ABSTRACT: *Recovery in mental illness is a person-oriented process that involves self-determination/choice, and growth potential. This article discusses eight components of* recovery-oriented *treatment, and how nurses in any setting can facilitate recovery and encourage the healthy role of spirituality in clients' lives during the recovery process. Biblical references relating to each component of the recovery-oriented process are offered.*
KEY WORDS: *faith community nursing, holistic care, nursing process, recovery-oriented care, self-management, spirituality, therapeutic alliance*

CE 1.5 contact hours

Treatment and Spiritual Care in Mental Health

Recovery As a Journey, Not a Destination

By Melissa Neathery

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The term *recovery* has various meanings and connotations. When a football team fumbles but then has a *recovery*, the team has regained possession and is now in control of the football. A surgical patient's transfer to the *recovery* area implies the process of waking up from anesthesia and beginning the return to a pre-illness state of health.

Recovery-oriented nursing care is not a list of additional activities tacked on to a treatment plan.

Are these examples relevant to recovery in mental illness? Is recovery from alcohol addiction, depression, or schizophrenia a state of being symptom-free? Does recovery mean that a person has complete control of the illness? This article examines the concept of recovery in mental illness, explores components of recovery, and includes ways biblically focused spiritual care can enhance recovery.

THE RECOVERY MOVEMENT

During the first half of the 20th century, mental illness was considered a deteriorating condition that often required lifelong institutionalization (Drake & Whitley, 2014). With the discovery of psychotropic medications and U.S. President John F. Kennedy's 1963 Community Mental Health Act promoting deinstitutionalization (National Council for Behavioral Health, 2017), many people with mental illness were released from institutions into what was named "community treatment" (Test & Stein, 1978, p. 351). However, at the time, treatment in community settings was ill-equipped and poorly funded (Test & Stein, 1978). The enactment of the Americans with Disabilities Act in 1990 (U.S. Department of Justice, n.d.), the Surgeon General's Report in 1999 (U.S. Department of Health and Human Services [DHHS]), and the President's New Freedom Commission on Mental Health in 2002 (Mental Health Commission) advanced the concept of recovery and identified the need for effective and evidence-based mental healthcare.

By 2000, mental health treatment shifted from a *medical model* to a *recovery model* of care. The medical model considers recovery as regaining a previous level of functioning and alleviation of symptoms in response to treatments aimed at a cure. In contrast, the recovery model defines recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012).

New terminology is preferred in the recovery model. Instead of a person *recovering from* mental illness, we say a person is *in recovery*. The term *recovery* is "often referred to as a process, an outlook, a vision, a conceptual framework, or a guiding principle" (Jacob, 2015, p. 117). The Surgeon General's report (DHHS, 2016) refers to recovery in substance abuse as broader than *abstinence* or *remission,* to include changes in "behaviors, outlook, and identity" (p. 5-3). Recovery is a holistic approach; it is a journey, not a destination. Terms used synonymously in mental health rehabilitation literature focusing on the emerging concept of the recovery model are: *recovery-oriented practice, recovery to practice, patient-oriented care,* and *consumer-based approach*.

Melissa Neathery, MSN, RN, is a clinical assistant professor at Baylor University School of Nursing, Dallas, Texas. She has taught psychiatric nursing in didactic and clinical settings for 15 years, with an interest in promoting spiritual care.

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COMPONENTS OF RECOVERY

In response to the confusion about what was meant by recovery, Jacobson and Greenley (2001) presented a conceptual model of recovery that considered internal conditions (attitudes, experiences, processes) and external conditions (policies, treatment practices, circumstances) experienced by those recovering. To be considered recovery-oriented, programs must contain four dimensions: 1) person-oriented, 2) person involvement, 3) self-determination/choice, and 4) growth potential (Farkas, Gagne, Anthony, & Chamberlin, 2005). Davidson, O'Connell, Tondora, Lawless, and Evans (2005) conducted a concept analysis and identified nine critical aspects of recovery: renewing hope and commitment; redefining self; incorporating illness; involvement in meaningful activities; overcoming stigma; assuming control; becoming empowered; managing symptoms; and being supported by others.

To provide health-promoting and evidence-based care, nurses must adopt a recovery-oriented view that promotes and nurtures recovery. From a Christian perspective, that view focuses on God as the ultimate source of identity, strength, and purpose. The recovery-oriented perspective entails the following components.

Renewing Hope and Commitment: Having a sense of hope in the prospect of living a purposeful and meaningful life is essential in recovery. Some purport that hope is the core component that allows belief that other recovery aspects are possible. Without hope, the recovery process will not be instigated or maintained (Park & Chen, 2016). For those in recovery, hope correlates with fewer psychiatric symptoms, and conversely, hopelessness is associated with increased symptom severity (Waynor, Gao, Dolce, Haytas, & Reilly, 2012). Although hope is critical for recovery, sources of hope are specific to each person. Threats of hopelessness also are unique, as described by mental health consumer Peter Amsel (2012): "Hope can be lost over virtually anything, no

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Having a sense of hope in the prospect of living a purposeful and meaningful life is essential to recovery.

matter how seemingly insignificant; had I allowed myself to enter that stream of hopelessness, I may well have lost my battle with this illness altogether" (p. 85).

Redefining Self: Identity can be defined as "persistent characteristics that makes us unique and by which we are connected to the rest of the world" (Slade, 2009, p. 82). After experiencing symptoms and receiving a mental illness diagnosis, people in recovery must not define themselves solely by a diagnosis. A healthy self-concept is based on many characteristics, abilities, traits, and behaviors of a person. Davidson and Strauss (1992) identified four steps of redefining a healthy sense of self in recovery as: 1) discovering the possibility that an identity exists apart from a diagnosis; 2) validating one's strengths and limitations; 3) putting aspects of one's identity into action; and 4) using the enhanced sense of self to address other aspects of recovery. A man in recovery describes his experience:

> They say that recovery is knowing oneself under new circumstances, redefining one's role, and reevaluating oneself to develop a new sense of respect for oneself. After living in darkness for many years and having died to my old self, thinking that my life was over and futile, a new birth emerged from within me that has made my life more meaningful and purposeful than before. (Scotti, 2012, p. 14)

Incorporating Illness: Although mental illness should not define someone, it cannot be denied either. Recognizing and accepting that one has a mental illness enables the person to seek treatment, to cope, and to pursue a meaningful and fulfilling life, despite the need to adjust for limitations. A systematic review of coping strategies in mental illness found that acceptance of mental illness is associated with more efficacious coping (Phillips, Francey, Edwards, & McMurray, 2009). A patient describes her experience (Salsman, 2012): "In the beginning, denial became my defense. I was angry and resentful." But then she continued, "I made an effort to open my eyes, to become aware of myself. I made a decision to stop wallowing in self-pity and to become responsible for the course my life would take" (p. 9).

Involvement in Meaningful Activities: Recovery is enhanced by pursuing goals and roles that have significant meaning. Feeling fulfilled in family roles (sibling, child, spouse, parent) or societal roles (employee, church member, friend, hobby participant) promotes recovery. Recovery approaches enhance constructive use of leisure and activities that a person finds meaningful and enjoyable, thus emphasizing the importance of "making life better rather than making life less bad" (Iwasaki, Coyle, Shank, Messina, & Porter, 2013, p. 54).

Overcoming Stigma: Stigma comes from the negative stereotypes and assumptions about people who have mental illness. Self-stigma refers to the process of adopting and internalizing negative assumptions about oneself. Unfortunately, societal stigmatization of mental illnesses affects people worldwide (Seeman, Tang, Brown, & Ing, 2016). Stigmatization interferes with care-seeking behaviors (Corrigan, Druss, & Perlick, 2014), promotes discrimination (Rüsch, Angermeyer, & Corrigan, 2005), and decreases adherence to treatment (Kamaradova et al., 2016). Therefore, recovery requires that a person not internalize stigmatizing beliefs, but promote accurate depictions of mental illness and support policies that eliminate discrimination.

Assuming Control and Becoming Empowered: Assuming responsibility for the recovery process is crucial for developing a healthy sense of self and health-promoting behaviors. As opposed to previous views that it was psychiatry's job to *fix* people with mental illness, the locus of control is on the individual. Instead of feeling helpless to the influences of mental illness, empowerment enables people to fight stigma, demand rights, promote awareness, and obtain effective available treatment and resources. Through her recovery process that propelled the recovery-oriented model, Deegan (1997) describes empowerment as,

> Founded on values that include a profound reverence for the subjectivity of other human beings, a belief that one can act to change his situation, an understanding that power is not finite but can be shared and created, and the willingness to love and be transformed by the love of those we serve. (p. 15)

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Managing Symptoms: Some people experience complete alleviation of mental illness symptoms, whereas many experience lifetime recurrences. Sometimes symptoms are more controlled and less severe than at other times. Symptom management may include medication, counseling, stress management, and lifestyle changes. Decades ago, the term *treatment compliance* described a patient's response to treatment. Because of the connotation of coercion, *treatment adherence* or *management* is now used. This shift in focus acknowledges that a person has choices and autonomy in how to incorporate therapeutics into one's life and recognizes that someone with mental illness is an active participant in his or her care (Vuckovich, 2010).

Being Supported by Others: Instead of being alienated, a person with a mental illness needs connection to and support by others. Positive relationships enhance recovery by providing role modeling, resources, encouragement, information, and understanding. Research exploring subjective and objective reports of social support by people with mental illness indicates a significant association with recovery (Corrigan & Phelan, 2004) and coping (Davis & Brekke, 2014). Sometimes called *peer specialists* or *consumer-providers*, individuals with experiences of living successfully with mental illness, who support others with similar issues, is a growing modality in recovery. Professional peer providers obtain training and certification in helping others by promoting hope, advocacy, resources, socialization skills, and sharing their lived experience to engage others in treatment (Salzer, Schwenk, & Brusilovskiy, 2010).

NURSING FACILITATION

Regardless of the setting, nurses are posed to promote and nurture recovery from mental illnesses and substance abuse. It is important to remember that recovery is what clients do; facilitating recovery is what nurses and other mental health professionals do. Through the therapeutic nurse/patient relationship, nurses address self-concept, decision-making, resource attainment, social support, advocacy, and self-care activities, while conveying empathy, dignity, and respect for each person's lived experience.

In conjunction with the SAMHSA, the American Psychiatric Nurses Association (2017) provides interprofessional education to enhance recovery-oriented practice. Interventions specified in the Psychiatric Mental Health Standards of Practice address the needs of those in mental illness recovery (American Nurses Association, 2014). Recovery-oriented nursing care is not a list of additional activities tacked on to a treatment plan. Instead, care reflects a mindset, attitude, and motivation integrated into all aspects of the nursing process. Table 1 offers questions to help you assess if you have a recovery-oriented mindset.

Nurses have the power to create a milieu that enhances recovery and provides the care needed to recover, as Deegan (1996) points out:

> Choice, option, information, role models, being heard, developing and exercising a voice, opportunities for bettering one's life—these are the features of a human interactive environment that supports the transition from not caring to caring, from surviving to becoming an active participant in one's recovery process. (p. 92)

Interestingly, recovery-oriented care also benefits nurses. For example, Kraus and Stein (2013) found that case managers who worked for facilities with perceived higher levels of patient-focused services reported less burnout and higher job satisfaction.

SPIRITUALITY IN RECOVERY

Many mental health service consumers and mental health professionals view spirituality as an integral aspect of well-being for recovery, and life in general. Spirituality sometimes includes

Table 1. Self-Assessment: Do You Have a Recovery-Oriented Mindset?

✓	Do you believe that people with mental illness can get better?
✓	When you see a person in a symptomatic state of mental illness, do you imagine him/her being in recovery in the future?
✓	Do you focus on the person and not the disease? For example, refer to someone as a "person with schizophrenia" rather than "a schizophrenic."
✓	Do you remind people that they are the expert on their experience?
✓	Do you encourage people to consider various options when deciding on treatments?
✓	Do you encourage people to ask questions about their diagnoses and recommendations?
✓	Do you listen to people's stories and view each one as a unique experience?
✓	Do you assess each patient's source of hope, meaning, and support?
✓	Do you acknowledge and reinforce each patient's positive qualities and abilities?
✓	Do you professionally confront others who use derogatory language about people with mental illness or who perpetuate stigma?
✓	Do you advocate for the rights of people with mental illness?
✓	Do you encourage clients to imagine themselves in 6 months and describe how they would like to be?
✓	Do you write treatment goals with the client and use empowering language? For example, "Patient will identify 5 realistic methods of managing symptoms" instead of "Patient will be compliant with treatment."
✓	Do your treatment plan interventions use verbs, such as "promote," "enhance," "encourage," "assist," "teach," "offer," and "reinforce"?

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religiousness. In general, *religion* is viewed as a system of beliefs, doctrine, or worship that is shared by a group of followers. *Spirituality* tends to be a broader concept that encompasses personal transcendence and meaning. However, spirituality and religion both refer to:

> The feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. The term *search* [emphasis added] refers to attempts to identify, articulate, maintain, or transform. The term *sacred* [emphasis added] refers to a divine being, divine object, Ultimate Reality, or Ultimate Truth, as perceived by the individual. (Hill et al., 2000, p. 66)

Based on this conceptualization, spirituality/religiousness is not deemed *good* or *bad*. The feelings, thoughts, experiences, and behaviors that result from the search for the sacred can be acceptance, hope, fulfillment, and strength; or guilt, self-blame, abandonment, and isolation. Mental health service consumers and providers together can identify the role of spirituality/religiousness in the promotion or hindrance of a client's recovery.

Many people with health-promoting spirituality believe that recovery is rooted in a connection to God, and they search for relationship with him. Dr. Daniel Fisher, a psychiatrist with a previous diagnosis of schizophrenia, who has advocated extensively for the recovery model, says:

> [Recovery] is essentially a spiritual revaluing of oneself, a gradually developed respect for one's own worth as a human being. Often when people are healing from an episode of mental disorder, their hopeful beliefs about the future are intertwined with their spiritual lives, including praying, reading sacred texts, attending devotional services, and following a spiritual practice. (2013)

Faith and religious beliefs can be sources of hope, meaning, self-concept, empowerment, support, and motivation to take responsibility for treatment. Spiritual experiences influence sense of self, philosophy of life, growth after episode of acute symptoms, and peacefulness for people in recovery from severe mental illness (Ho et al., 2016). The innate desire to feel connected, inspired, and strengthened by a power greater than ourselves is core to the recovery narratives of many (Slade, 2009). In fact, themes such as hope, reconciliation, faith, grace, fellowship, surrender, regeneration, and belief are entwined throughout the recovery process (Fallot, 2001). Table 2 offers biblical references that support recovery-oriented care. Faith community nurses will find these references especially helpful in their spiritual care of clients.

Table 2: Biblical References That Support and Encourage Recovery-Oriented Care

Renewing Hope and Commitment	Psalm 33:22, 42:11, 62:5, 130:5; Proverbs 13:12; Jeremiah 29:11; Romans 8:25, 15:13; Hebrews 10:23
Redefining Self	1 Samuel 16:7; Jeremiah 29:11, 30:17; Ephesians 2:10; Hebrews 11:1; 1 John 3:1-3
Incorporating Illness	Psalm 25:5; Proverbs 3:7-8; Romans 5:3-4; 2 Corinthians 5:17
Involvement in Meaningful Activities	Psalm 90:17; Proverbs 16:3; Matthew 5:16; Ephesians 2:10, 6:7; Hebrews 6:10; 1 Peter 4:10
Overcoming Stigma	Genesis 1:27; Psalm 9:18, 25:3, 119:114; 1 Timothy 5:5
Assuming Control and Becoming Empowered	Exodus 15:2; 1 Chronicles 16:11; Psalm 31:24; Isaiah 40:31; Romans 5:4, 12:1, 15:13; 1 Corinthians 6:19-20; Philippians 4:13
Managing Symptoms	2 Chronicles 15:7; Psalm 119:66; 1 Corinthians 9:27; 3 John 1:2
Being Supported by Others	Psalm 133:1; Proverbs 12:26; Ecclesiastes 4:9-10; John 15:12; Romans 15:1; Galatians 6:2; Philippians 2:4; 1 Thessalonians 5:11

INCORPORATING SPIRITUALITY INTO CARE

Nurses can address spirituality in recovery throughout all steps of the nursing process. Begin by examining your beliefs about mental illness, substance abuse, recovery, and spiritual care. As with any form of care, spiritual care should be offered ethically, effectively, and within the nurse's scope of practice and expertise.

Assess a person's spiritual beliefs and how those beliefs influence the client's understanding of recovery. Motivational interviewing, a clinical approach that helps people make positive behavioral changes (SAMHSA, n.d.), and formalized spiritual assessment (Timmins & Caldeira, 2017), can help identify beliefs that should be encouraged and strengthened or recovery barriers that should be explored. Spiritual assessment guidelines identified by Gomi, Starnino, and Canda (2014) include developing a therapeutic alliance, identifying a client's readiness to discuss spirituality, focusing on past and present spiritual strengths, considering the client's cultural context, and "letting the client direct whether and how spirituality can be used in an assessment to develop treatment plans" (p. 452).

Core tenets of recovery-oriented treatment planning are promotion of client autonomy, empowerment, and decision-making (Slade et al., 2014). The client is viewed as a member of the treatment team and collaborates in development of the treatment plan. Recovery-oriented programming uses strength-based and self-management approaches (Kidd, Kenny, & McKinstry, 2015). Spirituality should be included in the treatment plan, based on the client's direction. Goals focused on

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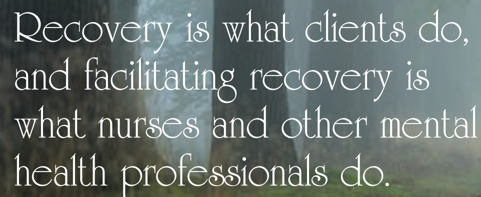

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employing spiritual strengths and addressing spiritual deficits can promote overall recovery. Spiritual resources, such as church attendance, spiritual readings, prayer, worship, service, and interaction with a religious leader, can be part of a client's treatment plan.

Interventions based on accurate assessment and planning can encourage the healthy role of spirituality in clients' lives. Nurses can direct spiritually seeking clients to consider beliefs that encourage and guide recovery, as well as nurture the faith of those who have a spiritual/religious grounding.

Promotion of the client's spiritual recovery journey can occur in many ways:

- Encourage clients to develop a healthy, God-based view of self;
- Treat clients in ways that convey dignity, value, and respect;
- Encourage participation in meaningful spiritual activities, such as prayer, reading Scripture, worship, and attending services;
- Listen to the client's personal journey through discussion and encouraging further exploration through writing, art, or photovoice (expression of experience through multimedia);
- Acknowledge the value and uniqueness of the client's experience;
- Encourage clients to focus on helping others and provide opportunities to do so;
- Suggest and help clients accept divine strength to manage treatment;
- Pray with clients who request prayer, for divine interventions, such as wisdom, insight, grace, forgiveness, and physical and emotional strength;
- Provide information for supportive community resources that are congruent with the client's spiritual and recovery needs;
- Help reframe negative thoughts to biblically aligned thoughts;
- Encourage clients to accept love and support from family, peers, providers, support groups, and religious community;
- Explain that relapse is not an indication of failure but is often a part of the overall recovery process and an opportunity to grow spiritually and emotionally;
- Connect client to a peer provider (a person trained to share his or her lived experience of recovery to promote recovery and resilience in others).

Faith can be a source of hope, understanding, and strength in recovery, as described in this first-person account of a client in recovery:

Sidebar: Implementing Components of Recovery

Ray, a 29-year-old male, visits a church-based mental health support group led by Jana, a faith community nurse. Hot meals are offered at each meeting. Seeing Ray is unwilling to interact with group members, Jana catches him after the meeting to introduce herself. He doesn't say much but states he recently relocated to the community. She affirms his positive action in attending the meeting and invites him to return.

At subsequent meetings, Ray avoids group interaction and barks "no" when Jana mentions establishing care with a behavioral healthcare provider. Noting his blunted affect, facial grimacing, mumbling speech, and pervasive social avoidance, Jana asks privately, "Ray, are you struggling with mental health issues?" Ray mumbles, "I don't want people to know me; they won't like me."

Having identified his need for healthcare, Jana offers to accompany Ray to a community clinic. He shows her a recent prescription for chlorpromazine from a local clinic for the uninsured. Jana asks Ray what he understands about the medication and if he is taking it as prescribed.

As trust is built with Ray, Jana ascertains the absence of social supports. She encourages him to volunteer at the local food bank and introduces him to the manager. At each encounter, Jana offers to pray for Ray; she and other group members invite him to Sunday services and social gatherings; he is unresponsive.

Seven months after his first support group visit, Ray makes eye contact more often and sometimes responds to members' conversation. He consistently interacts with Jana after meetings and volunteers at the food bank a few times each month.

Reflect:

- How did Jana acknowledge Ray's journey in recovery?
- Which components of recovery has Jana successfully addressed?
- Has she made missteps in her interactions with Ray? If so, what could she have done differently?
- What steps toward overcoming stigma would you offer Ray?
- How could a peer specialist benefit Ray in his recovery?

—JCN

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Web Resources

- American Psychiatric Nurses Association—http://www.apna.org/i4a/pages/index.cfm?pageid=4100
- American Psychological Association—http://www.apa.org/monitor/2014/09/recovery.aspx
- Department of Veterans Affairs—http://www.mentalhealth.va.gov/mentalhealthrecovery.asp
- National Alliance on Mental Illness—http://www.nami.org/Learn-More/Mental-Health-Conditions
- SAMHSA—http://www.samhsa.gov/recovery
- U.S. DHHS—www.mentalhealth.gov/basics/recovery/index.html

> It was times like these I realized God was with me and had been with me all along. He didn't actually give me what I'd asked for (a life free of anxiety and sadness), but he put it within my reach. Looking back, I see he had done this all along, but he required me to work for it so I could be a better and stronger person. (Grazia, 2012, p. 133)

Evaluating treatment success cannot be solely based on reduced symptomatology, fewer hospitalizations, or decreased relapses. Helping a client determine if a treatment goal was unrealistic can help establish if plan modification is needed. Through ongoing collaboration, nurses can help the client explore how his/her spirituality is or is not benefiting recovery.

Sometimes an intervention must be changed to better suit the client's needs. For example, to increase socialization, feelings of connectedness, and opportunities for service, a client may set a goal to participate in a faith community. If an initial visit was not positive, the nurse and client can explore specific faith community characteristics the client is seeking. Provide realistic expectations by explaining that it may require visits to several faith communities before a client finds a good fit.

Mental health consumers identify positive outcomes of treatment partnerships if providers promote the acceptance of mental illness, management of symptoms, improvement in self-esteem, and development of positive meanings and life goals (Anthony, 2008). Nurses can incorporate spiritual outcomes into these areas of partnership. The sidebar, Implementing Components of Recovery, explores applying the recovery-oriented model by a faith community nurse in a support group setting.

CONCLUSION

The perspective that mental health and/or substance abuse treatment consists of professionals telling passive patients what to do is a paradigm of the past. Recovery-oriented care is a collaborative partnership that views the person with a mental illness holistically. Core components of recovery are well aligned with one's spiritual life themes. Nurses must remember:

> There are many pathways to recovery. It is self-directed and empowering, with a personal recognition of the need to change and transform. There is a holistic healing process, with a gradual return to mind, body, and spiritual balance, based on the individual's personal cultural beliefs and traditions. (Baird, 2012, p. 147)

Nurses can and should help people in recovery promote healthy spiritual and religious beliefs and practices. In so doing, we may help those on the journey of recovery discover God's path that leads to understanding (Psalm 119:32) and life (Psalm 16:11).

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