FEATURE ARTICLE

RECOVERY, REHABILITATION, REINTEGRATION: WORDS VS. MEANING

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So much has been said and written about the terms "recovery," "rehabilitation" or "reintegration" by so many different voices, that it is, at times, difficult to know what exactly we are talking about. Some people believe that "recovery" means "cure" and therefore do not feel that it can really apply to persons with serious psychiatric disabilities. Some people believe that "rehabilitation" means "training" and providing services to people with serious psychiatric disabilities in specific facilities—facilities in the community or in a hospital setting. Some people believe that "reintegration" is different from "rehabilitation," because "rehabilitation," to them, is a technique to train people with serious psychiatric disabilities in skills rather than helping people to become part of the social fabric once again. I would like to discuss these terms once again, because I believe that they speak to more than semantics and linguistic differences. They often reveal a confusion in the practice of rehabilitation that has long been discussed in the literature.

What is Recovery ?

In several fields of practice, including psychiatric rehabilitation, mental retardation (or developmental disabilities), neurological and physical disabilities, the old assumption that disability precluded growth and development and prevented people from attaining full citizenship in their communities, is finally fading in some parts of the world (Moxley, 1994). The field has begun to understand that serious psychiatric illness does not necessarily mean life long disability. In fact, the term "chronic mental illness" may be becoming an anachronism.

As Harding and Zahniser (1994) point out, the longer investigators followed an identified intact cohort of subjects, the more varied the outcome and the greater the improvement in functioning (e.g., Ciompi & Muller, 1976; Huber, Gross & Schuttler, 1979; Tsuang, Woolson & Fleming, 1979; Harding et al., 1987). The studies reviewed indicated that from **half to two-thirds** of the subjects improved significantly. Improvement was defined as: no current signs or symptoms of mental illness, no current psychiatric medication and lack of vocational and social dysfunction.

The concept of recovery itself has been best described in the writings of consumer survivors (e.g., Houghton, 1982; Deegan, 1988; Unzicker, 1989). Anthony (1993) has written that it is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skill and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitation caused by illness. Recovery involves the development of new meaning and purpose in one's life, as one grows beyond the catastrophic effects of mental illness. Recovery does not mean that the suffering has disappeared, with all symptoms removed and/or that the functioning has been completely restored (Harrison, 1984). Recovery from mental illness involves much more than recovery from the illness itself. It involves recovering from the stigma people have incorporated into their being; from the iatrogenic effects of treatment settings; from the lack of recent opportunities for self determination; from the negative side effects of unemployment and from crushed dreams (Deegan, 1988; Weingarten, 1994). Sue Estroff (1989) has said that schizophrenia is an "I AM" illness. Strauss (1992) has examined the active role of the Self in the recovery process, while Spaniol and Koehler (1994) have developed material based on first person accounts of how people describe their own techniques for coping and recovery. Is it possible to recover from serious mental illness? Both data and first hand experiences tell us that it **is**. Where do rehabilitation and reintegration fit in this emerging understanding of recovery?

Rehabilitation and Reintegration

Recovery is the process that the consumer-survivor undergoes. Rehabilitation is the process that practitioners use to facilitate recovery. There are many interventions that can be helpful for recovery to occur: crisis interventions, treatment, self help, basic support, case management to identify only a few, in addition to rehabilitation. Rehabilitation is not one specific intervention. It is a field of knowledge with a set of

values, a philosophy, principles and an approach to helping consumers (see WAPR, vol. 5, no. 4, Oct. 1993). Reintegration and rehabilitation, from our point of view, is part of the same process. Rehabilitation focuses on people regaining valued roles in their communities so that they have success and satisfaction (Anthony, Cohen & Farkas, 1990). Reintegration is the part of the process that allows people to assimilate into daily life. Both imply a change in the person and a change in the environment. Rehabilitation is not a place (a specific facility, for example), nor is it a series of places, because places are only buildings. A rehabilitation training center may in fact NOT be organized according to rehabilitation values, principles or an overall approach. A center may house practitioners who use a variety of techniques to help clients. Those techniques may or may not lead to rehabilitation outcomes. Rehabilitation outcomes include variables such as decent housing, life in the community, decent work, or school as would be appropriate for anyone in the peer group that the consumer should and wants to be a part of. "Rehabilitation facilities" often are organized in graduated steps that require people to achieve certain abilities within a certain period of time. No one, including consumers, recovers in graduated steps. People advance, they regress, they maintain the status quo, they take great leaps forward. Their rehabilitation usually takes a variety of forms depending upon factors such as: the person and their experiences of life; what his or her specific hopes are in the world of work, home/community or school are; how accommodating is the environment that they want to go to; how much energy they have; how many resources are available to them. Rehabilitation, as a process, helps people to define who they want to be within the world of work, community or home and school. Rehabilitation helps people to figure out what abilities and resources they need and want to succeed in the goals they would like to achieve and then helps them to acquire what they need, as much as possible. Learning skills and practicing them are important. However, if those skills come from a standardized checklist and not an analysis of what the person specifically needs to do to succeed in a specific setting and a specific role, learning skills does not lead to rehabilitation outcomes. It will produce people who are more skilled but no further ahead in their hopes and dreams for a decent future than they were previously. If families are only taught how to manage their loved ones symptoms and problems, then, while families will achieve some relief, consumers will be no further ahead in their hopes and dreams. Rehabilitation helps consumers and families work together to achieve a decent life. That is a very different philosophy from helping families to manage their loved ones. The philosophy of the discipline or field of rehabilitation is that a consumer, regardless of his or her disability, has as much right to hope for a better future as anyone else in their community, no more and certainly no less.

I am not saying that technique is not important. I am arguing that one intervention does not represent a whole field and an entire philosophy. A rehabilitation approach requires a series of interventions, whether there are facilities or not and regardless of who performs them, that focus on the individual in his or her real world environment as well as focusing on changing the environment. When we use words interchangeably, we subtly change the direction of our attitudes and what is acceptable in our work. Any psychotherapy is not rehabilitation or recovery. Any skills teaching is not rehabilitation, nor will it lead to recovery. Any facility is not rehabilitation, nor will it produce an atmosphere of recovery. The meaning of recovery, rehabilitation and integration is not about technique or facilities as the defining feature. It is about providing a comprehensive process that allows consumers to hope for a full life in their community, that takes that hope seriously and then figures out what approaches turn those hopes into a reality.

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Region of the Americas

La Asociación Mundial de Rehabilitación Psicosocial WAPR y el Capítulo Mexicano de la WAPR, en coordinación con la Vicepresidencia Regional para las Américas, está organizando el Congreso "De la Exclusión a la Rehabilitación Psicosocial: Redes Comunitarias y Dispositivos de Salud", el cual se llevará a cabo del 23 al 25 de Febrero de 1997 en la ciudad de México con la participación de expertos en el campo de la rehabilitación.

Information en Mexico: Secretaria National, Ma. Eugenia Ruiz-Velasco Fax: (525) 682-2222 or Vicepresidenta WAPR, Rosalba Bueno-Osawa (525) 596-7502 ◆

PARADIGMS OF PSYCHOSOCIAL ATTENTION

In the face of wide-spread stigma and inattention, mental health must now be placed on the international agenda. (World Mental Health Report, 1995)

Psychosocial rehabilitation has to do with the way we look at the ill person and with the wider context in which illness occurs. Coming to terms with the paradigms involved in the therapeutic process could lead to cognizance and, as a result, to an improvement in psychiatric assistance.

"Paradigms of Psychosocial Attention" is the title of the 1st Congress of Mental Health promoted by the World Association for Psychosocial Rehabilitation (WAPR), the Institute of Psychiatry (IPUB) of the Federal University of Rio de Janeiro and the Instituto Franco Basaglia (IFB), to be held November 20 to 23, 1996, in Rio de Janeiro.

Leading thinkers concerned with the South American psychiatric assistance will discuss paradigms and paradigm shifts - in Brazil a delicate subject that has caused a "heated" debate because of the special situation in Brazilian mental health politics.

One of the main shifts that has occurred in psychiatric assistance is the Antimanicomial Movement, which actually has one representative in the Federal Congress and has led to important changes in public health administration. The scientific community is divided in its opinion of these measures, but there is practically no interaction between the groups apart from an ever present ideological battle. Return-