Community Ment Health J (2010) 46:482–485
DOI 10.1007/s10597-010-9315-3

ORIGINAL PAPER

The Pain and the Possibility: The Family Recovery Process

LeRoy Spaniol

Received: 23 January 2009 / Accepted: 27 April 2010 / Published online: 13 May 2010

Abstract The onset of a mental illness is a traumatic experience for all the members of a family. While the mental illness in their family member may be life long, family members can experience their own recovery from the trauma, just as their family member with a mental illness can experience recovery. This article will describe the family recovery process.

Keywords Recovery · Families · Mental Illnesses

The onset of a mental illness is a traumatic experience for all the members of a family. While the mental illness in their family member may be life long, family members can experience their own recovery from the trauma, just as their family member with a mental illness can experience recovery (Davidson et al. 2005, 2006; Spaniol et al. 2000, 2002).

Recovery is a painful and deeply emotional process. It involves facing the reality of our experience and its emotional impact, and, readjusting our attitudes, feelings, perceptions, and beliefs about ourselves, others, and life in general. Recovery is also a process of self-discovery, self-renewal, and transformation. Recovery means that people can deal with their pain and have a life that includes hope, personal meaning, intimate connections with others, and goals for the future.

L. Spaniol (✉)
Boston University, Boston, MA, USA
e-mail: lspaniol405@comcast.net

Present Address:
L. Spaniol
159 Selden Hill Drive, West Hartford, CT 06107, USA

All people experience recovery at various times in their lives from accidents, illnesses, and loss. The more painful the particular event, the more it shakes the foundation of who we are and how we experience our lives. These powerful events break inner and inter-personal connections we take for granted and shatter our perceptions and dreams. Clearly these processes involve profound adjustments in our lives and intensive periods of recovery. Recovery for all family members is long-term with many cycles of despair and hopefulness. Yet the outcome of recovery can be the emergence of a new sense of self that is more empathic, alive, and connected to ourselves, to others, and to a greater depth of participation, meaning, and purpose in life. In this article the author presents information about the recovery process of family members based primarily on the author's own personal family experience and his experience in working with many family members over the years. In addition, where appropriate, references from the literature will be cited.

While there is a growing literature on recovery of people with mental illnesses, there is little information about the recovery process in other family members. Yet, understanding their recovery process, as well as that of their family member with a disability, can provide a welcome long-term perspective. This perspective is important when family members are caught up in a particular stressful event; because it is hard to recognize it as a process—it seems as if the pain will never end. Understanding the process can sustain hope when family members are caught up in the many difficult daily events of caring for a family member with a mental illness.

Professionals also need to understand how family members react to the trauma of a mental illness in a family member. This knowledge can help professionals understand the family's experience and respond to it in a helpful

and empathic way, and, to give family members a sense of hope about their lives and the life of their family member with a mental illness.

In this paper the author will focus on the recovery experience of family members without the disability. However, there are some inevitable overlaps with that of their family member with the disability, because recovery is a generic process that we all experience when we have been in a traumatic situation. For more information on the recovery process of people with a psychiatric disability see the references identified in the first paragraph of this paper.

General Characteristics of the Family Recovery Process

Before beginning a description of the process of family recovery, there are several general characteristics of the recovery of family members that should be noted.

Recovery is a process of consolidation and transformation. Consolidation has to do with a healing process that is multidimensional and long-term. It is multidimensional because it involves emotional, physical, social, vocational, and spiritual changes. A mental illness in the family affects every area of our lives. Consolidation involves integrating, settling in with, grounding ourselves in, and giving meaning to this challenging life experience. Consolidation is a long-term, episodic, non-linear process. It involves periods of intense activity and long periods of concentrated quiet and rest—when it "appears" that nothing is happening. Strauss et al. (1985), a psychiatrist, compared it to "mountain climbing." i.e., gaining a foothold on a difficult climb and resting to restore our resources before moving on. It is an active process where something is always happening. It is transformative because the outcome is a dramatically changed person. Many family members have said "I am not the same person I was when this started." While it may not feel transformative at the time, and can be very painful, it is still a powerful growth process.

The particular impact of the illness differs in various family members. A mother's experience is different from a father's experience. A parent's experience differs from a sibling's experience. A younger sibling's experience is not the same as a sibling who is older than the family member with the illness (Marsh et al. 1993a, b). Each person in the family recovers at his or her own rate. This means that family members may be in different phases of recovery at any given time. Families need to be aware of each other's phase of recovery in order to be empathic and helpful to one another.

The recovery process of family members can be described as a series of phases. It is important to note that these phases are only guidelines. While they help us to understand the process of recovery, they do not define the process for each individual. Each phase contains many experiences, tasks, barriers and facilitators to change and personal shifts.

Recovery is not linear, so family members will recycle themselves through the phases for a variety of reasons at different points in time. Family members retain a vulnerability to recycling for many years, even when they are well into their recovery. They are particularly vulnerable when relapses or negative changes occur in their family member with the disability or memories of painful events are recalled. This ongoing vulnerability is a natural part of the recovery process and family members should be prepared to periodically experience "being back where I started from." However, with time and experience, while the pain may still be as intense, the frequency and duration of the pain should diminish. The diminishing is often the result of being able to recognize ourselves as in a process, realizing that this too will pass, and the development of more effective coping skills and support.

Emotional reactions of family members during the recovery process, even intense ones, are natural reactions and do not imply that there is something wrong with the family members. The key risk to this very emotional process is the possibility of further damaging the underlying relationships among family member, including the person with the disability. Damage occurs when the inevitable hurt and anger in the reoccurring bruising within relationships lead to giving up of hope and even retaliation. The greatest threat in any relationship is the possibility that it may be lost and the accompanying sense of personal loss—even when these profound emotional consequences are denied by either or both parties. Whatever attaches us in our relationships, whether it is love, loyalty, family, or spirituality, can be the motivation to repair the periodic bruising and reaffirm the value of the relationship above any particular event that threatens it. And at times this reaffirmation needs to be explicit or clearly stated, even when there are natural consequences as a response to a specific event.

People may cycle through the phases and then return to complete incomplete tasks. This is why family members may feel they are losing ground in their recovery process at times. They experience themselves returning to issues they feel they have resolved but important emotional, intellectual, or physical tasks may have not been completed.

Phases of the Family Recovery Process

Shock, Discovery, Denial

The occurrence of an acute onset of a mental illness is often a shocking experience for family members (Johnson 2000). The abrupt changes they see occurring are hard to

understand. "What is happening?" or "These are not ordinary behaviors of the person I have known" are common reactions. As family members become aware that something is happening they may explain it away. Family members may believe that their loved one's condition is not really so serious. They may not be aware of the nature of the symptoms they are seeing if they have not been exposed to mental illnesses before. Or, they may have negative or exaggerated images of people with mental illnesses from the media and their family member may not conform to those images. Even family members who are mental health professionals may have the same puzzled reactions. They may develop alternative and more "acceptable" explanations for their family member's behavior such as "The must be due to alcohol, drugs, laziness, or bad friends."

As the relationship with the family member begins to change, family tensions and frustrations increase. Family members often attempt to find answers through any possible source, such as friends, clergy, or professionals. An all too frequent lack of clear and specific communication about what is happening supports the confusion family members feel. These attempts to seek out information are often frustrating because of shame, embarrassment, and self-blame, and, the frequent lack of knowledge or resources on the part of the person being asked (Spaniol et al. 2000).

As the family member becomes overwhelmed with symptoms a serious breakdown or downward shift in functioning occurs. He or she loses control of thoughts, actions, and feelings. If the family member does not seek help it is often forced upon him or her. It can be a very painful experience for the family to hospitalize their family member. The distress, shame, and guilt can be overwhelming.

Denial can be persistent and can linger throughout all aspects of this early phase. It is hard to begin the recovery process when denial persists because some level of acceptance is necessary to move onto solutions. It is hard to take steps to alleviate a problem we don't accept or understand. And because the level of understanding will always vary with each family member, so will their level of active recovery vary. Thus, each member of the family must deal with his/her own recovery (Spaniol et al. 2000). Members of the family can support one another but they cannot recover for one another.

Disbelief is sometimes a more accurate word to describe the experiences of some families then denial. Disbelief is primarily a conscious process and it implies some acceptance, but "it is hard to believe it is happening to us." Belief begins to set in gradually as the reality of the disability makes it difficult to avoid. Family members need to be supported during their disbelief and they need to be gradually helped to see the disability for what it is.

Recognition and Acceptance

Acceptance is a process. It occurs as family members gradually become aware that their family member has a major mental illness. Initially this awareness may increase their hope in professionals because professionals are expected to know the answers. However, as awareness of the seriousness of the illness increases, so may feelings of guilt, embarrassment, and self-blame. Family members are part of the general culture which has supported negative feelings toward people with mental illnesses. If family members encounter professionals who maintain that families are responsible for the illness, then family members will have a double burden, because their worst fears will be confirmed by an "expert."

As family members begin to accept that there is a serious long-term illness, they experience a deep sense of loss. Perhaps the most striking loss is the image of the life that they had envisioned with and for their family member. This feeling of loss is also experienced by the family member with the illness. All family members share and must come to terms with this deep sense of loss. Acceptance of the loss is often made more difficult by the cyclical nature of the illness. Improvement of the family member raises hope that their family member will return to normal previous functioning. This on-again, off-again experience becomes an emotional roller coaster ride for family members. As the persistence of the illness becomes obvious to the family, the grieving process can begin more fully as family members let go of old hopes and expectations and begin to create new ones.

It should be noted that this new awareness also creates a crisis in meaning. Questions about oneself, one's relationships to others, to one's work, and to meanings and purpose in life become important. As these meanings change, family members change. As family members begin to develop new answers to these basic questions, which incorporate the reality of their loved one's disability; openness to the possibilities for unanticipated outcomes for their loved ones; and a developing sense of their own changing sense of self; they are often transformed in profound ways.

Coping

Coping implies struggling with a problem with inadequate knowledge, skills or support. This is how family members begin to cope. At some point it becomes clear that family members need to continue on with their lives and begin to think of supporting their loved one over the long run. This is when coping begins to take the place of grieving. Family members cope with the disruption in normal family life, recurrent crises, and the persistence of the illness, the loss

of faith in some professionals and the mental health system, and the aspirations of their family member with a mental illness. Professionals may feel family members are intrusive at this phase because family members may become more angry and assertive. They may question professional competency and demand additional services. Their anger at professionals and outrage at the mental health system derive from their frustrations when seeking adequate care (Johnson 2000). Sometimes their anger derives from poorly trained professionals or inadequate resources. However, it is important to be aware that the anger family members feel is augmented by the hopelessness they often feel. They cope with pessimism and despair.

As families persist in their coping, they experience more success. Belief in the coping expertise of other family members grows. Family members value the support of other families who are struggling with a family member with a mental illness and gradually learn to accept the limits of what they can do about the illness. They begin to focus increasingly on the management of symptoms and improving the functioning of their family member. They become more interested in improved inpatient care, community services, housing, and rehabilitation. They gradually identify professionals on whom they can rely, and work more closely with them. Family members come to see valued professionals as necessary, but not sufficient to their efforts to cope.

Personal and Political Advocacy

Family members gradually come to a new awareness of themselves in the recovery process. This awareness can include a greater level of personal advocacy and increased assertiveness and confidence (Lefley 2006). Family members say they feel differently about themselves. Even though the illness of their family member continues, they have changed. They blame themselves less. They let go of what they can't change or don't want to change and become more focused on efforts to bring about the changes they see as necessary. They work out new roles and relationships with professionals which are more collaborative and based on equality (Lefley and Johnson 2000). Their interest in the training of professionals may increase. They become more persistent over the long run. For many, political advocacy becomes more important. United action to change the system becomes more valued. Family members experience their power, often for the first time in their life. They experience their ability to influence the systems that are supposed to support their family member. At this point, they have integrated and/or deepened new meanings and values about themselves, others, their work, and larger concerns in life.

References

Davidson, L., Harding, C., & Spaniol, L. (2005). *Recovery from severe mental illnesses: Research evidence and implications for practice*, Vol. 1. Boston: Boston University Center for Psychiatric Rehabilitation. www.bu.edu/cpr.

Davidson, L., Harding, C., & Spaniol, L. (2006). *Recovery from severe mental illnesses: Research evidence and implications for practice*, Vol. II. Boston: Boston University Center for Psychiatric Rehabilitation.

Johnson, D. L. (2000). The family's experience of living with mental illness. In H. P. Lefley & D. L. Johnson (Eds.), *Families as allies in the treatment of the mentally ill*. Washington, DC: American Psychiatric Press.

Lefley, H. (2006). Advocacy, self-help, and consumer-operated services. In L. Davidson, C. Harding, & L. Spaniol (Eds.), *Recovery from severe mental illnesses: Research evidence and implications for practice*, Vol. II. Boston: Boston University Center for Psychiatric Rehabilitation.

Lefley, H. P., & Johnson, D. L. (2000). *Families as allies in the treatment of the mentally ill*. Washington, DC: American Psychiatric Press.

Marsh, D. T., Appleby, N., Dickens, R. M., Owens, M., & Young, N. (1993a). Anguished voices: Impact of mental illness on siblings and children. *Innovations and Research, 2*(2), 25–34.

Marsh, D. T., Dickens, R. M., Koeske, R. D., Yackovich, N. S., Jr., Wilson, J. M., Leichliter, J. S., et al. (1993b). Troubled journey: Siblings and children of people with mental illness. *Innovations and Research, 2*(2), 13–24.

Spaniol, L., Wewiorski, N., Cagne, C., & Anthony, W. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry, 14*, 327–336.

Spaniol, L., Zipple, A. M., Marsh, D. E., & Finley, L. Y. (2000). *The role of the family in psychiatric rehabilitation*. Boston: Center for Psychiatric Rehabilitation, Boston University.

Strauss, J. S., Hafez, H., Liberman, P., & Harding, C. M. (1985). The course of psychiatric disorder, III: Longitudinal principles. *American Journal of Psychiatry, 142*(3), 289–296.