# What Does Putting Recovery into Practice Mean for Psychologists?

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Psychological practice can be paternalistic and disempowering. This article suggests more recovery focused psychologists could attend to processes of informed consent, develop ways of working that value the expertise of experience and contribute to the evidence base in relation to people's experience of therapy.

**Key words:** recovery, informed consent, expertise of experience

The term recovery is now widely used to describe the journeys of people who have experienced mental health difficulties and distress, towards personally determined, meaningful and fulfilling lives. A number of guiding principles which mental health workers can apply in support of this process have been identified, which reflect three core components: hope, control and opportunity (Repper & Perkins, 2003). Recovery principles have been widely adopted as a basis for mental health practice, and form the basis of current English mental health policy (Department of Health, 2011). They have also been endorsed by the major mental health professions (Care Services Improvement Partnership and Royal College of Psychiatrists and Social Care Institute for Excellence, 2007; Department of Health, 2006), including the British Psychological Society, which in 2009 issued a policy statement that 'Mental health services should fully embrace the recovery approach'.

Recovery is presented as a radical alternative to traditional mental health practice, to the extent that it has been described as a 'paradigm shift' (Slade, 2009). Many psychologists may already see themselves as practising outside the dominant paradigm, and so are likely to welcome these developments, or see them as a validation or extension of their existing practice. At first glance there does appear to be considerable overlap between recovery and psychological approaches, with their emphasis on exploration of personal meanings and adopting a person-centred, collaborative stance. It is not then surprising that professional psychologists in England and the United States

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have made significant contributions to the development of recovery based practice, including the author of one of the most commonly used definitions of recovery, William Anthony (1993). Two of these, Pat Deegan and Rufus May, also have a background of personal experience of recovery, suggesting that to dissatisfied customers, psychology may seem to represent a viable alternative to traditional psychiatric practice. Certainly for Deegan and May it has been a professional basis for developing empowering practices, in which people are enabled to become active participants in their recovery process (May, 2004; Deegan & Drake, 2006). However, there are aspects of psychological practice which are less compatible with recovery principles and which can be seen as equally paternalistic (Mitchell & Purtell, 2009), and so as open to challenge, as other traditional approaches. As psychological practice is informed by a number of different models, with very different assumptions, it is to be expected that some approaches will be much more consistent with recovery than others. In this paper, I will explore the ways in which psychologists could be said to be already be putting recovery into practice and identify areas where fully embracing the recovery approach would require a change of emphasis, to allow people using our services to genuinely experience hope, control and opportunity.

**The lived experience of psychological therapy**

The emergence of the recovery paradigm has largely been driven by the testimony of people who have personal experience of distress and recovery, reflecting on the ways in which mental health services have helped and hindered that process. This has led to a recognition of different forms of expertise, that which is gained by training and research and that which is gained by living through an experience, and that both should make an equal contribution to understanding and moving forward from mental distress (Roberts & Boardman, 2013). In understanding the ways in which psychological practice is supportive of recovery it is therefore important to know about the experiences of people who have used such services. Perhaps it is telling that limited formal research has been done in this area and the arguments that are offered in defence of this suggest that clients would be unable to accurately communicate about what happens in therapy (Hodgetts & Wright, 2007). This suggests that psychologists may not yet be entirely comfortable with the notion of expertise by experience.

Where people have described their experiences of psychological therapy, either in response to specific research or requests for feedback (BACP Scottish Counselling Reference Group, 2010; Hodgetts & Wright, 2007; Gideon et al., 2009; Martindale et al., 2009; McGowan et al., 2005) or as part of more general information gathering about factors that support recovery (Lapsely et al., 2002; Rethink, 2009), these are predominantly positive. People using services are often keen to explore psychological therapy as an alternative to using medication (Baker et al., 2013) and they often express serious concerns about the length of waiting times to access what is perceived as an important resource for supporting people's recovery (Rethink, 2013). Where people have received

therapy, they have described valuing being able to talk openly about their feelings, being listened to and offered reassurance, understanding and a different perspective on their experiences. People have also appreciated collaborative approaches, where the therapist was honest and open and sought to involve them in the process. Where people described negative experiences, these seemed to reflect approaches that were too rigidly applied: therapists were experienced as judgmental or confrontational, did not seem to understand them or make helpful suggestions or the model was difficult to apply to their lives. When people did have negative experiences it was very difficult for them to access an alternative and this reflects a commonly raised concern about lack of choice in relation to psychological therapy. There have been calls for access to greater choice in therapy approach, therapist characteristics, length of treatment and when and where sessions take place (BACP Scottish Counselling Reference Group, 2009; Gideon et al., 2009; Rethink, 2009; Rethink, 2013).

Where resources are limited, it is naturally difficult to offer people as much choice as would be desirable. However, some people also describe not being given enough information to make a meaningful choice about whether to participate in what they were being offered, or, to give informed consent (Gideon et al., 2009; Martindale et al., 2009). In raising this issue, there is a recognition from users that this is not straightforward in relation to psychological therapy, that it requires an ongoing process of learning through experience and may change as therapy progresses. The British Psychological Society (2009) Code of Ethics and Conduct is clear both that informed consent should be obtained and that it may need to be revisited, so this suggests that practice may at times fall short and that therapists are not always sufficiently sensitive to the power imbalances that make it difficult for people receiving therapy to question the process (Martindale et al, 2009). The use of shared decision making, where a person is supported to weigh the pros and cons of all available options, is now being championed as a recovery based approach to mental health prescribing (Baker et al., 2013; Kaminskiy et al., 2013). This presents an intriguing possibility for the development of similar processes in decision making around therapy. Rufus May (2009) gives examples of how he has done this in his work with people with psychosis and describes his experience of people having 'a wisdom and expertise about what line of inquiry might be most helpful to them at what time'.

**Are we doing it already?**

One of the most frequently raised objections to the promotion of recovery-based practice is that 'we're doing it already' and that it is little more than good practice, as espoused by existing guidelines and standards (Roberts & Boardman, 2013), such as those provided by the British Psychological Society. Psychologists do seem to have a particularly good case and there are clear links between the aims of most psychological therapies and three of the four 'recovery tasks' identified by Slade (2009) through analysis of common themes in recovery

narratives: developing a positive identity, framing the 'mental illness' and self-managing. The fourth is 'developing valued social roles', something which in most models sits outside the domain of psychological therapy, and I will discuss this further below. The experiences of people using psychological services reflected above suggest that, as with other professions there may be a gap between guidance and practice (Roberts & Boardman, 2013). It would be possible to account for much of the dissatisfaction expressed by acknowledging that there will inevitably be some psychologists who apply models in ways that are not intended and unhelpful and some people using services who have unrealistic expectations of what psychologists can do. I would argue though that there are some fundamental inconsistencies between the assumptions of many models of psychological practice and recovery principles.

A key element of recovery based practice is the way in which it redefines the role of the helping professional from 'expert' to 'coach', someone who offers their knowledge and skills as resources the person can use in a process of learning and discovery, to move forward into a personally valued life (Shepherd et al., 2008): This has been characterised as professionals being 'on tap rather than on top' (Repper & Perkins, 2003). This has been expanded into a model of support for recovery that is conceptualised as education rather than treatment or therapy, with a focus on identifying the person's strengths, supporting them to find their own solutions, achieve their ambitions and take control of their lives. Recovery colleges, intended to deliver this approach have been developed around England (Perkins et al., 2012). In contrast, models of psychological therapy have assumptions about the nature of psychological health, of which the expert therapist uses their knowledge to identify what is wrong with the person and must therefore change in order to achieve this. Their expert knowledge directs not only what is talked about but also how and in psychodynamically informed models resistance may be seen as evidence of pathology. As psychological therapies are well evidenced and highly valued by people using mental health services (Rethink, 2013) it would not be in the service of recovery to abandon them. Instead, it is worth considering how they can be practised in ways that are most compatible with recovery ideals.

**Framing the experience of distress**

Psychologists are well placed to support people to 'frame', or develop a personally satisfactory meaning in relation to, their experience of distress, due to their skills in formulation. Recent good practice guidance (British Psychological Society, 2011) illustrates how formulation can be used to offer people using services an understanding of how theoretical psychological knowledge can be applied to their difficulties through a collaborative process, in which hypothetical frames are tested for their usefulness rather than considered to be reflections of the truth. Used in this way, formulations have a lot in common with the use of 'constructs' for making sense of voice hearing, that have been developed by the Hearing Voices Movement as an alternative,

person-centred, empowering approach (Romme & Escher, 2000). In some models, however, such as psychodynamic or systemic, the formulation may never be explicitly shared with the person using therapy but instead be used to guide interventions developed by the therapist, which may seem bizarre, opaque and not open to question, potentially disempowering the client. In behavioural and cognitive behavioural therapies, there may be psycho-educational components, which risk imposing particular understandings on a person's experience, in a way that is not dissimilar to the diagnostic processes used in psychiatry and which have been extensively criticised by people using services (Thomas & Bracken, 2004). The model of Narrative Therapy, developed by Michael White (1990) has attempted to engage with the dilemma of how to support people in making sense of their experience without imposing explanatory frameworks and offers techniques for supporting the person to use their own language and concepts. This approach, developed from a social constructionist perspective, is more consistent with recovery principles, as it acknowledges the existence of multiple truths and the highly individualised nature of personal meanings. A narrative therapist would not necessarily make these assumptions clear to the client and there is a sense in which this approach could be disingenuous and disempowering, through denying the existence or potential relevance of psychological knowledge. I would argue that formulating in a recovery based way requires psychologists to help people understand that there are many possible ways of making sense of their difficulties, that while we may have a professional preference for one, there is no reason that should be the most useful for them and to support them in exploring the ideas that they find most interesting. This would require us to look beyond our preferred models in the service of helping people identify theirs.

**Focusing on strengths and wellbeing**

Another key aspect of recovery based practice is a focus on the person's strengths rather than deficits (Shepherd et al., 2008). Again, good practice guidance identifies that a high quality formulation will incorporate these (British Psychological Society, 2011) but in practice, the focus of a formulation is most likely to be on problems and difficulties, which are usually understood as the target of intervention. This reflects a requirement for evidence-based practice, in which the success of interventions is determined by clinical outcome measures rather than a personally defined measure of life satisfaction (Slade, 2010). An alternative, and evidence-based, approach is offered by Positive Psychology (Seligman & Csikszentmihaly, 2000), which focuses on wellbeing rather than pathology. Using strategies derived from these theories has been identified as supportive of the processes that are important in recovery, not just in addition to, but instead of the traditional focus on addressing difficulties (Slade, 2010). Some other therapy models are also interested in the ways in which a person is already successfully overcoming their difficulties, in the form of unique outcomes in Narrative Therapy or exceptions in solution-focused therapy. If a

person is seeking to have painful feelings or experiences heard and understood, these approaches may give them limited opportunity and there remains an issue around how to support people in developing understanding of and preference for different therapeutic techniques.

**Redefining therapeutic relationships**

A traditional feature of therapeutic relationships is that they are largely determined by the therapist, who is responsible for establishing and maintaining the boundaries. While this is understood as being in service of the client, through offering therapeutic containment and protection from abusive practice, it is also a way in which therapists can be understood as being 'on top' rather than 'on tap'. This approach to therapeutic relationships has been described as 'detached' (Slade, 2011), in contrast to 'real' relationships, where professionals and clients relate to each other simply as people rather than people in particular roles. People using services have described the experience of 'real' relationships as helpful to recovery (Deegan, 1990; Slade, 2011) and there has been a call for professional distance to be replaced by a stance that people working for and using services are all people, facing the challenges of being human (Davidson, 2008). There has also been a recognition of the value of personal experience of recovery in providing support to others, or peer support (Repper, 2013) and this has led to a recommendation for professionals to share relevant aspects of their personal experiences (Perkins & Dilks, 1992; Shepherd et al., 2008). Many psychologists find this challenging although there is evidence that this is mostly helpful to clients, in making the relationship seem more human and genuine although there are risks associated and it can sometimes have a negative impact on the relationship (Hodgetts & Wrights, 2007; Tsai et al., 2010). This may contribute to a reticence among psychologists to self-disclose although there are emerging attempts to develop guidance in this area (A. Ruddle, personal communication, October 30, 2013). Some useful guidelines have recently been developed by the Dorset Wellbeing and Recovery Partnership (2013), which identify that some therapies, such as Dialectical Behaviour Therapy encourage openness, and offer a structure for reflection around disclosure. These identify again the value of offering people the choice, so that they can make decisions about the kind of therapeutic relationship that works for them.

**Giving up expert status**

These shifts of emphasis reflect the fundamental re-balancing of power between professionals and people using services that is required by recovery based practice. Consequently it is likely to be experienced as threatening (Slade, 2009), and strikes at the very heart of some readings of what it means to be a professional (Rogers & Pilgrim, 2010). Clinical psychology is a relatively young profession which has sought to build a power base equivalent to psychiatry through establishing an identity as scientifically based, and therefore objective and neutral, and has only recently achieved

the legitimacy of professional registration (Pilgrim, 2010; Rogers & Pilgrim, 2010). In this context it seems likely that psychologists may demonstrate just as much resistance to adopting practices that are rooted in values and subjective interpretation as other disciplines.

It is also important not to discard the baby of psychological knowledge with the bathwater of expert status, as it offers a range of useful techniques that can support recovery processes (Slade, 2010) and as service user testimony reflects, has successfully supported recovery for many people. Instead, we must engage with a dilemma of how to become non-expert experts, making our knowledge accessible to people in distress, so that they can make informed choices about how to use it, or not, in the service of their own recovery. This is analogous with the move towards shared-decision making within psychiatry, a development which psychologists, including myself, have advocated and promoted (Baker et al., 2013; Deegan & Drake, 2006; May, 2004; Slade, 2009). It seems appropriate that we should also attempt to develop our own practice to find ways of effectively combining expertise through training and the expertise of experience.

**Recovery focused psychological practice**

People in recovery clearly value psychological therapy, including those approaches that are less consistent with recovery principles. One way of understanding this apparent tension is to see therapy as a discrete recovery tool, the process of which may be at odds with the 'control' aspect of recovery, but which the person can make an informed choice to use in the understanding that the outcome is likely to be supportive of their overall journey. In this way, it has similarities with the complementary therapies, which are also frequently cited as important self-management tools (Rethink, 2003): the person agrees to allow another's expert knowledge to operate on them, in the belief that it will improve their wellbeing. In order to ensure that our practice is recovery focused, the actual process of therapy would not need to change but careful attention would need to be given to the way in which we secure informed consent and negotiate the therapy contract, so that the person is as informed and involved as they want to be. As psychological therapy is highly individualised and often unpredictable, this would need to include consideration of uncertainty and an expectation that it would be kept under review. This may seem no more than the implementation of existing standards of good practice, but a key contribution of recovery may be in re-emphasising and supporting the proper use of these (Roberts & Boardman, 2013).

I believe that fully embracing the recovery approach would also require us to adopt different practices. Slade (2010) argues that mental health professionals should become social activists, whose role is to address wider social barriers to recovery through addressing stigma and discrimination and using their knowledge to promote mentally healthier societies. This would require psychologists to look beyond the individual and consider how to support people

in engaging with the fourth recovery task of 'developing valued social roles'. There are already models of psychological practice available with this aim, in the form of community psychology (Mitchell & Purtell, 2009) and power mapping (Hagan & Smail, 1997), which seek to bring people together for solidarity and collective action to improve their social circumstances. This can be empowering for people using services, especially the move away from the dynamic of 'well' people helping 'ill' people to one of mutual understanding and support (Rethink, 2009). Psychologists have the relevant knowledge and skills to support the development of self-help groups and recovery education courses, working alongside people with lived experience and supporting them in taking on peer support worker roles.

A major barrier to adopting such practices is likely to be service contexts that are focused on targets and outcomes that are unrelated to recovery principles. For example, the introduction of 'payment by results' within the NHS is likely to firmly place the number of people recorded as receiving a particular evidence-based intervention as the highest priority in determining how employees allocate their time. This is likely to limit opportunities to offer more flexible, user centred and empowering approaches. Psychologists will need to especially creative if we are to find ways of 'feeding the beast' (W. Roeg, personal communication, December 12, 2013) of organisational requirements and continuing to genuinely engage in recovery based practice.

**Our recovery journey**

Although strongly committed to the expert-driven scientist practitioner stance, psychology is not a monolithic profession and there exist within it many alternative perspectives and approaches, which exemplify the ways in which recovery could be implemented in psychological practice. There are competing pressures upon us alongside the drive for recovery based practice, including our professional status and organisational contexts, which may influence the approaches we feel most comfortable with. It seems that as psychologists we need to engage in our own journey, to evaluate the different forms of knowledge that are available to us and decide how best to use them in support of a meaningful professional life, achieving the kinds of outcomes to which we give value. We only have limited knowledge of how what we offer can contribute to recovery and developing this could be a useful way of influencing what is required of us, so that we have an evidence base built on personally defined outcomes, relating to interventions beyond our traditional therapy models that may better promote hope, control and opportunity.

**References**

Anthony, W.A. (1993). Recovery from mental illness: The guiding vision of the mental health system in the 1990s. *Innovations and Research, 2*, 17–24.

BACP Scottish Counselling Reference Group (2010). *Scottish psychological therapies: Improvements identified by service users*. Retrieved November 15, 2013 from www.pctscotland.co.uk/documents?task=document.download&id=11ý

Baker, E., Fee, J., Bovingdon, L., et al., (2013) From taking to using medication: Recovery-focused prescribing and medicines management. *Advances in Psychiatric Treatment 19,* 2–10.
British Psychological Society (2009). *Code of Ethics and Conduct.* Leicester: BPS.
British Psychological Society (2009). *Psychological Health & Wellbeing: A new ethos for mental health.* Leicester: BPS.
British Psychological Society (2011). *Good Practice Guidelines on the use of Psychological Formulation*. Leicester: BPS
Care Services Improvement Partnership, Royal College of Psychiatrists & Social Care Institute for Excellence (2007). *A Common Purpose: Recovery in future mental health services*. London: SCIE.
Davidson, L. (2008). *Recovery – Concepts and Application.* Devon Recovery Group (www.scmh.org.uk)
Deegan, P. (1990). Spirit Breaking: When the helping professions hurt. *The Humanistic Psychologist*, *18* (3), 301–13.
Deegan, P. & Drake, R.E. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services, 57, 1636–39.*
Department of Health (2006). *From Values to Action: The Chief Nursing Officers review of mental health nursing*. London: Department of Health.
Department of Health (2011). *No Health Without Mental Health.* London: Department of Health.
Dorset Wellbeing and Recovery Partnership (2013). *Supporting the recovery journeys of staff.* Dorchester: Dorset Mental Health Forum.
Gideon, N., Hancock, E. & Nelstrop, L. (2009). Talking treatment: Developing a service user satisfaction questionnaire for a National audit. Retrieved November 15, 2013 from http://www.rcpsych.ac.uk/pdf/report%20on%20development%20of%20Talking%20Treatment.final.pdf
Hagan, T. & Smail, D. (1997). Power mapping II. Practical Application: The example of child sexual abuse. *Journal of Community & Applied Social Psychology, 7,* 269–84.
Hodgetts, A. & Wright, J. (2007). Researching clients' experience: A review of qualitative studies. *Clinical Psychology and Psychotherapy, 14,* 157–63.
Kaminskiy, E., Ramon, S. & Morant, N. (2013). Exploring shared decisionmaking for psychiatric medication management. In Walker, S. (Ed). *Modern Mental Health: Critical perspectives on psychiatric practice*. St. Albans: Critical Publishing.
Lapsley, H., Waimarie Nikora, L. & Black, R. (2002). *'Kia Mauri Tau!': Narratives of recovery from disabling mental health problems.* Wellington, NZ: Mental Health Commission.
Martindale, S.J., Chambers, E. & Thompson, A.R. (2009). Clinical psychology service users' experiences of confidentiality and informed consent: A qualitative analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 82,* 355–68.
May R. (2004) Making sense of psychotic experiences and working towards recovery in Gleeson, J. & McGorry, P. (Eds) *Psychological Interventions in Early Psychosis*. Chichester: Wiley.
McGowan, J. F., Lavender, T. & Garety, P.A. (2005). Factors in outcome of cognitive behavioural therapy for psychosis: Users' and clinicians' views. *Psychology and Psychotherapy, 78,* 513–29.
Mitchell, A. & Purtell, R. (2009). Community approaches, social inclusion and user involvement. In Beinart, H., Kennedy, P. & Llewelyn, S. (Eds) *Clinical Psychology in Practice.* Chichester: BPS Blackwell.
Perkins, R., Repper, J., Rinaldi, M. & Brown, H. (2013). *Implementing Recovery through Organisational Chage: Briefing 1 Recovery Colleges.* London: Centre for Mental Health.
Perkins, R. & Dilks, S. (1992). Worlds apart: Working with severely socially disabled people, *Journal of Mental Health, 1,* (1) 3–17.
Pilgrim, D. (2010). British clinical psychology and society. *Psychology Learning and Teaching, 9,* 8–12.
Repper, J. & Perkins, R. (2003) *Social Inclusion and Recovery.* London: Balliere Tindall.
Rethink (2003). *The experiences and views of self-management of people with a diagnosis of schizophrenia.* London: Rethink.
Rethink (2009). *Getting back into the world: Reflections on lived experiences of recovery*. London: Rethink.
Rethink (2013). *We Still Need to Talk.* London: Rethink.

Romme, M. & Escher, S. (2000). *Making Sense of Voices: A guide for professionals working with voice hearers.* London: Mind.

Roberts, G. & Boardman, J. (2013). Understanding recovery. *Advances in Psychiatric Treatment, 19,* 400–09.

Rogers, A. & Pilgrim, D. (2010). *A Sociology of Mental Health and Illness (4th Ed).* Maidenhead: Open University Press.

Seligman, M. & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55,* 5–14.

Shepherd, G., Boardman, J. & Slade, M. (2008). *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

Slade, M. (2009). *Personal Recovery and Mental Illness: A guide for mental health professionals*. Cambridge: Cambridge University Press.

Slade, M. (2010). Mental Illness and wellbeing: The central importance of positive psychology and recovery approaches. *BMC Health Services Research, 10,* 26.

Slade, M. (2011). Breaking down boundaries. *Mental Health Practice, 15,* 9.

Thomas, P. & Bracken, P. (2004). Critical psychiatry in practice. *Advances in Psychiatric Treatment*, *10,* 361–70.

Tsai, M., Plummer, M.D., Kanter, J., Reo, W., Newring, R.W. & Kohlenberg, R.J. (2010). Therapist grief and functional analytic psychotherapy: Strategic self-disclosure of personal loss, *Journal of Contemporary Psychotherapy, 40*: 1–10

White, M. (1990). *Narrative Means to Therapeutic Ends.* London: W.W. Norton & Co.