The Impact of Language and Environment on Recovery

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Introduction

Finding a way to promote and support recovery for every person who has experienced or is experiencing a mental illness is a daunting task. This new obligation requires rethinking and retooling our role(s) as mental health service recipients and/or as helpers of persons with a mental illness.[1] We all need to make substantial changes in our practice(s), especially in the language we use to describe service recipients and the services they receive. One of the greatest challenges relating to language is using words that can be understood from an individual and cultural point of view. Wilma Townsend (2004) believes that "lay" terminology in both the written and spoken word is essential. One caveat, however, is necessary; changing language is a very small piece of the recovery puzzle. Without changing the thinking and attitudes of helpers[2], the authors believe a language change is unlikely to make a significant difference.

As if changing words was not enough, environments that are comfortable and conducive to the process(es) of recovery must be created. It is well established that environment is an important regulator of behavior. In Atlanta, a young man was not recognized by his psychiatrist at a community program because his behavior and dress were so different from his presentation at the clinic where the doctor saw him for medication management. When the doctor queried the young man regarding his change in behavior and appearance, the young man informed the doctor that he intentionally attempted to look like others in attendance while he was present at the program rather

[1]It is important to note that service recipients and helpers are not mutually exclusive.
[2] The myriad activities associated with changing a system that (1) relies heavily on a medical funding source; (2) confers status for the use of "big words;" and (3) has long standing negative attitudes about the potential of service recipients cannot be addressed in this paper, but eventually if they are not faced head on, real change is unlikely.

than a mental patient. This example alone is reason enough to consider the environment(s) that people experience and how they are personally affected.

Language

Focusing first on the impact of language on recovery, the following quote depicts the significance of language choice and its affect on personal and organizational behavior, attitude, and environment.

> *"Words are important. If you want to care for something, you call it a 'flower'; if you want to kill something, you call it a 'weed'."* Don Coyhis

It was very tempting at the outset of this endeavor to tell readers what not to say – which words not to use. However, with the exception of the IAPSRS Language Guidelines[3] (2003) and "The Power of Language in the Helping Relationship" (1997), there isn't much guidance for recovery-friendly language. In this paper, we will discuss positive communication[4] and vocabulary changes that we believe can make a difference for persons who are struggling to recover. We will also present words and phrases that may be harmful, and we will discuss these briefly.

Hope and Spirituality

Mark Ragins (2003) called hope the first stage of recovery. He said, "During times of despair, everyone needs a sense of hope, a sense that things can and will get better" (p.6). More importantly, however, he said that hope has to be more than an ideal, that "it has to take form as an actual, reasonable vision of what things could look like if they were to improve" (p.6). Whether it is the first step of the recovery journey or the motivation for pursuit of a later goal, hope is the word that is often mentioned in conversations about recovery by persons with a serious mental illness.

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[3] The International Association of Psychosocial Rehabilitation Services was renamed the United States Psychiatric Rehabilitation Association (USPRA) in 2004.

[4] We believe that communication is considerably more than words; we may change words but if they are not said with empathy and encouragement, we are missing the point.

What communicates hope? It will be different for different people and language will need to be individualized. For some, saying that a particular intervention might reduce the pain of the illness will offer hope; for others it may be necessary to help find the right apartment or job. Conversations with peers who can tell of their positive experiences in spite of the illness are also good generators of hope.

One of the best ways to communicate hope is by assistance to individuals who are setting recovery goals. Last fall, Ms. Townsend and I had the good fortune to speak with a gentleman whose "reasonable vision" was to find a companion or partner. He worked hand-in-hand with us discussing actions that might help his dream come true. He was perplexed that no one earlier had taken him seriously and tried to help him in his search for a significant other. We were reminded how often helpers fail to hear and help when the person served doesn't have the same agenda as the helper.

Hope and spirituality go hand in hand. Young and Ensing (1999) discussed spirituality as a source of hope and inspiration and found in their research that a number of persons in the study reported reliance on spirituality to help them get through tough times. Ragins (2003) said helpers have been reluctant to help service recipients with their spiritual side. He goes on to discuss the importance of a positive atmosphere "... where positive spiritual values – like acceptance, love, hope and compassion – can thrive" (p.41). However, it must be acknowledged, that helpers simply have a difficult time relating to the spiritual paths that some persons choose. There is still much to learn about useful ways to talk about and support spirituality. Consider Jay Mahler's (1997) very poignant quote: "The whole medical vocabulary to describe what has hit us brings with it a new set of conflicts and disturbances that they don't address as they put us in the role of a 'labeled' diagnosed victim" (p. 1). This comment was made in response to questions about a reference to his mental illness as a spiritual journey. Mr. Mahler gave an explanation of the devastation associated with the assignment of a diagnostic label. He also offered advice about the conversation(s) and

compassion that are required by people facing a mental illness. Estroff (1997) reinforced Mahler's experience, saying, "We are apparently much more skilled at identifying evidence of illness than we are at recognizing and assessing the presence of person and condition of self" (p.46).

Today most practitioners are likely to provide information about the diagnosis and practical advice about following instructions related to taking the medicines, avoiding alcohol and drugs, and keeping appointments. Harding and Zahniser (1994) believe that in addition to education, supportive psychotherapy is crucial for integrating the experience of a psychosis and enhancing continuing development.

Where is the conversation about life with meaning in the face of the diagnosis; where is the hope that life is worth living? Yes, we are saying that at onset of the illness and maybe always, there has to be exploration and acknowledgement of the meaning of the illness to the person, and while we aren't saying that practical education should be abandoned, we are promoting education in the context of the person's life.

Recovery Planning

Townsend and Glasser (2003) wrote of a man who desired to be an astronaut who on two occasions was thwarted when his dream was seen as a delusion and/or pipe dream. Finally a helper took him seriously and while he did not become an astronaut, he did get a job working for a company affiliated with NASA.

No matter the funding source[5], the person served must articulate the statement of goals that must become the basis for the recovery plan. Additionally, these goals must be communicated using the words of the service recipient. The words of the people who are served offer evidence that they have been heard and reduce misunderstandings.

[5] Medicaid and Medicare are both medical funding sources and as such there is a need to balance the goals of individuals with requirements. Medicaid, however, requires that the goals be the goals of the service recipient.

Although the helper may express points of view and/or goals that are different from the service recipient's, it is the point of view and/or goal of the person served that must prevail. This often means that facilitators of recovery must know the language of negotiation and mediation.

Treatment Works[6]

There is a belief that people recover because things are done to them by helpers. This notion is disempowering and simply not true. The original intent of such a slogan declaring that treatment works was to offer hope, but it may also suggest that one's recovery is the responsibility of others.

While there are treatments that work, it is essential to promote the role of the individual service recipient in recovery. Recovery facilitating language starts from the premise that individuals have relationships and resources that they can bring to bear and that treatment augments and enhances their participation in the recovery process. Many times qualities like empathy and encouragement help persons do things they were unable to do with treatment alone, but it is they who must recover. It is incumbent upon helpers to use the best practices/treatment that are available in a context of partnership, choice and sensitivity to culture with individuals as they begin their recovery journey.

Nonjudgmental Language

Spaniol and Catteneo (1997) presented important advice for both oral and written communication. They described several ways to avoid judgmental language. First, often a lack of specificity will lead to the use of terms like "appropriate and inappropriate", "low and high functioning" or words like "issues". More specific/nonjudgmental communication of "low functioning" could include "requires assistance in socializing with others; at times needs help in

[6] This is not an original idea. It was presented in a paper "The Rhetoric of Recovery Advocacy: An Essay on the Power of Language by William White that is undated and unpublished.

keeping his schedule; and often has difficulty in sustaining her motivation for extended periods." Rather than issues,[7] specific words such as "fear of the unknown, anxiety about meeting new people, possible discrimination by the landlord" should be used. Appropriate and inappropriate should be replaced with behavioral descriptions.

Second, the use of negative or fatalistic language such as "poor prognosis" can serve to demoralize persons. This is a "medical model" term that can be better left unsaid since it may leave helpers and individuals served feeling helpless and hopeless. Lack of insight can be restated as "is just beginning to learn more about her illness" and denial[8] can best be talked about in terms that the person served suggests. (The more you go to the source, the more likely you are to find words that are acceptable to the person.)

Finally, making a statement that implies a fact rather than a possibility conveys finality and suggests judgmental thinking unless there was direct observation. "Maybe", "might be", "perhaps", "could be", "possibly", "a question about" and "seems" are all words/phrases that temper information by conveying a lack of certainty. No communication at all may be more prudent than giving misinformation.

Words That May Hurt

Language in our field serves many purposes - some intended and some unintended. First and foremost language is a basic means of communicating with each other. Words, however, which are (1) unfamiliar and technical; (2) acronyms that sometime seem to be a secret code; (3) unexplained scientific terms; and (4) pejorative references to individuals all can be used to establish control over and to disempower some persons.[9] Service recipients and their families could greatly

[7] The authors think issues have become one of the most over used words in the mental health field.
[8] Denial used by helpers often connotes a willful refusal to accept the problems of and treatments for a diagnosed mental illness. Service recipients, however, often use the word to describe a period in their lives when the acceptance of the illness was a burden too great to bear.
[9] Quite frankly, we have been such good teachers that persons served have often adopted much of our language!

assist helpers by creating lists of words that have been used that were not explained. The use of lay language is the single best defense against using words that are not known by the service recipient. Most helpers would disavow any intent of using language to establish control, but, regrettably, words that are not helpful are still said or written.

It is true that language and vocabulary changes referenced in this paper seem simple. What is never simple, however, is changing behavior. Do not expect anyone to easily embrace these changes. Nothing less than relentless attention to our words is enough.

Environment

The technical definition of environment is "the aggregate of social and cultural conditions that influence the life of an individual" (Webster's Ninth New Collegiate Dictionary, p. 416). For purposes of this paper, however, the focus is on environs associated with the provision of mental health services. In the lives of persons recovering from a mental illness, close attention must be paid to how environments make those who spend time in them feel. Are feelings of acceptance, safety, trust, hope, dignity and self-worth engendered? Clearly, not enough thought and energy have gone into designing places that are recovery-friendly. Consider the following example.

Molfenter (2004) reported the experience of a woman named Sarah as she began substance abuse treatment. Upon entering the agency, Sarah found the environment dreary and prison like. The walls of the agency were bare. The furniture in the waiting area was old; no special accommodations for her child were available. There also were no private intake areas. Sarah painfully described the stress, humiliation, and frustration she experienced trying to provide private information in a public area and in keeping her child, who became bored and restless, occupied. Sarah also reported that she anxiously waited to leave the agency and had no intention of ever returning. Sarah's scenario is one that should be avoided in the future.

Creation of a supportive environment begins with the building entrance and the first contact(s) people experience. Unfortunately it is not unusual to see a waiting room with chairs that are rigidly lined against a wall. Reading materials often are not current and are haphazardly arranged. It is not unusual to see staff pass without acknowledging the persons in the area. Often, there are physical barriers between the clientele and the office staff, and the initial greeting is "Do you have your Medicaid card?" rather than "How are you feeling today?"

Bakos, M., et al. (1979) believe that "physical settings can work to support therapeutic programs. Or they can be destructive to even the best programs or the efforts of the most dedicated" (p.1). Considering this, unless the physical layout is conducive to recovery processes, there is a risk of hurting rather than helping.

Lowes (1998) recommended arranging chairs in small clusters that allow for choosing whether or not to interact with others. Without question, one of the most important considerations is the provision of space that allows for private communication(s). Bakos, M., et al. (1979) suggested that personal, private space is an important feature that also conveys value to both helper and the service recipient. Special seating arrangements for children that include toys and books should also be in the waiting area.

Equally important to the layout of the reception area is the ambience or feeling associated with the room. Does someone greet and welcome persons as they arrive? Is the expectation of recovery communicated through written materials and "shining examples"? Are the furnishings comfortable? Is the lighting harsh and artificial? Lowes (1998) believes that although a few overhead fluorescent lights are ideal for reading, there should be some reliance on less intense lighting sources such as table lamps to create a more relaxing atmosphere.

The colors used throughout the environment also play a crucial role in how the agency is perceived by the individual. Dellasega (2004) reported that many health facilities often feature drab colors such as gray and brown. This choice of colors has the potential to negatively affect the

moods of both the individuals receiving service as well as helpers. According to Johnson (2004), blue and green may have a more positive impact on individual moods as well as the ambience of the agency. Blue is believed by Johnson (2004) to encourage peace, calmness, and tranquility and green is believed to be a "calming, refreshing color" that "symbolizes nature". Although the use of bright yellow is often believed to encourage happiness and cheerfulness, Johnson (2004) stated that "people loose their temper more in yellow rooms, and babies will cry more" [in yellow rooms] (p.2). Soft shades of blues and greens are the ideal colors to be used when creating an environment that helps people feel calm, relaxed, and comfortable.

Representations and symbols of nature are also helpful in creating a recovery-friendly atmosphere. Fountains, fish tanks, plants, and nature-oriented artwork bring warmth to any room and can have a positive affect on service recipients. Natural lighting sources and colors of green can add tranquility. An environment that highlights nature is less likely to be perceived as cold and lifeless, which are opposite characteristics of the warm and inviting environment that should be created.

Decorative artwork and reading materials that are reflective of a diverse range of ethnic groups and cultures are essential to ensure that all individuals feel included and valued. Displaying artwork produced by service recipients and helpers serves to promote a positive atmosphere.

Sounds, smells and order must also receive consideration. Dellasega (2004) suggested that music may increase comfort and that it can also be used to mask undesirable sounds. Carpeted floors muffle sounds, creating a quieter and calmer environment (Lowes, 1998). Odors are particularly important since many persons have allergies and react negatively even to good smells. Agencies need to be aware that certain smells bring about the perception of an institutional settings like hospitals and may have a negative impact on some individuals. Assessment and elimination of undesirable odors must be ongoing. Finally, an orderly environment that is free of clutter is more conducive to recovery. Disorder is often a distraction to both the helper and the service recipient.

At this point in time the technology of creating a physical environment that is recovery-friendly is limited. The authors urge that opinions of service recipients, family members and helpers be used to analyze current conditions at the service site and to make recommendations that they believe will enhance the environment.

In addition to the environment created by the physical set up and appearance of an organization, the quality of the personal interactions that take place within the agency contributes to the overall atmosphere of the organization. Often, individuals receiving mental health services are treated as if they were merely a number with a diagnosis, rather than a worthwhile human being. Individuals must be acknowledged and made to feel welcome by those with whom they come into contact. In an environment that supports recovery, service recipients are made to feel valued and respected by the physical environment of the agency as well as by how they are viewed, treated, and spoken to by agency staff. Constant vigilance by all is essential during the initial stages of establishing the "new" way of doing business.

Mental health service providers must also become familiar with a variety of cultures and practices to honor the diversity of individuals receiving and providing mental health services in order to avoid unintentionally behaving or speaking in an offensive manner. Valuing diverse customs, practices, and traditions also aids in creating an environment that encourages successful recovery.

Conclusion

It has been established herein that both the language used in service settings as well as the environment in which recovery takes place can drastically affect an individual's recovery process. It is essential that organizations assess how both language and environment are currently affecting individuals receiving and/or providing mental health services within their facility and work toward improving the overall atmosphere of their agency. It is recommended that both individuals receiving services and individuals providing services be granted the opportunity to offer their

opinion on how the language used within their agency as well as the agency's environment are affecting those involved in the recovery process. Once areas of needed change have been identified and agreed upon by involved parties, steps toward change should be made to create the ideal recovery-oriented atmosphere. By dedicating time and effort toward creating an environment that aids and positively affects those involved in the recovery process, organizations become better equipped to fulfill their goal of restoring hope within individuals and bettering their quality of life.

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