop comprehensive recovery-based prescribing to be a part of recovery-based programs and systems.

Introduction

Medicine is one of the last great guild professions. We spend a great deal of time and money being mentored, trained, and certified by other physicians. Our current "apprenticeship" process was systematized about a hundred years ago following the Flexner Report[1] in 1910 to separate ourselves from the folk and faith healers, the snake oil salesmen - and also historically black medical schools. The current system, while incorporating scientific and medical progress, has been impressively stable in its structure and practice. The treatment relationship and process - presenting complaint, history and examination, making a diagnosis, giving treatment orders to relieve illness

[1] Duffy TP. The Flexner Report--100 years later. Yale J Biol Med. 2011 Sep;84(3):269-76. PMID: 21966046; PMCID: PMC3178858.

symptoms, and tracking compliance and progress, followed by rehabilitation if needed – has persisted largely unchanged.

A century ago, the expected life span was 50 years and most people got ill or died from acute conditions, mainly infections and accidents, rather than chronic or degenerative conditions. Our ongoing, illness-centered, "medical model" is still best at treating acute conditions, now even including cancer, but currently with our much longer life expectancies, more people have chronic conditions. Beyond that, most people have heavy impacts from lifestyle, trauma exposure, social determinants of care, and substance use. Today, illnesses have become a major part of many people's ongoing lives and self-identities, not just medical conditions but also profound human experiences.

There have been some targeted efforts to adapt our medical practices to this changed reality. Notably, Edward Wagner developed a Chronic Care Model[2] at the University of Washington based on collaborating with an informed, activated patient, centered on their perceptions and goals. Other adaptations have occurred in highly complex, impacted areas including person-centered care in hospice, peer support in 12-step programs, family approaches in neonatal ICUs, patient-driven birthing plans in obstetrics, and anti-stigma and civil rights approaches with AIDS patients.

Acute Illnesses vs. Chronic Illnesses	
Recovery Goals	**Recovery Challenges**
Recovery from acute conditions usually results from removing illness or symptom relief Recovery from chronic conditions usually results from: o Being able to maintain self-image and have hope o Being able to maintain wellness and responsibility for self-care o Being able to do things that make life meaningful o Being able to replace professional supports with natural supports	With acute illnesses it's reasonable to withdraw from life while being treated, whereas, with chronic illnesses the patient should try to maintain their "normal" life while being treated. The ongoing symptoms of chronic illnesses often make it hard to maintain a "normal" life, necessitating rehabilitation to increase function, personal adaptations to cope, and community adaptation to maintain access to life. Chronic illness more often than acute illnesses effect people's self-identity.

[2] Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? Eff Clin Pract. 1998;1:2-4.

For acute illnesses recovery is illness-based *For chronic illnesses recovery is person-based* *People with long term conditions with persistent symptoms are those most in need of recovery-based services*	• Hope is more difficult to maintain for both patients and professionals with chronic illnesses because the symptoms resist treatment and helplessness settles in.

People with serious mental illnesses being treated in community mental health rarely have acute, uncomplicated conditions or lives. They have high concentrations of multiple factors that make them very difficult to treat with a traditional medical model or even a multi-specialty approach. Since deinstitutionalization, and especially within the Recovery Movement, a number of important adaptations and new services have been developed, many by people with mental conditions, to more effectively serve these people. Unfortunately, there has usually evolved a separation between these psychosocial recovery-based services and our traditional psychiatric services.

This lesson describes these recovery-based adaptations, how to collaborate with them, and how to apply them directly to medication services.

Examples of Recovery Based Programs and Approaches

Much of the Recovery Movement began with a "consumer movement", with outspoken, often angry people, upset at how we treat them. Instead of focusing on these "angry outsiders", let's begin by trying to learn from people who have recovered with serious mental illnesses, especially those who have made a career out of helping others to avoid some of the suffering they went through to recover too, the "inside reformers".

Here are a handful of key inspiring and instructive examples:

- In the 1930s Bill W and Dr Bob, both alcoholics, developed the Alcoholics Anonymous program[3], a 12-step journey of recovery, that incorporates rational, emotional, interpersonal, and spiritual strategies to facilitate recovery for each other. Treatment professionals are excluded, replaced by peer support, as is the non-alcoholic, likely rejecting, public to create a counterculture of acceptance.
- In the 1940s, patients discharged from Rockland State Hospital in New York were lonely and isolated in New York City and began meeting with each other on the steps of the library next to the stone lions there. Instead of just kicking them out, community volunteers helped raise money for a building of their own, Fountain House[4]. The patients run the entire program using their strengths and skills.

[3]https://www.aa.org/alcoholics-anonymous
[4] https://www.fountainhouse.org/

Unlike in clinical settings where they are helpless and cared for, at Fountain House they are needed and responsible. Their work there is essential and meaningful. In order to preserve this culture, they do not include mental health professionals in their program.

- In the 1980s Patricia Deegan[5], who recovered from schizophrenia, became a PhD psychologist. She describes her first experiences with medications and a lifelong prognosis of disability, as taking away her dignity and hope. She created a "conspiracy of hope", cofounded the national Empowerment Center, created a training for professionals to experience what it's like to hear voices to increase our compassion, and created the Common Ground program to help people take more control of their medication appointments negotiating their own "personal medicine".
- At the same time, Dan Fisher[6] recovered from his schizophrenia to become an MD PhD psychiatrist by realizing that he wasn't just a product of the chemicals in his brain, he had free will, and that he was going through an emotional crisis he couldn't handle alone, but needed close emotional supportive relationships. He created the PACE (Personal Assistance in Community Existence) recovery program, has championed peer support, and created the Emotional CPR program to help the public be able to support each other through emotional crisis rather than relying on professionals.
- Also in the 1980s, Marsha Linehan[7] recovered from Borderline Personality Disorder connected to childhood trauma to become a psychologist. She created Dialectic Behavioral Therapy (DBT) to help people develop emotional and mindfulness skills to deal with the consequences of their past trauma. She didn't reveal her own history until after she was well established professionally.
- "Voice hearer" Patsy Hage and her Dutch psychiatrist Marrius Romme founded the international Hearing Voices Network[8] in 1987 for people to meet with other people who hear voices to help make meaning of them, integrate them, and live with them as real experiences in their lives.
- Mary Ellen Copeland, PhD, developed the Wellness Recovery Action Plan (WRAP)[9] with a group of people with lived experience who were attending a mental health recovery workshop in 1997. This program for self help includes

[5] https://www.patdeegan.com/
[6] https://power2u.org/
[7] https://behavioraltech.org/
[8] https://www.hearing-voices.org/#content
[9] https://www.wellnessrecoveryactionplan.com/what-is-wrap/

three levels – maintaining when doing well, ramping up in stressful times, and responding to crisis.

All of these programs have been carefully developed and are quite effective, but, except for AA, they are not widely available or included in our system of care. Even AA is funded and run independently of the system. Before we discuss what we can learn from these programs, let's add some more programs and approaches to the list:

- By focusing on illness treatment, we've largely insisted that people need to be symptom free before they can reintegrate with life. They're not "ready" until they're stable. This approach ignores the reality that most people are motivated to engage in treatment because they're struggling to achieve life goals, rather than motivated to pursue life goals because they've been well treated. It also deprives the vast majority of still symptomatic (or still using substances) people from opportunities to rebuild their lives, often segregating them in "treatment settings" away from the community. Led by staff at Boston University, Dartmouth, UCLA, and others, psychiatric rehabilitation, psychosocial rehabilitation, housing-first, and "supported" housing, education, and employment services all give people support and opportunities to learn by failing (and succeeding), and to grow by doing (the same way people normally best learn and grow).
- Instead of focusing family interventions on mental illness management education, so families can implement psychiatric treatment within their families, the Open Dialogue[10] approach developed in rural Finland has been used for several decades quite effectively, focusing on helping families and communities sustain a natural network of relationships around a person in a mental crisis to support them in their recovery. The staff hold frequent meetings in the home and community with whoever cares about the person, helping them stay connected.
- Instead of telling people who are abusing alcohol and drugs that they need to get sober before we can help them, or waiting for them to "bottom out", harm reduction[11] and motivational interviewing[12] techniques have been developed to work with people who are still using, often denying using, and who don't want to or can't stop, "meeting them where they're at".
- Building on early therapeutic communities in hospitals and using staff with skills "talking down" people on drugs, NIMH director Lauren Mosher developed the

[10] https://open-dialogue.net/
[11]https://www.samhsa.gov/find-help/harm-reduction
[12] Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd edition). Guilford Press

Soteria house[13] approach in the 1970s - being with people in crisis with early psychosis, usually without medications, focusing on relationships and personal healing, in a home-like environment – that was cheaper and more effective than hospitalization and medications. This approach has been incorporated into various peer-run crisis and residential programs, and integrated "living room" crisis programs.

- Inpatient facilities, and ERs can lower the use of seclusion and restraints by relating empathetically instead of confrontationally to the patients who are likely more frightened of us than we are of them and are being triggered and retraumatized by our actions[14]. "Trauma informed" staff can help people recognize and better cope with their triggers instead of escalating them by trying to control and contain them. Bolstered by the findings in the Adverse Childhood Events Study (ACES)[15] more attention has been paid generally to the role of trauma (along with protective factors and resilience) in the development of behavioral and medical conditions. For example, Gabor Mate heavily included trauma and its biological impacts in his work with severe addicts in Vancouver's skid row[16] and Dr. Bessel van der Kolk[17] has repeatedly unsuccessfully tried to get Developmental Trauma Disorder into DSM while building treatment expertise[18].

Since about 1990, many of these programs have loosely identified themselves as part of the Recovery Movement. The list is now quite extensive, but the prevalence and availability of these programs is quite low. They are largely excluded from the standard Medical Model system, considered "gravy" to be provided after the core psychiatric

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[13] Mosher L.R. (March 1999). "Soteria and other alternatives to acute psychiatric hospitalization: a personal and professional review". Journal of Nervous and Mental Disease. 187 (3): 142–149.

[14] https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-1.pdf

[15] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American journal of preventive medicine, 14(4), 245-258.

[16] Mate, Gabor (2010) In the Realm of Hungry Ghosts: Close Encounters with Addiction. North Atlantic Publishing

[17] van der Kolk, Bessel (2015) The Body Keeps the Score: Brain, Mind, and Body in the healing of Trauma. Penguin Books

[18] van der Kolk, B. A. (2005). Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories. Psychiatric Annals, 35(5), 401–408.

needs are met (which they rarely are). Additionally, most psychiatrists have limited exposure to these programs, don't refer to them or coordinate with them, or work within these Recovery Model settings.

Recovery Model Programs	
Public Health	Emotional CPR Decrease child abuse / neglect Strengthen families and communities Substance abuse prevention
Individual Prevention	Headspace Programs (in malls for adolescents) Building protective factors (financial, housing, family, relationships, positive self-identity, emotional development, spiritual beliefs / practices) Building resilience (internal and external) Building emotional awareness, self-care, and relationship skills Decrease isolation / loneliness
Engagement	Drop-In Centers Consumer and Family Greeters and Outreach Workers Housing First Programs Harm Reduction and Motivational Interviewing Open Dialogue Police Quality of Life and Homeless Outreach teams Mental Health, Drug, and Homeless Courts
Rebuilding Life / Recovery	Supported Housing /Employment / Education ("in vivo" skill building) Psychosocial Rehabilitation\ Clubhouses Voice Hearers Wellness Recovery Action Plans (WRAP) Personal Medicine / Common Ground (Patricia Deegan) 12-step recovery programs CBT, including CBT for Psychosis Moral CBT DBT Person Centered Therapy Narrative Therapy Compeer PACE (National Empowerment Center) NAMI programs[19]

[19] Duckworth, Kevin (2022) You Are Not Alone: The NAMI Guide to Navigating Mental Health—With Advice from Experts and Wisdom from Real People and Families. Zando Publishing

Service Coordination / Intensive Ongoing Support	Peer support Peer Bridgers (from institutions to the community) Personal Service Coordinators Full Service Partnerships (ACT based) Integrated Service Agencies (“One Stop Shops”)
Crisis Response	Soteria model crisis residential programs Living Room crisis programs Psychiatric Advanced Directives Collaborative mental health / law enforcement teams Trauma-informed inpatient care to reduce seclusion and restraints

Let’s look next at what these programs have in common, and what differentiates them from even good Medical Model services.

Recovery Movement Transformations:

These programs all require three paradigm shifts from the traditional Medical Model: From Illness-Centered to Person-Centered, from Professionally-Driven Compliance to Client-Driven Collaboration, and from Deficit-Based to Strengths-Based[20]. To include these programs, the “system” needs to make these three transformations. For psychiatrists to collaborate and integrate with these programs, we need to make these three transformations in our practices.

1) From Illness-Centered to Person-Centered:

We move from centering our efforts on the treatment of illnesses and the reduction of symptoms to a holistic service rebuilding lives. This transformation is the one that allows us to focus on helping people have better lives, instead of just having less symptoms. It integrates the psychosocial, developmental, traumatic, and even spiritual factors as crucial components of the person’s individual “story of a life” rather than relegating them to background in the “history of present illness”. It allows us to focus on life stressors, protective factors, and quality of life outcomes. *Recovery is something a person does, not what an illness does*.

Examples for psychiatric practice

- Relationship-based services: Instead of beginning our treatment with a diagnostic assessment to base treatment upon, we can begin with engagement in a trusting, working relationship. We can do that with emotional listening,

[20] Ragins, M and Sunkel, C (2023) “The Recovery Model and Other Rehabilitative Approaches” in A. Tasman et al. (eds.), Tasman’s Psychiatry. Springer, Cham

self-disclosure of shared experiences, building hope, personalized responses ("you treated me like more than just another case"). Doing so increases the chances they will disclose more about their lives, come to see us again, collaborate more fully, and even have more positive and less negative nonspecific, "placebo" treatment responses

- Using formulations instead of check list diagnosis: By together creating a holistic story of their lives, (for example they had their children taken away when they lost their job, even though they promised themselves as a foster child that they'd never let that happen, and now they're heartbroken, ashamed, and withdrawn and can only face life with drugs.) that they can recognize and agree with, instead of a set of generic, jargony diagnoses, they're more likely to feel understood, find meaning and strengths in their suffering, and be more likely to be able to see a hopeful path forwards, a recovery narrative.
- Quality-of-life goal-driven medications: By targeting medications at their personal, concrete goals (generally better abilities, functions, and roles), they can judge whether medications are helping them in ways that matter to them, without needing biological "insight". They can also determine when to stop medications based on sustained goal achievement, rather than "feeling better".

2) From Professionally-Driven Compliance to Client-Driven Collaboration*:*

We move from professional directed relationships emphasizing informed compliance with prescribed treatments to individualized relationships emphasizing empowerment and building people's self-responsibility. This transformation is the one that focuses on outreach and engagement, preserving hope and dignity, motivation, and self-determination. Rather than teaching peer supporters to act more professionally, it teaches professionals to act more emotionally connected, supportive, and empathetic walking alongside people. Power, perspectives, and decision making are shared. *Recovery isn't something a professional can do to a person. It is a process they must engage in to help themselves.*

Examples for psychiatric practice

- Empowerment through education and patient choice: We should present information, and opinions, using a variety of paradigms, not just a medical model paradigm, including culturally informed paradigms. We should encourage them to tell us what they've learned and believe. Especially when we're coercing people, we should give as much choice as possible, to push towards self-determination and self-reliance.
- Shared decision making instead of informed consent: Instead of the professional creating the plan, or even choice of plans, explaining it to them to get their

consent (and protect us from liability) we can combine their deep knowledge of what they're personally experiencing, their values and goals, and what works and doesn't work for them, with our deep knowledge of what options and resources are available and usable for them and the probable impacts, both short and long term to come to a shared decision that is better, more personally applicable, and more likely to create motivation and follow through, than any decision that either of us would've come to on our own

- Trial-and-error learning: People are going to actually take medications in a variety of ways besides complying with our orders. We should be open to them describing what they're doing and how it's working good and bad, to help them learn from their "experiments", instead of criticizing them for "playing with their medications" or sabotaging their treatment". We need to help them learn to "use" medications, not just "take" medications to get long-term positive usage.
- Using patient explanations / perspectives of their conditions to avoid "lack of insight": Working form our "shared formulation' of the story of their life, in their words, we can describe how medications can help them move their stories forwards. For example, sometimes medications help keep down overthinking, or stop other people's feelings form overwhelming you, or help keep your emotional unconscious in your dreams instead of during the day, or help you be more glued together, or separate yourself from your anxiety so you can manage it instead of drowning in it.

3) **From Deficit-Based Cures to Strengths-Based Resilience**:

We build hope for recovery upon each person's strengths, motivations, and learning from suffering rather than upon the competence of professionals and medications to reduce or eliminate the burden of their illnesses. This transformation focuses on building protective factors, emotional skills, and resilience. It expects people to generate hope, personal identities, relationships, and community roles from their strengths and what gives their lives meaning, rather than on being stable enough not to be troublesome. *Recovery doesn't happen when the person never has any more symptoms, even serious ones, but when they have the strength and resilience to handle whatever stressors and symptoms occur.*

Examples for psychiatric practice:

- Building protective factors and resilience: Risk factors lead to symptoms and crisis in the absence of protective factors (enough money to make it through the month and extra for emergencies, stable reasonably safe housing, family connections, other supportive adults, a personal identity beyond being mentally ill, emotional development and maturity, and spiritual beliefs and practices). If we focus on

proactively building these factors, people are more resilient (both internally and externally) when the inevitable next risk occurs, and we can more easily break the cycle of crisis.

- Building on their strengths: Our life story formulations should focus not just on what their risks and triggers that knocked them down are, but also on what helped them, again internally and externally, to get up again. "I can already see in you the strengths you're going to use to recover."
- Finding meaning in suffering: Just relieving suffering by eliminating symptoms, helping people recompensate "back to themselves", will usually set them up for the next deterioration / relapse. We need to help people learn "from the school of hard knocks" how to stop the cycle of suffering. Crisis are opportunities for growth and recovery, if we can make meaning out of our suffering.
- Deprescribing[21]: Since the invention of Prozac, and then other easily tolerable medications, we have largely moved from a "targeted / episodic" method of prescribing (adding pills when needed, then tapering off when the episode has improved, or been "grown out of", watching for warning signs to restart medications before things get too bad again, while learning other ways to deal with the underlying issues or changing your life) to a "maintenance / preventive" method of prescribing (taking medications indefinitely to keep an "underlying chemical imbalance" under control). This move, initially driven by positive side-effect medication profiles, has led to a reversal of describing our DSM diagnostic categories as "results" of a variety of issues - including biological, emotional, trauma, social, cultural) to "causes" of symptoms (You feel depressed and slowed because you have a Major Depression, not because you're a battered wife or are impoverished and repressed or you lost your job for using drugs or you're hiding that you're gay or…). We've created a lot of psychological helplessness and dependency on medications. Responsible deprescribing can help contribute to growth and learning.

Without these paradigm transformations our attempts to include recovery-based practices will be distorted from their original intents and lose their power. For example, if motivational interviewing is used in a professionally-driven practice, it will become a manipulative, self-serving tool to promote compliance rather than facilitating and promoting the person's internal growth and decision-making processes. If harm reduction is used to reduce the system's negatives of ER and hospital visits, it can become cynical and sometimes feel unethical, rather than being a tool of engagement and trust building. Housing-first that doesn't include supported, in-vivo skill building,

[21] Gupta S, Cahill JD. A Prescription for "Deprescribing" in Psychiatry. Psychiatr Serv. 2016 Aug 1;67(8):904-7.

based on the person's goals, ends up being a staff-driven process of enforcing housing rules, and tolerating or kicking out people.

Comprehensive Recovery Model Prescribing[22]

Let's move on to integrate these recovery-based transformations and these recovery-based practices and programs, not as an add-on to successful illness-based treatment, but as a transformed, comprehensive recovery-based prescribing process. Here's an introduction for patients:

> *"You're born with whoever you are – your strengths, weaknesses, talents, temperament, even a blueprint for your growth and development comes in the factory packaging in your DNA.*
>
> *And then life happens. Sometimes it's warm and supportive and you blossom and grow. Sometimes it's neglectful and traumatic and you're bent and bruised, growing in ways you never expected to or wanted to. Lots of times it's supportive in some ways and traumatic in other ways.*
>
> *Sometimes you get stuck, spinning your wheels, banging your head against a wall, getting more and more damaged. We call the results of getting stuck and damaged mental illnesses and give diagnostic names to common clusters of suffering. Since there are lots of ways of getting stuck and damaged, there are lots of causes of mental illnesses. We're looking for what you need to change about your life, or how you're dealing with your life, or how you're feeling, or maybe some medications to help you get unstuck and back on track again.*
>
> *It's likely that when you're not stuck anymore, when you're growing again, when you're back in balance and connected to others, you can get off the medications and the therapy. Down the road, it's certainly possible that life will damage you again, but at least you'll know what's going on. You might not get as stuck and damaged, and you'll know what to do to get back on track again, maybe even on medications again.*
>
> *I'm more concerned with how to get you growing again to become the person you were meant to be, than in figuring out a biological diagnosis for some brain dysfunction or imbalance I don't even have any tests for."*

[22] Ragins, Mark (2021) Journeys Beyond the Frontier: A Rebellious Guide to Psychosis and Other Extraordinary Experiences. Amazon publishing

Here's a step-by-step Recovery Model prescribing process, contrasting it with the Medical Model process we were all taught:

Medical Model Prescribing	**Recovery Model Prescribing**
Take a history and collect objective signs and symptoms Make a diagnosis Informed consent (may include family psychoeducation) Prescribe medications Assess impact on target signs and symptoms of diagnosis and creation of undesirable side effects Adjust medications until effect maximized Continue effective medications to avoid relapse and deterioration If medications have been effective and the patient is motivated, may add rehabilitation to overcome disabilities and recovery services to enhance quality of life	Engage the person in the process building a trusting relationship Find out their goals to motivate them and build hope for positive change Create a shared story of their lives, a "formulation" that stands up to self-reflection and makes them feel understood Work together, using shared experience and decision making, to learn how they can use medications and other tools to achieve their goals, change, and recover Support adaptations to their changes and develop a recovery narrative Help them internalize the meaning of their changes so they can be self-sustaining

Engage the person in the process building a trusting relationship:

While the Medical Model basis emphasizes "professional engagement" the Recovery Model emphasizes "personal engagement. This differentiation can be especially important for people who have had bad experiences with professionals in the past and are looking for evidence that "You're not like everyone else. You treated me like a person, not just your next case."

Many recovery practices were created to improve engagement of difficult people (for example person-centered plans for people without biological insight, client-driven plans for non-compliant people, trauma-informed care for easily triggered people, and harm reduction for people with substance dependence.

Find out their goals to motivate them and build hope for positive change:

Most people are far more likely to be motivated to pursue their goals than our goals, to do what they want to do rather than what someone else says is good for them. They're also more likely to trust us if we "prove our value" by helping them with something they want, before we expect them to do what we want them to do. Often, that means beginning with "charity" instead of "treatment" – we begin by giving them something without strings attached (like food, or a hotel voucher, or a letter for disability or help getting an ID, or a letter for work or to get off jury duty or a bus token, or any number of things tha require a doctor's signature)

Beyond that, however, people are more likely to make progress if they're hopeful, than if they aren't. Hope, very concretely, means believing things can get better in the future. For goal setting to generate hope it must have three things: 1) The person must be able to see a detailed, practical version of the goal clearly enough to believe it's possible ("when I could see it, then I could do it"), 2) The goal has to have meaning for them. (Watch out for making goals "more realistic" and losing the meaning along the way. It's better to keep the big, hopeful goal and work on steps towards it, than to lower the goal itself.) 3) They have to be willing to take, a couple concrete steps towards that goal.

People are more likely to be motivated to tell us their story, and to trust us with the shameful and unsavory parts, if we've established some helpfulness and mutual hopefulness before we really dig in with questions about their lives. Also, knowing what's important to them, and what they're most likely to work on, ahead of time, helps us focus on their priorities while we're obtaining their story. They're more likely to understand "why do you need to know all this stuff about me?"

Create a shared story of their lives, a "formulation" that stands up to self-reflection and makes them feel understood:

The "assessment product" isn't a symptom checklist, a DSM diagnosis, and a history of present illness, though we may need those things for charting and billing. We want to create, together with the person, a story of their lives that incorporates their childhood development and trauma, their protective factors, their childhood aspirations, how they were impacted by events and adapted to them, how emerging substance use, mental issues, and relationships intertwined in their lives, positively and negatively, and what

strengths have emerged from their struggles, as they developed into the people they are today.

Many times, it takes time and effort to put this story together. Begin with “before you met a lot of doctors and mental health workers, what did you think was going on with you?” since that’s likely what they still think. and Along the way, they may be surprised by “insights” into themselves (how different parts have impacted them and how it fits together. not necessarily into their neurochemistry). Look for times they’ve done what they promised themselves they never would (like having their kids taken away). These “tragic ironies” are likely to be the ”heart” of the story. Consistently feeding back to them the story as it unfolds, in words they can recognize, correcting our misunderstandings, and getting their approval of the story, is crucial. Emphasize the process of self-reflection, that we’ll be using heavily later on to learn to use medications effectively. Make sure the story includes “the strengths they’re going to use to overcome this”.

Focusing on empathetic listening makes it most likely they’ll recognize their story as theirs, not ours. Open our heart to welcome their story, with all of their emotions, knowing full well that it might change us in unexpected ways.

If we’ve done this well, they will feel understood. They will feel less alone, because we’ve “borne witness” to their story. They will be more likely to trust us and feel like we can work together. We can use the shared, narrative formulation to base our hopeful, collaborative plan. They will feel empowered by the knowledge in the story, instead of feeling like we’ve taken over just so we can make case notes in their chart. (The second time you see someone, read out loud the shared story from their chart to them. That forces us to write it in respectful language, they’ll understand, let’s them know we were really listening, and demystifies what we’re writing about them. Also, it prepares us for patient portals.)

Work together, using shared experience and decision making, to learn how they can use medications and other tools to achieve their goals, change, and recover:

Now we need to offer them several choices, given how we understand their story, of how medications can help them get unstuck and achieve their goals. We ca individualize our description of how a medication works to fit their language, understanding, culture, and desired impact. (For example, SSRIs can help reduce overthinking which can help with a lot of other things, SNRIs can help reduce sluggishness from holding all your emotions in your body. Wellbutrin can help with energy, enjoyment, and focus so you’ll get more out of what you do. Remeron and Trazodone can help sleep and knock out disturbing dreams, without being addictive. Any given person might think that one of those actions is more likely to get them

unstuck than the others.) This is personalized medication, with personalized target outcomes.

This is also a good time to ask in detail about their psychoactive substance use, not for diagnostic purposes or to judge them, but to “understand how your mind responds to different chemicals so we can pick the best medications”. This does get a good substance use history, and predict interactions, but more importantly, it really can help us choose medications and dosage.

At each subsequent visit, check how they actually took their medications, without being critical or judgmental, and what their rationale was for doing it that way (especially if it is substantially different from what we expected them to do). Each time, we guide them to learn as much as possible about how the medications affect them (“What surprised you about the medications this month?”), and just as importantly how they can exploit what the medications do, (for example, “what do you think you’ll do with the empty space in your mind if you’re not overthinking as much?”), and then set up the next experiment for learning how to best use medications.

Other interventions, like therapy, changing behaviors, self-help, 12-step, peer support, and self-care, should always be included in the session, so the person isn’t helplessly depending on medications alone.

Support adaptations to their changes and develop a recovery narrative:

These last two steps don’t really exist within the Medical Model because the assumption is if the illness has been effectively treated, the person will do well. Unfortunately, without focusing on the person themselves they’re not likely to sustain taking medications and even if they do, they’re not likely to sustain the benefits. “The illness treatment was successful, but the patient never recovered” is a common outcome of our current systems.

It isn’t just a matter of never dealing with the underlying causes of their mental illnesses (though that is frequently the case), or even of failing to deal with the consequences of their illnesses, like shame and guilt, loss and grief. Mental illnesses, trauma, and substance use, all get integrated into who the person is, their relationships, and their life stories. Without directly dealing with all those changes, and helping them regrow in positive ways, and readapt, they’re likely to return to the old patterns. Think about how hard battered women’s programs and 12-step recovery programs work to get long term growth and change while the person keeps “relapsing”. Think about their strategies too (including group support, building acceptance, and moral inventories).

People can't be expected to go on as though nothing has happened even if their symptoms are relieved. They need to create a recovery narrative to put their suffering and damage into perspective, to go on. (For example, people who survive suicide attempts have to live with knowing they went 'beyond the pale", they lost control, they spread suffering, and that they'll always be looked at differently, for the rest of their lives even though the overwhelming majority won't die from suicide.[23]) They need to be more than just a victim, or even a survivor. They need to find meaning in their suffering and change their lives to accommodate that meaning and purpose, to reconnect ot the community.

Under the motivation of avoiding harmful stress and relapsing or risk management, people, their families, their mental health workers including their psychiatrists, and their schools, jobs, and judges, "err on the side of caution" and routinely deprive people of the opportunities they need to return to life and resume growing. This pervasive approach builds fear, avoidance, and learned helplessness, not resilience and recovery. Their recovery narratives are crippled by protectiveness. This is one of the main reasons many people feel they have to leave the mental health system, and our medications, to recover.

Help them internalize the meaning of their changes so they can be self-sustaining:

Some people will be able to make and sustain the needed changes without too much self-reflection and meaning making. They'll say" I learned to stay away or from my ex", or "I got sick and tired of being sick and tired, and stopped using". or "the voices just stopped being that important to me. I moved on" or "when the nightmares and the panic attacks stopped I could live in the present". Other people will want and need more understanding, more meaning making, more purpose, or more personal healing, to embrace what's happened to them and feel whole again. They can't, or won't, just push it aside.

"I wouldn't have wished this condition on my worst enemy. You can't really know the pain and suffering and loss I went through if you havne't experienced it. But in a strange way, going through this has made me the person I am today. If not for going through this, I wouldn't know what's really important in life. I've found strengths inside

[23] https://livethroughthis.org/

me I never knew I had. There has been gifts from my wounds. As terrible as it's been, it's also been a blessing in disguise."

That's what a real recovery sounds like.