

1 **Chapter 20**

2 **The recovered subject**

3 **A socio-cognitive snapshot of a new subject in**
4 **the field of mental health**

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6 **Abstract** Recovery represents a new paradigm in the field of mental health. It
7 refers hereby less to the possibility of relief from symptoms than to the indi-
8 vidual's capacity to develop a meaningful life and a self-concept beyond the
9 illness. Several countries adopted recovery oriented approaches to implement
10 mental health service reforms and attracted considerable scientific interest on
11 that subject matter. A comprehensive theory of the recovery process is how-
12 ever still missing. The present article argues for an analytic approach to the
13 socio-cognitive components in the different stages of the subject's recovery
14 process. By the means of narratives from mental health patients, a dramatic
15 loss of internal territoriality ("locus") is evidenced in psychiatric treatment,
16 whereby a subject in crisis renounces its internality to the professionals' au-
17 thority. The eventual process of a subject's recovery, we suggest, has to be
18 regarded as an inverse process, in which internality is privately and socially
19 reclaimed and defended in terms of ownership and responsibility. The phe-
20 nomenon of users' social movements, such as Madpride, is suggested as a
21 form of re-conquest of social territory by the means of emancipatory pride.
22 The mental components of the recovery process represent, in a large part,
23 concepts from the theoretic framework of Cristiano Castelfranchi and his as-
24 sociates. A conception of the subject emerges whereby recovery is ideated
25 literally as a process of "re-covering" aka protecting the subject's internality
26 against the psychiatric/institutional gaze and rule of private affairs.

27 **Keywords:** Recovery, Ownership, Responsibility, Self-trust, Pride, Internality

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

20 **1 Recovery: a new paradigm in mental health**

21 Recovery is a key concept of the new mental health approach to mental ill-
22 ness and to reorient mental health services. In the last years, the recovery
23 oriented paradigm has been adopted in many countries for the implemen-
24 tation of mental health service reforms (e.g. UK, Australia, USA). The Care
25 Services Improvement Partnership, the Royal College of Psychiatrists, and the
26 Social Care Institute for Excellence (2007), announced Recovery as a common
27 purpose for the future of mental health services, emphasizing the need for
28 a better understanding of the recovery approach. Definitions, methods, the
29 role of agents in the process as well as its measurement stand and fall with
30 the conceptual strength of the underlying theory (see hereto also chapter X
31 in the policy manual as published by the American Psychological Association
32 (2009); and the same published by the American Association of Community
33 Psychiatrist: Sowers (2005)). Even if researchers have investigated the field and
34 proposed intuitive models to grasp the recovery process, its components and
35 conditions (e.g. Anthony, 1993; Jacobson & Greenley, 2001), explanation and
36 description of the phenomenon have remained ambiguous.

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

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

6 “Etymological dictionaries: c.1300, “to regain consciousness,” from Anglo-Fr. rekever-
7 erer (late 13c.), O.Fr. recoverer, from L. recuperare “to recover” (see recuperation). Mean-
8 ing “to regain health or strength” is from early 14c.; sense of “to get (anything) back”
9 is first attested mid-14c.

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

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

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

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

35 An influential model of recovery developed for the state of Wisconsin ex-
36 perimentation was proposed by Jacobson and Greenley (2001) in which they
37 undertook a principal division of recovery’s key conditions into internal and
38 external factors:

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

42 The “model”, however, provides no clear definitions of the concepts de-
43 scribing these conditions, nor sufficient explanations of their functioning, but
44 just gives an account of a number of fuzzy concepts.

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

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

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

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

- 33 ● People, since “Recovery is by definition wholeness and no one can be whole
 34 if they are isolated from the society in which they live and work” (Coleman,
 35 2004, p.14); further,
- 36 ● “Recovery requires self-confidence, self-esteem, self-awareness and self-
 37 acceptance without this recovery is not just impossible, it is not worth it.”
 38 (ibid, p.15); and
- 39 ● Ownership “For it is only through owning the experience of madness can
 40 we own the recovery from madness” (ibid, p.16).

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

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

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

24 Besides these empirical and autobiographic accounts of the recovery pro-
25 cess, an interesting contribution has been provided by Hopper (2007). He pro-
26 poses Amartya Sen’s (1993) notion of capabilities as an alternative framework
27 for the analysis of recovery. The capabilities approach

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

33 The capability approach serves indeed an interesting reference point for
34 our analysis, since it readdresses recovery as a question of resources, agency
35 and opportunities. Nevertheless, we should keep in mind that the capabilities
36 approach originates from, and is dedicated to structural problems of resource
37 distribution and the opportunities for education etc. It misses however the
38 adequate theoretic tools to grasp issues, in those cases in which structural
39 factors are less involved in the conditioning of the individual’s capabilities,
40 whereas a major role is played by an acute personal crisis of loss of power
41 which impairs the subject’s capabilities and functionings. We will focus on
42 the recovery process in precisely this sense, analyze the socio-cognitive com-
43 ponents with the theoretic tools of Cristiano Castelfranchi’s framework. This
44 means that the actual beliefs and goals involved, the emotions implied in the
45 subject’s journey from mental illness to recovery, will be sought for, in order to
46 draft a social cognitive model of recovery. Starting point must be the impaired
47 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).

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

6 "I was a schizophrenic, they said "please remember that, oh, and while you are it,
7 remember to stop thinking there is a cure, you are a chronic, a chronic schizophrenic,
8 a biological defect with an incurable disease." (Runciman in Romme et al., 2009, p.
9 256).

10 This kind of prognosis, and the contact with psychiatric facilities create neg-
11 ative expectations for the future, disappointments and existential delusions:

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

18 Psychiatric care is experienced as

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

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

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

28 2.1.1 Compliance

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

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

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

5 Evidently, what is at stake with compliance, regards a large part of a per-
6 son’s natural ownership, where a significant portion of existential decisions is
7 delegated to the hands of the professional:

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

12 2.1.2 Medication: a reductionist annihilation

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

- 17 • “Your compliance (taking the medication) is essential for the success of
18 the treatment” → “the plan for your treatment is not yours but part of
19 professional expertise”
- 20 • “The cause of your mental suffering does not depend on you but on your
21 physiological state” → “you do not control your body, but the body controls
22 you”

23 The administration of psychotropic drugs as a principal focus of the profes-
24 sional intervention combined with the patient’s compliance to the treatment
25 lead to the often described annihilation of the person. The reductionist ap-
26 proach is methodologically and even epistemologically based on the assump-
27 tion of strict upwards causation¹. The reductionist approach to mental illness
28 is for this reason necessarily an approach which transgresses the subject as
29 an arbitrary entity of social life, since the search and focus of the treatment
30 is centered on the elementary constituents of the same. What might be a cu-
31 rious (however legal) technicality of treatment from the “objective” point of
32 view of the medicating therapist, becomes a peculiar experience for the sub-
33 ject of mental illness and even paradox when the subject’s compliance is taken
34 into account: through compliance, both, the therapist as well as the patient
35 “decide” to act *as if* the subject were complying. From the reductionist point
36 of view – and what is even more dramatic – from a legal point of view, the
37 “decision” itself is to be regarded a formal (though legal) technicality, given
38 that the subject is regarded as subjected (caused) by its mental illness, a cause
39 beyond the subject’s “control”. From a consequent reductionist point of view
40 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 unacceptable notion of a *causa sui*.

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

3 **3 Recovery**

4 **3.1 "Recovery exists": Surprise and Admiration**

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

7 "(...) a fellow voice hearer who at my first hearing voices group asked me if I heard
8 voices and when I replied that I did, told me that they were real. It does not sound
9 much, but that one sentence has been a compass for me showing me the direction
10 I needed to travel and underpinning my belief in the recovery process." (Coleman,
11 2004, p.12)

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

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

21 In fact, the belief on which the personal hopeless condition was previously
22 based gets questioned, and generates desires and goals which have been com-
23 promised by the beliefs of incurability and chronicity. The belief revision pro-
24 cess represents an essential turning point in the career of the survivor where
25 the aspirations for a meaningful life beyond the illness regain momentum.

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

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

7 **3.2 From Hope to Trust**

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

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

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

- 41 • As a trustor, when the subject has to evaluate the source of the recovery
 42 information as a trustworthy evidence of recovery (“trust-that” recovery).

- 1 At this level the subject has to act as a social trustor – the ability to trust
 2 and believe what was formerly assumed impossible (social trust as a key-
 3 element of the belief revision process after the initial surprise);
 4 ● As a trustee:
- 5 – at the individual level, when the person needs to trust *in* its own capa-
 6 bilities – the capabilities which need to be trusted and appropriated, that
 7 is, recovered (trust-in);
 - 8 – at the social level, when the individual has to recover its role as a valuable
 9 trustee. At this level the evident complex of problems originating from
 10 stigmatization have to be confronted.
- 11 In both roles – as a trustor as well as a trustee – the resumed power to decide
 12 and not to comply, the commitment to pursue one’s own trusted goals and to
 13 decide to count on trusted others rather than entitled professionals, constitute
 14 instances towards the reestablishment of ownership and responsibility.

15 3.3 “Recovery happens”: Ownership as the Core of Recovery

16 “Ownership is the key to recovery. We must learn to own our experiences whatever
 17 they are. Doctors cannot own our experiences, psychologist cannot own our experi-
 18 ences, nurses, social workers, support workers, occupational therapist, psychothera-
 19 pists, carers, and friends cannot own our experiences. Even our lovers cannot own our
 20 experiences. We must own our experiences. For it is only true owning the experience
 21 of madness can we own the recovery from madness.” (Coleman, 2004, p.16)

22 Coleman’s emphasis on the role of ownership in the recovery process is
 23 shared by many survivors in one form or another as a core piece on the jour-
 24 ney to recovery. Formulations such as “regaining one’s life”, “taking your
 25 life in your own hands”, “claiming responsibility for one’s decisions and ac-
 26 tions”, indicate essential parts of ownership in the survivors’ description of
 27 the recovery process.

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

33 3.3.1 Recovering the resources: Acceptance

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

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

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

7 What is considered unacceptable, the targeted object of an effort at elimina-
 8 tion, the mental source of suffering and frustration, has to be reframed and
 9 reevaluated as a form of resource. Especially in the case of mental illness, where
 10 the perceived source of suffering constitutes an intrinsic part of the self which
 11 is continuously objectified and externalized ("singled out", "identified") for
 12 treatment purpose ("symptom control"), a radical belief revision process ded-
 13 icated to the inversion of the clinical estrangement process has to take place,
 14 whereby symptoms become accessible resources:

15
 16 "I accepted my voices as real
 17 I stopped trying to get rid of them, but accepted them as personal
 18 I became conscious of ownership of my voices
 19 I stopped looking for a cause outside myself
 20 I looked for solutions in my self
 21 I explored what had happened in my life that might have a relationship with my
 22 voices
 23 I accepted those emotions which I did not like and could not easily master"
 24 (Sue Clarkson in Romme et al, 2009, p 316f)

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

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

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

4 **3.3.2 The social grounding of Recovery: Responsibility**

5 Even if responsibility as a concept does not form an explicit part in many
 6 accounts of recovery from mental illness, it needs to be regarded as the consti-
 7 tutive frame of ownership on which the whole complex of mental illness and
 8 recovery rests. It is for the loss of accountability that mental illness is repre-
 9 sented as a sever threat to the society and forms the reason for neglecting the
 10 subject's rights of ownership in the court of legal judgment. The legal system
 11 defines and prescribes accountability as a necessary condition for the indi-
 12 vidual to be judged as a subject of responsibility. The legal consequences for
 13 the subject of mental illness, often considered a sort of collateral to its mental
 14 suffering, builds necessarily the forefront of the recovery process.

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

23 The psychological literature treats responsibility mainly against the back-
 24 ground of Heider's (1958) attribution theory, evidencing the mental compo-
 25 nents of responsibility such as internal attribution of the cause, intention of
 26 the actual effect, foreseeability of the effect and social justification of the cause
 27 (Hamilton, 1978). The more existential implications which are at stake with
 28 the judgment of responsibility have however remained in the backdrop of this
 29 conception of responsibility. Responsibility is not just about the question of
 30 whom to address for guilt and merit of effects, about the social *coverage* of
 31 actual and potential risks and events, but about a *social* frame of reference
 32 whereby a subject's *significance* as an agent is included or excluded, present or
 33 absent, declared or denied. The social negation of responsibility is therefore not
 34 just the negation of ownership (object of responsibility), but must be consid-
 35 ered as the negation of a "true" locus of decision or intention (el Sehty, 2011).
 36 In its generalized form, as in the case of severe mental illness, the complete
 37 negation of accountability cannot but bring about a progressive annihilation
 38 of the subject.

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

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

1 By renouncing responsibility, the subject transfers the ownership of its pow-
 2 ers to the “custody” of a more powerful/competent party. This transfer can be
 3 regarded as a standard component of tutorial relations (Conte & Castelfranchi,
 4 1995; Castelfranchi & Falcone, 2010): The subject itself lacks sufficient aware-
 5 ness of its true interests so that another party is put in charge to decide for it. In
 6 the subject’s state of acute mental crisis, the tutor takes over the full powers of
 7 the individual and is charged with the responsibility for the same. From there
 8 on the subject finds itself in a situation of “structured irresponsibility” where
 9 the tutor forms a socio-cognitive shield not only against failure and blame but
 10 also success and merit.

11 As stressed by Castelfranchi, the tutor should have the active goal to resti-
 12 tute the delegated powers to the individual as soon as possible. This would be
 13 natural, given the overwhelming weight of responsibility the tutor assumes.
 14 The tragedy of the transfer of responsibility in the psychiatric context lies
 15 however in the fact (1) that the tutorial relation is embedded in an institutional
 16 frame, where the subjects are confined to their roles based on “responsibility”
 17 (professional) and “non-responsibility” (client), and (2) that the delegated
 18 responsibility cannot be recovered from “the” professional, but must be claimed
 19 in the social arena by the means of trusted exchanges, and more specifically, in
 20 the subject’s role as a veritable trustee². Reclaiming responsibility represents
 21 the main struggle of the recovering subject, a struggle that is ventured socially
 22 in the sense of gaining back the right of ownership as a trusted subject of
 23 responsibility, and individually, through the reestablishment of an internal as
 24 well as stable “locus of control”.

25 3.3.3 Recovering internality: The social claim

26 The acceptance of proper resources and the claim of responsibility for these
 27 formulate a social claim, for what is considered to be responsibly owned by
 28 one cannot be meaningfully claimed by another. The social claim of own-
 29 ership addresses an essential component of the recovering individual as an
 30 autonomous subject. The recovery process necessarily conflicts with the pa-
 31 tient role which is defined by the subject’s compliance to the expert treatment it
 32 is submitted/committed to. The social claim of ownership represents therefore
 33 an essential emancipatory act towards the subject’s full rights as a citizen:

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

² A socio-cognitive account of responsibility could find seminal foundation within the theo-
 retic framework of the trustee as recently presented in Castelfranchi and Falcone’s compre-
 hensive monograph “Trust Theory” (2010). Of specific interest for the analysis of responsi-
 bility has to be considered their chapter “On the Trustee’s Side: Trust as Relational Capital”
 (2010, Chap 10).

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

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

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

23 Self-trust and Recovery Exchange

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

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

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

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

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

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

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

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

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

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

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

31 **Mad-pride**

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

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

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

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

10 Anti-stigma movements are devoted to the change of their participants’
 11 social identity by the construction of a “political identity”. Anspach (1979) de-
 12 scribes how the participation of former psychiatric patients in political move-
 13 ments generates an experience of self-determination, which replaces the feeling
 14 of powerlessness and helplessness. The movement’s objective transfers into a
 15 new self-conception, a process which implies the development of a feeling of
 16 pride.

17 When the subject stops to believe that its experience of mental illness is
 18 something to be ashamed of, accepting and reevaluating it, several emotions
 19 are likely to emerge: anger and revenge for the personal experience of social
 20 discrimination, and indignation for this kind of social injustice. This is the
 21 emotive base of a form of pride that we call “emancipatory pride” which has
 22 an internal as well as social reparative function (Pocobello and Castelfranchi,
 23 2009):

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

36 4 The re-covered Subject

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

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

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

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

13 Evidently, the whole story of the subject's recovery process can be recounted
 14 more coherently in terms of power relations, against the background of disem-
 15 powerment as well as empowerment processes. Hopefully you remain avail-
 16 able to this chapter of the recovered subject, Cristiano?

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1

2

Part V

Trust & delegation