

Applying Stages of Change Models to Recovery from Serious Mental Illness: Contributions and Limitations

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ABSTRACT

Research on recovery has proliferated in recent years. Some investigators have advanced stages of change models that segment the overall process of recovery into discrete and sequential phases, through which a person progresses from being overwhelmed by mental illness to taking on an increasingly active role in understanding, managing and overcoming the impact of psychiatric disability. The authors review this body of literature, and reflect on the contributions and limitations of stages of change approaches to understanding mental health recovery. They conclude that stages of change models need to more accurately reflect the non-linear nature of recovery, the fact that processes are influenced by person-disorder-environment interactions, and the fact that the person's own motivations for change and decisions in this regard—while of central importance—are by no means exclusive factors in recovery, as they do not take into account sufficiently such issues as discrimination and the presence or absence of crucial resources and supports. A richer set of concepts is needed as we continue to deepen our understanding of the complex, dynamic and ongoing process of mental health recovery.

Qualitative research into the nature of processes of recovery in mental illness has begun to proliferate in recent years. This line of research began with the pioneering longitudinal studies of Strauss and colleagues in the 1980s (1-3) into the early 1990s (4). Such research has gradually expanded beyond its original focus on what

might be considered “full” recovery—referring to an absence of psychiatric symptoms or signs of impairment and a return to normative social functioning—to include the current focus on processes involved in learning how to live a full and gratifying life in the presence of enduring psychiatric symptoms and disability—which we have suggested referring to as “being *in* recovery” as opposed to “recovery *from*” mental illnesses (5).

While there remains much to be learned about various forms of recovery and the possible relationships among them, a number of characteristics seem to be common to all such processes. These characteristics were initially noted by Strauss and colleagues in their pioneering work and have been confirmed by numerous studies since. They include the active role of the person with the disorder, the influence of person-disorder-environment interactions, the semi-independent nature of recovery across various domains (what Strauss and colleagues [1] referred to as their being “loosely linked”), and the fact that the change process is non-linear and can be either incremental or abrupt in nature.

Some of the work carried out over the last decade has built upon this earlier foundation and sought to expand upon these initial insights to more fully elaborate theories of recovery. An increasing number of recent studies have begun to adopt a “stages of change” approach, in which investigators describe a series of inter-related stages which they hypothesize together constitute an overall process of recovery. Such an approach makes intuitive sense. Theoretical and empirical ideas about stages of development and their associated tasks have greatly enriched our understanding of processes of change and growth and have strongly influenced men-

tal health practice. Freud, Erikson, Mahler and Piaget all devised influential stage theories, and stage models have also informed medical practice. Kubler-Ross (6), for example, developed a stage model to describe processes of death and dying that resulted in a radical shift in approaches to end of life care.

Within the broader behavioral health field, one stage of change model has become increasingly influential over the last decade: the Transtheoretical Model, which emerged initially from research on addiction (7). It has been tempting for investigators examining processes of recovery in mental illness to adapt this framework for their work, and to identify and understand various stages of mental health recovery as following a similar path (e.g., 8-10). The identification of well-defined stages of change may be useful in deepening our understanding of complex processes, and in generating implications for policy and for clinical practice in mental health as it has in the field of addictions, in which services and supports are now being tailored to meet the needs of people at various stages of substance use recovery.

In this paper, we examine recent efforts to understand processes of recovery in mental illness according to stages of change models. Our assumption is that such approaches have both strengths and limitations, and that it would be useful for the field to pause and consider both prior to moving further down this path. We begin by providing a brief description of the Transtheoretical Model. We then review a series of qualitative studies that have attempted to identify phases of mental health recovery, and integrate these findings into a provisional account of what has been learned to date with respect to identifiable components of the recovery process. We also consider several recent quantitative studies that have tested the applicability of the Transtheoretical Model to mental health recovery. In closing, we reflect on the contributions, as well as the complexities, generated by applying stages of change approaches to mental health recovery and offer a few cautions in relation to limitations of this approach.

A BRIEF INTRODUCTION TO THE TRANSTHEORETICAL MODEL OF CHANGE

The Transtheoretical Model of change (11-14) emphasizes that behavioral change is a multi-faceted process that occurs in increments and involves varied tasks in each of a variety of stages. According to this theory, health related change efforts involve a series of steps

through which people pass as they make significant progress in altering patterns of behavior. Stages include pre-contemplation, contemplation, preparation, action and maintenance (13). We describe each of these stages briefly below.

The process begins in the stage of “pre-contemplation,” which refers to the period prior to any actual behavioral change, in which the individual is not yet considering (has not even yet begun to think about) change. From there the person may move into a period of “contemplation,” which refers to a stage in which the person begins to consider the possibility of change and to evaluate the pros and cons associated with such efforts. Should the benefits of change be viewed as outweighing the drawbacks, the person then moves on to “preparation” and begins planning to make changes to which he or she is truly committed. After the planning stage, the person then goes on to take “action” and makes specific changes to end unhealthy behaviors and/or increase health-engendering behaviors. When the action stage is successful a person may enter the fifth and final stage of change, termed “maintenance,” in which the person works to sustain the positive behavioral change over the longer term. While progress toward maintenance of healthy behaviors is the goal, a person may also relapse and recycle through earlier stages (15), retracing his or her steps through a kind of successive approximation, learning and accumulating experiential knowledge even through setbacks as the process evolves over time. In fact, Prochaska and colleagues (7) have described the Transtheoretical Model in terms of a spiral in which people may return and advance across stages over time.

While developed initially as a heuristic for understanding recovery in addiction, the Transtheoretical Model has subsequently been applied in a variety of behavioral health areas, including seat belt use, smoking cessation, dieting and exercise, and others. Investigators have found these concepts to be relevant across many health-related changes, suggesting that while the targets for behavioral change may differ, the structure of the change process remains basically the same (16). One important implication of these findings is the suggestion that treatment approaches will be most effective when they are matched to a given individual’s current stage of change and oriented toward facilitating the person’s movement along this continuum (13). Conversely, interventions mismatched to the person’s stage of change will likely have little positive impact. For exam-

ple, action-focused interventions will have little effect upon someone who is at a pre-contemplation stage, while a person actively engaged in learning relapse triggers no longer needs persuasion to enter recovery. With this background in mind, let us now turn to see what progress has been made in applying stages of change ideas to recovery in mental health.

REVIEW OF CURRENT CONCEPTUAL MODELS OF PHASES OF RECOVERY

We begin our review of relevant recovery research with the pioneering work of Strauss et al. (1) mentioned above. These investigators conducted an intensive prospective study of 63 individuals with psychotic disorders, combining quantitative and qualitative data collected bi-monthly, with follow-ups over a 2- to 3-year period. Their results suggested conceptualizing the evolution of recovery as a dynamic process that is influenced by the person interacting with both the disorder and the environment. Emphasizing the non-linear nature of the course of serious mental illnesses, the authors did not propose a linear sequence of stages, but rather attempted to identify several core mechanisms associated with turnaround and improvement. For instance, Strauss first introduced the term “moratorium,” and later the term “woodshedding” (17), to refer to a phase during which there are important internal changes underway in the person that are generally hidden from, or not observable to, others. Similarly, Strauss used the term “mountain climbing” to refer to a mechanism through which successful efforts to make changes in one context (e.g., making friends or managing symptoms) were used to stimulate or scaffold change in other life contexts (e.g., returning to work).

Extending this line of research, Davidson and Strauss (4), in work based on follow-up interviews with 63 individuals recovering from a psychotic episode, described a four-phase process of self and identity reconstruction. The phases involved the person’s: 1) discovering the possibility of a more active sense of self than that which had been taken over by the illness; 2) taking stock of the strengths and the weaknesses of this emerging self, and assessing possibilities for change; 3) putting into action some of the recently discovered or rediscovered aspects of the self and integrating the results of these actions into a revised sense of identity; and 4) employing the enhanced sense of self to provide a refuge from the disorder, thereby creating additional resources for coping.

Baxter and Diehl (18) identified a three-stage recovery process based on interviews with 40 mental health program participants. The first stage in their model, “recuperation,” included feelings of dependence, denial, confusion, despair and anger. The second stage was one of “rebuilding,” which they characterized as involving regaining independence, is often accompanied by powerful emotions of self-doubt, grief, the need for acceptance and active learning. Finally, the third stage they posed was “awakening,” which included reclaiming a sense that “I am somebody,” and having a dream, accompanied by accepting self and others, and building confidence. In a similar vein, Pettie and Triolo (19) used two case examples to highlight two key developmental tasks they viewed as crucial to recovery: the struggle for meaning and the reconstruction of a positive sense of identity.

Based on interviews and focus groups with 18 people living in the community who were diagnosed with severe mental illness, Young and Ensing (20) identified three general stages of recovery. The first, “initiating recovery,” included overcoming “stuckness,” acknowledging illness, having the desire and motivation to change, and finding a source of hope and inspiration. The second stage, “regaining what was lost and moving ahead,” focused on a redefinition of self including gaining insights about self, about the relationship between self and illness, and about living in the world following the onset of mental illness. It also included learning, returning to basic functioning including taking care of self, being active, and connecting to others. The third and final stage referred to improving quality of life, attaining an overall sense of well being, and striving to reach new potential and higher functioning.

Roe and Ben-Yishai (21) used a narrative framework to analyze interviews conducted with 43 people recovering from psychosis, and identified five distinct phases that speak to different relationships between the person and the disorder. In the first phase, participants separated their “healthy” self from their “ill” self. In the second phase, the “healthy” self remained a subject, whereas the illness became an object. In the third phase, the self used the narrator’s position to change the object, the illness, making it more tolerable. In the fourth phase, the narrator became the protagonist of his or her own story. In the fifth and final phase, participants reached a point at which they demonstrated the capacity to integrate self and illness.

Spaniol et al. (22) analyzed interviews conducted every four to eight months over a four-year period with

12 people with a psychiatric disability and identified four stages of recovery. In the first stage, the participants were “overwhelmed by disability,” and felt primarily confused, lacking control, and powerless. The second stage was characterized by “struggling with psychiatric disability,” including developing an explanation for what was happening and recognizing the need to develop ways to cope with the challenge of mental health problems. The third stage, “coping and living with the disability,” included gaining a stronger sense of self, utilizing coping strategies, and feeling more in control and confident about managing the condition. In the fourth stage people began “establishing a lifestyle beyond the disability,” at which point mental illness became a much smaller part of the person’s world and no longer got significantly in the way of the person having a satisfying and productive life.

Jacobson (23) conducted a dimensional analysis of 30 recovery narratives. While acknowledging the recovery process may be a unique subjective experience for each person, she identified component processes that corresponded to four central dimensions: 1) “recognizing the problem,” which involves naming and framing one’s experience and creating an explanatory model; 2) “transforming the self,” using methods in congruence with one’s explanatory model; 3) “reconciling the system,” which entails finding ways of using the mental health system; and, 4) “reaching out to others,” which is an on-going process of connecting with other people.

Ridgway (24) analyzed four published first-person narratives of recovery. While this work did not propose a specific set of stages, and acknowledged the non-linear nature of recovery, it did emphasize several common passages or tasks in the recovery process, including “moving from despair to reawakening of hope,” “from withdrawal to engagement and active participation in life,” “from denial to achieving understanding and acceptance,” “from passive adjustment to active coping,” “from seeing oneself primarily as a person with a mental disorder to reclaiming a positive sense of self,” and “from alienation to having a sense of meaning and purpose in life.” Ridgway also highlighted the social nature of the recovery process.

Based on a select sample of the recovery literature, Andresen, Oades and Caputi (25) proposed a 5-stage model which included: 1) a moratorium characterized by denial, confusion, and withdrawal; 2) awareness of a possible self other than that of “sick” person; 3) preparation, in which the person begins working on recovery;

4) rebuilding, through working on a positive identity, setting and working on goals, and regaining meaning in life; and 5) growth, which involves living a full and meaningful life and looking forward to the future.

In addition to these studies, stage models of recovery developed by group consensus have had an important influence within the field. Ralph and the Recovery Advisory Group (26) created a stage model of recovery based on consensus of lived experience among a group of consumer/survivor leaders (26, 27). This model included six stages: “anguish” or bottoming out, “awakening” or turning point, “insight” or beginning of hope, “action plan” or finding a way, “determined commitment to be well,” and a final stage of “well-being and empowerment.” Ralph and colleagues emphasized that complex internal and external factors have an impact on the recovery process and that movement across the stages is often non-linear and recursive. A recovery stage model developed by the Office of Consumer Services in Ohio also suggests that people go through clearly delineated stages in the process of recovery, leading gradually from being dependent/unaware, through becoming dependent/aware, to becoming independent/aware, and finally achieving the status of being interdependent/aware. The level of dependence relates to service use and self-sufficiency in achievement of optimal functioning, and the level of awareness relates to insight into one’s own condition and knowledge of the available system and community resources one can draw upon to move forward in recovery (28).

Finally, we are aware of four attempts to use quantitative measures to test the validity of the Transtheoretical Model of change for people with mental illnesses. Three of these studies found that people with psychiatric disorders could generally be classified as falling into one of the five stages of pre-contemplation, contemplation, preparation, action, and maintenance based on an assessment of their readiness to make behavioral changes, as follows.

Hilburger and Lam (29) conducted a study in which 193 participants completed the Change Assessment Questionnaire (CAQ-TBI). Their results suggested that stages of change can be identified among people with serious psychiatric disorders, and that the pattern of stages of readiness for change found in this population were similar to those found in previous studies. Similarly, Rogers and colleagues (10) conducted a study in which 163 people with serious mental illnesses who were receiving intensive services completed a Change

Assessment Scale (CAS) along with a number of other rating scales. Their results demonstrated that psychometric properties of the scale did not differ significantly when used by people with mental illnesses as compared to other populations.

Similar results were reported in a study conducted in China that assessed 120 people with mental illnesses who received psychiatric rehabilitation services in Hong Kong and Taiwan using the CAQ-SPMU, which was adapted for this population from the standard Change Assessment Questionnaire (8). Finally, in a novel self-rating approach, Ridgway and Press (30) developed a 7-item subscale related to the stages of change in the Transtheoretical Model as part of a larger recovery instrument. In a study of more than 300 long-term service recipients, they found that almost all participants could place themselves within one of the stages of change, and that stage of recovery was related to patterns of service use and to the number of recovery markers (intermediate outcomes) the person currently experienced, with progressive stages of recovery related to higher numbers of positive outcomes, and experience of setback related to a severe decline in the number of recovery markers claimed. Taken together, these initial attempts to test the validity of the Transtheoretical Model of change through quantitative research provide preliminary empirical support for the possible relevance of the model for mental health recovery and suggest that stages of change hold potential for contributing to our understanding of processes of recovery.

In order to consider this potential more closely, we will now map the findings of the qualitative studies described above onto the five stages of the Transtheoretical Model in Table 1 below. One thing that is apparent from a cursory glance at this Table is that the findings do not map neatly onto the five stages of change; it is not readily apparent in several instances which phases of recovery belong in which category. We have attempted to achieve a “best fit,” though, and will now consider the elements from each model within each of the stages of change, prior to considering the applicability of the Transtheoretical framework for the mental health field.

CONTRIBUTIONS AND LIMITATIONS

In terms of potential contributions, application of the Transtheoretical Model to recovery in serious mental illness seems to assist in the integration of diverse findings and to result in a somewhat more coherent picture of the various components present in this complex set of phenomena. The presence of stages of change makes intuitive sense, and has been confirmed empirically in a preliminary set of quantitative studies. Finally, it is conceivable that progress might be made in mental health services comparable to that enjoyed by services for persons with addictions, should mental health interventions be oriented to where a given person is in relation to the stages of recovery at any given time.

Much more work remains to be done, however, as we know relatively little about the earliest stages of the

Table 1. *Plotting of Research Findings Regarding Phases of Recovery within the Framework of the Stages of Change Model*

Study	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Davidson & Strauss (4)		Discovering a more active self	Taking stock of the self	Putting the self into action	Employing the enhanced sense of self
Baxter & Diehl (18)		Recuperation	Awakening, Rebuilding		
Pettie & Triolo (19)	Struggle for meaning			Reconstruction of a positive sense of identity	
Young & Ensing (20)	Initiating recovery			Regaining what was lost and moving ahead	Improving quality of life
Roe & Ben-Yishia (21)	Separating self from illness	Illness become object	Self as narrator	Self as protagonist	Integrating self & illness
Spaniol, Wesiorski, Gagne & Anthony (22)	Overwhelmed by disability		Living with disability	Struggling with disability	Disability becomes smaller part of person's life
Ridgway (24)	Despair, withdrawal, passive adjustment	Hope	Engagement	Active coping, Reclaiming a positive sense of self and meaning and purpose in life	
Jacobson (23)		Recognizing the problem		Transforming the self	Reaching out to others
Andresen, Oades & Caputi (25)	Moratorium	Awareness of possible self	Preparation	Rebuilding	Growth
Ralph et al. (26)	Anguish	Awakening, Insight	Action plan	Determination	Well-being

Table 2. *An Emerging Model of Stages of Change in Mental Health Recovery*

Stage	Description
Pre-contemplation (or pre-recovery)	This stage concerns the period before the individual considers or undertakes change and, in this instance, could be called "pre-recovery." Only a few of the models reviewed labeled such a stage explicitly, generally in bleak terms. Young and Ensing (20) characterized this phase as one of stuckness, while Baxter and Diehl's (18) first stage included dependence, denial, confusion, anger, and despair. Despair or anguish also may be considered pre-recovery states in the models of Ralph and colleagues (26) and Ridgway (24). The idea of the self being taken over, engulfed, immersed, or overwhelmed by the disorder prior to recovery is seen in Davidson and Strauss (4), Roe and Ben-Yishai (21), and Spaniol and colleagues (22), who also describe people as feeling confused and powerless prior to recovery. The lack of awareness of one's own needs and condition and dependence upon others may also be elements of pre-recovery (28).
Contemplation	This stage involves a growing awareness of the desirability of behavioral change and beginning attempts to think through what such changes might entail. Only a few of the models described activities associated with this stage. Young and Ensing's (20) first stage of "initiating recovery" included tasks that may fall within this stage, including acknowledging illness and having the desire and motivation to change. Jacobson's (23) phase of recognizing the problem is one task that may fit here, while Ridgway (24) describes the need for acceptance of the challenge of recovery. It is interesting to note, however, that most models do not emphasize this stage or attribute much content to what is transpiring during this period.
Preparation	This stage involves planning for change and making sure that the person and his or her environment have what it will take for change to be effective. Several aspects of existing models fit within this stage, such as Davidson and Strauss' (4) discussion of people taking stock of their strengths, weaknesses, resources, and possibilities for change prior to engaging in action. Andresen, Oades and Caputi (25) explicitly include a preparation stage in their model, while Spaniol and colleagues (22) and Jacobson (23) include the tasks of developing an explanation for what is happening and recognizing the need to develop ways to cope with this challenge. Ridgway (24) includes moving from despair to hope, while Ralph and others (26) included cultivating insight within their model. Finding meaning and purpose appeared to be an important task of this stage as did a transformation of sense of self from passive to active (4, 19, 21, 23, 24).
Action	In this stage the person makes intentional efforts to cope with or overcome his or her illness and may refer to the person's active involvement in mental health care, such as taking medication or participating in skills training, cognitive-behavioral therapies, and supported education or employment. This stage also involves developing resources for active coping, devising and putting coping efforts into practice, and feeling more in control and more confident about managing one's condition (4, 22, 24). In this regard, Davidson and Strauss (4) include in their model the development of a more active sense of self and putting into action newly discovered and rediscovered aspects of the self. Baxter and Diehl's (18) stage of rebuilding independence is clearly an aspect of the action phase, although they found that this stage may be accompanied by mixed emotions and required on-going learning. Andresen, Oades and Caputi (25) explicitly included a rebuilding phase as people in recovery set and worked on personal goals. Young and Ensing (20) identified being more active, including working to regain what was lost, returning to basic functioning, taking care of self, and moving ahead as elements of this phase. Finally, several of the models indicated that the action phase involves and results in reclaiming a stronger sense of self and regaining a larger scope on life, as well as moving in a determined fashion away from a life space more fully claimed by the disorder (4, 18, 19, 21, 22, 24, 25).
Living beyond disability (formerly labeled maintenance)	In addition, this stage involves sustaining the positive behavioral change once it is accomplished. In this respect, however, mental health recovery models seem to transcend the Transtheoretical Model in posing an ongoing phase of personal growth and development rather than a steady state of "maintenance" as the final stage of change. For Spaniol and colleagues' (22), this is referred to as "living beyond the disability," while Young and Ensing (20) refer to attaining an overall sense of well being, but also discuss improving quality of life and a continuous striving to reach new potential and higher functioning. Andresen, Oades and Caputi's (25) final phase is growth, which involves both living a full and meaningful life and looking forward to the future. Ralph and colleagues' (26) final stage involves both well-being and empowerment. We should note that while these stages differ from the original idea of "maintenance," they are consistent with more recent advances in models of change within the addictions field, in which a new stage of "transcendent recovery" is being proposed to capture the heightened level of personal and interpersonal functioning that some people achieve as a result of having transcended the limitations imposed by addiction (44). Transcendent recovery is more consistent with the mental health findings, and suggests that people do not reach a point at which they can simply stand still, but continue to move forward beyond their illness.

process; those stages which may hold the most promise for the development of new interventions. The studies reviewed here had little to say about the pre-recovery and contemplation stages in particular, and have yet to identify the possible mechanisms or "turning points" (1, 3) by which people are able to move from despair to hope or from being overwhelmed and powerless to entertaining the possibility of acting on their own behalf. This is disappointing, as the possibility of matching interventions to stages of change holds particular

promise for the field of mental health mostly in terms of developing effective interventions for these earliest stages of the recovery process. A word of explanation is in order.

Prior to development of the Transtheoretical Model, a common assumption in addiction practice was that people had to "hit bottom" and decide to pursue abstinence on their own before professional interventions could have any effect. When people left treatment prematurely, had relapses, or found treatments ineffective,

addiction providers could explain these occurrences as being due to the person's "lack of readiness." A major advance has been made in addiction treatment through the introduction of motivational interviewing targeting the pre-contemplation and contemplation stages, offering providers tools they can use to increase an individual's awareness of, and motivation for, change (31, 32).

The need for early-stage interventions is equally relevant in the mental health field. It has been extremely difficult for people to benefit from active interventions when they do not believe that they have a psychiatric disorder to begin with. In a field that has tended to use such labels as "denial," "lack of insight," "resistance," and "lack of motivation" as much as our addictions colleagues—and which is equally fraught with premature treatment drop out and high relapse rates—interventions that increase a person's interest in and motivation for a turnaround to recovery and active treatment would be enthusiastically embraced by providers and family members alike. But the models reviewed above offer little instruction in this regard.

It also has been proposed that stage models might influence the field to increase attention to the need for active support in the preparation for recovery through practices such as person-centered planning (33, 34), and might also increase the potential for successful interventions in the active recovery phase, as in areas such as self-directed care. Innovations in assessment methods might suggest where a person is in the change process, help to identify what roles he or she wishes to play, and determine how much authority and responsibility he or she wishes to take on in advancing his or her own recovery, as people set their own goals for change (34). To date, the Ohio emerging best practices in recovery model provides the only approach which links stage of change to a fully explicated set of relevant treatment modalities (28), but other implications for a match between stage of recovery and specific interventions are beginning to be advanced (35).

Prior to going further down this road, though, there are a few concerns about such approaches that we would like to point out. First of all, and perhaps most importantly, the Transtheoretical Model assumes that the primary driver of the behavioral change process is the person him or herself. While most of the qualitative studies reviewed above highlight the active role of the person in recovery—perhaps in part to counter-balance over one hundred years of history during which the person was viewed as passive and helpless in the face of

an all-consuming illness (36)—we argue that we should not draw a simple equivalence in this regard between addiction recovery and recovery in mental illness.

There are many influences on mental health recovery that have been described over the preceding 25 years that lie beyond the reach of the person's own behavior. Elements such as the presence or absence of one or more accepting others, hope-filled environments, and availability of opportunities and the provision of ongoing community supports (e.g., decent, safe, affordable housing, job coaches) lie largely outside of the person's control. In addition, some psychiatric conditions are relatively unpredictable, and a person may relapse and have set backs despite intensive active coping efforts and adherence to treatment. While such complexity may also be true in some respects in the case of addiction recovery, there is no equivalent act akin to the decision to abstain from alcohol or other substances within mental health recovery.

Motivational interventions have generally proven to be successful in assisting people to engage in treatment and improve substance use outcomes (37-39) as well as to increase readiness to engage in and adhere to various health promoting behaviors (40-42). At the core of the approach is helping people to explore and resolve ambivalence to accomplish behavior change. While many of the core principles of motivational techniques—such as their basis in a collaborative, non-coercive approach involving active listening—are consistent with recovery-oriented practice and likely to be effective in helping people with psychiatric disabilities resolve ambivalence as well, *this is relevant only when ambivalence poses a barrier to recovery*. These techniques inadequately account for instances in which people are motivated, active agents in behavioral change but yet nonetheless confront barriers to recovery that are beyond their control.

Our concern in this regard is that viewing the recovery process in mental health solely through the lens of a model of personal behavioral change runs the risk of putting all the onus and responsibility for recovery on the shoulders of the person with the psychiatric disability, effectively absolving other people, the mental health system, and society at large from their responsibility for making hope-filled and culturally appropriate environments, adequate opportunities and resources, effective treatments, responsive supports, and welcoming communities available to people in need. As a result, important issues of social justice, such as discrimination and

the restoration of the civil and human rights of persons with mental illnesses, can be downplayed or left out of the picture altogether (43). Only the model offered by Ralph and colleagues (26) begins to tackle the complex interaction of internal and external factors that can influence the recovery process.

Beyond this basic challenge posed by the complex nature of serious mental illness and its place within the ecology of contemporary society, none of the models so far described deal adequately with the non-linear nature of recovery. Most stage models imply linearity, and even when disclaimers are made that the stages do not necessarily unfold in a linear or sequential fashion (see, e.g., 26), the models themselves tend to lead people to view the various stages as building upon each other. But simply stating that recovery is more complicated than a linear sequence—as we have ourselves done in the past—contributes little to new knowledge. The field needs to build models of recovery that acknowledge the non-linear nature of the process from the start, and which allow for the fact, for example, that many people can make significant progress in recovery without ever having accepted having a mental illness to begin with. As Strauss and colleagues pointed out twenty years ago, one person may wait to enter the job market until his or her symptoms have responded to anti-psychotic medication, while another person can find returning to work to be a more effective way of reducing the same kinds of symptoms than taking medication. In this regard, increased attention to concepts of “regulatory mechanisms” or “change points” as suggested by Strauss and his colleagues (1) may prove useful, as they do not go beyond available data and do not purport to speak to any broader, normative, overarching step-wise process. They refer instead to discrete components or junctures within a multi-dimensional and multi-determined context, in which the person and his or her own efforts play a central and crucial, but by no means exclusive, role.

CONCLUSION

We have learned much over the previous 20 years about the various processes and components involved in both recovery from and being in recovery with a serious mental illness. We still have much more to learn as we attempt to translate our understanding of recovery into effective interventions. For the time being, we suggest continuing the exciting and promising work of exploring the terrain of first person accounts of recovery, but

also suggest proceeding with caution when adopting or adapting stages of change models or otherwise speculating beyond the data which are currently available. We must build increasingly more finely grained and complete models that reflect the reality that recovery is not a simple linear or sequential process and that demonstrate how recovery is influenced by many factors in addition to the person's own degree of motivation to make specific behavioral changes in his or her life.

Focusing on understanding and building knowledge concerning the earliest phases of recovery may be imperative in order to generate new interventions that may more effectively assist people in their turnaround to recovery, encourage active engagement in treatment and rehabilitation, provide access to needed recovery supports, and encourage increasing self management of one's condition. In general, models of recovery need to do a better job of accurately reflecting the non-linear nature of the processes involved, the importance of understanding that these processes are influenced by person-disorder-environment interactions, that the various domains of functioning affected are only loosely linked, and the fact that the person's own motivations for change and decisions in regard to recovery—while central—are by no means the only important factors positively or negatively influencing his or her potential for recovery. More targeted exploration to gain knowledge of the micro-processes of recovery and more detailed and specific understanding of regulatory mechanisms and change points will be useful in filling in some of this missing knowledge as we continue to deepen our understanding of this complex, dynamic and ongoing process.

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