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An Empowerment Model of Recovery From Severe Mental Illness: An Expert Interview  
With Daniel B. Fisher, MD, PhD  
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***Editor's Note:***

*What is an empowerment model of recovery? How is it useful, perhaps invaluable, in the daily practice of psychiatry? What data support it? To get to the core of these issues, Randall White, MD, interviewed Daniel B. Fisher, MD, PhD, Executive Director of the National Empowerment Center in Lawrence, Massachusetts.*

**Medscape:** In your publication "Personal Assistance in Community Existence: A Recovery Guide," you write that the recovery model emphasizes that emotional distress is a temporary disruption in life.<sup>[1]</sup> Can you elaborate?

**Dr. Fisher:** Our description of mental illness is a combination of severe emotional distress and an interruption of a person's place in the community and social role -- being a worker, parent, student, a participant in overall community life -- which is not dissimilar from what is considered a mental disorder in DSM-IV.<sup>[2]</sup> The most important finding in our research is that people who have shown significant or complete recovery from severe mental illness -- by that I mean schizophrenia, bipolar disorder, or schizoaffective disorder -- have cited hope as an extraordinarily important component in their recovery. Part of the recovery was being around people who saw their condition as not permanent, a condition from which they could take increasing control of their life and reestablish a place in society.

**Medscape:** You also write, "It is much more difficult to recover once a person is labeled mentally ill." How have you found that to be true?

**Dr. Fisher:** If people don't have the internal capacity, and the severity of their distress is too overwhelming, and they don't have the finances, the education, the social surroundings, and family to help them, they end up with the label of mental illness. The severity becomes greater because, in addition to having to recover from the severe distress that interrupted their capacity, they also have to recover from the role of being mentally ill.

The biggest example of that is Social Security; another is the loss of rights and the trauma that often occur in being hospitalized. For many people, it's very traumatic being hospitalized.

**Medscape: Can you talk some more about Social Security?**

**Dr. Fisher:** If you don't have the resources, or if the duration of distress lasts too great a time, a person needs to be on Social Security. I've been on the psychiatrist's side of that and I know that, unless someone is able to get a job that pays up to \$16 per hour and has full benefits, it's very hard to duplicate the benefits. I've worked with legislators on the Ticket to Work legislation to try to correct some of the shortcomings of Social Security, one of the biggest being you're either on it or off it.<sup>[3]</sup> Once you have been on it, there's great fear of going off it because you might not get back on.

**Medscape: Your publications make reference to the difference in outcome of schizophrenia in less-developed societies compared with industrialized societies. What does the research indicate?**

**Dr. Fisher:** The evidence is from 2 studies by the World Health Organization (WHO), one in 1979 and the second in 1992, comparing the recovery rate, mostly from schizophrenia, in developing countries with the recovery rate in industrialized countries. In 1979, WHO had about 1800 cases validated by Western diagnostic criteria in developing countries matched with controls from industrialized countries, and they found that the recovery rate was roughly twice

as high in the developing countries compared with the industrialized.<sup>[4]</sup> They were so surprised by this that they said, "Well, this must be a big mistake." So they repeated the study in 1992, and they got the same results.<sup>[5]</sup>

**Medscape: How do you interpret this and what are the implications for us as psychiatrists in industrialized societies?**

**Dr. Fisher:** The implications are profound. It shows that schizophrenia is more pronounced and prolonged in industrialized countries. I've started to gather information from developing countries about how they approach treatment and healing. They have a completely opposite approach from Western countries. They're very socially oriented, and they instinctively recognize the importance of keeping people connected to the community. We have ceremonies of segregation and isolation, which is really what our labeling and our hospitalization process is. They have ceremonies of reintegration and connection.

**Medscape: Can you contrast the medical model with your empowerment model in the approach to psychosis?**

**Dr. Fisher:** The first contrast is that we say to the people going through the experience that this is not a permanent condition and that other people have recovered. We try to expose them to people who have recovered and who can be role models. When I'm working with people who are undergoing psychosis or long-term severe mental illness, I share some of my own experience with them and how I too at times heard voices and had the television talk to me.

The second part is that we help them understand that these symptoms are expressions of distress over their lack of a connection on a deep emotional level to the people around them, that they involve loss and trauma and interruption in social development. We go through with them a set of 10 principles of recovery that we have established through our research, which is the qualitative study of

people who have shown complete recovery from severe mental illness, mostly schizophrenia.

Through this model we emphasize the reestablishment of personal connections. It's often peers who are the most significant guides for recovery. This is because, if you've been through the experience yourself, you're often able to connect with another person in a verbal and especially a nonverbal fashion that is hard for people to do who have not been through the same experience. That connection is vital to people's recovery.

**Medscape:** This reminds me of the recovery model of addiction.

**Dr. Fisher:** We certainly see some similarities to the addiction field. In the addiction field, a person's first-hand experience with addiction is valued; whereas in the mental health field, it's only now starting to be valued. Until fairly recently it was something you didn't talk about. Part of the recovery is society's recovery from placing so much discrimination and stigma on the person who's been labeled with mental illness. It's hard to recruit peers as long as the stigma is so great; people don't want to step back into the system.

I went through this. It was hard for me to disclose. I waited until after my residency, but this is the major resource for the empowerment model -- finding and training people who have shown significant recovery, who can come back and help other people and train other providers, too.

Groups are an important modality in this model because they enable people to share their experiences and see that they're not alone. I do a weekly recovery group at a day program, and what I try to do is put into lay terms what's been learned over the last 50 years about what helps people psychologically in their recovery. In psychoanalysis they've developed a lot of understanding; Carl Rogers did some very good work, as did Harry Stack Sullivan. So in some ways, the empowerment model of recovery is drawing on earlier knowledge of

working with people interpersonally rather than exclusively medically.

**Medscape: What is the role of medication in your model?**

**Dr. Fisher:** Ideally we would like to see settings provided -- Soteria House you may have heard of -- where people can go when they need more intensive social supports.<sup>[6]</sup> We expect that if there were more of these settings, there would not be as much need for medication. The need for medication I tend to see as a failure of the person's world and their own internal resources to sustain emotional equilibrium sufficiently to remain in consensual reality, and I don't know whether it's one or another neurotransmitter, but clearly when people are feeling very frightened or confused, it's hard for them to be reached by another person. During those times I do prescribe medication and say, "This is to help you to gain control of yourself and your life. Hopefully, you won't have to take it for a lifetime."

I think it's very important that people hear that it's to be used as a tool. I always point everything toward how can you learn to be with other people, to make friends, to get a job, to go back to school, and to perform adequate self-care. Because if you don't, and I'm afraid I see this a lot of times the way medication is used today, people start to believe that the medication will solve their problems, and that's a kind of magical thinking. And it takes away responsibility, motivation, initiative.

I think that ultimately psychiatrists need to hear that a recovery approach is going to assist them in their practice. We're often asked, "Doesn't an empowerment approach increase risk? If people make their own decisions, doesn't that increase the risk involved in practicing psychiatry?"

**Medscape: You mean medicolegal risk?**

**Dr. Fisher:** Yes, medicolegal risk, and the position that I take in my own practice

is that the recovery approach is really a risk-reduction approach, because the biggest risk is a rupture of communication between the person receiving services and the person providing. Most lawsuits are the result of bad feelings and poor communication much more than bad outcomes; furthermore, if people lose communication with their caregiver, they're not going to say when they are not taking medication, that they're feeling suicidal, or that they're thinking about hurting somebody.

**Medscape: You write that psychotic symptoms may persist after recovery but "those are no longer symptoms of mental illness." How so?**

**Dr. Fisher:** I'll give you an example from my own life. I've developed, for instance, ways of talking myself through frightening periods in ways that normalize them to me. I might, at times, if I'm driving along and see a police car, think, "I wonder if they're following me." Then I'll just think it through -- "Why would they be following me?"

**Medscape: What you're describing is cognitive therapy.**

**Dr. Fisher:** Yes, it is in a way, but it's actually what I think people who are not labeled mentally ill instinctively know how to do. We all are confronted at various times in our life with potentially psychotic thoughts. It's just unavoidable. If you're in a new situation and you're uncertain about things, and you can't quite identify the people around you, you can have a misperception. But the difference between misperception and delusion is how you think about it.

**Medscape: Would you say that this kind of cognitive-therapy approach is a part of your model?**

**Dr. Fisher:** It is, actually. In fact, part 2 of our PACE [Personal Assistance through Community Existence] program is a cognitive model.<sup>[7]</sup> We've taken 10 of the major principles of recovery and framed them within a cognitive-

behavioral approach.

For instance, a misapprehension might initially be, "I have a permanent condition and I'll never recover from it." Having another person around you who can help you understand through their life that other people have been through it and you're not alone plays a huge role in shifting that misperception to a new understanding.

**Medscape: Can you briefly describe your personal journey to doing the work that you're doing?**

**Dr. Fisher:** It's a very significant part of my reason for becoming a psychiatrist -- wanting to bring to the field what I wish had been there when I was going through my psychosis. I very clearly remember thinking, during my second hospitalization, "If the people who are talking to me had only been where I am right now, they'd know the way to communicate with me so that I would feel once again part of the world around me." I also hoped there'd be a way to be helped short of having to be involuntarily hospitalized, which I went through 3 times.

In my second hospitalization, I decided that I would become a psychiatrist and try to change the way mental health is provided. I was lucky -- I was able to find a psychiatrist who was able to provide me with many of the principles we find have worked in recovery. He believed in me. When I told him, several months after coming out of the hospital the second time with a diagnosis of schizophrenia, that I wanted to go to medical school and become a psychiatrist, he said he would be at my medical school graduation. And about 7 years later, he was there.

My life's work is here at the National Empowerment Center, which I helped start 13 years ago, and that resulted in my being a member of the President's New Freedom Commission on Mental Health. I think I played a significant role in

getting "recovery" into the national lexicon by my role there. I see my role as a bridge between the consumer movement and the rest of the mental health system. Through my credibility in both worlds, I've been able to help each world understand the other.

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