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Chapter 20
The recovered subject
A socio-cognitive snapshot of a new subject in the field of mental health

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Abstract Recovery represents a new paradigm in the field of mental health. It refers hereby less to the possibility of relief from symptoms than to the individual's capacity to develop a meaningful life and a self-concept beyond the illness. Several countries adopted recovery oriented approaches to implement mental health service reforms and attracted considerable scientific interest on that subject matter. A comprehensive theory of the recovery process is however still missing. The present article argues for an analytic approach to the socio-cognitive components in the different stages of the subject's recovery process. By the means of narratives from mental health patients, a dramatic loss of internal territoriality ("locus") is evidenced in psychiatric treatment, whereby a subject in crisis renounces its internality to the professionals' authority. The eventual process of a subject's recovery, we suggest, has to be regarded as an inverse process, in which internality is privately and socially reclaimed and defended in terms of ownership and responsibility. The phenomenon of users' social movements, such as Madpride, is suggested as a form of re-conquest of social territory by the means of emancipatory pride. The mental components of the recovery process represent, in a large part, concepts from the theoretic framework of Cristiano Castelfranchi and his associates. A conception of the subject emerges whereby recovery is ideated literally as a process of "re-covering" aka protecting the subject's internality against the psychiatric/institutional gaze and rule of private affairs.
Keywords: Recovery, Ownership, Responsibility, Self-trust, Pride, Internality

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The explanatory power of the concepts Cristiano Castelfranchi developed with his group in the field of artificial intelligence extends as far as to the realm of mental health, a field of research where Cristiano made occasional interventions and contributions since the start of the anti-psychiatric movement in Italy led by Franco Basaglia. While his main focus of activity has remained over the years on AI and theoretic psychology his work is getting growing attention in fields as various as economic psychology, sociology, clinical psychology and philosophy. The contribution at hand reports to a large extent a theoretic draft on recovery from mental illness as discussed and elaborated with Cristiano in various occasions. In the past years, we had the great opportunity to exchange with Cristiano on several issues, ranging from recovery from serious mental illness up to the psychology of money. We have gradually metabolized (the process is still ongoing) and appreciate the significance of the large theoretic body of Cristiano's work and even more learned to esteem him as an admirable tutor and generous friend. Besides the evident use of a theory of recovery which we will draft here, we present this work as a case of how his theoretic approach allows for the understanding of almost any domain of human action. How and under what conditions does the goal of recovery emerge and be achieved will be the guiding question of the paper at hand.

1 Recovery: a new paradigm in mental health

Recovery is a key concept of the new mental health approach to mental illness and to reorient mental health services. In the last years, the recovery oriented paradigm has been adopted in many countries for the implementation of mental health service reforms (e.g. UK, Australia, USA). The Care Services Improvement Partnership, the Royal College of Psychiatrists, and the Social Care Institute for Excellence (2007), announced Recovery as a common purpose for the future of mental health services, emphasizing the need for a better understanding of the recovery approach. Definitions, methods, the role of agents in the process as well as its measurement stand and fall with the conceptual strength of the underlying theory (see hereto also chapter X in the policy manual as published by the American Psychological Association (2009); and the same published by the American Association of Community Psychiatrist: Sowers (2005)). Even if researchers have investigated the field and proposed intuitive models to grasp the recovery process, its components and conditions (e.g. Anthony, 1993; Jacobson & Greenley, 2001), explanation and description of the phenomenon have remained ambiguous.

First, a clear definition of recovery is missing (Farkas, 2007; Sowers, 2005). It is worthwhile noting that the origins of the Recovery approach had and still have a considerable difficulty to cross the Anglo-Saxon-language borders. This difficulty might be due to a missing correspondence of the recovery term in other languages without losing its rich semantic and metaphoric sense which might constitute an element to the success of the recovery approach's spread:

"*to re-cover*: 1) To obtain again after losing; regain, as property, self-control, health, ect. 2) To make up for; retrieve, as a loss. 3) To restore (oneself) to natural balance, health, etc. 4) In sports, to regain (one's normal position of guard, balance, etc.). 6) *Law* **a** To gain in judicial proceedings: to recover judgment. **b** To gain or regain by legal process." (Webster Comprehensive Dictionary, 2003).

"Etymological dictionaries: c.1300, "to regain consciousness," from Anglo-Fr. rekeverer (late 13c.), O.Fr. recovrer, from L. recuperare "to recover" (see recuperation). Meaning "to regain health or strength" is from early 14c.; sense of "to get (anything) back" is first attested mid-14c.

The academic literature on mental health distinguishes at least three facets of recovery. It is conceptualized as

1. a spontaneous event of recovery from all the symptoms after illness;
2. a symptomatic recovery caused by treatment;
3. an experience of revitalization of proper life in a state of illness even in the persistence of symptoms (Ralph and Corrigan, 2005) – some authors refer to the last form of recovery as "social recovery" to distinguish it from "clinical recovery".

Clinical recovery concerns the alleviation of symptoms and the return to premorbid functioning (Young and Ensing, 1999), whereas social recovery implies neither symptom remission nor necessity of a return to the premorbid state (W. Anthony, Rogers, & Farkas, 2003; Deegan, 1996).

Analyzing first-person narratives of recovered persons, the Center for Psychiatric Rehabilitation at Boston University has developed a working definition of recovery as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (W. A. Anthony, 1993). Very similar but based on personal experience, Deegan (1988) defines recovery as "a process, a way of life, an attitude, and a way of approaching the day's challenges". In both perspectives a basic agreement on the conceptualization of recovery exists as a social process, as an outcome and both. However, both definitions imply a number of unspecified concepts such as attitudes, values, feelings and goals.

An influential model of recovery developed for the state of Wisconsin experimentation was proposed by Jacobson and Greenley (2001) in which they undertook a principal division of recovery's key conditions into internal and external factors:

- Internal key conditions: hope, healing, empowerment and connection;
- external key conditions: human rights, a positive culture of healing, recovery-oriented services.

The "model", however, provides no clear definitions of the concepts describing these conditions, nor sufficient explanations of their functioning, but just gives an account of a number of fuzzy concepts.

Farkas (2007) identifies four “core recovery values” that support the recovery process and which appear to be commonly reflected and referred to in consumer and recovery literature:

1. Person-orientation has emerged from the narratives of the consumers since most of them report damages due to the non holistic approach of the services. Hence, a recovery oriented service is based on the strength instead of the deficits of the persons. With respect to the design of recovery oriented mental health services Farkas recommends the consideration of
2. Person-involvement in the planning and delivery of the services to develop a sense of empowerment;
3. Self-determination and self-choice are considered the cornerstones of a recovery process to strengthen the self;
4. Hope is an essential ingredient for the recovering user and not least for the professionals who need to support the aspirations of recovery especially during the setbacks. “Hope means remembering, (. . .), that recovery can be a long-term process with many setbacks and plateaus along the way.” (Farkas, 2007, p. 68).

Clearly, these “core values” refer to recovery-oriented services more than to the recovery process per se. There is an agreement in the literature on mental healthcare that the disregard of personal aspects is necessarily ruinous so that person-centered models are mandatory. A person-centered model of care is considered to be based on the needs and preferences of the person, involves its primary relationships as sources of support, focuses on capacities and strengths, and accepts risks, failures, uncertainties, and setbacks as natural and expected parts of learning and self-determination (Davidson et al, 2003; O’Brien & Lovett, 1992). In such a model, professionals learn to respect the users will and start to “involve” them in each decision of their process to recovery.

Ron Coleman’s autobiographic description of his recovery published in “Recovery An Alien Concept” (2004) presents important material for a socio-cognitive theory. He identifies “people”, “self” and “ownership” as the three stepping stones to recovery:

- People, since “Recovery is by definition wholeness and no one can be whole if they are isolated from the society in which they live and work” (Coleman, 2004, p.14); further,
- “Recovery requires self-confidence, self-esteem, self-awareness and self-acceptance without this recovery is not just impossible, it is not worth it.” (ibd, p.15); and
- Ownership “For it is only through owning the experience of madness can we own the recovery from madness” (ibd, p.16).

In his view to achieve recovery, a shift in the paradigm from biological reductionism to one of societal and personal development is necessary. As other recovery key issues he elaborates on the reclamation of power and the demand of acceptance.

Taking into account the narratives of Ron Coleman (2004) and other recovered voice hearers, Marius Romme (2009) defines recovery as the "taking life back into your own hands (. . .) using one's own capabilities and making one's own dreams come true.(. . .) Recovery means take back power and use it to cope with own voices and problem, (. . .) create choices that make it possible to take responsibility for their life and emotions, and by doing so heighten their self-esteem" (Romme, 2009 p. 9, p. 27).

Other researchers which have analyzed the narratives of recovered persons (Topor, 2001; 2006; 2011; Davidson, 2003) stress the role of "the others" for the recovery process. Particularly, friendships before the start of an illness and family members create the red thread in a person's life, often guarantying affective and even material support. The peculiar emphasis on the relations with others which share the same experiences can be traced in the biographies as well as in academic literature. In biographies the role of peers is central: peers facilitate the renewing of a sense of hope for the future; create the climate of support and solidarity which helps the person in the feeling of mutual understanding and help for the others and reduces loneliness. For so called "schizophrenic" patients the "discovery" that voices are a reality for others as well, allows for a reframing of the voice hearers' personal condition. Peers also have a positive effect on the self-management of symptoms. They have a privileged position in teaching the know-how of managing the symptoms, since they can convey the lessons they have learned from personal experience, whereas professionals cannot.

Besides these empirical and autobiographic accounts of the recovery process, an interesting contribution has been provided by Hopper (2007). He proposes Amartya Sen's (1993) notion of capabilities as an alternative framework for the analysis of recovery. The capabilities approach

> "(. . .) reworks recovery not from within (where it remains hostage to a rhetoric of suffering) but from without (informed by an idiom of opportunity). Not healing but equality becomes the operant trope (. . .). This arms us to undress both immediate grievances experiences of humiliation and shame (. . .) and long-term prospects for growth and development." (Hopper, 2007, p.875).

The capability approach serves indeed an interesting reference point for our analysis, since it readdresses recovery as a question of resources, agency and opportunities. Nevertheless, we should keep in mind that the capabilities approach originates from, and is dedicated to structural problems of resource distribution and the opportunities for education etc. It misses however the adequate theoretic tools to grasp issues, in those cases in which structural factors are less involved in the conditioning of the individual's capabilities, whereas a major role is played by an acute personal crisis of loss of power which impairs the subject's capabilities and functionings. We will focus on the recovery process in precisely this sense, analyze the socio-cognitive components with the theoretic tools of Cristiano Castelfranchi's framework. This means that the actual beliefs and goals involved, the emotions implied in the subject's journey from mental illness to recovery, will be sought for, in order to draft a social cognitive model of recovery. Starting point must be the impaired subject's suffering from mental illness.

2 Suffering from Mental Illness

According to Maria Miceli and Cristiano Castelfranchi "psychic suffering is defined as the suffering implied by a frustrating assumption, that is, a particular kind of discrepancy between a belief and a goal, embedding a time specification for both the goal and the belief representation" (Miceli and Castelfranchi. 1997 p. 769).

The frustrating assumptions implicated in the phenomenon of mental illness are multiple. Several narratives of people with severe mental illness focus on frustration assumptions which concern the belief and feeling to be unable to trust in one's own perception and capabilities, or, its self-trust.

> "Slowly I descend into a paranoid state, of course afraid to tell anyone about it. The feelings become possessive and I feel myself without a sense of knowing who I am. Am I a vent for the fear in humanity? Is it the unconscious fear in humanity or am I just afraid my humanity has become? Perhaps there is no difference. These intellectualizations do not distract me from my worry." (Paul Hewitt, 2001; p.5)

The loss of self-trust has a huge impact on the system of beliefs and goals of the agent, since it represents an instrumental capability for the totality of an agent's goals. What happens can be conceptualized as a vicious circle of a loss of powers (Castelfranchi, 2003):

> "There is either a virtuous or a vicious circle between (...) personal power (...) (i.e. being able and in condition to achieve goals) and Social Power. Any lack of personal power (lack of abilities, competence, knowledge, controlled resources) reduces the various forms of social power, and the probabilities of having goal-adoption relationships able to increase that power." (Castelfranchi, 2003, p. 232)

Not surprisingly, people with experience of mental disease are exposed to conditions of disadvantage on multiple levels (e.g. HEA, 1997; Lahtinen, 1999; Wilkinson and Marmot, 1998; Eaton and Harrison, 1998; Hosman and Llopis, 2004; Patel and Kleinman, 2003). As outlined by Castelfranchi above, both the inherent nature of mental health problems and the discriminatory responses to them have ruinous effects on interpersonal relationships, causing a significant reduction of social contacts (Huxley and Thornicroft, 2003). Psychiatric patients are four times more likely than the average not to have a close friend, and more than one-third of patients say that they have no one to turn to for help (Meltzer et al, 1995; Evan and Huxley, 2000).

Mental illness goes hand in hand with the process of psychiatric treatment. Starting from the first diagnosis, to the actual therapeutic treatment mainly based on pharmacological interventions and the support provided by mental health facilities, the individual becomes an object of treatment by professionals.

2.1 Psychiatric treatment

> "For the majority (...) the first contact with psychiatry represents a further turn on the downward spiral. It is confirmation of one's worthlessness, an extension of the experience of neglect in early life" (Topor, 2001, p.182).

Despite the number of longitudinal studies (Ciompi, 1980; Bleuer, 1978; Harding et al, 1987; WHO, 1973; WHO, 1979; Leff et al, 1992) documenting the positive development of mental illness mostly in the absence of psychiatric institutions, a large share of psychiatric professionals still considers it incurable (Bachrach, 1996).

> “I was a schizophrenic, they said “please remember that, oh, and while you are it, remember to stop thinking there is a cure, you are a chronic, a chronic schizophrenic, a biological defect with an incurable disease.” (Runciman in Romme et al., 2009, p. 256).

This kind of prognosis, and the contact with psychiatric facilities create negative expectations for the future, disappointments and existential delusions:

> “At the day centre I got a picture about expectations of what life was going to be like. I was then only fifteen and I spent my day with older people (. . .). I was given a diagnosis of schizophrenia and different professionals- nurses, social workers, psychologist and psychiatrists- all gave the same sort of message, time and time again: my prospect for the future were “not great”: I shouldn’t have expectations about school, or work, or having any relationships” (Hendry in Romme et al., 2009 p. 310).

Psychiatric care is experienced as

> “Going round in circles and not going anywhere. It was very frightening and I felt such hopelessness. No one in the psychiatric services gave me any hope, in fact, it was the opposite” (Reid, in Romme et al., 2009, p. 119).

Hopelessness is due to the establishment of the belief about the impossibility to recover. The goal to recover becomes a mere wish:

> “In other words, hopelessness still implies wish or desire. What is lacking is precisely the belief of possibility, which is replaced by its opposite: a belief of impossibility. It is the persistence of the desire, coupled with the belief of impossibility that accounts for the suffering of hopelessness.” (Miceli and Castelfranchi, 2010, p.258)

2.1.1 Compliance

> “To my astonishment the psychiatrists that I tried to tell (abuses in childhood) either denied my experience or told me that I would never, ever recover from what had happened. They told me that I had an illness. I was mentally ill. I was expected to be the passive recipient of treatment for a disorder I had; that medications was the only option open to me, and that, actually, I would never really get better anyway. No one ever asked me what I thought might help” (Dillon in Romme et al., 2009 p.189).

Psychiatry offers treatment in exchange for compliance. Compliance refers to the subject’s “acceptance” of the role of the patient in its relation with the mental health professional. Due to the enormous legal powers (even coercion) of the psychiatrist as an institutional agent, the significance and implications of compliance are substantial for the life of the patient. To consider is here that the psychiatrist potentially decides where the patient should live (stationary or hospitalized treatment), the psychotropic substances for the treatment, whether or not to work, the patient’s legal accountability, etc. Consider further the desperate mental state of a person turning to psychiatry for help to get treatment under the condition of compliance:

> "I got the message that I was a passive victim of pathology. I wasn't encouraged to do anything to actively help myself. Therapy meant drug therapy. It was hugely disempowering. It was all undermine my sense of self, exacerbating all my doubts about myself." (Longden, in Romme et al., 2009, p. 143).

Evidently, what is at stake with compliance, regards a large part of a person's natural ownership, where a significant portion of existential decisions is delegated to the hands of the professional:

> When I became a client of psychiatry I lost everything job, studies, friends not to mention my self-respect, self-worth, hope and dreams. When I got back my life I thought it was only temporary as I had been taught and told that schizophrenia was chronic and incurable." (Runciman in Romme et al., 2009, p. 259).

2.1.2 Medication: a reductionist annihilation

The impact of medication in the context of mental illness is not limited to its mental effects and its "side-effects" on the mental as well as physiological level, but touches upon the conceptual level of agency and the self. The medical intervention implicitly or explicitly conveys a reductionist message:

- "Your compliance (taking the medication) is essential for the success of the treatment" → "the plan for your treatment is not yours but part of professional expertise"
- "The cause of your mental suffering does not depend on you but on your physiological state" → "you do not control your body, but the body controls you"

The administration of psychotropic drugs as a principal focus of the professional intervention combined with the patient's compliance to the treatment lead to the often described annihilation of the person. The reductionist approach is methodologically and even epistemologically based on the assumption of strict upwards causation[1]. The reductionist approach to mental illness is for this reason necessarily an approach which transgresses the subject as an arbitrary entity of social life, since the search and focus of the treatment is centered on the elementary constituents of the same. What might be a curious (however legal) technicality of treatment from the "objective" point of view of the medicating therapist, becomes a peculiar experience for the subject of mental illness and even paradox when the subject's compliance is taken into account: through compliance, both, the therapist as well as the patient "decide" to act *as if* the subject were complying. From the reductionist point of view – and what is even more dramatic – from a legal point of view, the "decision" itself is to be regarded a formal (though legal) technicality, given that the subject is regarded as subjected (caused) by its mental illness, a cause beyond the subject's "control". From a consequent reductionist point of view on the relation between the medicating therapist and the medicated patient

[1] Consequently, the notion of downwards causation, or even mental causation represents for the reductionist the inacceptable notion of a *causa sui*.

there remains only one reasonable instance of observation *for both parties*: the monitoring eyes of the therapist.

3 Recovery

3.1 "Recovery exists": Surprise and Admiration

Probably the most important starting point in the recovery process lies in some form of surprise:

> "(. . .) a fellow voice hearer who at my first hearing voices group asked me if I heard voices and when I replied that I did, told me that they were real. It does not sound much, but that one sentence has been a compass for me showing me the direction I needed to travel and underpinning my belief in the recovery process." (Coleman, 2004, p.12)

Often the surprise consists in the evidence that equal others (peers) have managed to recover from the same kind of disease, despite all expectations, and even severer, against all expert prognosis. The surprise leads to a belief revision process (Lorini and Castelfranchi, 2007) necessary to initiate the recovery process.

> "My recovery started when I met another service user who worked for a charity. It was a real eye-opener, because she was also a user but she had a job, a partner, a house, all things I was led to believe I couldn't have, things that were beyond me." (Steward Hendry in Romme et al, 2009, p.11)

In fact, the belief on which the personal hopeless condition was previously based gets questioned, and generates desires and goals which have been compromised by the beliefs of incurability and chronicity. The belief revision process represents an essential turning point in the career of the survivor where the aspirations for a meaningful life beyond the illness regain momentum.

Evidently, a crucial condition lies in the trusted source of the information, characterized by a large body of shared experiences. By the example of a *trusted* equal, the subject gains an awareness of its own powers and its "real" chances to recover. Even if the source for the initiation of the recovery process lies external to the subject, the fact that it comes from an evaluated "equal" changes the objective uncertainty into a felt degree of certainty, *as if* it were a repetition task in the form of a script of something already achieved. The powerful cognitive shortcut whereby another's successful goal achievement evaluated as if it were one's own achievement, brings about an interesting emotional shift concerning the self: from a sense of helpless inferiority (wanting p [meaningful life] alike Y [another] but not being able to achieve p) to a sense of admiration (esteeming Y for achieving p unlike X [oneself]) to emulation (evaluating Y equal to X and deducing that X can achieve p) (see Castelfranchi and Miceli, 2009, p.225ff). This is why especially self-help groups need to be considered of fundamental value for the recovering subject.

Mutual understanding in the exchange of experiences provokes more than just the insight of new possibilities – it creates a mind-frame in which recovery is experienced *as if* it were already happening to oneself. It is not theory and reasoning which convinces about a "probability of recovery" as it might even be presented from mental health professionals, but the actual evidence of its *real* possibility.

3.2 From Hope to Trust

As presented in our recovery review above, the hope to recover forms the conceptual core in many accounts of recovery. Hope as the motivational base of the recovery process is however overstressed. As evidenced in Miceli and Castelfranchi's (2010) analysis of hope, though referring to a desired goal, the individual's expectations of its actual achievement are not certain at all. Hope is characterized by an uncertainty which does not allow to engage in the actual planning of actions or decisions, since the hoping individual has no "clue" about what to do or how to decide in order to achieve the desired goal. For this reason, hope is characterized by temporal permanence, since it misses the actual criteria which would allow for the "falsification" of the goal it refers to. Further, the hoped for goal achievement concludes almost necessarily in a positive surprise, similar to the receiving of a gift which is obtained without a deeper understanding of the circumstances which have brought it about. While forming the positive ground for the mere possibility of recovery to exist, and as such constituting a necessary condition for the recovery process to take place, hope is insufficient for the activation of the recovery process, for it lacks a plan execution, the know-how for acting to achieve the desired goal (Castelfranchi and Pocobello, 2007). Rather, external circumstances might be vaguely assumed to bring about the hoped for goal.

> "If we did not distinguish what is most likely to happen from our wishes about mere possibilities, we might undergo serious consequences in terms of planning, commitment to, and pursuit of unfeasible goals." (Miceli and Castelfranchi, 2010, p266)

A form of efficiency rationalization, whereby probable goals are distinguished from possible ones, presents a class of goals which can be taken into account, however not be counted on. As such, hoped-for-goals remain in the hands of unknown factors and powers and would not only be insufficient to maintain the recovery process, but also contraindicated since this feeling induces some sort of passivity due to lack of (action-) plans an agent could be committed to. Therefore, rather than hope, it is trust (Castelfranchi, 1998; Castelfranchi and Falcone, 2010) which must be considered an essential form of motivation for the goal of recovery. The role of trust in the recovery process should be considered two-ways:

- As a trustor, when the subject has to evaluate the source of the recovery information as a trustworthy evidence of recovery ("trust-that" recovery).

At this level the subject has to act as a social trustor – the ability to trust and believe what was formerly assumed impossible (social trust as a key-element of the belief revision process after the initial surprise);

- As a trustee:
  - at the individual level, when the person needs to trust *in* its own capabilities – the capabilities which need to be trusted and appropriated, that is, recovered (trust-in);
  - at the social level, when the individual has to recover its role as a valuable trustee. At this level the evident complex of problems originating from stigmatization have to be confronted.

In both roles – as a trustor as well as a trustee – the resumed power to decide and not to comply, the commitment to pursue one's own trusted goals and to decide to count on trusted others rather than entitled professionals, constitute instances towards the reestablishment of ownership and responsibility.

3.3 "Recovery happens": Ownership as the Core of Recovery

> "Ownership is the key to recovery. We must learn to own our experiences whatever they are. Doctors cannot own our experiences, psychologist cannot own our experiences, nurses, social workers, support workers, occupational therapist, psychotherapists, carers, and friends cannot own our experiences. Even our lovers cannot own our experiences. We must own our experiences. For it is only true owning the experience of madness can we own the recovery from madness." (Coleman, 2004, p.16)

Coleman's emphasis on the role of ownership in the recovery process is shared by many survivors in one form or another as a core piece on the journey to recovery. Formulations such as "regaining one's life", "taking your life in your own hands", "claiming responsibility for one's decisions and actions", indicate essential parts of ownership in the survivors' description of the recovery process.

To grasp some of the essential components of the appropriation process generally, and re-appropriation more specifically, it is necessary to consider ownership as a socio-cognitive process in various stages: from recognition and acceptance of the object of ownership to its social claim and defense against others to the taking of responsibility and its social recognition.

3.3.1 Recovering the resources: Acceptance

Next to the surprise trigger in the belief revision process, acceptance forms a substantial mental settling process in which a gradual change of perspectives takes place:

> "An acceptance attitude can serve adaptive functions (. . .). The acceptance of the problem, and hence, its inclusion in the reality perceived by the person, permits a form of adaptation that extends beyond dealing with, and possibly solving, that

> specific problem. Even when one's goals are irrevocably thwarted, acceptance of these facts permits to readjust one's plans, project, and aspirations. By recognizing the harm suffered, the person can, in fact, not only avoid useless persistence (by accepting things that cannot be changed) but also ascertain whether the existing situation also presents some unexpected positive aspects and take advantage of them" (Miceli and Castelfranchi, 2001, p.294)

What is considered inacceptable, the targeted object of an effort at elimination, the mental source of suffering and frustration, has to be reframed and reevaluated as a form of resource. Especially in the case of mental illness, where the perceived source of suffering constitutes an intrinsic part of the self which is continuously objectified and externalized ("singled out", "identified") for treatment purpose ("symptom control"), a radical belief revision process dedicated to the inversion of the clinical estrangement process has to take place, whereby symptoms become accessible resources:

> "I accepted my voices as real
> I stopped trying to get rid of them, but accepted them as personal
> I became conscious of ownership of my voices
> I stopped looking for a cause outside myself
> I looked for solutions in my self
> I explored what had happened in my life that might have a relationship with my voices
> I accepted those emotions which I did not like and could not easily master"
> (Sue Clarkson in Romme et al, 2009, p 316f)

The acceptance of what was a mere symptom as something "real" plays a fundamental role in the acceptance process, for what is not real should not be there and cannot form a reliable resource for whatever goal. For Coleman (see p. 357 above) this reframing was the starting point of the recovery process. What is at stake here is the subject's essence in the power to claim its own reality, not in the form of a delirium, but as a fact it can actually share with equals (e.g. voice hearers). Once this fundamental question is settled, the resources can be accessed and employed, in a search for their use, and even more, in a search for their use for the recovering subject.

Thus, the motivational dimension – as outlined when discussing trust – builds an essential prerequisite in the means-ends-reasoning, for means are to be defined by the goals they serve for. Due to the emergence of a feasible scheme through the emulation of the recovery process as demonstrated by a trusted survivor, instrumental goals and the necessary means for their achievement are recognized. The guiding example of recovered individuals as well as the technique of recovery oriented training interventions provide valuable evidence for the way in which the object of suffering is reevaluated and accepted as a part of oneself, rather than fought as a symptom. Instructive are here the first steps towards the re-appropriation of voices in the voice-hearer trainings which are based on the principle of giving sense to voices (Romme and Escher, 1993, 1996) and working towards the recognition of voices as a personal and deeply connected part with one's life-story. The accidental nature of the symptom, a view inherently expressed through the medication treatment in the reductionist approach to mental illness, is necessarily elaborated as a *causal*

part of the personal life-story. The symptoms are recognized as a part of one's self. The deficit is recovered as a source of information for the subject to accept and meaningfully incorporate it in its self-conception.

3.3.2 The social grounding of Recovery: Responsibility

Even if responsibility as a concept does not form an explicit part in many accounts of recovery from mental illness, it needs to be regarded as the constitutive frame of ownership on which the whole complex of mental illness and recovery rests. It is for the loss of accountability that mental illness is represented as a sever threat to the society and forms the reason for neglecting the subject's rights of ownership in the court of legal judgment. The legal system defines and prescribes accountability as a necessary condition for the individual to be judged as a subject of responsibility. The legal consequences for the subject of mental illness, often considered a sort of collateral to its mental suffering, builds necessarily the forefront of the recovery process.

Reclaiming the ownership of resources, be they cognitive, social or material, internal or external, is not just a claim of access to their use, but implies a social justification process for their use. Counting on the owner of resources to have awareness about the potential effects of their use is what account-*ability* refers to. The impressive consequences on the subject, once accountability is psychologically and even legally disapproved, give plain evidence of the significance of ownership, and more precisely, the psychological significance of responsibility.

The psychological literature treats responsibility mainly against the background of Heider's (1958) attribution theory, evidencing the mental components of responsibility such as internal attribution of the cause, intention of the actual effect, foreseeability of the effect and social justification of the cause (Hamilton, 1978). The more existential implications which are at stake with the judgment of responsibility have however remained in the backdrop of this conception of responsibility. Responsibility is not just about the question of whom to address for guilt and merit of effects, about the social *coverage* of actual and potential risks and events, but about a *social* frame of reference whereby a subject's *significance* as an agent is included or excluded, present or absent, declared or denied. The social negation of responsibility is therefore not just the negation of ownership (object of responsibility), but must be considered as the negation of a "true" locus of decision or intention (el Sehity, 2011). In its generalized form, as in the case of severe mental illness, the complete negation of accountability cannot but bring about a progressive annihilation of the subject.

Let us consider here the case where responsibility is not just denied to the subject ("we know, it is not your fault. . . ") but personally given up by a subject in crisis:

> "It was clear to me then, too, that I wanted someone else to take over the responsibility. I couldn't do it on my own. I desperately wanted someone else to do it." (Narratives in Topor, 2001, p.183)

By renouncing responsibility, the subject transfers the ownership of its powers to the "custody" of a more powerful/competent party. This transfer can be regarded as a standard component of tutorial relations (Conte & Castelfranchi, 1995; Castelfranchi & Falcone, 2010): The subject itself lacks sufficient awareness of its true interests so that another party is put in charge to decide for it. In the subject's state of acute mental crisis, the tutor takes over the full powers of the individual and is charged with the responsibility for the same. From there on the subject finds itself in a situation of "structured irresponsibility" where the tutor forms a socio-cognitive shield not only against failure and blame but also success and merit.

As stressed by Castelfranchi, the tutor should have the active goal to restitute the delegated powers to the individual as soon as possible. This would be natural, given the overwhelming weight of responsibility the tutor assumes. The tragedy of the transfer of responsibility in the psychiatric context lies however in the fact (1) that the tutorial relation is embedded in an institutional frame, where the subjects are confined to their roles based on "responsibility" (professional) and "non-responsibility" (client), and (2) that the delegated responsibility cannot be recovered from "the" professional, but must be claimed in the social arena by the means of trusted exchanges, and more specifically, in the subject's role as a veritable trustee[2]. Reclaiming responsibility represents the main struggle of the recovering subject, a struggle that is ventured socially in the sense of gaining back the right of ownership as a trusted subject of responsibility, and individually, through the reestablishment of an internal as well as stable "locus of control".

3.3.3 Recovering internality: The social claim

The acceptance of proper resources and the claim of responsibility for these formulate a social claim, for what is considered to be responsibly owned by one cannot be meaningfully claimed by another. The social claim of ownership addresses an essential component of the recovering individual as an autonomous subject. The recovery process necessarily conflicts with the patient role which is defined by the subject's compliance to the expert treatment it is submitted/committed to. The social claim of ownership represents therefore an essential emacipatory act towards the subject's full rights as a citizen:

> "Even if I am an unlucky person, I'm still a free citizen and no one can make me take anything. They can say "why don't you try to get better?" and Dr. M. is a doctor who cures people with medicine, all doctors cure people with medicine. (. . .) I definitely needed something more complete, a more complete course of treatment. When we disagreed on this, I practically bared my teeth at him and said: "we're not going to get into legal things here, are we? Or give me social assistance which I have a right to, remembering that I'm, to all intends and purposes, a free citizen or I'm going to call

[2] A socio-cognitive account of responsibility could find seminal foundation within the theoretic framework of the trustee as recently presented in Castelfranchi and Falcone's comprehensive monograph "Trust Theory" (2010). Of specific interest for the analysis of responsibility has to be considered their chapter "On the Trustee's Side: Trust as Relational Capital" (2010, Chap 10).

> a lawyer, what do you want from me?" . . . And now I don't take anything." (Luca in Mezzina et al., 2006, p.50)

Without the social claim of one's own decisions, own rights, agency powers, the individual's ownership would turn into mere properties in the sense of an object's qualities, but not constitute potentials at full disposition of the individual. Ownership in general, and more specifically in the recovery process from mental illness, leads necessarily to an emancipatory act, whereby the subject's internality is (re)established and socially claimed as the definite *locus* (a claim implicitly and explicitly undermined by the medical approach to mental illness, when the focus is set on the pharmacological treatment). This claim requires not only the personal commitment to control but also depends on the social recognition and acceptance of the same.

The aggressive attitude shown in Luca's statement above further indicates an instrumental emotive component of the recovery process where the subject's struggle for personal power becomes palpable. Recovering from a long-standing career of "structured dis-empowerment" (medication, manipulation, coercion to-, persuasion to-, suggestion to- and conviction to comply), a fundamental rearrangement of social dependencies and power-balances has to be considered as an almost inevitable part of the recovery process in which the emotive dimension is decisive. We will address two forms of this dimension relevant for the reclaim of the individual power-to and the social reclaim of power-over respectively: self-trust and emancipator pride.

Self-trust and Recovery Exchange

On the individual level a self-trust task is the necessary condition for the recovering subject to challenge the socially recognized powers of experts and professionals, and their prognostic judgments about its future.

> "Within the realms of psychiatric practice it is accepted that the most powerful practitioner is the psychiatrist. Their power is rooted not only in the authority given to them by the state, but also in their singular right to make diagnosis. It is this ownership of a supposed expert knowledge that gives them so much power over their clients. I would content that the real expert of the client's experience is the client and it is they not the psychiatrist that own the knowledge that makes recovery a possibility." (Coleman, 2004, p.56)

The belief that one's recovery is not just possible but even probable is necessarily based on self-trust, that is, trust in one's own powers, for:

> "It is not enough 'to be able to': in order to really be able, having the power of, the agent must also belief (be aware) of having the 'power of', otherwise they will renounce, they will nor exploit their skills nor resources." (Castelfranchi & Falcone, 2010, p.48)

The attitude of acceptance, its underlying cognitive process of belief-revision, provides an essential cognitive output which needs to be trusted in order to form a solid base for the social claim of ownership to be ventured. Self-trust is likely best initiated and promoted by the experience of being socially considered a veritable trustee. To be counted on, to be entrusted with real

values, such as the case in significant economic exchange relations, provides the individual with an evidence based belief in its formerly lost accountability.

It is well recognized that reciprocation plays an important role for the individual's health and well-being in interpersonal relationships in self-help groups (Buunk & Schaufeli, 1999). Different to the implicit or explicit subjection to professional expertise (power), help is offered by request and not by default. Equally, there is no social role by default which might lead to the subject's subalternity. This reciprocity leads to the reestablishment of meaningful relationships repairing the social damage inflicted by the isolation and discrimination of mental health users. Through self-help groups the subject recreates a network of mutual dependencies accounting for its powers as well as its needs:

> "The main function of pro-social or positive sociality is the multiplication of the power of the participating agents. (. . .) Any agent, while remaining limited in its capabilities, skill and resources, finds the number of goals it can pursue and achieve increased by virtue of its "use" of others' skills and resources." (Castelfranchi, 2003, p. 228f)

With each step in the reciprocal exchange the subject regains confidence in its powers leading to the rehabilitation of its identity:

> "Positive experiences prepare the groundwork for improving one's self-image. As the person's self-image becomes increasingly more positive, it becomes a resource for coping with symptoms and the stigma that the person now has to contend with. The new self-image begins more and more to function as a protective shield against residual signs of illness and detrimental aspects of the environment and living conditions. The insight that one can influence one's environment provides a foundation for managing the illness." (Topor, 2001 p. 122)

The conquest of self-trust inevitably brings about a growing conquest of social ground, rejecting on one hand the unjust presumptions and on the other hand challenging the community with the subject's unexpected powers. The latter finds its open expression in the form of emancipatory pride as evidenced by social movements such as Mad-pride.

Mad-pride

The experience of mental illness is unfortunately too often connected to an experience of shame and humiliation. Shame represents hereby an experience with painful and devastating effects on the subject as a whole and not only just a specific behavior. Shame is a moral emotion, in the sense that it acts as an element of self-assessment with profound relational implications (Castelfranchi and Poggi, 1988 [2005]). Humiliation refers to an action (humiliate or being humiliated) and the experience of the subject (to feel oneself humiliated). It is a mental process of subjugation that damages or dampens pride, honor or dignity since the negative evaluation of the humiliator is shared by the humiliated subject (Silver et al, 1986).

For the subject's recovery process it is indispensable that the originally shared humiliating evaluation is reevaluated and disagreed upon at a certain stage. The subject perceives the unjust evaluation as expressed by others as

an offensive act to which it wrongfully agreed upon. Through hindsight, the recovering subject reframes the humiliating events of its negative evaluation as direct evidence of social injustice and discrimination, as an offence against its social integrity it needs to oppose to.

> "We make a radical demand, one of the most difficult to fulfill: we insist that people get inside our heads and skins and try to empathize. This is something that all outsider groups have demanded, yet the experience of psychosis may be the most forbidding of all. Our plea cannot be "we are just like you" because that isn't true. On the other hand it is not completely untrue." (Stephen Weiner, in Hatfield & Levley, 1993, p. 4)

Anti-stigma movements are devoted to the change of their participants' social identity by the construction of a "political identity". Anspach (1979) describes how the participation of former psychiatric patients in political movements generates an experience of self-determination, which replaces the feeling of powerlessness and helplessness. The movement's objective transfers into a new self-conception, a process which implies the development of a feeling of pride.

When the subject stops to believe that its experience of mental illness is something to be ashamed of, accepting and reevaluating it, several emotions are likely to emerge: anger and revenge for the personal experience of social discrimination, and indignation for this kind of social injustice. This is the emotive base of a form of pride that we call "emancipatory pride" which has an internal as well as social reparative function (Pocobello and Castelfranchi, 2009):

- Internally, emancipatory pride is functional to the subject to recover from shame. Not necessarily the subject is truly convinced that "madness" is something to be proud of, but it needs to be convinced that it is something for which it unjustly felt ashamed of, that it is not justified to be judged negatively for mental illness. The emergence of this form of pride promotes the key-elements of the recovery process such as self-acceptance, self-trust and reduces the sense of inferiority caused by the experience of stigmatization.
- Socially, the exhibition of a "mad-pride" is functional and probably even strategic to the change of the social evaluation of "madness" and the social conditions in which persons with mental disease live. This pride implies a message of non subjugation - "I do not care about your judgment" and a provocation challenging the societal evaluation of madness.

4 The re-covered Subject

> "I had a longing to come back to myself. I had almost left my good house for good, to see it as such, so to speak." (Richard in Topor, 2001, p.181)

The semantic core of re-covery in terms of to-cover offers a rich metaphoric message concerning the actual situation of the subject of mentally illness: the psychiatric patient's condition as a nude existence vis-à-vis a reductionist search to un-cover the subject's dysfunctional components, cannot be better

captured than in the subject's claim for a "cover" to re-cover. The deprivation of internality due to the investigative clinical procedure, due to the transparent existence in the clinic, due to the continuous exhibition of its pathology in the therapeutic activity, due to delegated or even negated personal accountability, due to growing unilateral dependencies, due to the justification of means and needs etc. a literal re-covering is mandatory for a subject to reclaim "a life in its own rights".

The processes and stages from mental illness to recovery as outlined in this draft unfold along the narrative of an uncovered/discovered human subject and its need for its own cover. The last act of this drama of the re-covered subject touches upon the social context, the social admiration – even if silent – of the shameless subject of madpride.

Evidently, the whole story of the subject's recovery process can be recounted more coherently in terms of power relations, against the background of disempowerment as well as empowerment processes. Hopefully you remain available to this chapter of the recovered subject, Cristiano?

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Part V
Trust & delegation