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Recovery Processes in Individuals with Persistent Mental Illness

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I give my deep appreciation to Don Cooper and Lisbeth Riis Cooper, Virgil and Lis Stucker, and the entire CooperRiis community for welcoming my family and me to this incredible place of healing and growth. And I wish to thank the residents who allowed me into their lives and gave me a glimpse into their personal pathways to recovery.

Abstract

This study was conducted to examine how living, working, and recovering in a therapeutic community affects individuals suffering from mental illness. The study involved participant-observation and interviews with residents of CooperRiis, a residential healing farm community for individuals with mental illness. In-depth interviews were designed to directly examine the recovery experience from the resident's perspective. The principal guiding question was "How do the person's experiences and activities in this community affect processes of recovery in mental illness?" I was especially interested in learning about how the community and the emphasis on wellness impacted the residents' recovery process. Using qualitative-phenomenological data analysis, I analyzed participants' interviews and used participant-observation for external validation of the interview findings. Themes around recovery were identified and included such factors as the influence that the environment, the community, and setting have in the healing process. Also, the impact of integrating a strong wellness program (e.g., exercise, nutrition, yoga, qigong, etc.) with traditional forms of therapy on physical and mental health is discussed.

Recovery from severe and persistent mental illness involves a shift from despair to hope, alienation to purpose, isolation to relationship, passive adjustment to active coping, and from withdrawal to involvement (Ridgway, 2001). Often, the shift includes major changes in behaviors as well as changes in emotions and cognitions. The processes that impact that shift are complex, dynamic, personalized, and ongoing. There needs to be a much clearer understanding of recovery from severe mental illness, particularly from the individual's perspective. William Anthony (2004), a pioneer in psychiatric recovery research, argued that "the time to make a significant transformation in our research agenda is upon us. There must be a concerted focus of study on what makes people well, and what are the barriers and the facilitators to recovery" (p. 303). Anthony and others have urged researchers to take a closer look at the human process of recovery.

The use of qualitative-inquiry research strategies has been invaluable in encouraging patients/participants to convey the depth and range of their experiences. Yet qualitative methods are not widely used by researchers in the mental health field – perhaps due to the emphasis on quantitative evidence-based outcome evaluations. The qualitative approach, according to Larry Davidson (author of *Living Outside Mental Illness*, 2003), "provides rigorous methods for psychological research, well grounded in an explicit theory of human subjectivity, and therefore particularly well suited to describing the role of the person in recovery" (p. 27). In this study, I used a qualitative-phenomenological approach to investigate the recovery process. The phenomenological approach to inquiry and data analysis emphasizes a constructivist view of knowledge, derived from the perspective of the patient/participant. In this case, a study was conducted to examine in great detail how a community-based therapeutic farm that integrates holistic care deeply into its treatment

program affects the physical and mental health of individuals suffering from mental illness. It was designed to add to a small, but growing body of qualitative psychological research illuminating the process of recovery, yielding information unlikely to emerge from a more traditional quantitative-outcome study.

Method

Participants

All participants were recruited from CooperRiis, a residential therapeutic community for people with severe and persistent mental illness. Diagnoses of the participants included schizophrenia, schizoaffective disorder, personality disorders, bipolar disorder, severe anxiety disorders, and unipolar mood disorders. The maximum number of CooperRiis residents at any one time was 36. There were also former residents ("graduates") who participated in some of the activities and therapies on site.

Procedure

In conducting research with human participants, I adhered wholly to the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2003). In accordance with these principles, I received institutional approval for my research protocol from the Social Sciences Institutional Review Board (IRB) of Warren Wilson College as well as from the Research Review Board of CooperRiis. Throughout the study, I remained sensitive to the fact that the intimate nature of a participant's disclosures raises ethical issues. These issues involve what constitutes truly informed consent; what potential effects might come about through the participant's involvement, both for the participant and for others; and what responsibility I carry in relation to these effects and in publishing the results. In accordance with these guidelines, all residents

were fully informed regarding these issues and their rights as research participants to confidentiality and anonymity in any publication of the data. All residents were informed of the research study in a community meeting, or during their first few weeks after they were accepted into treatment at CooperRiis.

Participant-observation. I lived at CooperRiis for five months. I spent the first few weeks getting to know staff and residents so that they would feel more comfortable with my presence. All were fully informed as to my role there and were allowed to participate in the project as they wished. The participant-observation component of the study allowed me to share meals with the community, participate in the work program, attend meetings for both staff and residents, engage in wellness activities with community members, and spend time sharing in community life.

Interviews. A subset of the CooperRiis population participated in one-on-one interviews with me. Some residents approached me and asked to participate in the interviews. I approached the others and asked whether they would be willing to talk with me. All residents who indicated interest in the research were given an informed consent document which detailed the purpose, procedures, potential risks and benefits, and general conditions of participation (e.g., confidentiality). With those who provided their informed consent, I conducted semi-structured interviews lasting approximately an hour. All participants agreed to have their interviews taped and later transcribed. Questions and follow-ups were designed to directly examine the recovery experience from the resident's perspective. The principal guiding question was "How do the person's experiences and activities in this community affect processes of recovery in mental illness." For this part of

the study, there were 15 men (mean age = 32) and 15 women (mean age = 35). All resident interviewees were caucasian and were their own legal guardians.

Results

Data Analysis

Qualitative-phenomenological data analysis was used to examine the interview transcripts. I sought to discover naturally arising meanings among the participants' responses, analyzing and interpreting these data to describe credibly and vividly the processes of recovery. By reading and rereading transcripts, I attempted to identify consistent themes and processes, grouping them into topics of related meaning. Internal validation of these themes was achieved by referring back to the original statements to judge their accuracy. The participant-observation component of the study allowed me to put the interviews into a clearer context and provided external validation of the interview data. Findings are a compilation and synthesis of my observations from being a community member, my notes from attending meetings and reading about the treatment philosophy at CooperRiis, and the thoughts and feelings about the recovery process communicated to me directly from the participants.

Findings

CooperRiis is a healing farm community in Western North Carolina. It is situated on approximately 80 acres of farmland and includes residential lodges for 36, a five-acre organic garden, animal pastures, a chicken coop for providing free-range organic eggs, two large greenhouses, a potting barn, an arts and crafts barn, a woodshop, and a kitchen and bakery. It also has a number of spaces devoted to exercise and physical health including a weight room, fields for sports, a tennis court, a yoga room, a massage hut, a pergola for Qi

jong and other activities, and a small lake for swimming. The community/farm is designed to "create a place of peace, as well as a community that works as a catalyst for learning…. The architecture of the buildings nestles them into the landscape and each features lots of windows, allowing for stunning views of the mountains and the rolling countryside and filling the buildings with light" (www.cooperriis.org). This emphasis on the importance of the role of the environment in the healing process was conveyed to me by a majority of the community members.

At CooperRiis, the emphasis is on relationship-centered care. The community is designed to empower residents in their growth towards mental and physical health. All of the residents live on campus, eat their meals in the dining room, and work on various crews in the community (i.e., garden, art barn, woodshop, landscaping, housekeeping, and kitchen). The community is designed to help residents move from being "stuck" and disengaged to participating fully in the community's activities. In addition to traditional care, such as psychiatric medication, group and individual psychotherapy, and social work, residents are encouraged to develop their "whole person" including their physical health. The residents are consistently taught about the reciprocal relationship between physical and mental health, and are encouraged to participate in a variety of activities including exercise, nutritional programs, and "balance" programs (e.g., Qi jong, meditation, yoga).

Based on my observations and interviews, it is evident that there are a variety of recovery pathways and methods Nevertheless, it appears that there are recovery themes which are common to many residents.

Community / Being supported by others. This aspect of recovery was mentioned by all of the residents. Most residents place a lot of value in the community and were quick to

identify specific individuals at CooperRiis who were truly making a difference in their life. "Before I got here, I had a real tendency to isolate. The program here gets you up, moving, and not isolated." Many others agree that moving from isolation and withdrawal to engagement with others is incredibly important to their recovery. "I felt needed right away [with the work program]. People were great here." This community support also helped move residents from despair to hope. This transformation in thinking was primarily attributed to the incredibly accepting environment. Residents stated that they feel little stigma at CooperRiis and that people tolerated their behaviors and emotions.

The community was often described as a healing entity in itself. In the case of CooperRiis, this appears to be related to two major factors. First, the natural beauty of the environment and the setting of the community is conducive to healing. Several residents mentioned that taking walks through the farm, visiting the animals, and just being in such a peaceful place were key to their recovery process. "When I feel frustrated or contained, I just go for a walk. That helps tremendously. Whereas if you're in an institution, you're not even allowed outside the doors. The possibility of going to the farm, feeling free, helps me to strive for greater independence, all the while interacting with the staff and learning about my disorder." Second, the social component of "being in a community is a big part of it. I enjoy living in a community with people who have different functions." Further, the community serves an important purpose in learning how to connect and coexist with different types of people. "When you are in a community like this, you bump up against other people and there are bound to be challenges. I had people that I rubbed against the wrong way in the beginning, but I've kind of found a way to get to know them and it's gotten better." Finally, it is important to note that approximately 90% of the active staff

members of CooperRiis live on-site. For the residents, this provides significant opportunities for healing; they can interact with staff in many informal settings throughout the day – for example, during meals where staff and residents sit together, during "down times" in the afternoon, and during the evening in the lodges where several staff members reside.

Feeling safe. Many residents said that CooperRiis was a very safe place. People feel comfortable and they feel that there is tremendous tolerance for everyone. This, to some, is both good and bad. Several residents mentioned that there had been one resident who had been erratically disrupting lodge life (with angry outbursts). After attacking another resident, he was finally expelled from the campus. Several residents confided that they thought he had been given too many chances and that his presence had diminished the feeling of a safe community. For the most part, however, residents feel positive about the environment. "I really need to have a safe environment to do my healing in and I feel very safe here and more than anything it is supportive. I feel supported and I feel safe."

Regaining hope from hopelessness. A number of residents revealed that they felt a significant amount of despair and hopelessness as they came to CooperRiis. Many were coming from other psychiatric facilities in which they felt they had received little help. Some were coming from deep states of depression. In most cases, the residents indicated that they felt hope when coming to CooperRiis. This spark of hope is nurtured by staff and fellow residents who feel that it is key to recovery. A unique aspect of CooperRiis is that graduates interact regularly on campus providing hope and modeling for "life beyond a diagnosis" (e.g., employment). Once they begin to regain hope, residents are able to commit more to their recovery.

Managing symptoms. Most residents indicated that a key to their recovery was managing their symptoms to allow a return to functioning. "Recovery equals functioning. I was spending 4-5 hours in bed before I came here." What is interesting is the degree to which residents view their recovery as active coping vs. passive adjustment. Some view managing their symptoms as relatively passive (e.g., the medications are doing the bulk of the work) while others see themselves as committed and active – availing themselves of as many opportunities to heal as possible. Some referred to the cost of the program and wanted to make sure that they were active recoverers ("getting my money's worth").

Participating in activities. The number and diversity of activities in which residents can participate is extraordinary. After the work program ends for the day, the activities begin: softball, yoga, art barn, groups (e.g., Actor's group, Bipolar awareness group), ballroom dancing, drawing lessons, movies, card games, and more. "It's been a learning experience for me, having different workshops… the acting workshop, spirituality group, writer's workshop. All of these little things have been good for me… activities that kind of push me." Residents vary tremendously in how much they participate in these activities and to what extent they view the activities as part of their recovery. Resident-initiated activities are a good example of empowerment, in which a resident's internal strengths are combined with social connectedness. Paradoxically, having too many choices may overwhelm the residents (and the staff, who often seem – and describe themselves as – very busy).

Weekends are generally described as more difficult for the residents. Some reported feeling bored and didn't want to go on the planned outings. One observation from community meetings is that residents didn't seem strongly engaged in choosing the activity

for the weekend. Some residents see the positive side of the less-structured weekend and state that this is like the real world, in which one has to create one's own schedule more on the weekends.

Work. The work program (now known as the Life Skills Program) is an intensive element of the CooperRiis program. Residents spend between 20-30 hours per week helping the community to function. In addition to their work crew (e.g., farm, wood shop, housekeeping, kitchen), residents help wash the dishes for the whole community several times a week.

Most of the residents discussed the work program in their interviews. For many residents, the work program builds basic job skills (i.e., a work ethic, showing up on time, learning how to follow instructions). Now a reliable worker, one resident recalled his first month in the program: "I didn't think I could work five days a week. I had never done that before." Another praised the kitchen crew since she was learning basic skills in cooking; despite being in her 30s, she had never learned how to cook.

With higher-functioning residents, some reported the benefits of having a structure and a chance to learn skills through an apprenticeship system. "I have been able to build things for CooperRiis – that feels good," stated a resident from the Woodshop crew. Others were less enthusiastic.[1] Their perceptions included: "Lots of other residents seem lazy and skip work," and "There aren't any consequences for missing work." Others commented that the connection between their work and their recovery from their mental health condition is fuzzy. "For example, housekeeping. I guess the purpose is to keep us active, get us working…. But at the same time, I'm scrubbing floors and it's not what I

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[1] The work program was in a state of transition during my study. These results may not be valid for the current Life Skills Program, in which some of the problematic issues of work were being addressed.

want to be doing. I'd rather be in the art barn, or cleaning my room, or calling a friend. So, I feel somewhat that the work program can be empowering but also disempowering. Still, I've gained independence through the work program." Finally, a few residents stated that they resented working without getting paid.

Holistic health. Improving feelings of wellness is an essential component to recovery. Most residents appreciated the wide variety of activities (e.g., yoga, strength training, walking, smoking cessation support, massage) that are available. The exercise was cited most often as positive. Residents value the ability to exercise at different times throughout the day. One can walk around the farm in the morning, after meals, and in the evening. They also are invited to play sports several times a week. The benefits that residents describe from increasing their exercise include more energy, improved mood, improved self-efficacy, and reduced stress and anxiety (all consistent with the large body of research supporting the benefits of exercise for mental health).

Many of the residents who smoke said that they appreciated the fact that smoking cessation support was provided, but that they didn't want to be coerced into quitting smoking. Several mentioned that quitting smoking would be detrimental to them while they were going through such a difficult process as recovering from mental illness. This is consistent with literature suggesting that smoking may be a part of self-regulating emotion in people with severe psychiatric disorders (e.g., Lucksted, Dixon, & Sembly, 2000).

The focus on nutrition as a part of wellness/healing was discussed by almost all of the residents. The nutrition program is specifically designed to improve physical and mental health synergistically. The diet is centered on wholeness and freshness, with vegetables coming from the organic garden as frequently as possible. Fish is eaten 2-3

times weekly, consistent with recommendations for optimal physical and mental health. Also, essential fatty acid supplementation (e.g., Omega-3s from fish oil) are prescribed for most of the residents. Many residents stated that they had made major changes in their diet while at CooperRiis. Improvements reported by residents included more successful weight management, a reduction in sugar intake, and an increase of fruits and vegetable intake.

To some residents, despite their acknowledgement that the nutrition program has many benefits, issues around food choices and portion sizes were mentioned. A number of the male residents stated that they had lost weight (without wanting to) on the meal plan. They said that they felt deprived of enough calories and could not understand why portion sizes were so controlled. They were puzzled by why portions were identical, independent of one's caloric needs. Some expressed resentment about feeling over-controlled with what and how much they could eat. This may have paradoxically contributed to residents obsessing about food, rather than seeing it as a nurturing component to their health. The obsession with food was observed in the off-campus trips to stores, when many residents stockpiled soft drinks, sugar snacks, and other "goodies" which they desired.[2]

The recent creation of a new staff position – Wellness Coordinator – will likely be of great benefit to the community. This person will bring together the many components of wellness programming and coordinate the efforts of many community members. An attempt to more closely follow and support residents in their wellness efforts will be made.

Conclusions

CooperRiis has an innovative treatment approach consistent with the view that recovery is an active process done *by* the person, not *to* the person (Davidson, 2003). The

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[2] Nutrition and eating at CR seemed to be a "hot button topic" for the community – there were strong feelings about the most effective ways to encourage healthful eating. As my time was ending at CR, a shift towards more individualized nutrition plans seemed to be occurring.

treatment approach is based on the Enhanced Recovery Model (Young & Ensing, 1999) which delineates three basic stages of recovery. The first stage is characterized by acceptance of one's illness while concurrently developing a sense of hopefulness to move forward. The middle stage is characterized by multiple processes, including gaining new perspective and insight, discontinuing harmful coping strategies, and beginning to take more control of one's own recovery and one's own life. The third phase of recovery involves striving for a stable sense of well-being, a better quality of life, and a sense of meaning and purpose in one's life (CoooperRiis, 2003).

The most important factor that helps propel the residents through all three stages appears to be the community itself. This, of course, includes the social support that residents find moves them away from alienation, isolation, and withdrawal to connection and involvement in their lives. Also, everything from the design of the buildings to how the residents interact with the natural environment is intended to improve mental and physical health *synergistically*. For example, participating in growing one's own food, gathering one's own eggs, and then helping prepare the meals empowers individuals in their strivings to recover mental and physical health. The community provides many opportunities for empowerment. The importance of this cannot be overstated in a population which has for the most part been disempowered, stigmatized, and/or simply ignored. Larry Davidson writes

> It is not so important what activities or roles people choose to become involved in or to pursue as much as it is important for them to participate in personally meaningful and gratifying activities that also afford them a sense of making worthwhile contributions to their community. This kind of participation also affords the person a sense of purpose and direction in his or her own life. (Davidson, 2003, p. 48).

This concept of meaningfulness is imperative for the CooperRiis community. One key question that the staff continually addressed was how to make a resident's activities (especially work) *meaningful* in the context of his/her recovery. My observations gained from volunteering on several crews are that those residents who show up and participate regularly are getting quite a lot out of the program. Ideally, for example, working in the vegetable garden allows an individual to produce food and to heal simultaneously.

The second major factor appears to be the focus on holistic health. The knowledge that mind-body-community health is interconnected with one's symptomatology is taught early and often. This is a strength of the CooperRiis program. For example, exercise, diet, stress management, and nutritional counseling are encouraged to help individuals manage their weight successfully. Weight management in individuals with severe psychiatric disorders is of major concern, especially since weight gain is a well-known adverse effect of many anti-psychotics (Tardieu, Micallef, Gentile, & Blin, 2003). Being able to manage one's weight successfully may have many positive consequences for the individual in recovery from mental illness. These include improvements in adherence to medication regimens, self-esteem, and health-risk profile (e.g., decrease in diabetes risk, improved cholesterol ratios).

The focus on holistic health at CooperRiis creates a system of healing that goes beyond *recovery*, as defined by regaining what one has lost due to one's illness. It also includes *discovery* – creating new meanings, roles, identities, and connections in one's life. It includes the joy that is experienced when a resident accomplishes some new task (e.g., playing soccer, planting a flower bed), **and** the space to reflect on and deal with one's illness. In this sense, recovery isn't so much moving past one's illness, but being able to

embrace it while continually making gains in coping and personal growth. CooperRiis facilitates this process such that each resident “ultimately become[s] the architect and engineer of his or her own recovery” (White, Boyle, and Loveland, 2005, p. 237).

The findings from my study have been shared with the operations team at CooperRiis. A response to my observations and suggestions has been articulated and an action plan created. In this way, I hope that the study directly benefits the CooperRiis community. Also, I hope that this project will benefit mental health practitioners and consumers more broadly, as the findings are presented publicly. I hope that these data shed some light on how to best provide care that focuses “on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms” (President’s New Freedom Commission, 2003).

References

American Psychological Association (2003). Ethics Code. See *www.apa.org/ethics*

Anthony, W. (2004). The recovery effect. *Psychiatric Rehabilitation Journal*, *27*, 303-304.

CooperRiis (2003). Summary of CooperRiis Clinical Program. Available from CooperRiis, Mill Spring, NC.

Davidson, L. (2003). *Living outside mental illness: Qualitative studies of recovery in schizophrenia*. New York: NYU Press.

Lucksted, A., Dixon, L., & Sembly, J. (2000). A focus group pilot study of tobacco smoking among psychosocial rehabilitation clients. *Psychiatric Services, 51,* 1544-1548.

Ridgway, P. (2001). Restorying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal, 24,* 335-343.

President's New Freedom Commission on Mental Health (2003). www.mentalhealthcommission.gov/reports/reports.htm

Tardieu, S., Micallef, J., Gentile, S., & Blin, O. (2003). Weight gain profiles of new anti-psychotics: Public health consequences. *Obesity Reviews, 4,* 129-138.

White, W., Boyle, M., & Loveland, D. (2005). Recovery from addiction and from mental illness: Shared and contrasting lessons. In R. Ralph & P. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 233-258). Washington D.C.: American Psychological Association.

Young, S. & Ensing, D. (1999). Exploring recovery from the perspective of people with psychiatric disabilities, *Psychiatric Rehabilitation Journal*, 22, p. 219-232.