

Play, Pleasure, and Other Positive Life Events: “Non-Specific” Factors in Recovery from Mental Illness?

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As part of the emerging recovery paradigm, there is an increasing need for psychiatric treatment and rehabilitation to be strengths-based and to be driven by the desires and preferences of the person with mental illness. Yet if mental illness is a brain disease, it is not at all clear how these characteristics contribute to improvement in the person's condition or influence the course and outcome of the disorder. To avoid these aspects being relegated to the role of nonspecific factors, the field must develop an understanding of the role of strengths and interests in recovery. To contribute to this effort, we review the existing empirical research on the protective and stress-buffering effects of positive life events and qualitative data on the importance of play and pleasure in the lives of people with mental illness. We conclude by considering briefly the implications of this research for clinical practice.

Seeing too much sadness hath congeal'd
your blood,
And melancholy is the nurse of frenzy:
Therefore they thought it good you hear
a play
And frame your mind to mirth and
merriment,
Which bars a thousand harms,
and lengthens life.

—William Shakespeare,
Taming of the Shrew

As part of the emerging recovery paradigm in community mental health, featured among other places in the President's New Freedom Commission Report (2003) and

Mental Health: A Report of the Surgeon General (DHHS, 1999), much is being made of the need for psychiatric treatment and rehabilitation to be strengths-based and to be driven by the needs and preferences of the person with the psychiatric disability (e.g., Jacobson & Greenley, 2001; Rapp, 1998; Ridgway, 2001). Defined, in part, in contrast to the traditional deficit-based model derived from the clinical discipline of psychopathology, *recovery-oriented care* is described as eliciting, fleshing out, and cultivating the positive elements of a person's life—such as his or her assets, aspirations, hopes, and interests—at least as much as an attempt to ameliorate, decrease, or

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remediate his or her symptoms and other difficulties (Davidson, Tondora, et al., 2001).

One of the many things that have yet to be made clear about this paradigm, however, is precisely *how* recovery-oriented care is to contribute to improvement in the person's condition. If, in fact, schizophrenia and bipolar disorder are brain diseases, then by what mechanisms are a person's pursuits of his or her aspirations or interests thought to influence the course and outcome of the disease? For example, by what processes are person-centered care (Marrone, Hoff, & Helm, 1997), collaborative treatment planning (Chinman, Allende, Bailey, Maust, & Davidson, 1999), or strengths-based case management (Rapp, 1998), thought to impact on the severity of the illness itself?

If not by affecting the illness, then by what processes might recovery-oriented practices such as these alternatively decrease or minimize the disability associated with mental illness? To the extent that they do so, are these practices any more effective for, or required by, mental illness than for or by other chronic medical conditions such as asthma, diabetes, or cardiac disease? If not, then why is more being made of the need to shift to a recovery paradigm in mental health than in general medicine? For these dimensions of care not to be consigned to the same fate as the so-called nonspecific factors in psychotherapy (which have been consistently found to be both the most important and the least understood factors in treatment), both theories and evidence are needed to examine their specific, and perhaps crucial, role in promoting recovery.

In this article we begin to address these questions by exploring the mediating role of pleasure in recovery from mental illness. Based on previous qualitative (Davidson, 2003; Davidson, Haglund, et al., 2001) and quantitative (Shahar & Davidson, 2003) research—and consistent with recent interest in positive psychology (Seligman, 2002a, 2002b; Seligman & Csikszentmihalyi, 2000)—our hypothesis is that play and other positive life events positively impact on the course and outcome of mental illness both

broadly through their general restorative power but also more specifically through their contributions to the person's efforts to rebuild an effective sense of social agency with which to battle the illness. First, we review the empirical evidence suggesting that positive life events promote resilience and adaptation in the face of chronic illness. We next review first-person accounts of recovery to draw more specific links between play, pleasure, and other positive life events and processes of improvement in mental illness. We close with a brief discussion of the implications of this view for recovery-oriented clinical practice.

POSITIVE LIFE EVENTS

In contrast to the extensively studied role of negative life events in physical illness and psychopathology, research on positive life events is conspicuously scarce (Needles & Abramson, 1990; Zautra & Reich, 1983a). Nevertheless, evidence accumulates to suggest that positive events do play an important role in adaptation, either in directly ameliorating emotional and/or physical distress or by buffering the adverse effect of negative events (Cohen, McGowan, Fooskas, & Rose, 1984; Cohen & Hoberman, 1983). In the former, positive events are thought to exert a main effect on distress, meaning that being involved in positive events lowers an individual's risk for distress. The latter pertains to an interaction between positive events and negative events in their effect on distress such that when the person has few positive events, negative events are more likely to be experienced as distressing, while in the presence of many positive events, negative events exert a small effect, or no effect, on distress.

Empirical support for either the direct effect or stress-buffering protective mechanisms has been obtained among varied populations, including people suffering from anxiety disorders (Lteif & Mavissakalian, 1995) and chronic fatigue syndrome (Ray, Jefferies, & Weir, 1995), and from community-based samples of adolescents (Caputo, Rudolph, & Morgan,

1998; Kanner, Feldman, Weinberger, & Ford, 1991; Shahar, Henrich, Reiner, & Little, 2003; Shahar & Priel, 2002, 2003; Wills, Sandy, Shinar, & Yaeger, 1999; Wills, Vaccaro, & McNamara, 1992), young adults (Cohen et al., 1984; Cohen & Hoberman, 1983), and the elderly (Krause, 1988). Reich and Zautra (1981) provided particularly compelling evidence. Those authors encouraged college students to engage in either two or twelve enjoyable events during a 1-month period as compared to controls. Participants in the two experimental groups reported greater quality of life than did controls. Moreover, participants who reported more initial negative events exhibited lower distress when instructed to engage in twelve activities rather than two or none.

While this study might strike some readers as proving the obvious, these findings can be compared to other studies in which the benefit of positive events was not demonstrated (Johnson, Crofton, & Feinstein, 1996; Johnson, Han, Douglas, Johannet, & Russell, 1998; Sarason, Sarason, Potter, & Antoni, 1985; Zautra & Reich, 1983b). Interestingly, studies that are consistent with the protective effect of positive events are similar to studies that are inconsistent with this effect with respect to the samples selected, the designs utilized, and the analytic procedures performed (e.g., Cohen & Hoberman, 1983 vs. Sarason et al., 1985). Indeed, in one study (Cohen et al., 1984) both confirming and disconfirming findings were obtained. The authors assessed depressive symptoms and positive and negative events of undergraduates at two points in time. Analyses of Time 1 data revealed statistically significant direct and stress-buffering effects of positive events. Analysis of Time 2 data replicated the direct effect, but the stress-buffering effect only approached significance. In longitudinal analyses, both effects were nonsignificant. In still other studies, positive events were shown to exert an adverse effect on adaptation (Brown & McGill, 1989; Hirsch, Moos, & Reischl, 1985). For example, among children of depressed and rheumatoid arthritis patients, positive events were shown to predict elevated, rather than reduced, distress (Hirsch et al., 1985).

To address this seemingly inconsistent pattern, Shahar and colleagues (Shahar & Davidson, 2003; Shahar & Priel, 2002, 2003; Shahar, Heinrich, Reiner, et al., 2003) embarked on a program of research that draws on recent developments in statistical modeling. Specifically, these authors hypothesized and showed that positive life events are both risk related and resilience related, because they include a stressful aspect of change and a protective aspect of enjoyment (Shahar & Priel, 2002). These contradictory aspects tend to cancel each other out, making the detection of the protective effect of positive events particularly challenging. Furthermore, the authors have shown that the stress-buffering effect of positive events is difficult to detect due to two reasons. First, this effect is relatively weak, with enhanced methodological conditions needed to demonstrate it (Shahar & Priel, 2003). Second, previous studies over-sampled interpersonal events at the expense of performance related ones, and because both types of events are conducive to adaptation, this bias has impeded detection of the protective effects of positive events.

Another complexity inherent in positive life events is that, like negative ones, they do not simply occur *to* people but are, in part, actively generated by them. To illustrate this, Shahar and colleagues (Shahar, Henrich, Blatt, Ryan, & Little, 2003; Shahar & Priel, 2003) investigated Israeli and American adolescents, and found that adolescents with different personality constellations generated different patterns of negative and positive events. Specifically, adolescents with strong dependency needs were found to generate both negative and positive events, contributing to the mixture of risk and resilience that is associated with this personality construct (Borenstein, 1998; Shahar, 2001). In contrast, adolescents with strong self-critical tendencies were shown to generate negative events and to fail to generate positive events (Shahar et al., 2003a). Because the lack of positive events and resulting positive affect have been identified as the defining feature of clinical depression, this failure to generate positive

events on the part of self-critical adolescents may explain, at least in part, why these individuals are so vulnerable to depression and to a host of other clinical conditions (Blatt, 1995; Shahar, 2001, 2004).

Why would self-critical adolescents fail to generate positive events? As part of one of the two aforementioned studies that focused on personality and life events during adolescence, Shahar and colleagues (2003a) found that this default has to do with the motivational structure implicated in self-criticism. Namely, among American adolescents, self-criticism was strongly associated with lower levels of "intrinsic motivation orientation"; in other words, the tendency to engage in activities because of the joy they inspire. In turn, and in quite a straightforward manner, lower levels of intrinsic motivation predicted lower levels of positive events, and this effect fully accounted for the previously demonstrated effect of self-criticism on positive events.

In another study that is particularly pertinent for the purposes of this report, Shahar and Davidson (2003) examined the role played by positive life events in recovery from severe mental illness. Investigating 260 people with serious mental illness who participated in a peer support intervention, these authors found that those participants who, in the course of the intervention, improved in terms of their ability to engage in pleasurable activities were able to regulate depressive symptoms better to the point where these symptoms had a nonsignificant effect on their self-esteem. In contrast, among participants who did not improve in terms of engaging in pleasurable activities, depressive symptoms had a significant demoralizing effect, eroding their self-esteem. This study is noteworthy because it identifies a hitherto undetected protective mechanism of positive events: Not only do these events directly ameliorate distress and provide a buffer against stress, but the findings obtained by Shahar and Davidson also suggest that positive events facilitate the regulation of depressed mood, preventing it from spilling over into other phenomenological domains, such as one's sense of self.

THE ROLE OF PLAY AND PLEASURE IN RECOVERY

Having joy is one way to stay out of depression.

—Woman with psychosis talking to interviewer

Qualitative data on the role of play and pleasure is drawn from over 100 qualitative interviews with people living with, and recovering from, serious mental illnesses from a number of studies (Davidson, 2003). These include studies of people re-entering the community after extended inpatient care (Davidson, Hoge, Merrill, Raakfeldt, & Griffith, 1995), people cycling through repeated acute inpatient hospitalizations while trying to establish a basis for recovery in the community (Davidson, Stayner, Lambert, Smith, & Sledge, 1997), people who are considered stable but socially isolative outpatients participating in supported socialization programs (Bizub, Joy, & Davidson, 2003; Davidson, Haglund et al., 2001; Davidson, Stayner, Nickou, Styron, Rowe & Chinman, 2001), and longitudinal studies of people who demonstrate improvements over time both in the United States (Davidson & Strauss, 1992, 1995) and in several Western European countries (Davidson et al., 2005). All of these studies have in common the utilization of a narrative-phenomenological methodology which we have described in detail elsewhere (e.g., Davidson, 2003; Davidson et al., 1995). In brief, it involves collection of narrative data through open-ended interviews which are audiotaped, transcribed verbatim, and then analyzed independently by several investigators. Each investigator identifies themes both within and across these interviews before coming together as a team to develop consensus on each individual interview and on the sample as a whole. Finally, the interviews are reviewed again for confirmatory and disconfirmatory evidence of each theme and the findings are integrated prior to being presented back to study participants for their review and feedback.

These studies consistently have identified experiences of pleasure, play, and other positive life events as playing crucial roles in the recovery of people with serious mental illness in several inter-related ways: by providing respite from the illness and its effects and offering the person something to look forward to; as a source of renewing hope and commitment; by imbuing life with a sense of meaning and purpose; as evidence of the ways in which one can contribute to the lives of others and to the broader community, and thus of one's value as a human being; as avenues to re-discovering one's own remaining areas of strength, competence, and health in the midst of persistent dysfunction; and, finally, as a way to reconstruct an effective sense of social agency with which to do battle with the illness and its associated effects and side effects. We describe each of these briefly.

"It was just realizing . . . that life isn't one big horror."

The first function served by pleasure in the lives of our participants has been to provide them with respite from their illness and its effects and to offer them tangible evidence, in the words of one female participant, that "life isn't one big horror" (Davidson, Haglund, et al., 2001). For people whose lives had become constricted to the point of being dominated by treatment appointments, wasting away days at the social club, or alone in their apartments or on the streets, and being preoccupied with their suffering and other difficulties, the value of simply having fun or experiencing pleasure should not be underestimated. Experiences that had nothing to do with their mental illness *per se*, and which instead offered some degree of enjoyment or pleasure, were described as offering them temporary relief from their suffering, distracting them from their usual preoccupations, expanding their range of opportunities and activities, breaking up the monotony of their impoverished lives, and giving them something positive to look forward to. As a participant in a supported socialization study described: "At least [now] I've got something to think about other than

to think about the bad part, the lonely part. At least I know I can think about: I'm going to go out with [my friend]. It's only lunch, but it'll be good" (Davidson, Haglund, et al., 2001, p. 284). Said another: "It's been nice, knowing that I had something more interesting to have planned for the day, an outing or somewhere to go instead of sitting here at the house" (p. 284).

"It was really a lovely day. Just a lovely day."

In addition to providing respite from the illness and offering the person something positive to look forward to, many people have described ways in which experiences of pleasure and joy have counteracted overwhelming feelings of despair and demoralization and renewed their sense of hope and belief in the goodness of life in general. Following on many years of repeated failures, rejections, disability, and disappointments, having a glimpse into the nicer things life still has to offer can provide an important anchor for people whose lives otherwise feel adrift among a sea of misery. In a lengthy narrative that we have published previously (Davidson, Stayner, et al., 2001, pp. 384–385), the man quoted above was referring to the lovely day he spent with a friend in a supported socialization study eating seafood and sipping iced tea on a hot summer afternoon overlooking the ocean. He described this and other similar experiences as enabling him to get away from the confines of his illness and his life at a nursing home and to feel "immeasurably" better (p. 384).

Other participants have described this same outcome from similar experiences of gardening, traveling through autumn foliage in New Hampshire, going out to the movies, or simply spending time with friends. One young woman with a history of affective disorder and repeated suicide attempts captured the contrast these kinds of experiences provided against the backdrop of her usual day-to-day struggles when she described her decision one day to accompany her friend to Dairy Queen for an ice cream sundae as a

more appealing alternative to trying (again) to kill herself. This sense that life has something better to offer than just disease, disability, and despair appears central to people's ability to remain hopeful in the face of persistent dysfunction and disappointment and to become committed to making things better.

"I could choose to be a no body, a nothing, and just [say] the hell with it."

Most people find little in the way of meaning or purpose in fulfilling the role of mental patient. To make the effort to improve their lives, however, it appears essential for people to be able to find sources of meaning and purpose in their lives. In the reports of our participants, these sources are most often found in experiences of enjoyment and pleasure, including the pleasure of giving to others. The man quoted above, who could "choose to be a no body," went on to acknowledge that there are times when he feels like that, like choosing just to withdraw and do nothing. "And yet," he recognized, "I'm part of the world, I'm a human being, and human beings usually kind of do things together to help each other out" (Davidson, Haglund, et al., 2001, p. 288). Like this gentleman, many participants described initially rediscovering a sense of meaning and purpose through giving to others. It mattered less what they had to give—ranging from picking up a neighbor's trashcan, to sending birthday cards, to giving advice, to becoming a mental health care provider—than it did that they were giving something of value to another person which would add positively to his or her life. For others, meaning and purpose could be derived from their efforts toward personal expression; from contributions they made to scientific research (by participating in interviews) that will eventually help others down the road; or from their enjoyment of music, animals, or nature. What all of these experiences appear to have in common is the "general awareness" that participants describe underlying them which offers them a sense of where and how they "fit in" to the

broader community and to the world as a whole (Davidson, Haglund, et al., 2001, p. 287).

"I enjoy myself by making other people happy also."

Building on the sense of meaning and purpose that comes from these experiences of "fitting in," participants talked at length about the importance of "giving back" in their recovery. Perhaps because they had experienced such long periods of disability and of being a relatively passive recipient of the care and actions of others, a common theme that emerged in our interviews was the importance, and pleasure, of contributing meaningfully to the lives of others. This experience marked a departure from their usual sense of being "on poverty row," of "being a charity case," of being a mental patient or a "loser." In contrast, experiences of doing "my own fare share, pull[ing] my own weight," helped people to feel like valuable and worthwhile human beings. While certainly not curing their mental illnesses, such experiences nonetheless reassured participants that, in one woman's words, "your mind isn't *all* gone. You know it's not always good, but you can still make it" (p. 288). Prior to experiencing this kind of evidence of one's continuing worth and abilities, participants were more likely to report that they "didn't feel like I deserved to have a halfway decent life." By seeing that they were still able to give things to others, they then describe coming to "not be afraid to take things from people in return" (p. 288).

"I have some evidence, I've got something done, I've been productive."

As a further refinement of the sense of being valuable and worthwhile, participants emphasized the importance of rediscovering, through these and other positive experiences, their remaining areas of strength and competence. This component of experience refers to the specific type of pleasure that comes from

experiencing one's own mastery, from being able to do things well, and from having the tangible evidence of one's generativity to refer back to when things are not going so well. For people who are struggling to survive the onslaught of their illness, this sense of mastery can come from the seemingly trivial experiences of being able to turn on and off one's own radio, making drawings or keeping a journal, making a cake from scratch, being able to sit through an entire movie or television show, or being able to get through the grocery store successfully without "freaking out." For others, developing those parts of their lives that take place outside of their mental illness requires sustained efforts at such things like returning to school, doing volunteer work, getting and keeping a job, or pursuing social and recreational interests like horseback riding, bowling, hiking, or the arts (Davidson, 2003). As a young man from Sweden described: "At the bowling alley it doesn't matter if you're mentally ill, if you're a foreigner, an asthmatic, a dyslexic. . . . In a bowling match everyone's a bowler. It's the number of strikes that counts, nothing else" (Davidson et al., 2005). Such activities constitute both the stuff of recovery (i.e., of what else would recovery consist than just such ordinary experiences of ordinary activities?) and a foundation for the work of recovery, as described below.

"... and then I have the control, the self-esteem, the confidence, and it's manageable."

In addition to establishing a life for oneself in the community outside of the limitations of one's illness, the other major task of the work of recovery appears to involve finding ways to manage, compensate for, and otherwise minimize the disruptive intrusions of the illness into one's daily life. This challenge appears to be considerably complicated by the fact that people who are more significantly disabled describe having less in the way of internal resources to use in managing the illness when they also are the ones who have the most to manage. In other words, the more intrusive

and disruptive the illness, the more it robs the person of the very capacities he or she needs to deal with the illness constructively. What appears to be entailed in this component of the work of recovery, at least early on in the process, is first re-establishing those very capacities the person will need to be able to use in fighting against the illness. A central route to escaping this *Catch-22* situation of needing to free oneself from the clutches of the illness in order to develop the capacities needed to free oneself from the clutches of the illness is for the person to reconstruct an effective sense of social agency in the midst of persistent symptoms and dysfunction (Davidson, 1997, 2002; Davidson & Strauss, 1992).

Simply stated, having an effective sense of social agency means being able to view oneself as a person capable of choosing, initiating, doing, and accomplishing things in the world one inhabits along with other people. The degree to which this can pose a fundamental challenge to people with serious mental illness has been suggested, and later confirmed, by a number of our studies. In our initial efforts to prevent relapse and readmission among recidivist patients, for example, we discovered that it was premature to attempt to teach people how to better manage their illnesses when they were convinced that they had no ability to impact on their lives in general, not to mention on their illnesses more specifically. Recognizing early warning signs of relapse and taking proactive steps to avert re-hospitalization were seen as overwhelmingly daunting tasks to people who felt that they had no control over or in their lives as a whole. As one woman responded when asked what she could do to improve her situation, all she could do was "just take my medicine and pray" (Davidson et al., 1997). It is within the context of this sense of a basic lack of agency that such seemingly trivial actions like turning on and off one's own radio or making drawings can be seen as providing important and tangible evidence of a person's potential to do and to get better (Davidson & Strauss, 1992).

What is entailed in reconstructing such an effective sense of social agency? According to the participants in our studies, this process

involves several inter-related elements including, but not limited to, the following: a reawakening of a sense of hope that one's life can improve and that one can take a more active role in it; identifying those areas of competence and health that have survived the illness relatively intact and/or discovering previously untapped areas of interest and strength which thereby offer opportunities for developing new competencies; establishing goals in order to accomplish and increase the level of confidence in one's ability to exercise areas of competence and health in achieving these goals; putting aspects of discovered or rediscovered areas of health and competence into action in pursuit of these goals, and finding that it is possible to do so with at least some degree of success; deriving pleasure and satisfaction from these actions and their consequences; and, finally, incorporating these experiences of pleasure and success, and what they convey about one's abilities and efficacy, back into an expanded sense of self.

The attentive reader will recognize much of this process in the previous paragraphs describing the various forms of pleasure experienced by people with serious mental illness. For example, reconstructing an effective sense of social agency appears invariably to involve a reawakening of hope that one's life can improve. We know from our first theme above that hope may be reawakened in people with serious mental illness through experiences that offer glimpses into the nicer things life still has to offer and through experiences of enjoyment or pleasure that offer respite from the illness and its effects while offering people tangible evidence that "life isn't [just] one big horror." Similarly, while reconstructing one's sense of agency may require identifying or discovering areas of competence and health that have survived the illness, these areas of health and competence are likely to be found through pursuing individual areas of interest (e.g., nature, animals, art) and through making meaningful contributions to the lives of others (i.e., by giving back). The elements of deriving pleasure and satisfaction from one's own successes in activating parts of the self and in being able to

expand one's sense of self based on these successes speak directly to the issue of mastery as described above. In short, reconstructing an effective sense of social agency appears to require, and to build on, all of those other experiences of play, pleasure, and positive life events described earlier.

Many of these elements may not themselves be specific to serious mental illness. Hope, mastery, a sense of meaning and purpose, and being able to contribute to the lives of others likely play similar positive roles in the lives of people with other chronic conditions or for others who are surviving prolonged traumatic or stressful events (e.g., prisoners of war). Perhaps the last two themes, which build on and require these other elements, may be specific to the nature of serious mental illness and its effects and side effects. Although there are a variety of serious illnesses that are tragic and impose considerable burdens of suffering and disability, few prolonged illnesses or life conditions pose fundamental challenges to a person's basic sense of being a human being of value who has worthwhile things to contribute. Psychosis, on the other hand, has a history of leaving people feeling like something other or less than a person, varying over time to include such common alternatives as phantoms or demons, machines, robots, other undefined objects (Davidson, 1993, 1997, 2002; Deleuze & Guattari, 1982), or simply a "nobody nowhere" (Weingarten, 1994) or a "nothing" (Davidson, Haglund, et al., 2001, p. 288).

If, as existing research suggests, patients coping with chronic physical illnesses and other stressful life events require the feeling that they have some control and that they can effect changes in their lives (i.e., having an internal locus of control and sense of personal efficacy; e.g., Burish & Bradley, 1983; Dohrenwend & Dohrenwend, 1981; Forsyth, Delaney, & Gresham, 1984; Lazarus & Folkman, 1984; Rodin, 1989; Smith & Baum, 2003; Taylor, Kemeny, Bower, Gruenewald, & Reed, 2000), then we can understand how establishing a sense of one's own agency and efficacy can constitute a necessary first step for many people in learning how to cope with,

compensate for, and manage their psychiatric disability. It is this step, which we do not anticipate finding at the same basic level or in the same way in the experiences of people with other conditions, that we view as being both unique to serious mental illness and as requiring, specifically, the contributions made by play, pleasure, and other positive life events to prepare the person to take a more active role in his or her own recovery.

DISCUSSION

One will ask me why on earth I've been relating all these small things which are generally considered matters of complete indifference . . . [I] answer: these small things—nutrition, place, climate, recreation . . . are inconceivably more important than everything one has taken to be important so far. Precisely here one must begin to *relearn*.

—Friedrich Nietzsche,
Ecce Homo, 1967, p. 256

To date, Nietzsche's comment about the importance of focusing on "small things which are generally considered matters of complete indifference" has been equally relevant to the role of nonspecific factors in psychotherapy and to the role of play, pleasure, and other positive life events in recovery from serious mental illness. In both cases, we have identified a group of factors that we have reason to believe make significant contributions to the effectiveness of our interventions and to our clients' chances for achieving recovery from their mental illness. In both cases, these factors have yet to become focal points of empirical research or theory, at least partly due to perceptions that they are hard to conceptualize and/or measure. For play, pleasure, and other positive life events not to succumb to the same fate as nonspecific factors, we will need to heed Nietzsche's advice and develop credible and replicable (i.e., rigorous and scientific) strategies for learning about the range and nature of the important ways in which such events enhance people's efforts to cope with,

manage, compensate for, and overcome their disabilities in reclaiming their lives in the community.

For example, current clinical approaches to the treatment and rehabilitation of people with serious mental illnesses typically accentuate medication administration and adherence, maintaining activities of daily living (e.g., nutrition, hygiene, laundry), and attending or participating in other treatment and rehabilitation programs (e.g., social clubs, day programs, vocational training). The person's own role in this process remains ambiguous or unclear for many people, and the implicit expectations that they derive from health care providers are often those of passivity and compliance with the wishes or instructions of others (e.g., both loved ones and well-meaning professionals). For our part, mental health professionals are trained primarily to reduce or contain symptoms, ameliorate suffering, and, perhaps, attempt to remediate dysfunction in our clients. When combined, these two approaches paint a picture in which providers are active in identifying and addressing the intrusions and impacts of the illness while the person takes his or her medication as prescribed, follows the directives of others, and passively awaits improvement in his or her condition (with the possible exception of praying). Such a picture unfortunately leaves little room for a focus on facilitating the person's own efforts to establish, exercise, and eventually deploy an effective sense of social agency in doing battle with the illness.

As we noted in our introduction, community mental health has begun to move more in the direction of encouraging people to set and pursue their own goals, cultivate their own interests, and identify and build on their own strengths as part of the emerging recovery paradigm. The descriptions above begin to shed some light on the ways in which these activities and pursuits may play useful, if not crucial, roles in the recovery process. What remains to be developed are the opportunities and supports needed to enable people with mental illness to experience play, pleasure, and joy in these and other ways. Unlike pre-

scribing antibiotics for an infection, providers face new and intriguing challenges in facilitating a person's development of his or her own sense of agency and efficacy. Based on the preliminary findings presented in this article, we suggest a few guiding principles for these efforts.

First and foremost, we suggest viewing people with psychiatric disabilities—even if at first only in terms of their potential—as active agents directing their own lives (Davidson & Shahar, in press). Second, we suggest shifting the conceptualization of health from one of being the natural result of nothing going wrong to being the fortunate coincidence of a lot of things going right (Davidson & Strauss, 1995). An implication of this shift is that recovery will be unlikely to occur while a person waits passively for treatment (with the exception of medications) to take effect. Rather, as

it involves the restoration of community living, recovery is more likely to occur in and through the person's own activity and efforts. Finally, consistent with our focus on those things “which are generally considered matters of complete indifference,” we suggest that neither the person's efforts nor our own as professionals should be limited to reducing symptoms and dysfunction. Just as life cannot be lived by minimizing dysfunction alone, we suggest that recovery is not achieved solely through minimizing illness (Davidson et al., 2005). On this basis, we can set about relearning what it is that people with serious mental illness can do for themselves both to minimize the destructive impact of the illness and to reclaim the lives they led prior to the illness or, more likely, the lives they aspire to lead in its wake.

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