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Adding mental health to the treatment of mental illness : a qualitative content analysis of the construction of recovery in psychiatric journals, 1990-2016

Amy Ann Armstrong

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ABSTRACT

ADDING MENTAL HEALTH TO THE TREATMENT OF MENTAL ILLNESS: A QUALITATIVE CONTENT ANALYSIS OF THE CONSTRUCTION OF RECOVERY IN PSYCHIATRIC JOURNALS, 1990-2016

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During the past two and a half decades, recovery has come to dominate mental health policy and the discourse surrounding mental illness. In this thesis, I analyze how recovery from severe mental illness has been constructed within psychiatric journals between 1990 and 2016. I use data-driven qualitative content analysis to describe the discussion of recovery in articles published in the psychiatric journals *Psychiatric Services*, *Psychiatric Rehabilitation Journal*, the *American Journal of Psychiatry* and *JAMA Psychiatry* since 1990. This discussion centers on four main themes: the meaning of recovery, treatment methods used to promote recovery, the role of service providers in recovery, and recovery-orientated mental health systems.

I then argue that the introduction of recovery into mental health care represents the addition of the promotion of mental health, defined as subjective well-being, into the treatment of mental illness. The meaning and components of recovery reflect how a person with mental illness can have a life filled with the positive elements of mental health while still having a mental illness, and the discussion of services that have been adapted or created to best help achieve recovery, the roles both professional and peer service providers have in promoting recovery, and the discussion of changes to the mental health system to become recovery

orientated all represent the ways in which mental health care from the level of policy and service design to the day-to-day interactions between service providers and consumers serve to achieve mental health goals along with treating mental disorders.

NORTHERN ILLINOIS UNIVERSITY
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ADDING MENTAL HEALTH TO THE TREATMENT OF MENTAL ILLNESS: A
QUALITATIVE CONTENT ANALYSIS OF THE CONSTRUCTION
OF RECOVERY IN PSYCHIATRIC
JOURNALS, 1990-2016

BY

AMY ANN ARMSTRONG
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A THESIS SUBMITTED TO THE GRADUATE SCHOOL
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Thesis Director:
Fred Markowitz

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DEDICATION

For McKenna Kaidence Marie Elkins

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CHAPTER 1: INTRODUCTION

Recovery as a hope for persons diagnosed with severe mental illness and as a stated goal within policy emerged from the results of longitudinal studies that contradicted the long-held view within psychiatry that persons diagnosed with severe mental illness, specifically schizophrenia, not only could not improve in symptoms and well-being, let alone recover, but would face a lifetime plagued by symptoms, disability and declining functioning, therein establishing an evidence base for the concept and the advocacy and work of persons with lived experience of severe mental illness who refused to accept the outcomes predicted for them and instead learned that the symptoms and disabilities of mental illness need not necessarily prevent them from achieving their goals and attaining psychological well-being (Calabrese and Corrigan 2005; Corrigan and Ralph 2005). In this sense, recovery was founded on the principle of returning hope to a marginalized population, long considered hopeless by mental health professionals and society at large.

Within the past decade or so, trends in mental health treatment (at least at the policy level) have reflected a move toward “recovery-orientated” services. The 1999 Surgeon General’s report on mental health presents recovery as a potential for persons with severe mental illness and a goal within organized treatment services (Department of Health and Human Services 1999). A few years later, the New Freedom Commission on Mental Health recommended a transformation of mental health care in the United States to “ensure that mental health services and supports actively facilitate recovery, and build resilience to face life’s challenges,” stating as

a problem that, “too often, today’s system simply manages symptoms and accepts long-term disability” (Department of Health and Human Services 2003).

In 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) created a working definition of recovery that includes ten guiding principles: “recovery emerges from hope, recovery is person-driven, recovery occurs via many pathways, recovery is holistic, recovery is supported by peers and allies, recovery is supported through relationship and social networks, recovery is culturally-based and influenced, recovery is supported by addressing trauma, recovery involves individual, family, and community strengths and responsibility and recovery is based on respect” (SAMHSA 2012).

SAMHSA’s current website has a section devoted to Recovery and Recovery Support on which it further explains that recovery is comprised of “health—overcoming or managing one’s disease(s) or symptoms—Home—having a stable and safe place to live, purpose—conducting meaningful daily activities and the independence, income, and resources to participate in society and community—having relationships and social networks that provide support, friendship, love, and hope” (SAMHSA 2016). Recovery support has the stated goal of “partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence); increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen community” (SAMHSA 2016).

While the recovery paradigm, and the government and non-government organizations that support it, certainly has its dissenters, it stands as an organizing feature within policy and personal goal setting and is thus important to understanding the current state of mental illness at all levels. The sociology of mental health has long contributed to the understanding of how social processes and social structure influence mental conditions and perhaps to a lesser degree to the understanding of the social and personal consequences of mental illness. Building on these contributions, a sociology of recovery, while still fairly new, can similarly further the conversation about recovery on the level of policy and research and its implications for individuals and society. This study contributes to the sociology of recovery by performing qualitative content analysis of psychiatric journals. I explain recovery as the addition of the promotion of the positive symptoms of mental health to the treatment of the symptoms of mental disorders. The content analysis of psychiatric journals performed in this study discovered that the psychiatric discourse represents recovery through defining what is meant by and what components make up recovery, by describing and evaluating recovery-orientated mental health services and the role of service providers in recovery-orientated care, and the systematic transformation toward putting recovery into practice. I explain psychiatry's construction of recovery by arguing that recovery shifts the focus of mental health care from a singular goal of treating illness to a goal of also promoting mental health within people with mental illness.

CHAPTER 2: LITERATURE REVIEW

Around the same time that long-term, epidemiological studies demonstrated a less pessimistic outlook for severe mental illness, specifically schizophrenia, helped to establish an evidence base in psychiatry for recovery, sociologists of mental health shifted their attention away from serious mental illness in favor of studying psychological distress (Pescosolido, McLeod, and Avison 2007; Watson, McCranie and Wright 2014). Because of this preference for psychological distress and the social factors that produce it, the sociology of mental health has, with some exceptions, failed to give recovery more attention.

As used within the sociological literature, recovery denotes how persons diagnosed with severe mental illness manage symptoms that interfere with their functioning and cause subjective distress, regain a positive sense of self and lead a productive and personally fulfilling life (Corrigan and Ralph 2005; Markowitz 2001; Markowitz, Angell, and Greenberg 2011). While not considering recovery an endpoint in a person's experience with mental illness, much research in the sociology of mental health relies upon "core outcomes," which a person may achieve to a greater or lesser degree at any given point, including "symptoms of the illness, self-concept (e.g. esteem, efficacy and identity) and socioeconomic well-being (e.g. employment, housing and relationships)" (Markowitz 2001; Markowitz et al. 2011). In addition to the research more directly addressing recovery, I include an overview of research on stigma and labeling as they relate to outcomes since many of the concepts overlap.

The continued study of stigma and labeling contributes much to the understanding of the effect that social phenomena have on the course and outcome of mental illness—similar to recovery, although not necessarily referred to as recovery. The research on stigma and labeling looks at the consequences and positive effects of official diagnosis and treatment for a mental illness, defining outcome originally as stabilization of mental illness into a chronic state, but more recently as variables like social connections and self-concept.

Stigma, as Goffman (1963:3) defined it, reduces a person's identity "from a whole and usual person to a tainted discounted one." Stigma lies in the relationship between an attribute, such as a diagnosed and treated mental illness, and the stereotype attached to that attribute, dangerousness, incompetence, untrustworthiness and uncleanliness in the case of mental illness (Goffman 1963; Link and Phelan 2014). Expanding upon Goffman's definition, Link and Phelan (2001, 2014) conceptualize the process of stigma as entailing the "selection of salient characteristics and the creation of labels for them" (as the DSM does when demarking the boundaries of psychiatric disorders), the linkage of "the labeled differences to negative stereotypes," the connotation of a separation of "us" and "them" (such as saying "a person who develops schizophrenia 'is' a 'schizophrenic'—a different sort of person than the rest of 'us'"), the emotional response "from the vantage point of the person who is stigmatized, emotions [such as] embarrassment, shame, fear, alienation or anger" and a negative feedback loop where "a persistent pattern of unequal social relationships" result in "social structures of disadvantage" that "reinvigorate the labels, stereotypes, setting apart and emotional reactions that disadvantage stigmatized groups" (Link and Phelan 2014:79-80).

Also, and unique to, Link and Phelan's (2014:80) definition, stigma is "dependent on social, cultural, economic and political power." For instance, a psychiatrist possesses the power to confer upon the individual a label that has discriminatory consequences for the labeled person and that can alter a person's self-concept in such a way that triggers the process through which internalized stereotypes lead to an altered sense of self, which can contribute to poor outcomes. The media has the power to use language that shapes damaging cultural concepts of mental illness, and legislators have power in that they set policy agendas that define the acceptable level of coercion, a concept tied to felt stigma and thus outcomes (Link and Phelan 2014). In this way, differences in access to material resources, partially determined by interpersonal and institutionalized discrimination and the ability to shape cultural concepts of what it means to have a mental illness and what that illness means for the person's life chances, become relevant to a sociology of recovery. One way in which psychiatrists exercise this "stigma power" is through the discourse that occurs within psychiatric journals. Within these journals researchers establish the culture of psychiatry that subsequently is imparted to mental health consumers within the provider-consumer relationship where labeling and treatment occur. For this reason, understanding the discourse within the more influential psychiatric journals contributes to the understanding of stigma more generally and the recovery outcomes it affects.

Scheff's labeling theory views societal reaction as the most significant reason for the stabilization of mental illness, or the failure to recover (Scheff 1966:54). He argues that when residual deviance comes to the attention of the public, it activates the stereotype of the mentally ill, inevitably leading to the hospitalization, diagnosis and treatment of the individual (Scheff 1966). From that point forward, the individual will always be considered mentally ill and treated

as such, preventing her from ever escaping the role. This claim brought criticism to Scheff but also inspired much research about the effects of labeling for a person's future opportunities.

Gove (1970) examined the empirical evidence to determine whether societal reaction could explain the perpetuation of mental illness and concluded the evidence does not support Scheff's formulation. As relevant to outcome, Gove found that a serious disturbance that has become unbearable precedes hospitalization, and hospitals, far from accepting everyone as Scheff claimed, screened out many potential patients, which provided evidence against the victimization labeling theory implies. The individual diagnosed with a mental illness has an illness, beyond society's reaction, which they must address in order to recover. In addition, Gove (1970), citing Sampson et al.'s 1961 study of the effect psychiatric hospitalization had on marriage, suggests that hospitalization can actually lead to restitutive processes such as the prevention of further and perhaps unresolvable damage and allow for the separation of the patient's deviant behavior from her real self. Gove (1970) also cites as evidence a study of women treated in a hospital that found that for the majority of people, treatment did not negatively affect their functioning in the community. From that, he concluded that in the long term, stigma does not present a serious issue for past patients. If this conception were to hold true, stigma would be unrelated to the on-going process of recovery, especially once the initial symptoms were addressed. Further research revealed this to be too simplistic and naïve a conclusion.

Despite the validity of the criticism of labeling theory's assertion that the chronic course of mental illness is a result of labeling, more recent research, such as that on modified labeling

theory, has shown that labeling and stigma, mediated by the diagnosed individual's awareness of society's perceptions of mental illness (anticipated stigma), do create social consequences in a variety of aspects of the person's life. Modified labeling theory provides a mechanism through which public conceptions, and thus stigma, cause consequences for an individual (Link and Phelan 2014:90). The theory, although building off the original labeling theory (discussed above), focused not on how the label itself caused and perpetuated mental illness but on how the label and its associated stigma diminished one's life circumstances, potentially damaging employment, social networks and self-esteem, which in turn can lead to a more negative outcome (Link and Phelan 2014:90).

Like Scheff's labeling theory, modified labeling theory (Link et al. 1989) begins with the assumption that everyone, drawing on the representation of mental patients in the media or in jokes, internalizes the meaning attached to the status of mental patient. Society's attitudes toward persons diagnosed with a mental illness, Link et al. (1989) argue, operate as part of the generalized other (Mead 1934). Once learned, the meaning of the mental illness—specifically how much a person expects “most people” will devalue and discriminate against a person with a mental illness—becomes relevant only to those people officially labeled when seeking treatment (Link et al. 1989). The authors hypothesize that individuals labeled with the stigmatizing status will respond in one of three ways: “secrecy, patients may choose to conceal their treatment history from employers, relatives or potential lovers to avoid rejection”; “withdrawal, or limiting social interaction to those who know about and tend to accept one's stigmatized condition”; or “educating others in hopes of enlightening them so as to ward off negative attitudes” (Link et al. 1989:403).

When Link et al. (1989) tested their modified labeling theory, they found that both current and former patients and non-patients feel that “most people” will reject persons labeled as mentally ill, that persons diagnosed with a mental illness do use the proposed strategies for coping with stigma and current patients have significantly less extensive social networks, including reduced contact with people outside their immediate family. Restricted social networks can have harmful consequences, inhibiting recovery, both in that they curtail access to jobs, housing and other resources that promote recovery and also in that they limit the available social support. Ultimately, the effect of stigma in modified labeling theory is to leave the individual vulnerable to further episodes of illness—in that way, interfering with a person’s potential for recovery (Link et al. 1989).

Rosenfield (1997) argues that labeling both hurts and helps the subjective quality of life of an individual diagnosed with a mental illness: greater perceived stigma is negatively related to general life satisfaction, and use of services, at least the range of services—including vocational rehabilitation, fulfillment of basic needs and socialization, along with psychiatric treatment—provided in the study, which follows an empowerment approach that promotes independence, decision-making and personal responsibility, positively affects overall quality of life and life satisfaction. Controlling for stigma, service use improves quality of life, and controlling for service use, stigma harms quality of life. In integrating labeling theory and the psychiatric perspective on diagnosis and treatment, Rosenfield (2007:670) suggests that the most positive outcomes for patients require both the reduction of stigma in the community and the provision of quality services.

In a study of men with a dual diagnosis of substance abuse and a mental disorder, Link et al. (1997) found that the damaging effects of stigma—particularly perceived devaluation and discrimination and reports of discrimination—continued even after treatment reduced symptoms. Stigma and rejection had a larger effect on depressive symptoms during the one-year followup, than did baseline symptoms. Furthermore, Link, Castile, and Stuber (2008) find that addressing symptoms through treatment, even coerced, in that it reduces distressing, damaging symptoms, leads to better functioning and quality of life; however, despite the benefits of treatment, it brings felt stigma, which negatively affects self-esteem and quality of life. The research that weighs the costs and benefits of labeling in order to receive treatment refers to this phenomenon as a “package deal”—in which “people face real choices and real dilemmas as they navigate its parameters” (Link and Phelan 2014:95).

Markowitz (1998, 2001, 2005) has created perhaps the only sociological models specific to the process of recovery by integrating the various theories and models that predict outcomes in severe mental illness, including stigma and self-concept, psychiatric and social stress-social support models, and modified labeling theory and reflected appraisals, and considering the direction of the association between these variables. A psychiatric model predicts that the severity of symptoms causes a reduction in life satisfaction and creates problems within personal relationships and social interactions, whereas a “social stress-social support perspective suggests that a person’s economic and interpersonal well-being may affect the severity of their illness” (Markowitz 2001:65). Models of stigma and global self-evaluation and efficacy show a negative association (Markowitz 1998). In addition, the consideration of reflected appraisals contributes an understanding of what a mental health consumer thinks others, whether family or friends,

mental health professionals or society in general, think and how these appraisals in turn affect the person's outcomes. The appraisals of mental health professionals—particularly psychiatrists—about the future prospects of persons who present with severe mental illness are shaped in part by their exposure to psychiatric discourse. Thus, looking at what psychiatry's discourse says about outcomes in severe mental illness adds to the understanding of the processes that affect recovery.

In testing his sociological model of recovery, Markowitz (2001, 2005) finds that “consistent with the stress-process and social causation perspectives [a low social position causes symptoms of mental illness]...as life satisfaction increases, symptoms decrease, suggesting that improvements in social relationships and economic circumstances may help improve mental conditions” (2005:93). On the other hand, “in line with a social selection perspective [the presence of mental illness and its debilitating symptoms cause downward movement in social position], the findings also showed that the reverse relationship is happening—that severity of symptoms has an adverse impact on subjective interpersonal and economic well-being” (Markowitz 2005:93). In addition, this study also helped to “confirm that self-concept, as both a social product and social force, is an important part of the recovery process” and showed that “self-esteem has a positive effect on life satisfaction and a negative effect on symptoms,” suggesting “to the extent people think highly of themselves and believe that they can affect what happens to them, people may be more motivated to engage in behaviors that help improve their interpersonal, economic and psychological well-being” (Markowitz 2005:93).

Markowitz et al. (2011) present a model of how stigma affects self-concept through the appraisals of others, self-appraisals and reflected appraisals and thus affects

the recovery outcomes of symptoms, self-efficacy and quality of life. The study finds a link between initial level of symptoms, self-efficacy and quality of life and the appraisal of a mother about her adult child diagnosed with schizophrenia (consistent with the psychiatric model) and that these maternal appraisals affect what adult children with mental illness think their mothers think of them (Markowitz et al. 2011:159). Reflected appraisals then (albeit not strongly) affect self-concept, and self-concept affects the recovery outcomes (Markowitz et al. 2011:159-60). The authors conclude that “recovery is, at least to some extent, a process that is influenced by the expectations and feedback provided by significant others in the lives of persons with mental illness...the presence of positive identity-related feedback may reduce symptoms while negative feedback may facilitate sustained symptoms” and that “stigmatized self-concepts may reduce sense of control, empowerment in treatment programs and motivation to seek jobs and make friends, and thus contribute to diminished quality of life” (Markowitz et al. 2011:160).

Sociological models of recovery, beyond further elucidating how the process of recovery and the course of mental illness works, call attention to the importance of “recovery-orientated” mental health programs that manage symptoms but also include training in social and vocational skills” (Markowitz 2001, 2005).

Beyond modeling the causal processes that affect outcome and recovery, sociologists have contributed to the research on recovery in other ways, mainly contextualizing the concept within the wider literature and mental health treatment policy and treatment programs (Watson et al. 2014). McCranie (2011:472) argues that recovery should be seen as a “concept and a movement in modern mental health services” and that while recovery could reflect yet another shift from pessimism to optimism in the historical view of mental illness, its breakthrough and

continued presence in organized mental health care makes it an important, albeit contested, concept to study. Within clinical psychiatric discourse, the loose conceptions of recovery as “hope” or a “personal journey” have caused frustration for researchers seeking to operationalize the term and who want an “‘objectively measurable’ functional criteria focused on symptom reduction and remission” (McCranie 2011:477). In addition, the concept of recovery may have penetrated the psychiatric rehabilitation journals, but the rest of the psychiatric community has remained silent—as evident by the fact that a working group of psychiatrists and neuroscientists while discussing criteria for remission in schizophrenia specifically ignored the concept of recovery and that clinical psychiatric journals have remained silent about it (McCranie 2011).

Also discussing the contestation of the meaning of recovery, Pilgrim (2008) calls recovery a “polyvalent concept” whose different usages reflect the interests of different groups—biomedical psychiatrists, for whom recovery would mean “recovery from illness, i.e. an outcome of successful treatment” (mainly medical); social psychiatrists, for whom recovery means “recovery from impairment, i.e. an outcome of successful rehabilitation,” which entails improving social functioning and keeping the person out of the hospital; and dissenting service users—who consider recovery to be from “invalidation” and have as an outcome “successful survival” from “the social invalidation of rejection and stigma” and “the invalidation of professional action (objectifying diagnoses, detention without trial and iatrogenic treatments)” (Pilgrim 2008:297-8).

Yanos, Knight and Roe (2007) analyze the process of recovery using the concepts of structure and agency. Their framework, which uses Fine’s (1992) work as a “springboard,” “considers important ‘obdurate’ factors such as laws and codified social processes that constrain

the lives of people with severe mental illness, ritualized forms of stigma and discrimination, as well as the ways in which internalized identity processes come to impact the lives of persons [with severe mental illness]” and how “people with severe mental illness work within constraints to make choices of action that can help them work toward recovery and gain greater control over their lives” (Yanos et al. 2007:410).

Among the obdurate structural constraints, Yanos et al. (2007) include the physical barriers of hospitalization or imprisonment, legal restrictions on civil rights, the institutionalized poverty created by enrollment in Social Security Insurance or Social Security Disability Insurance, residence in custodial housing that leaves persons with only a small “personal needs allowance” that prevents participation in beneficial activities that require money and a lack of independent housing in safe, non-impooverished neighborhoods (Yanos et al. 2007:412-6). In response to these structural constraints, some individuals may “work the system,” viewing disability as a “safety net” and work as “a means to an end of having more income, and as an opportunity for engaging in productive activity that may have its own positive effects,” or some may advocate for themselves and demand the system provides them with the services or choose homelessness over the problems of custodial living, which could actually provide them access to independent housing faster through funds set aside for the formerly homeless (Yanos et al. 2007:417). In addition, the expression of collective agency as in the consumer movement has pushed for systematic change, especially funding for consumer-run programs (Yanos et al. 2007).

Yanos et al. (2007), citing Lawn, Pols and Barber (2002) and Shaw (1991), also discuss other factors that affect recovery such as the unhealthy practices of smoking or inactivity among

persons with mental illness to “[cope] with profound boredom, lack of control and need for meaning in life,” which can cause physical disabilities that impede recovery, “routine practices” in the media that heighten stigma in the general public or among employers to discriminate against applicants with mental illness and “the ritualized practices of mental health professionals...such as ‘ritual conformity’ to biomedical concepts such as ‘compliance’ and the need for social control, in both their behavior and espoused ideologies” (420-1). In response to these practices, individuals may practice “proactive coping” as a way of avoiding problems and symptoms from emerging, and collectively, consumers may “speak out” against the perceived dehumanization and stigmatization by mental health professionals (Yanos et al. 2007:422-3).

The authors also discuss “role engulfment” in which individuals with mental illness lose past roles and come to view themselves as patients, which “may lead to a greater acceptance of the mental illness label but may restrict one’s ability to improve social functioning” and demoralization from failing to achieve expected social roles, which can further hurt self-concept (Yanos et al. 2007). Since a strong sense of self contributes to recovery, individuals may resist these structural constraints by shifting their identity from patient to other more positive ones in order to achieve better outcomes (Yanos et al. 2007).

Watson (2012) draws on Yano et al.’s (2007) conceptualization of the influence of social structure and individual agency to examine the impact of two models for addressing chronic homelessness among persons with mental illness and substance abuse—continuum of care, which hinges housing on continued engagement with treatment and abstinence from drugs and alcohol, putting residents under the constant risk of losing their source of shelter should they disobey in any way, and Housing First, which places no such restrictions on individuals. The

Housing First model is associated with numerous “factors related to recovery including ontological security...the sense of continuity a person has regarding their own life events, which is dependent on access to stable environments in which to develop a strong self-identity” (Watson 2012:5). The traditionally preferred model of continuum of care leads to constrained individual agency, alienating consumer-staff relationships and leaving consumers with lasting negative adaptations—all of which reduce the person’s ability to achieve recovery (Watson 2012).

In discussing potential research within the sociology of recovery, Watson et al. (2014:135) write “Sociologists also should examine more closely the social and historical origins and evolution of the concept of recovery itself.” These authors, and others, have looked at, and stressed the need to further clarify, recovery as a social construct and how recovery has emerged as an undeniably important, yet frequently debated topic. For this reason, and informing my current work, the authors continue “Work in this area will demand a thoughtful re-examination of the socio-historical construction of mental illness and a more careful consideration of the parallel emergence of the recovery construct as an equally contested, yet related paradigm (Watson et al. 2014:135).

To understand how a person with severe mental illness assigns meaning to and experiences recovery, how people encounter their friends’, family’s and the public’s conceptions of the course of their illness and their potential, their involvement in organized mental health care and their internalized conceptions of their lives as people with severe mental illness within these contexts, all factors that affect recovery, it necessitates understanding the construction of recovery within the psychiatric discourse. The knowledge constructed at this level forms the basis from which many of these processes act on the person, but little research

has looked specifically at it. In this study, I will analyze psychiatry's discourse as it exists within the prominent psychiatric journals, looking at how the course and outcomes of severe mental illness are constructed.

CHAPTER 3: METHODS

In this study, I use data-driven qualitative content analysis to analyze psychiatry's construction of recovery from severe mental illness, combined with grounded theory's coding method and theory reconstruction. My data are articles published between 1990 and 2016 in the psychiatric journals *Psychiatric Services*, *Psychiatric Rehabilitation Journal*, the *American Journal of Psychiatry* and *JAMA Psychiatry*, which represent the psychiatric discourse. These journals present psychiatric knowledge and demonstrate how psychiatric research connects to the practice of psychiatry and mental health care. Since organizations outside the field of psychiatric research have picked up the term "recovery" and integrated it into their values and policies, the way psychiatric journals present recovery establishes an underlying trend within mental health care.

In my analysis, I distinguish between clinical and psycho-social rehabilitation journals. The clinical journals focus more strictly on the medical model of mental illness, whereas psycho-social rehabilitation journals also discuss community-based mental health care. Therefore, I predict that the discussion of recovery will occur to a much greater extent within psycho-social rehabilitation journals.

Within the clinical group, I include the *Journal of the American Medical Association (JAMA) Psychiatry* and the *American Journal of Psychiatry* (previously the *Archives of General Psychiatry*).

JAMA Psychiatry, published by the American Medical Association, gives as its mission statement: “*JAMA Psychiatry* strives to publish original, state-of-the-art studies and commentaries of general interest to clinicians, scholars, and research scientists in psychiatry, mental health, behavioral science, and allied fields. The journal seeks to inform and to educate its readers as well as to stimulate debate and further exploration into the nature, causes, treatment, and public health importance of mental illness” (AMA 2016). Its 2015 impact factor is 13.234 (AMA 2016).

The *American Journal of Psychiatry*, the journal of the American Psychiatric Association (APA), says of itself: “*The American Journal of Psychiatry* is the most widely read psychiatric journal in the world...it is an indispensable journal for all psychiatrists and other mental health professionals who need to stay on the cutting edge of virtually every aspect of psychiatry. No other psychiatric journal reaches more psychiatrists with greater impact or immediacy than *The American Journal of Psychiatry*, the journal that the overwhelming majority of psychiatrists consider essential,” and “the *American Journal of Psychiatry* is committed to keeping the field of psychiatry vibrant and relevant by publishing the latest advances in the diagnosis and treatment of mental illness. The findings presented in this journal explore the full spectrum of issues related to mental health diagnoses and treatment. Original articles include new developments in diagnosis, treatment, neuroscience, and patient populations” (APA 2015). Its website states 12.295 as its latest impact factor.

For rehabilitation journals, I include *Psychiatric Services* and the *Psychiatric Rehabilitation Journal*.

Psychiatric Services, also published by the American Psychiatric Association, states about itself: “The peer-reviewed journal features research reports on issues related to the delivery of mental health services, especially for people with serious mental illness in community-based treatment programs. Long known as an interdisciplinary journal, *Psychiatric Services* recognizes that provision of high-quality care involves collaboration among a variety of professionals, frequently working as a team. Authors of research reports published in the journal include psychiatrists, psychologists, pharmacists, nurses, social workers, drug and alcohol treatment counselors, economists, policy analysts, and professionals in related systems such as criminal justice and welfare systems. In the mental health field, the current focus on patient-centered, recovery-oriented care and on dissemination of evidence-based practices is transforming service delivery systems at all levels. Research published in *Psychiatric Services* contributes to this transformation” (APA 2015). Its impact factor is 2.335

The *Psychiatric Rehabilitation Journal*, published by the American Psychological Association, states as its purpose: “*Psychiatric Rehabilitation Journal* publishes original contributions related to the rehabilitation, psychosocial treatment, and recovery of people with serious mental illnesses. *Psychiatric Rehabilitation Journal's* target audience includes psychiatric rehabilitation practitioners and researchers, as well as recipients of mental health and rehabilitation services. *Psychiatric Rehabilitation Journal* encourages submissions regarding mechanisms of change in rehabilitation and psychosocial treatment programs, as well as evaluation studies of model programs, and investigations of effectiveness and cost-effectiveness of programs conducted in ‘real world’ settings. Descriptive studies of ‘cutting edge’ programs,

especially those informed by the lived experience of mental illness, are also welcome” (APA 2015). It’s impact factor is 1.169.

I selected the past 26 years (since 1990) as the time frame for my analysis. A search of articles published through the years since the journals’ beginnings suggests that recovery entered the psychiatric discourse around this time. The first match for recovery in the title in *Psychosocial Rehabilitation Journal* appeared in 1991, and the first mention in context in *Psychiatric Services* happened in 1986 (although, the term appeared in 1952 and 1969 in the more traditional, clinical meaning). These search results agree with past literature that argues recovery first appeared in the psychiatric literature around 1990.

Schreier (2012:1) defines qualitative content analysis as a “method for describing the meaning of qualitative data...by assigning successive parts of your material to the categories of your coding frame.” Through qualitative content analysis, I identified the articles relevant to the representation of recovery and the specific content within those articles and described the discussion of recovery through the coding frame shown in Table 1. The meaning of recovery, treatment methods that promote recovery, the role of service providers in recovery and recovery-orientated mental health systems serve as the main categories on which I base my analysis. The codes below the main categories serve to explain and exemplify those categories.

Since my qualitative content analysis was data-driven in that my codes emerged purely from the content of the articles, I used the grounded theory method of coding to create my coding frame. To find the relevant articles, I searched in the database or website that contained the articles published within each journal between 1990 and 2016. For all the journals, I chose to use

Table 1. Coding Frame

Meanings of Recovery:	Treatment Methods that Promote Recovery	Role of Service Providers	Recovery-Orientated Mental Health Systems
Contested Meaning Components of Recovery: Religion/ spirituality Identity Work Regaining sense of self Activism Symptom control Consumer rights Empowerment Social support Hope Life in the community Meaningful Activities: Pursuing goals Work Moving beyond illness Responsibility for Life: Taking part in treatment Social relationships	ACT IMR Medication WRAP Coercion: Insight First-episode psychosis	Professional Services: Relationship Not support Support goals Person-centered care Peer Services: Benefits Model recovery Example Meaning	Problems Implementation Training Diversity

article title as an indicator of relevance to recovery because the title best captures the content—the word “recovery” in the title indicates discussion of recovery in some form as a main focus.

I read through the titles and abstracts of articles that returned from the title search within the journals, and from that initial review of the data, I devised the main categories. I was then able to distinguish the relevant articles from the irrelevant ones based off whether the article fell into one of those categories.

The title search within the *Psychiatric Rehabilitation Journal* yielded 192 results. Of those articles, I found 128 to be relevant to my specified main categories. The title search within *Psychiatric Services* yield 189 results, 47 of which I found relevant. *JAMA Psychiatry* and the *American Journal of Psychiatry* returned 20 and 8 results respectively, and I included three of the articles from *JAMA Psychiatry* and one from the *American Journal of Psychiatry*.

The relevant articles then served as the data I used in my full analysis. In the subsequent coding of the data in its entirety, I coded the articles into the subcategories shown in Table 1 and later sorted those categories into their respective main category, according to the main category they best explained. These codes described the content of the data and sorted them into analytical categories, forming a coding frame that describes how psychiatric journals represent recovery. Tables 2-5 show the articles I cite in my analysis, broken down by the chapter in which they appear, the journal in which they were published, and the research method or topic in each article.

I then use grounded theory method again in creating an analysis that asks what these descriptive categories that emerged from the data mean. I use grounded theory’s method of

theory reconstruction to move my argument beyond describing the construction of recovery to demonstrating what this presentation signifies.

Table 2. Articles Cited in the Meaning of Recovery

Article	Research Method/ Topic of Article	Journal
Whitley and Drake 2010	Analysis of dimensions of recovery	Psychiatric Services
Jacobson and Curtis 2000	Description of implementation strategies	Psychiatric Rehabilitation Journal
Lieberman et al. 2008	Examines domains of and evidence for recovery	Psychiatric Services
Liberman and Kopelowicz 2005	Explores evidence for and definition of recovery	Psychiatric Services
Gordon 2013	Personal experience to define recovery	Psychiatric Services
Davidson et al. 2006	Explains and addresses concerns with recovery	Psychiatric Services
Cook et al. 2012	Single-blind, randomized control trial	Psychiatric Services
Mancini, Hardiman and Lawson 2005	In-depth, semi-structured interviews	Psychiatric Rehabilitation Journal
Onken et al. 2007	Ecological framework to analyze definitions of recovery	Psychiatric Rehabilitation Journal
Ochock, Nelson and Janzen 2005	Longitudinal, semi-structured interviews	Psychiatric Rehabilitation Journal
Walsh 1996	Personal experience	Psychiatric Rehabilitation Journal
Yarborough et al. 2016	Semi-structured interviews	Psychiatric Rehabilitation Journal
Smith 2000	Semi-structured interviews	Psychiatric Rehabilitation Journal
Crowe et al. 2006	Pre-post training repeated measure	Psychiatric Services
Le Boutillier et al. 2011	Thematic analysis	Psychiatric Services
Geller 2012	Personal knowledge/ research literature	Psychiatric Services

(Continued on the following page)

Table 2 (Continued)

Barber 2012	Discusses recovery in relation to medical model	Psychiatric Services
Slade 2012	How services can support recovery	Psychiatric Services
Windell, Norman and Malla 2012	Semi-structured interviews	Psychiatric Services
Cabassa, Nicasio and Whitley 2013	Interviews	Psychiatric Services
Young, Green and Estroff 2008	Longitudinal, in-depth, semi-structured interviews	Psychiatric Services
Dunn, Wewiorski and Rogers 2008	Semi-structured interviews	Psychiatric Rehabilitation Journal
Provencher et al. 2002	Semi-structured interviews	Psychiatric Rehabilitation Journal
Krupa 2004	Multiple case study	Psychiatric Rehabilitation Journal
Young and Ensing 1999	Semi-structured interviews, focus groups	Psychiatric Rehabilitation Journal
Salyers et al. 2011	Quantitative—retrospective cohort study	Psychiatric Services
Pettie and Triolo 1999	Case study	Psychiatric Rehabilitation Journal
Fekete 2004	Personal knowledge	Psychiatric Rehabilitation Journal
Korsbek 2013	Personal knowledge/ research literature	Psychiatric Rehabilitation Journal
Turnton et al. 2010	Three-round iterative Delphi exercise	Psychiatric Services
Chang et al. 2013	Quantitative—survey	Psychiatric Rehabilitation Journal
Federici 2013	Personal knowledge/ Research Literature	Psychiatric Rehabilitation Journal

(Continued on the following page)

Table 2 (Continued)

Bussema and Bussema 2007	Quantitative—survey	Psychiatric Rehabilitation Journal
Fallot 2007	Review of literature, discussion groups and consumer perspectives	Psychiatric Rehabilitation Journal
Bergstresser, Brown and Colesante 2013	Focus groups	Psychiatric Services
Onken et al. 2007	Ecological framework to analyze definitions of recovery	Psychiatric Rehabilitation Journal
Geller 2012	Personal knowledge/ research literature	Psychiatric Services
Davidson 2012	Letter to editor	Psychiatric Services
Munetz and Frese 2001	Proposal of making coercion recovery-orientated	Psychiatric Rehabilitation Journal
Ashcraft and Anthony 2008	Analysis of records	Psychiatric Services
Scheyett et al. 2007	Examines role of PADs in recovery	Psychiatric Rehabilitation Journal
Piat et al. 2015	Quantitative	Psychiatric Rehabilitation Journal
Polvere, Macnaughton and Piat 2013	Semi-structured interviews	Psychiatric Rehabilitation Journal
Carpenter-Song, Hipolito and Whitley 2012	Focus groups	Psychiatric Rehabilitation Journal
Whitley and Siantz 2012	Participant observation/ focus groups	Psychiatric Services
Mueser and Cook 2014	Editorial	Psychiatric Rehabilitation Journal

Table 3. Articles Cited in Treatment Methods Used to Promote Recovery

Article	Research Method/ Topic of Article	Journal
Cook et al. 2009	Quantitative—interview at base/ one month after intervention	Psychiatric Services
Cook et al. 2012	Single-blind, randomized control trial	Psychiatric Services
Cook et al. 2010	Pre-post comparison	Psychiatric Rehabilitation Journal
Federici 2013	Personal knowledge/ research literature	Psychiatric Rehabilitation Journal
Levitt et al. 2009	Randomized control trial	Psychiatric Services
Salyers et al. 2009	Experience implementing IMR	Psychiatric Services
Roe et al. 2009	Follow-up to randomized control trial	Psychiatric Rehabilitation Journal
Salyers et al. 2011	Quantitative—retrospective cohort study	Psychiatric Services
Marshall et al. 2007	Review of past studies	Psychiatric Services
Felton et al. 2006	Observation	Psychiatric Rehabilitation Journal
Diamond 2009	How psychiatrists can promote recovery	Psychiatric Services
Deegan and Drake 2006	Discussion of shared-decision making	Psychiatric Services
Peysers and Shadoan 2006	Letter to editor	Psychiatric Services
Smith 2000	Semi-structured interviews	Psychiatric Rehabilitation Journal
Fekete 2004	Personal knowledge	Psychiatric Rehabilitation Journal
Deegan 2007	Discussion of role of medication	Psychiatric Rehabilitation Journal

Table 4. Articles Cited in the Role of Service Providers in Recovery

Article	Research Method/ Topic of Article	Journal
Russinova et al. 2011	Survey	Psychiatric Rehabilitation Journal
Green et al. 2008	In-depth interviews	Psychiatric Rehabilitation Journal
Young, Green and Estroff 2008	Longitudinal, in-depth, Semi-structured interviews	Psychiatric Services
Whitley and Drake 2010	Analysis of dimensions of recovery	Psychiatric Services
Davidson et al. 2006	Explains and addresses concerns with recovery	Psychiatric Services
Deegan and Drake 2006	Discussion of shared-decision making	Psychiatric Services
Le Boutillier et al. 2011	Thematic analysis	Psychiatric Services
Smith 2000	Semi-structured Interviews	Psychiatric Rehabilitation Journal
Walsh 1996	Personal experience	Psychiatric Rehabilitation Journal
Diamond 2009	How psychiatrists can promote recovery	Psychiatric Services
Resnick and Rosenheck 2008	Quasi-experiment	Psychiatric Services
Vayshenker et al. 2016	Quantitative interview-based measures	Psychiatric Rehabilitation Journal
Van Gestel-Timmermans et al. 2012	Randomized control trial	Psychiatric Services
Lewis, Hopper and Healion 2012	Ethnography, interview, focus group	Psychiatric Services
Pettie and Triolo 1999	Case study	Psychiatric Rehabilitation Journal
Corrigan 2006	Quantitative—interview-based measures, empowerment scale	Psychiatric Services
Perry et al. 2013	Description of peer training program	Psychiatric Services
Fukui, Davidson and Rapp 2010	Description of peer-run Intervention	Psychiatric Services
van Gestel-Timmermans, Brouwers and van Nieuwenhuizen 2010	Description of peer-run course	Psychiatric Services

(Continued on next page)

Table 4 (continued)

Firmin et al. 2015	Quantitative	Psychiatric Rehabilitation Journal
Dalgin et al. 2011	Survey	Psychiatric Rehabilitation Journal
Chang et al. 2013	Survey	Psychiatric Rehabilitation Journal

Table 5: Articles Cited in Recovery-Orientated Mental Health Systems

Article	Research Method/ Topic of Article	Journal
Anthony 2000	Suggests recovery-orientated practices/ systems	Psychiatric Rehabilitation Journal
Becker et al. 1998	Experience implementing IPS	Psychiatric Rehabilitation Journal
Pascaris, Reed and Wolf 2008	Qualitative	Psychiatric Rehabilitation Journal
Davidson et al. 2007	Qualitative	Psychiatric Rehabilitation Journal
Jacobson and Curtis 2000	Qualitative	Psychiatric Rehabilitation Journal
Hunt and Resnick 2015	History/ future of term recovery	Psychiatric Services
Piat et al. 2016	Communities of practice	Psychiatric Services
del Vecchio 2015	Recovery to practice	Psychiatric Services
Crowe et al. 2006	Quantitative	Psychiatric Services
Feeney, Jordan and McCarron 2013	Mixed—quantitative, Focus groups	Psychiatric Rehabilitation Journal
Chen et al. 2014	Pre-test/ post-test	Psychiatric Rehabilitation Journal
Russinova et al. 2013	Quantitative	Psychiatric Rehabilitation Journal
Davidson and Chan 2014	Therapeutic alliance	Psychiatric Services

(Continued on next page)

Table 5 (continued)

Piat and Lal 2012	Focus groups	Psychiatric Rehabilitation Journal
Ida 2007	Culture competency/ diversity in recovery	Psychiatric Rehabilitation Journal
Das 2012	Qualitative interviews	Psychiatric Rehabilitation Journal
Jacobson and Farah 2012	Qualitative	Psychiatric Rehabilitation Journal

Charmaz (2014:247) writes that constructing theory through grounded theory involves “raising categories to concepts include[ing] subjecting them to further analytic refinement and involves showing their relationship to other concepts.” The categories in the articles that describe the meaning of recovery resemble the distinguishing aspects of mental health. The remaining categories show how the mental health system has adapted to recovery and how service providers can promote recovery and the forms of treatment they use to do so in this system. Their inclusion reveals the ways in which psychiatric practice seeks to promote what has been conceptualized as recovery and in that way, promote mental health for those people with severe mental illness. Drawing upon the constructive categories of recovery I devised from the conceptualization of recovery within psychiatric journals, I explain the representation of recovery in psychiatric journals as signifying that recovery adds the promotion of mental health to the treatment of mental illness.

Chapter four explores the discussion of the meaning and component elements of recovery. Chapter five talks about how mental health care adapted to reflect the values of recovery and programs created specifically to promote recovery. Chapter six addresses the role

of mental health service providers, and chapter seven describes the ways in which mental health organizations have implemented recovery-orientated care.

CHAPTER 4: THE MEANING OF RECOVERY

In this chapter, I focus on the meaning of the concept of recovery as constructed within these psychiatric journals. I begin by setting the meaning within the debate surrounding how recovery should be defined, what criteria make up recovery and who can be said to experience recovery. I then describe the common components of recovery.

The Contested Meaning of Recovery

Psychiatric activists and researchers employ the term “recovery” to refer to a range of personal and social processes and outcomes. The various stakeholders within the psychiatric discourse define recovery in a way that reflects their interests, goals and histories with the term. For instance, psychiatric consumer-survivors reference empowerment, hope and independence, often eschewing purely clinical definitions, rooted in the medical model of mental illness, that define recovery as the elimination or reduction of symptoms to a sub-clinical level and resumption of normal functioning (Whitley and Drake 2010). Advocates place less stress on the absence of symptoms, although most definitions of recovery include some method of symptom control, whether it be personal or professional, but they may use functioning in a broader sense of the term to acknowledge that recovery entails engagement in valued social activities, like work or school and the pursuit of personally chosen life goals and a life in the community (Whitley and Drake 2010). This definition of recovery also reflects the extension by advocates of community living from existence to full citizenship. Many recovered activists express this citizenship by advocating for the rights, and essentially the potential for recovery, of other people

with mental illness and speaking out against the stigma by telling their own stories of mental illness and recovery (Jacobson and Curtis 2000).

Lieberman et al. (2008:488) summarize the position from which advocates use the term “recovery”:

Advocates, on the other hand, often use recovery to describe a process of managing one's mental illness, moving beyond its devastating psychological effects, and pursuing a personally meaningful life in the community. This latter meaning involves hope, motivation, personal responsibility, the pursuit of individual goals, and participation in community life, but not necessarily the absence of symptoms. Recovery in this more complex sense implies certain types of outcomes and treatments but is also connected to civil rights, stigma, self-help, opportunities, and other community concepts that are much broader than usual definitions of illness and level of functions of the health care system.

Clinical definitions of recovery give more concise outcomes. Liberman and Kopelowicz (2005), drawing upon the prior research of (Lieberman et al. 2002) in a meta-analysis of studies on clinical criteria for recovery, describe a clinical definition of recovery (specific to schizophrenia) as consisting of positive and negative symptoms below the criteria for diagnosis, functioning independently in ways such as managing one’s own medication and finances, socializing at least once a week and participation at least half-time in school or work, sustained for a duration of at least two years.

Given that recovery as a potential and later a codified expectation emerged from different sources—longitudinal studies and narratives of consumer-survivors—it makes sense that differing meanings and goals would result (Gordon 2013). In the past decades, recovery has come to dominate mental health policy, regardless of the lack of clarity, sometimes veering into contradiction and despite the lack of a firm model for how a mental health system that promotes

recovery would look (Davidson et al. 2006). The lack of consensus in recovery leaves the mental health system and providers with an uncertainty about which aspects of mental health care they should stress most in order to help the consumer best reach their recovery goals, making recovery-orientated services difficult to define as well (Davidson et al. 2006). The published research attempts to clear up this uncertainty, to explain which aspects of recovery consumers value so that policy makers can potentially pursue services that address these needs and researchers can design instruments and studies to measure recovery and recovery-orientated programs to further test to establish them as evidence-based practices available to implement in the mental health system.

Researchers seek a more precise, operationalized meaning for recovery so they can test it for validity and subsequent professional use, and policy makers seek a recovery construct that can guide services and receive insurance reimbursement (Gordon 2013). This need resulted in the development of instruments through which to assess recovery and its relation to other factors and the effects of interventions. Research frequently uses the Recovery Assessment Scale (RAS), which measures self-perceived recovery and “conceptualizes recovery as a status with components of empowerment, quality of life, hope, meaning of life, and tolerable symptom levels” and has “in addition to a total score, subscales [that] measure personal confidence, willingness to ask for help, goal orientation, reliance on others, and not feeling dominated by symptoms” (Cook et al. 2012:543).

Attempts at reconciling seemingly opposing conceptions of recovery suggest that a person can either experience recovery as “recovery from” (no longer symptomatic) or “recovery in” (having a life despite symptoms) an outcome or a process (Davidson and Roe 2007, cited by

Gordon 2013), or recovery can be viewed as a process (based on the consumer-survivor tradition of recovery) or as an outcome (derived from longitudinal studies) (Gordon 2013). Gordon (2013:270-1) argues against an exclusive focus on process because it potentially dooms consumers to a continual process without actualizing any goals and perpetuates the notion of chronicity. She also argues that consumer advocates of recovery do imply an outcome as well as process, albeit outcome defined differently, and contends that “broader concepts of outcome, including all those domains considered by consumers to be relevant to their recovery, have the potential to unite process and outcome into a single construct within which symptoms play, appropriately, a minor part” (Gordon 2013:271). Alternatively, Liberman and Kopelowicz (2005) blame the confusion on a conflation of the ideas of recovering and recovery. This argument calls “recovery” the outcome of the process of “recovering.” The process of recovering contains stages, set along personalized pathways that prepare the consumer for recovery.

At the core of the issue exists the disagreement of whether claim to the term “recovery” should lie with the objective, measurable and testable outcomes such as reduced hospitalization and symptomatic remission and increasingly operationalized measures of social functioning, achieved through evidence-based practices like medications and certain psychosocial rehabilitation programs or with the consumer-survivors who speak from the lived experience of recovery, describing it as a process of reclaiming one’s self and life within the limits one’s condition presents (Mancini, Hardiman and Lawson 2005). This disagreement, in turn, affects what the mental health system and dominant discourse should support. Largely the literature reflects no consensus, but studies published within journals on psychiatric practices that aim to clarify and explain processes of recovery, and the studies of mental health services created

to foster these components, contain the more abstract and the measurable elements.

The Constructive Elements of Recovery

Regardless of the specific meaning of recovery, or lack thereof, the psychiatric discourse has come to an at least tacit agreement that recovery entails more than a reduction in symptoms. Analyses of personal narratives by people with severe mental illness who have achieved some level of recovery reveal the typical component elements of recovery. Perhaps in contradiction with the earlier discussion of disagreement on the meaning of recovery, consumer descriptions of recovery include symptomatic and affective aspects, end goals and on-going processes. Psychiatric journal articles construct the meaning of the concept of recovery through the description of various components of recovery. All of these components of recovery relate and contribute to one another but represent distinct elements that factor into a consumer's experience of recovery. The components of recovery reflect how a person with mental illness can have a life filled with the positive elements of mental health while still having a mental illness.

Hope

Mental illness can devastate all sense of hope for the future, personal identity, valued goals and relationships with family and friends and can take from consumers all their markers of self and accomplishment. Hope begins the process of regaining what their illness took from them. Consumers can have hope for themselves and their futures, hope for improvement in their life circumstances or hope for a decrease in symptoms, but the process of rebuilding their lives and overcoming the difficult challenges of living with mental illness must include hope.

Hope inspires people with psychiatric disabilities to take the necessary steps and commit to improving their lives (Onken et al. 2007). Onken et al. (2007:11) stress the importance of hope to the recovery process:

Hope is central to recovery, as people must have hope for themselves and their futures in order to rally the resources necessary to surmount the challenges of the psychiatric disability. One's own and other's hopefulness has been identified as critical in launching the journey from despairing about a life situation to hoping for a better future, and for this reason the establishment of particular hopes and aspirations can be seen as an initial step in the process of recovery.

Hope makes expectations for the future more positive, encourages consumers to look at their strengths as people and not as their illness and actively take part in treatment relationships and decision making to actualize their hopes, underlying many of the other components of recovery.

Hope can stem from personal relationships with mental health professionals or family or friends; in fact, many people in recovery credit their recovery to having at least one person who never gave up hope for them, which allowed them the space to regain the needed hope for themselves. Other sources of hope include an awakening of potential within consumers that they can achieve the changes they imagine, which can happen within the depths of hopelessness or in more supportive environments, and a personal motivation or purpose that renews hope for a better future and provides the consumer with the strength to persevere through the recovery process (Ochocka, Nelson and Janzen 2005; Onken et al. 2007).

Walsh (1996) writes that hope began for her when she encountered other people with histories of psychiatric illness who had recovered. This hope encouraged her to actively take part in getting better, the opposite of the passivity she experienced in non-recovery-orientated care.

Based off her own experience, she says that the belief of people with mental illness that they cannot get better, that their diagnosis represents a death sentence, too often reinforced by mental professionals and conventional thought, have stripped them of hope. Mental health professionals who work with these consumers must not reinforce this hopelessness. They should create an environment and a relationship that stresses hope in order to inspire within the consumer that one can change one's life and take part in the process of recovery.

Hopes precedes other aspects of recovery and represents one of the original values of the recovery movement—that people with diagnoses of severe mental illness should not be consigned to life as a lost cause.

Responsibility for Life

This aspect of recovery means that consumers consciously assume personal control of their lives and managing their illness.

Liberman and Kopelowicz (2005:739) understand that the experience of severe mental illness can strip consumers of the ability and confidence to take care of themselves and, thus, include in their description of functional recovery “the ability to take care of one's personal needs without assistance.... [which] could be defined as managing one's own medication, health, and money without regular supervision.” Consumers echo this sentiment of personal control of their illness and independent functioning. Some participants in Yarborough et al. (2016:100) described recovery as “‘getting back’ ... a gradual process of coming to know your illness and its effects and how to best control or manage it to live a personally meaningful and satisfying life.” Other consumers described recovery as representing more independence in their lives, including

financial independence and the ability to take care of their day-to-day needs, which match psychosocial criteria in clinical definitions (Smith 2000). In addition, consumers progressing toward recovery sought to remain in recovery and not let their illness control their lives again (Smith 2000). Onken et al. (2007:12) consider a consumer managing one's illness as "driving one's formal treatment as well as taking responsibility for symptom management, self-care, and wellness."

Walsh (1996:87), from her personal experience, writes "that in order to travel the path of true recovery I could not rely on externals, wait, hope to be rescued, or be made better because of someone or something outside me. Instead, I learned that both the power and the possibility of change reside within me. I could make decisions that would affect my life," stressing the importance of consumers taking charge of their own recovery. Crowe et al. (2006) cite Allott, Loganathan, and Fulford's (2002:21) description of recovery as "building on personal strengths and resources to develop supports and coping mechanisms which enable individuals to be active participants in--as opposed to passive recipients of--their mental health care." The importance of this statement rests in the fact that recovery-orientated mental health care is not something that is done to the consumers. They must actively engage in the process and manage their illness, treatment and beyond to other aspects of recovery.

Another aspect of consumers taking charge of their lives says that the consumer must actively take part in directing her treatment. Service providers must recognize them as partners in determining the desired treatments and respect that consumers are experts in their own experience of illness (Le Boutillier et al. 2011). Onken et al. (2007:12) speak to engagement in treatment as self-determination— "the person's ability to state preferences and the necessity of

those choices being honored by mental health professionals, especially in times of crisis or when hospitalization is necessary.”

The Rights of Consumers

This aspect of recovery represents the rights of service users to have control over all aspects of their lives. Davidson et al. (2006) speak of recovery as a manifestation of self-agency: consumers must have control over their lives, they have the right to have a say in their treatment, including clinical interventions, and the right to determine their own journey to recovery. Le Boutillier et al. (2011) add that consumers have the right to the provision of accurate information about treatment options by mental health professionals and a choice in which services they will use in their recovery. Mental health professionals should only override this right to choice during circumstances that clearly warrant it, and the revocation of the right to choose should last temporarily, only until the resolution of the immediate crisis (Davidson et al. 2006). Geller (2012) argues that the effective use of involuntary treatment actually supports recovery, while others, including Davidson et al. (2006), maintain that the values of recovery and the use of force fundamentally oppose each other. Given the potential for crisis that prevents clear decision making, some advocates of this consumer right to choice suggest the use of psychiatric advance directives which dictate the treatments the person would want and who else can have a say in her care at that time (Onken et al. 2007).

Beyond clinical choice, this aspect of recovery means that consumers have the right to personally plan and live lives they want in the community—which means they not only have their hopes and dreams respected but have the right to pursue them and get to choose the

activities and environments in which they engage in these activities that bring them pleasure and fulfillment (Davidson et al. 2006). The continued presence of disability in consumers' lives should not preclude them from this right (Davidson et al. 2006).

Another described right of consumers grants them the right to take risks in the process of recovery, even accepting that they, like anyone else, have the potential to fail (Walsh 1996). Mental health professionals have relied on historical precedent to instruct people with severe mental illness to avoid stress and abandon their dreams and settle for a comprised life. Recovery changes that. To this end, mental health professionals must relinquish some power in the doctor-patient relationship in order to listen to and support the individual in everything the process of recovery entails. Psychiatrists in recovery-orientated services must acknowledge and respect this right.

Meaningful Activities

The term “meaningful activity” repeatedly appears in discussions of consumer-defined elements of recovery—and thus, more clinical ones as well. Definitions of recovery stress that consumers can identify activities, even when activities push the limits of their illness, within the community in which they would like to take part and receive the supports, if and when necessary, to find success and fulfillment (Le Boutillier et al. 2011). The focus on the importance of such activities comes from the aforementioned notion that recovery encompasses more than clinical remission and from understanding that people with mental illness can achieve this reduction in symptoms, so recovery-orientated mental health care should help consumers build a full life outside of their illness. Barber (2012:278) tries to reconcile the medical model of

mental illness with principles of recovery—often seen as at odds—by describing how medical treatment can serve the end goal of helping the consumer have a life:

When physicians consider the real possibility of remission as a long-term outcome, elements of recovery-focused care naturally follow. If the person has a good chance of recovery, we don't want to make clinic visits and medication adherence the end goals...we want to use medication and clinic visits as one part of helping the person build on the skills and strengths that he or she had before becoming ill. We want to encourage the person to undertake roles and missions in life other than being a patient—relationships, work, school, parenthood, hobbies.

The notion that leading a meaningful life, filled with meaningful activities, rather than treatment as an end goal, underlies much of recovery-orientated thought, such as Slade's (2012:703) contribution:

The central shift in a recovery-oriented system, therefore, involves seeing an individual not as a patient--someone who is fundamentally different and therefore needs treatment before getting on with life--but as a person whose efforts to live the most fulfilling life possible are fundamentally similar to those of people without mental illness...proponents of a recovery approach seek to reverse some priorities. People with mental illness don't need treatment--they need a life. Treatment may contribute to the process of striving for a life worth living, but it is a means, not an end.

Many consumers identify having a valued social role—such as working or going to school and having friends and a significant other—as aspects of functional and social recovery (Windell, Norman and Malla 2012). Some of these consumers considered having a so-called normal role relative to their stage in life, while others left behind past roles for new post-illness ones (Windell, Norman and Malla 2012). Accomplishments within work or education provided consumers with much-needed encouragement to keep moving forward and helped them to feel better about themselves by “[restoring] a sense of purpose and self-worth” (Cabassa, Nicasio, and Whitley 2013:839).

Consumers know that these activities might cause stress that could lead to increased symptoms, which presented consumers and their clinicians with the challenge of finding a workable balance (Young, Green and Estroff 2008). Trusting, collaborative relationships in which the clinician knew the consumer and her strengths and capabilities well best helped the consumer navigate new activities that would promote rather than harm recovery (Young, Green and Estroff 2008). Meaningful activities did not have to include work or education, though; for some consumers it meant attending church, being part of a peer organization and other support groups or social activities. The main point of this component of recovery comes from the necessity of these activities to arise from self-determination, provide a sense of connection to the something larger and lead to positive feelings.

Employment, while far from the only example of meaningful activity, was considered important to recovery by many consumers. Consumers generally found meaning in work, especially those who work as peers and take great pride in helping others like them, and view work as helping them recover because it made them feel valued and needed (Dunn, Wewiorski and Rogers 2008). Work also provided the opportunity to socialize with co-workers, gave them a routine, helped them build self-efficacy and allowed them to earn money, which contributed to another aspect of recovery—self-sufficiency—and helped them to afford material goods that signaled progress for them (Provencher et al. 2002). Consumers like anyone else want a job that matches their skills and in which they can find some enjoyment. Work encouraged active participation in treatment, especially working with their psychiatrists in order to find medications that allowed them to work (Krupa 2004). Consumers developed new skills and pride in themselves as they navigated the workplace, and such activity helped them reconstruct their

sense of self (Krupa 2004). Generally, when consumers chose to and could deal with the stress and any interfering symptoms, work benefited the recovery process.

Participation in meaningful activities, beyond the contentment they bring, also gives the consumer an opportunity to counteract the negative messages they might have received about their capabilities. Stepping out into the world and trying different things present a risk for the consumer, and this risk taking can be an act of resistance. Meaningful activities can help consumers overcome their fears, feelings of worthlessness and lack of control and teach them to learn from their failures in order to grow toward their recovery. The articles that discussed the pursuit of life goals for persons with severe mental illness viewed the purpose of mental health care as a means that consumers could utilize in order to reach their personal goals—essentially, recovery-orientated mental health care should help the consumer to have a life.

Empowerment

The internal states of “self-confidence, self-reliance, sense of personal control and self-esteem” characterize the empowerment component of recovery (Young and Ensing 1999:220). It can also encompass a reduction in internalized stigma and the taking of risks that goes beyond the consumer’s comfort zone but helps her toward recovery (Young and Ensing 1999).

In order to empower themselves when facing illness, consumers often develop and use personal coping strategies that help them remain in control of their illness (Young and Ensing 1999). The desire to not let symptoms control them fosters creativity and self-perception in the consumer to help them live better with their illness (Young and Ensing 1999). Consumers use these strategies to prevent relapse and deal with stress when it arises in their lives. In order to

prevent relapse, consumers get to know how they personally experience their illness so they can recognize and avoid triggers before they cause a potentially much more dangerous spiral, along with the continued, consistent use of medication and maintaining a healthy sleep schedule and diet, and to decrease stress, consumers might follow a set routine, keep a journal or practice another personally helpful de-stressor (Provencher et al. 2002). Also in pursuit of self-empowerment, consumers might rely upon self-affirmations that reframe their lives and experiences with mental illness toward focusing on their strengths and interests while understanding the limitations of their disability and holding on to the belief in their own ability to lead a better life (Provencher et al. 2002).

Onken et al. (2007) define empowerment as the expression of power of rejecting the notion that a psychiatric diagnosis should define one to take back one's identity as a complete individual. This power can also manifest through participation in peer-run communities. Within these communities, consumers find mutual aid and acceptance that support and encourage the consumer to take steps toward recovery. Onken et al. (2007:15-16) call recovery:

an ongoing act of expressing power...It involves the individual rejecting labels linked to psychiatric disabilities and regaining a sense of personal integrity. Power is reinforced in the acknowledgement and recognition of the personhood retained by the individual as he or she suffers and gains control over symptoms during the process of being ill, diagnosed, and in treatment... Information and education about the psychiatric disability, available treatments, and the possibility of recovery are types of knowledge that lead to choice, hope, and power. Participation in consumer self-help and mutual aid teaches new coping skills and methods of self-advocacy and encourages situations of mutual acceptance, support, mentoring, and socialization.

Life in the Community

Recovery relies upon persons with severe mental illness living and taking part in their communities. Integration, acceptance and leading a good life as part of larger society underscore recovery; life in a hospital harms consumer quality of life and hinders consumers' pursuit of their goals (Onken et al. 2007; Salyers et al. 2011). For consumers who have internalized the stigmatizing "otherness" thrust on those with mental illness, membership within the community can combat the stigma and begin to heal the disconnection from the rest of humanity that makes them feel that they do not belong among others. Life in the community requires both consumers to draw upon their own strengths to contribute to the community and also a community that welcomes them (Onken et al. 2007). The importance of living in the community for consumers in recovery can be summarized as:

the ability to participate fully in the community by building on strengths and reintegrating... one's close social network and the community at large become resources in the recovery process. Integration is necessary—both of the psychiatric disability into a sense of self and of the individual into a welcoming community. A person with a psychiatric disability is as capable of living a full life as anyone else, working collectively with others in their communities to achieve desired goals. The ability to live among (and interact with) others—mutual positive interdependence—is a hallmark of community and an underpinning of the recovery process. (Onken et al. 2007:17)

Life within the community affords consumers the opportunity to live as a non-diagnosed person would. They encounter successes and make improvements in their lives but experience negative aspects of life which will set them back. Recovery does not occur along a straight, upward line, nor can it protect them completely from relapse or other life stressors, but

access to external supports and opportunities within the community can make a substantial difference in a consumer's progression toward recovery.

Although the psychiatric literature frequently describes the importance of housing and meaningful activities, along with the other components of recovery that demand investment and continued funding, poverty, homelessness and a lack of a full range of services too often prohibit their actualization. Recovery cannot occur without resources and opportunities. Recovery then argues, against the long-standing tendency to not fully fund mental health services, for the provision of a full range of services that promote recovery. Consumers cannot claim these other rights without first having basic necessities.

Moving Beyond Mental Illness

Recovery in this sense encompasses all the self-directed potential that arises when the symptoms and other consequences of their mental illness no longer dominate their identity and use of time and resources. This point occurs later in the process of recovery, and by then, consumers have the freedom, often from symptoms, and self-reliance to move on with their lives (Yarborough et al. 2016). Consumers who considered recovery moving forward spoke of it as:

Most participants believed in recovery and conceived of it as reaching a point where they could get on with their lives, where illness and symptoms were no longer the dominant aspect of their identity or a primary strain on their resources. Where descriptions of getting back focused on the process of moving toward recovery, descriptions of "getting on" focused on the intended outcome of that process—moving forward. Recovery for individuals who described moving on meant reaching a point where they felt satisfied with how they were feeling and felt that significant others could see evidence of their ability to manage their symptoms. This allowed opportunities for independence and self-reliance that were desperately longed for... Among individuals who defined recovery as getting on with life, symptoms were typically described as improved or reduced.

Individuals talked about stability and described a sense of freedom to be themselves. (Yarborough et al. 2016:100)

Also at the point of moving beyond their illness, the participants in Provencher et al's (2002) study who considered recovery a "challenge," consumers have built up healthy internal states, found ways to make use of social support and overcome everyday problems that might have otherwise overwhelmed them. In this sense, recovery takes the form of wellness. Wellness builds on the successes of reducing the impact of the negatives but really means the active pursuit of maintaining health, through personalized ways of dealing with the struggles associated with psychiatric disability (Onken et al. 2007). Onken et al. (2007:15) refer to recovery as "an expression of one's ability not to only survive but to thrive [lives rebuilt after significant personal adversity have strengths not present before the troubles] in the midst of extremely difficult circumstances." In order to thrive, consumers must regain hope and must allow themselves to imagine a self-directed life. Moving beyond illness means the actualization of purpose and draws upon all the other components of recovery.

Identity

First-person accounts stress the importance of reconstructing a sense of self and identity, and this identity must be positive, encourage the seeking of a better life and must cast the consumer as a person and not an illness. The experience of severe mental illness devastates people's sense of self—forcing them to reconcile their past views of themselves with the negative ideas they hold about what it means to be mentally ill, to face the loss of the social roles and activities they once cherished and to consider that this illness could take from them their

hopes and dreams. For this reason, people in recovery must reconstruct a sense of themselves as complete people, which can mean restoring an old identity or establishing a new one.

In this new identity, mental illness does not dominate their sense of self. Continuing to conflate the self with the mental illness hinders the process of recovery. Yarborough et al. (2016:101) speak to establishing an identity outside of their illness—quoting a participant in their study: “Recovery means to me being able to say I have a mental illness, but it’s not me, it’s not who I am, it’s not all me.” A portion of the participants in Provencher et al. (2002) describe the reconstruction of a positive sense of self in their recovery process through wishing to resume former roles or activities, regaining independence, discovering new strengths and learning new skills and abilities and maintaining a positive view of themselves.

Pettie and Triolo (1999:260) describe how people in recovery integrate their mental illness into their identity by attaching a personally chosen meaning that explains the experience: “Chosen meanings can play a larger role in the recovery process when they adequately explain why we are and where we are in terms of our life and the larger picture. Consider the question of ‘Why me?’ Most survivors generally agree that ‘What now?’ is a more advanced and desirable place to be in the process than ‘Why me?’” Consumers’ chosen meaning for their illness (such as illness as an evolution) answers the preliminary question of “why me,” which then opens them to considering the second question—who will they become, where will they go from there (Pettie and Triolo 1999).

In his account of his loss of identity from his experience of bipolar disorder, Fekete (2004:190,192) describes how he found constructive meaning in the medical model of mental illness:

I had never been ‘crazy’ before. I was a normal person... [after the diagnosis of psychosis] ...I thought that I was less a part of the human race. I was on the other side of the wall between ‘normal’ people and ‘crazy’ people. I had left society and had become a ‘mental patient’ ...As I grew to understand the medical model of bipolar disorder, I was able to overcome the stigma associated with my illness and to redefine my person as it related to my illness. I found out that the chemicals that shoot forth from my neurotransmitters are imbalanced. This means that my illness isn’t mental at all—it is physical...And as a physical illness, I distinguish between bipolar disorder and what I mean by me, or my identity. My illness is a separate, alien thing from my identity. There is me, and then there is my illness. This means I am not a different class of person. I am not an illness. I am not a ‘mental patient.’ I am a person of the same kind as others, with a specific physical disorder. I am back with the regular, ‘normal’ human race.

The necessity that consumers recognize themselves as people, separate from their illness, who can have goals, accomplishments, self-worth and contribute to the world, is tied to acceptance of illness when discussed in terms of recovery.

Acceptance of Illness

Consumer-driven conceptions of recovery include some acknowledgment of the need for the consumer to accept her mental illness, regardless of whether one frames it through a biomedical model and which specific services one uses. For the participants in Young and Ensing’s (1999:222) study, recovery began at the point when the consumer accepted her mental illness. Along with the acceptance of illness, consumers must often take the often difficult step of seeking out help. With time, though, consumers in the process of recovery come to better terms

with the presence of the mental illness in their lives and the continued need for treatment, especially when they succeed in establishing an identity apart from their illness.

From a clinical point of view, psychiatrists would also contend that recovery would require an acceptance of the diagnosed mental illness—because they consider acceptance to indicate “insight,” which then leads to better compliance with medications that treat symptoms so the consumer can focus on other aspects of recovery. Some research on the matter does show that as both positive and negative symptoms increase, insight decreases—but it also suggests that as insight increases, depressive symptoms worsen (Korsbek 2013, citing Mintz, Dobson and Romney 2003). Korsbek (2013:223), drawing on her own experience, explains the complexity of insight and recovery that extends beyond pure symptoms: “Depression, hopelessness, suicidal thought, internalized stigma, and low self-esteem were all significant barriers in my recovery process, and my experience of illness insight was primarily an experience of non-recovery.” She credits her ability to separate her identity as a person from her diagnosis of schizophrenia with her ability to recover, which leads her to conclude that the “most important question for recovery is not the question of illness insight, but of transforming the identity as a patient into an identity as a person” (Korsbek 2013:224). Pettie and Triolo (1999:259) also partially frame insight as an issue of identity:

Acceptance exacts a price. The cost to one's identity of accepting certain professional advice should not be overlooked or underestimated. Newcomers to the mental health system often perceive that they are being invited to trade in the life they had been leading for one of second-class citizenship. This alternative is not received as an offer of help but as a direct threat to one's identity.

To help exemplify what psychiatrists call denial, but consumers might see as a protection of their identity and sense of self-worth, Pettie and Triolo (1999:258) give an analogy, asking the reader to:

imagine for a moment that you are on the set of a TV game show. Much to your surprise the host calls out your name....Come on down!...way down...to your new life as a mental health client. You lost your job, car, apartment, and boyfriend, but just wait until you hear about one of the many dazzling new goals we have in store for you in your new life! Your new goal is to drag yourself out of bed to get showered, dressed, and fed in time so you're no more than an hour late to the first group in your new day program!

Symptom Control

This component acknowledges that in order to recover, individuals with mental illness need some type of control and reduction, along with acceptance, of their psychiatric symptoms. A debate exists within the literature of whether a person can recover despite the continued presence of symptoms. Many advocates might say yes, but other reports from consumers present a more nuanced view.

Few participants in Windell, Norman and Malla's (2012) study of people experiencing a first episode of psychosis considered recovery possible without getting rid of their psychotic symptoms; the vast majority considered the alleviation of symptoms a vital aspect of recovery. Consumers wanted the sense of control of their symptoms and the distress it brought them (Windell, Norman and Malla 2012:549). Turnton et al.'s (2010:298) study found that the participants placed the most importance on the domain of recovery that reflected therapeutic interventions, which would be considered a more clinical definition of recovery, stressing often the "importance of appropriate and timely psychopharmacological treatment." Consumers in Smith (2000) echoed this notion, referring to the necessity of consistently taking medication and

forming a good relationship with a psychiatrist to recovery. Yarborough et al. (2016) describe symptom control as participants wanting a sense of self-control. Consumers in an early stage of recovery spoke of recovery as symptoms no longer overwhelming them, and as they progressed, they learned triggers and how to better get through their illness, until, as those farthest along said, they have their symptoms under control without much thought.

On the contrary, Chang et al. (2013:80) write that “advocates have also stated that people with psychiatric disabilities can pursue recovery even though symptoms exist” and that these symptoms “are simply viewed as one attribute of psychiatric disabilities in the consumer-oriented recovery perspective.” Chang et al. (2013:84) conclude that this position of advocates does have a basis: consumers even having some symptoms can experience recovery if they have the services they need.

Social Support

When consumers speak of recovery, they express the social support they received throughout their recovery as crucial to their success. Young, Green and Estroff (2008:1431) write that consumers with “strong, supportive social networks recover more quickly from symptom exacerbations, and those with better social relationships have a richer quality of life and improved functioning.” Chang et al. (2013:83) reiterate this finding: “People with more social support tend to have a better recovery status. This result is similar to that of previous research findings and indicates the importance of social support for people in recovery. It also suggests that programs that facilitate connections among people with psychiatric disabilities may

enhance their recovery.” Social connection also provides consumers with a way to overcome internalize stigma and reminds them that they have something to offer others.

Mancini, Hardiman and Lawson (2005:52) discuss how the participants in their study expressed supportive relationships as assisting them in their recovery: “Participants indicated that recovery is above all else a social process, with supportive relationships helping to foster hope by communicating the expectation that participants could live productive and satisfying lives.” Social support in this study that helped recovery came from family and friends who “provided an unwavering and steadfast belief in participants' ability to recover” and “did not view them through the lens of their disability, nor did they suggest that they abandon or water down their dreams and goals”; mental health professionals with whom they established a trusting, collaborative and respectful relationship; and with peers who provided valuable encouragement and inspiration that the consumer could get better (Mancini, Hardiman and Lawson 2005:52). Federici (2013:315) also stresses the importance of family and friends who provide continuous support and encouragement: “I had friends and family who supported and encouraged my own self-determination and supported me to stay connected to my community life. That support remained steady whether I was taking steps forward or not.”

While consumers do mention supportive relationships with non-consumer family and friends and others in the community, they also refer to relationships with other consumers as most beneficial (Young and Ensing 1999).

Religion and Spirituality

Consumers often mention the importance of spirituality to their recovery. Consumers use spirituality as a source of hope, strength and inspiration, and they will often use spirituality to get them through times of worsening symptoms and to maintain their recovery when their symptoms improve (Cabassa, Nicasio and Whitley 2013; Young and Ensing 1999). Later on in their recovery, consumers may also derive meaning for their lives from their spirituality (Young and Ensing 1999). A survey in one study reported that “71% of the participants reported that their spiritual lives played a significant role in their recovery, giving them a definite sense of purpose, peace and comfort” (Bussema and Bussema 2007:303). Spirituality could also have a negative effect of recovery, though. Consumers also reported anger toward God, a questioning of their faith and, to some extent, isolation from religious communities (Bussema and Bussema 2007).

Since spirituality plays such an important part of recovery for many consumers, some have suggested drawing on the therapeutic benefits of spirituality and integrating them into recovery-orientated mental health services (Cabassa, Nicasio and Whitley 2013). Fallot (2007) suggests that service providers should try to understand the role spirituality plays in each consumer’s life, and whether it hurts or helps one’s recovery so they can better respond to the consumer’s needs and wants in recovery. Given the potential benefits of including spirituality in personalized recovery-orientated services, Fallot (2007) calls for further training of service providers in spirituality.

Activism

Consumers view as part of their recovery full citizenship in their community.

Bergstresser, Brown, Colesante (2013) spoke of how people with psychiatric disabilities attach the symbolic meanings of inclusion and active membership in society and empowerment as consumers to voting and other forms of political engagement. Consumers who take part in advocacy organizations encourage other people with psychiatric disabilities to, for instance, vote, while some consumers attend demonstrations or speak publicly about their experiences with mental illness. These examples of activism speak also to another aspect of recovery—that consumers in recovery want to give back to other people with mental illness.

Walsh (1996), in her personal account, describes activism as coming out as someone with a mental illness to tell her own story and to declare the potential within the community of people with mental illness to reclaim their power and direct it toward recovery—recovery from their illness but also from the dehumanization they've encountered, the stigma they've internalized, from having their self-determination denied, their voices devalued and from the poverty so rampant among people with mental illness.

People diagnosed with mental illness, and their allies, have a long history of advocacy—in fact, the very idea that people with mental illness could live outside institutions in the community and have lives filled with hope and meaning arose from the activism of psychiatric service users and survivors—so this value placed on advocacy fits both with the collective history of people with mental illness and the power that comes from declaring one's identity and fighting for the rights and improved lives of others in the community. Given that lack of access

to a wide variety of recovery-orientated treatments, poverty and marginalization and devaluation still plague the lives of consumers and their families, the tradition of advocacy persists, taken up by people who have come to accept their illness, manage their symptoms and found hope and meaning in their post-onset-of-illness lives who want this same experience for others like them.

CHAPTER 5: TREATMENT METHODS USED TO PROMOTE RECOVERY

From an understanding of what recovery means and an acceptance of it as the goal of mental health care arises the need to create or adapt mental health treatments in order to promote recovery.

Regardless of the specific name and format given to the recovery-orientated care, they all contain many of the following attributes, which align with the components and themes of recovery (laid out in the previous chapter): strength based; helping consumers improve self-esteem, confidence and motivation through identifying and reminding them of personal strengths; stressing the personal/ individual nature of each consumer's recovery process; a holistic approach that sees each consumer as an individual, emphasizing hope, empowerment, independence, self-management of illness and symptoms; personalized coping skills and self-care to manage stress; taking care of one's physical health, setting and pursuing personally meaningful goals and believing in one's potential for recovery and wellness; self-advocacy and collaborative relationships in having one's treatment needs met to promote recovery; and educating one's self about their illness and its treatments.

These programs are often run in group formats with peers who are farther along in the recovery process and mental health professionals who believe in and support the cause of recovery, both of whom must receive detailed training in the specific model of recovery-orientated care they facilitate to ensure fidelity to the original model and to ensure the best

results in the group, and the programs often rely on workbooks to guide consumers through the process. The number of methods suggests that enough service providers, some of whom have personal lived experience with mental illness, and researchers have accepted and supported the values of recovery to work on developing effective ways to deliver these values and better outcomes to consumers. The discussion of treatment methods that help people achieve recovery represents a desire among researchers to move beyond just treating symptoms of mental illness to promoting mental health.

The following sections describe two commonly implemented and evidence-based methods of recovery-orientated care, the role of medication and use of coercion in recovery-orientated care.

Wellness Recovery Action Plan

Wellness Recovery Action Plan (WRAP) as a recovery-orientated mental health intervention seeks to teach consumers to self-manage their illness. WRAP encourages self-direction in creating and maintaining wellness and reliance upon natural strengths and supports. WRAP addresses the components of recovery such as self-determination, taking responsibility for one's own wellness and life, strength based and personalized and using peer support.

Cook et al. (2009:246) explain WRAP as a unique method of setting participants on course for recovery:

WRAP educators are taught to avoid talking directly about psychiatric diagnoses or using medical or illness-oriented language to frame people's needs. Instead, WRAP emphasizes holistic health, wellness, strengths, and social support. WRAP encourages people to move beyond simply managing symptoms to building a

meaningful life in the community by using a highly individualized plan for recovery. Instructional techniques promote peer modeling by using personal examples from facilitators' and participants' own lives to illustrate key concepts of self-management, allowing participants to witness the lived benefits of WRAP. Taught in a group format led by two peers in recovery, WRAP teaches consumers over the course of eight sessions to create personalized strategies to pursue and maintain recovery and wellness, to deal with difficulties in functioning, combat isolation, avoid relapse, learn warning signs of relapse to avoid crisis, seek out the right help when needed and determine what to do if a crisis does occur (Cook et al. 2012; Cook et al. 2009).

Evaluations of the program showed benefits in various aspects of recovery and symptoms. Cook et al.'s (2012) study found a reduction in symptoms of depression and anxiety, which lasts after the WRAP sessions ended, and increased self-perceived recovery, including greater confidence and goal orientation, and Cook et al. (2009:247-248) found an improvement in “global symptom severity [and] on several symptom subscales--psychoticism, depression, phobic anxiety, obsessive-compulsive, interpersonal sensitivity, paranoid ideation, and general anxiety”; in “overall recovery...all of the five recovery subscales showed improvement: personal confidence, willingness to ask for help, goal orientation, reliance on others, and freedom from symptom domination,” “participants' feelings of hopefulness,” “patient self-advocacy” and “self-perceived physical health.” After participating in WRAP, participants described seeing wellness now as “an attainable, ongoing process, influenced by the support of others,” being more aware and able to deal with triggers and symptoms, having better social support and feeling less isolated, practicing the skills they learned in their everyday lives and how they valued the hope portrayed by the peers leading the program (Cook et al. 2010:118).

Federici (2013:317) stresses the importance of ensuring that any use of WRAP must maintain fidelity to the original model to avoid its incorrect use. He says as WRAP has gained credibility and now has widespread adoption, it has seen usage that corrupts its original values.

WRAP must be voluntary, led by two properly trained peers and stick close to the values that make it effective in enhancing recovery:

1) encourage self-determination; 2) uphold a belief in equality; 3) facilitate a collaborative learning model; 4) complement rather than replace other kinds of therapy; 5) adapt to each individual's personal philosophy; 6) offer simple and safe practices that meet every participant's needs, regardless of the severity of their challenges; 7) rely on practical, achievable goals; 8) expand the body of knowledge on a continuing basis; 9) incorporate a wide range of philosophies; 10) promote a way of life rather than a program; 11) avoid medical and clinical language; 12) promote hope of recovery for anyone without limits; and 13) focus on strengths, choices, and options. (Federici 2013:317)

Illness Management and Recovery

Illness Management and Recovery (IMR) was designed in response to the call for a transformation to recovery-orientated mental health services (Levitt et al. 2009). It combines evidence-based practices with an emphasis on elements of recovery and teaches consumers the skills they need to plan and accomplish their goals for recovery and how to manage their illness (Salyers et al. 2009).

Levitt et al. (2009:1629-30) explain IMR:

The program begins with an exploration of the meaning of "recovery" with the consumer, followed by the identification of personal goals related to that individual's own concept of recovery. Goals are broken down into steps, and the clinician then teaches illness self-management skills using a combination of psychoeducational, cognitive-behavioral, and motivational teaching strategies to help the consumer make progress toward achieving those goals. Five empirically supported practices for teaching illness self-management...have been incorporated into the program, including psychoeducation about mental illness and its treatment, behavioral training to improve medication adherence by teaching strategies for incorporating the taking of medication into one's daily routine, relapse prevention planning, coping skills training to manage persistent symptoms, and social skills training to improve social support.

Roe et al. (2009:286) adds, “Sessions also use motivational techniques to help consumers find meaningful reasons to change behaviors and to instill a sense of hope and support for their recovery... [and] positive reinforcement, shaping, modeling behavior, role playing, cognitive restructuring, and relaxation training to help consumers manage their illness.”

Articles that discussed IMR studied its implementation and effectiveness in improving consumer outcomes in areas such as illness self-management, knowledge of illness and treatments, as well as the recovery-orientated pursuit of personally chosen goals. The studies demonstrated results that showed IMR did improve outcome over regular treatment. For instance, Levitt et al. (2009:1634):

Program participants improved significantly more in functioning on QLS-A [quality of life assessment] and reported less anxiety and depression and less overall symptom severity over time on the BPRS [indicates severity of psychiatric symptoms] compared with individuals in the control group. The findings suggest that the program can improve the ability of people with serious mental illness to manage persistent symptoms. In addition, the program's emphasis on setting and pursuing personal goals may result in a broader impact on psychosocial functioning, as reflected in improvements in domains of quality of life, including instrumental functioning, interpersonal relationships, and intrapsychic foundations such as having a sense of purpose.

At a one-year follow-up, the majority of the participants in Roe et al. (2009) reported that the intervention helped them, specifically in the areas of cognitive functioning, illness coping and self-management and social skills. The participants liked that the program focused on teaching them about their condition and its treatment and the program's goal-directed structure. Some of the participants indicated that they found unique the program's message of hope. Two participants said of the program: “It gave me the strength to believe in myself, that there is a

purpose, that progress can be done” and “the message was how to live with the illness and overcome it,” respectively (Roe et al. 2009:289).

Assertive Community Treatment

While not necessarily recovery-orientated itself, assertive community treatment (ACT) enters into the discourse around recovery because of attempts to integrate it with Illness Management and Recovery. ACT usually targets the subset of people with severe mental illness who frequently use inpatient psychiatric services and who have trouble engaging in office-based clinical services (Salyers et al. 2011). It provides an integration of personalized services delivered by a treatment team with different specialties that meet a client’s most urgent needs in community settings (Salyers et al. 2011). While ACT may reduce rates of homelessness and hospitalization, some (including consumers) consider it paternalistic, coercive and too focused on medication, which would suggest that at least from the consumer’s perspective it does not fit well with the values of recovery (Salyers et al. 2011; Marshall et al. 2007, citing McGrew, Wilson and Bond 2002). Drawing on the research of McGrew, Wilson and Bond (2002), Marshall et al. (2007), explain that participants preferred services in which providers worked to establish trust, collaborated with them in identifying goals and opportunities, encouraged them to take part in their community and believed in their potential—all elements of recovery.

To address criticism, programs began to include Illness Management and Recovery in ACT through, for instance, adding a peer farther along in the recovery process and training providers in how to properly use IMR (Salyers et al. 2011) and training ACT team members in recovery principles and how to use services to promote recovery, including Wellness

Management, which sets wellness goals and stresses collaborative relationships and personally chosen consumer goals (Felton et al. 2006). Felton et al.'s (2006) study focused on assessing the integration of ACT and IMR from the service provider's point of view and found that while ACT team members had concerns—revolving around whether it could work with consumers with substance abuse issues or those who did not accept their illness and who had frequent crises, feeling they should focus on risk management rather than goals because consumers either couldn't or wouldn't engage in a collaborative relationship; providers who believed consumers should follow provider goals, medication use, and basic living skills before any of other goals; and providers' fears about building helpful relationships with consumers—service providers who actually tried Wellness Management found it beneficial.

Felton et al. (2006:117) describe the benefits of the recovery-orientated changes:

Providers reported, “wellness works,” “it's great,” “she's made great progress” and described changes in their recipients which were positive for them: e.g., going back to school, getting a job, going to a clubhouse, and making friends. Virtually all comments here reflected a positive fit with recovery. The emotional tone of providers' comments suggested that providers were enjoying the process of utilizing wellness.

The experience of ACT service providers demonstrated that ACT and IMR could work together to benefit the consumer:

The most consistently positive were in trainees' accounts of their work with participants' goals using wellness and other strategies and in their descriptions of recipients in holistic terms, that is, in terms of their talents, strengths, and social and emotional concerns. Adopting a “client-centered” definition of the work to be done seems to necessarily invoke a view of recipients that transcends symptoms: when providers undertake to learn what individuals want they concurrently learn about them as whole people. In their comments about working with recipients' goals, trainees revealed an attitudinal stance and emotional tone suggesting a

thorough conversion: the sentiment “It works!” was typical. And these sentiments were even more pronounced among providers reporting on their actual use of the new techniques (Felton et al. 2006:117).

Medication

The discussion around the role of medication in recovery varies, with some consensus that consumers should work with psychiatrists to find the right medications that alleviate symptoms while allowing them to pursue their recovery, essentially framing medication as a means to the end goal of recovery. Diamond (2009:1155) sums up this view:

[Psychiatrists should] view medication as a tool that the client can use to support his or her own recovery. The issue with medication is effectiveness, not compliance. Medication is just a tool that is useful or not. The issue is not whether the client is adherent. The issue is whether the client uses this tool in a way that is effective in accomplishing what he or she wants the medication to do.

Deegan and Drake (2006) contribute that consumers find medications help and thus are more likely to stay on them in the recovery process when they better allow the consumer to take part in desired social roles and activities. In terms of medication management, shared decision making refers to the psychiatrist and the consumer working together to find the best medication at the right dosage that serves both the want of the psychiatrist to control the consumer’s symptoms and the consumer’s desire to pursue personally relevant recovery goals. Shared decision making reflects the value of a collaborative relationship between consumer and psychiatrist, understands the expertise the consumer has in terms of her own experience and allows the consumer to best use medication as a tool in one’s recovery.

According to Deegan and Drake (2006:1637), the psychiatrist and the consumer should work together to find the right medications so the consumer can pursue her chosen recovery goals. They write about the importance of this collaboration:

When medications support or enable people to more effectively pursue activities such as employment, parenting, and returning to school, they are perceived by clients as a valued tool in the recovery process. However, if medications interfere with personal medicine, such that clients cannot engage in valued social roles and activities, the medications are viewed as blocking the recovery process and are often rejected. Insistence on compliance in such situations is experienced as counter-therapeutic and unhelpful. On the other hand, shared decision making allows the practitioner to work as an expert collaborator, actively helping the client to identify personal medicines and to optimize regimens and dosages of specific medications to support and complement the recovery of valued social roles.

This arrangement does not have support from all, though. Peyser and Shadoan (2006:1812-13) respond in the Letters section of *Psychiatric Services* to Deegan and Drake's (2006) article, specifically to how they say shared decision addresses the non-recovery-orientated problems of paternalism and too much focus on compliance, arguing:

In psychic crisis, isn't someone in the parental role often what the troubled person needs and is looking for? ... The two clearest examples of the need for so-called "paternalism" are in the case of co-occurring disorders (substance use disorders and other mental illnesses) and of acute psychosis with delusional thinking. Patients in the former group can often spend their disability check on alcohol and drugs before they pay for housing and food, and patients in the latter group are dangers to themselves or others if they stop taking medication. Whenever possible, and certainly for patients with milder mental disorders, we strongly support "shared decision making with medication management." But for patients with co-occurring disorders and acute psychosis, shared decision making is not always possible because the disease can be serious, even dangerous. Such a client may not be able to be "an expert" and needs to be approached in a so-called "paternalistic manner."

In a study of consumer views on recovery, Smith (2000:152) found that participants viewed medication as important to recovery and also stressed the importance of finding a psychiatrist who would work with them in finding the appropriate medication. Participants in the study who agreed with the need for medication use in recovery said “the medications got to be number one, got to be number one” and “the most helpful I think is getting on the right medicine. The right medications are essential” (Smith 2000:152). Fekete (2004) attributes the improvement in his symptoms and the successful completion of his education to medication, and Deegan (2007) also talks about how, after resisting medication in her past due to associating it with accepting a poor prognosis, now uses psychiatric medication to help her recovery. Both of these views come from first-person accounts of their journeys of recovery from bipolar and schizophrenia respectively, conveying what they have found helpful along the way, medication representing a portion.

Use of Coercion

Many advocates of recovery-orientated care would argue that use of coercion violates principles of recovery. Early activists who pushed for the recovery model would too have said that use of coercion or involuntary treatment went against recovery, having experienced and witnessed involuntary, and sometimes harmful, treatment administered while kept against their will in psychiatric hospitals. Modern conceptions of recovery also stress control over psychiatric treatment and self-determination. Onken et al. (2007:12) speak to this point:

Self-determination encompasses the person's ability to state preferences and the necessity of those choices being honored by mental health professionals, especially in times of crisis or when hospitalization is necessary. This highlights the need for advance directives in treatment to thwart the use of constraining measures, such as forced medication, seclusion, and physical restraints. Because

of these threats to basic rights and the lack of adequate, recovery-oriented services, mental health advocates have come to define self-determination as people's right to be free from involuntary treatment, to direct their own services, to be involved in all decisions concerning their health and well-being and to have meaningful leadership roles in the design, delivery, and evaluation of supports and services.

In some degree of contradiction to this position, Geller (2012:495) suggests that psychiatry should “develop methods for humane, respectful, recovery-oriented involuntary interventions to specifically achieve recovery goals.” He argues that “community-based paralegal and legal commitments” underlie person-centered (he uses the term “patient-centered”), recovery-orientated care because consumers plagued by psychotic thoughts and disconnected from reality cannot form the “center” of their care; instead, he says, allowing choice, as opposed to coercive treatments, at such a time contradicts person-centered care and perhaps abandons this person (Geller 2012:494). Involuntary treatment represents the most person-centered treatment at this point because “it is treatment in which the patient is participating to the maximum extent possible” (Geller 2012:494). He also claims that SAMHSA does not address coercion in the context of recovery—a claim Davidson (2012), who drafted the SAMHSA materials Geller cites, disputes in the Letters section of *Psychiatric Services*.

Davidson quotes the SAMHSA document:

When a person is incapacitated by an acute episode of psychosis, is unable to make his or her own decisions, and poses a serious and imminent risk, the recovery-oriented practitioner is ... obligated to intervene on the person's and the community's behalf. There is no need to view such interventions as conflicting with a recovery orientation if you consider the parallels to emergency medicine

[where] ... it is incumbent upon the medical professionals present to intervene on the person's behalf prior to securing his or her consent. ... Recovery-oriented practice ... is not contradictory to emergency intervention on the person's and community's behalf. What recovery-oriented practice requires is that such interventions be performed respectfully, in ways that ensure the dignity of the

individual, with transparency, only for as long as is required by the emergent situation, and in ways that optimize the person's opportunities for exercising whatever degree of self-determination remains possible at the time (Davidson 2012:834)

He continues that Geller overlooks:

that generations of persons with mental illnesses underwent involuntary treatments (including lobotomies) and prolonged confinement not for any illegal or dangerous behavior but simply for having a mental illness. Until we can rest assured that this can no longer happen—that persons will no longer be coerced because of their psychiatric status—recovery advocates will continue vigilantly to challenge the use of coercion to ensure that it is used only when, and only for as long as, it is absolutely necessary (Davidson 2012:834)

Munetz and Frese (2001) also weigh in on the place of involuntary treatment in recovery-orientated care. They argue that psychiatrists should advocate for consumers to receive treatment so that the consumers can engage in the recovery process after the medication alleviates the worst of the symptoms —failing to do so abandons consumers, leaving them victims to their illness. Munetz and Frese (2001:39) continue that a consumer who lacks the capacity to make decisions vitally need involuntary treatment. With this treatment, such consumers have a chance at recovery, but without treatment given to them without their consent for as long as needed, they don't stand much chance of recovery--to advocate for self-determination for these people is "specious advocacy" (Munetz and Frese 2001:39).

To address the problem of people who do not pose a threat to themselves or others but who do not possess the capacity to consent to needed treatment and keep the recovery orientation, Munetz and Frese (2001:40) propose a "consumer-as-guardian" program where a peer who has lived experience with a psychotic disorder but is in recovery serves as a guardian. In this model, the peer guardian, who has experienced similar circumstances but gotten better, could help the consumer accept the treatment, since hearing the need and presumably benefits of

treatment from a peer would likely better convey the message, and the peer guardian could protect the consumer from “misguided paternalism” and help the consumer and the treatment team come up with a treatment plan with which the consumer will comply. They think this model could shift advocacy back to the “right to be helped” and away from the “right to refuse” (Munetz and Frese 2001:40).

Advocates of recovery will also argue that the use of seclusion and restraint oppose the values of recovery. Ashcraft and Anthony (2008) discuss an initiative that aimed to eliminate the use of seclusion and restraint in two crisis centers to move them closer to promoting recovery-orientated practices. Since mental health professionals have long practiced and considered seclusion and restraint necessary stopping reliance upon them required a cultural change. Against the initial resistance of the crisis center staff, the leadership at these crisis centers insisted on the initiative to stop using force. Staff learned new recovery-orientated beliefs and values to implement in order to stop using force, including “using the language of recovery in strength-based conversations...ways of building resilience through self-directed treatment planning...practices that would empower each consumer, instead of having staff striving for compliance and control...giving consumers as much responsibility as possible for their own lives and behavior” (Ashcraft and Anthony 2008:1200). The addition of peers to the crisis center also helped shift away from seclusion and restraint and improved the staff’s acceptance of the possibility of recovery.

Psychiatric Advance Directives

Recovery-orientated values generally address the potential for crises that prevent consumers from making informed decisions about their treatment through the creation of psychiatric advance directives (PAD). Consumers put together the PAD during times of wellness, and they lay out the consumers' choices for what should happen if they experience a worsening of symptoms that prevents their ability to make this choice, thereby maintaining the recovery value of directing one's own treatment, self-determination and avoiding use of involuntary treatment or seclusion (Scheyett et al. 2007; Onken et al. 2007). Consumers can control future treatment with a PAD by either advance instructions or establishing health care power of attorney:

Advance Instructions can include statements of acceptance or refusal of certain medications or other treatments such as electroconvulsive therapy, provision of information regarding actions to occur if hospitalized (e.g. contacting a family member), and advance informed consent for interventions such as hospitalization...Health Care Power of Attorney (HCPA) allows individuals to appoint a proxy decision maker for times when they are no longer capable of making treatment decisions. (Scheyett et al. 2007:71)

Peer support can improve the accessibility of PAD. Peers helping other consumers create PAD may have the advantage of being able to “more easily engage with those wishing to prepare a PAD, more readily establishing honest dialogue about the individual's crisis needs and preferences,” “may provide suggestions and insights from a perspective that professionals cannot offer” and “if the PAD facilitation also includes participation by the provider, family, and/or other support person, a peer facilitator can function as a mediator among the participants and an advocate for the individual, ensuring that the person's voice continues to be heard and choices honored through-out the PAD creation process” (Scheyett et al. 2007:73).

Housing as a Recovery-Orientated Service

Piat et al. (2015) state that recovery-orientated services must provide stable housing. A lack of stable housing makes other aspects of recovery, including control of symptoms, difficult. Summarizing prior research on recovery-orientated housing, Piat et al. (2015) describe it as offering consumers safety, quality, affordability and control over their own lives. The staff of recovery-orientated housing recognize consumers as having wants and needs, like any other person, and believe in the potential for the residents to recover. Without housing and access to other basic needs, people with psychiatric disabilities will struggle to move on in their recovery process. Access to housing, though, does not automatically reflect the principles of recovery. Piat et al. (2015) found in their study that congregate housing did not necessarily offer real choice in care or provide peer support and help finding employment to its residents.

Recovery-orientated services may use a Housing First (HF) model to provide housing to consumers. HF gives the consumer a place in which to live without the requisites of reaching a certain point in psychiatric treatment or sobriety (Polvere, Macnaughton and Piat 2013). Providing consumers with housing allowed consumers to imagine a future and pursuing other recovery-orientated goals—such as “people envisioned addressing mental health issues, rebuilding relationships, reconnecting with past interests, going back to school, and looking for work” (Polvere, Macnaughton and Piat 2013:111). This sense of the potential for the future provides consumers an opportunity to reclaim their identity and motivates them to move forward (Polvere, Macnaughton and Piat 2013).

Recovery communities also address the need for housing for people with severe mental illness. Recovery communities house consumers who live independently and receive service and support from case managers and other mental health professionals through a connected agency, and they embody recovery values such as valuing the residents' voices and input in aspects of running the community, treating consumers with respect, relying on social support from peers, and helping consumers toward growth with personalized services (Carpenter-Song, Hipolito and Whitley 2012). Carpenter-Song, Hipolito and Whitley (2012) look at how the housing environment in these recovery communities affect recovery. Consumers who live in these communities say that they have helped them with their recovery. They attribute to their recovery the quality of the mental health services provided, the safety of the environment in contrast to the dangers of homelessness in an urban setting, the security and pride of having their own home to which to return, and social factors such as the sense of community, acceptance by other residents, the constant availability of social support and the accountability to other consumers in recovery.

Similar to recovery communities, Whitley and Siantz (2012) look at a recovery center that offers supported housing but also runs classes to teach consumers skills they need for clinical and functional recovery. Recovery centers are built around the idea that consumers should strive for more than clinical recovery, focusing on helping consumers gain what they need to enter "appropriate educational facilities such as community college, to become competitive in the open job market with an eye to finding gainful employment, and to enhance skills such as cooking or anger management that may allow better daily functioning" (Whitley and Siantz 2012:12). The consumers who used the center spoke highly of it because the skills

they learned there helped their recovery both clinically and functionally—but as the authors point out, their study only evaluated the consumers’ opinions not the center’s effectiveness on recovery outcomes.

First-Episode Psychosis Programs

In recent years, programs have been, and are being, developed and researched that specifically focus on treating mainly young people with first episode-psychosis (FEP)—such as the National Institute of Mental Health’s RAISE (Recovery After Initial Schizophrenia Episode) initiative and NAVIGATE (Mueser and Cook 2014). FEP programs are designed around the idea that interventions that reduce the duration of untreated psychosis and that happen before the establishment of disability will lead to better clinical and functional outcomes (National Institute of Mental Health 2016). They provide recovery-orientated care that intervenes in many aspects of the person’s life, for instance supported employment and education, psychotherapy that builds coping skills, resilience and illness management, education for family on supporting recovery, and use of medication strategies specific to FEP (Mueser and Cook 2014).

CHAPTER 6: THE ROLE OF SERVICE PROVIDERS IN RECOVERY

The interactions between the provider of mental health services and the consumer and the relationship or lack thereof produced play a significant role in the recovery process and consumers' personal experience in the mental health care system and in their quality of life. This relationship is perhaps one of the main determinants of recovery. In recovery-orientated mental health services, a consumer will most likely encounter various mental health professionals, such as a psychiatrist, therapist and case manager, and some services delivered by peers in recovery. The focus on the consumer-provider relationship and the inclusion of non-medical peer services shows the concern that the delivery of services goes beyond just controlling symptoms.

This chapter describes the role of professional mental health services providers and peer support services.

Professional Services

Provider-Consumer Relationships

Relationships with service providers can either promote or impede recovery. Recovery-orientated care focuses on building trusting, collaborative relationships between service providers and consumers that focus on alleviating distressing symptoms and helping the consumer manage her illness. In addition, service providers respect the consumer as a person without judgment and believe in the person's potential—essentially relationships in which recovery values manifest (Ruscinova et al. 2011).

Green et al. (2008) describe how the relationship between psychiatrist and consumer affect recovery. Participants in the study expressed the need for a good fit with their psychiatrist, which came from things such as listening to the consumer, providing feedback and knowing when to push them and being hopeful and compassionate toward them and would choose to find a new one if they did not feel comfortable. Consumers also expressed the need to trust their psychiatrist and have them trust the consumer in return and the value of having a relationship with psychiatrist that more resembled a friendship than being purely clinical—more “friendly” relationships helped people feel “normal” rather than “mentally ill.” Consumers in this study reiterated the importance of collaboration in the relationship, especially when it came to medication management.

The psychiatrist-consumer relationships that consumers saw as “most helpful and collaborative took significant time to establish...with mutual experience and trust developing over a number of years,” which makes the high turnover rate in public mental health care problematic for the delivery of recovery-orientating care (Green et al. 2008:20). To this end, Young, Green and Estroff (2008) suggest creating mental health systems that train professionals in establishing beneficial relations and give them the opportunity to practice them and that allow for longer periods of time between consumers and providers.

Person-Centered Care

Recovery-orientated care is often framed as being person centered. Recovery shifts that balance in the doctor-patient relationship so the care focuses on the needs and wants of the consumer, not purely what the psychiatrist views as necessary—person-centered care. Whitley and Drake (2010:1248) say person-centered care “attempts to perceive and assist the whole person in his or her social context, working with that person to provide help in a holistic and personally meaningful fashion. Well-known person-centered, recovery-oriented interventions include supported housing, supported employment, peer support, and programs that attempt to harness religion or spirituality.”

Davidson et al. (2006:643) describe person-centered care in recovery as requiring “reframing the treatment enterprise from the professional's perspective to the person's perspective.” Person-centered care means that the psychiatrist respects and recognizes the consumer as an individual, acts transparently so consumers have adequate information to make decisions and understand their condition, explains to them when they would need to involuntarily hospitalize them, and regards consumers as partners in finding a treatment regime that both works for them and to which they will adhere. Shared decision-making as Deegan and Drake (2006) describe exemplifies how person-centered care can work in medication management.

Supporting Recovery

A recovery-orientated clinician should support the consumer in having the opportunity to choose and pursue one's goals and social roles and in having hope for a better future—that is, in pursuing recovery. Psychiatrists should center recovery in their practice, using everything else they do as a way to support it (Le Boutillier et al. 2011).

Psychiatrists' expectations for the consumer can shape the consumer's own expectations. Whereas before recovery-orientated care, psychiatrists may have told a consumer he could hope at best to control his symptoms and avoid stress, conveying low expectation for that person, in recovery-orientated care, psychiatrists should maintain and through their relationship with the consumer help him move forward with his recovery while respecting the consumer's strengths and limitations. Supporting a consumer's recovery can take the form of believing that a consumer will find a treatment that works, retaining hope for the consumer even when she encounters the inevitable setbacks in recovery and treating the whole person in the context of her life, not only alleviating symptoms (Green et al. 2008; Smith 2000)

While the psychiatrist cannot force any recovery values on consumers or “do” recovery for them, they can support consumers in the process of recovery (Le Boutillier et al. 2011). Walsh (1996:87) agrees with this point: “No one else, including the best of service providers, can do anything but facilitate the healing process. However, this facilitation—if it takes the form of good attention, respect, validation, and genuine connection--is an essential part of recovery.”

Diamond (2009:1155) describes ways that psychiatrists can support recovery:

Support the attitude of recovery whenever and wherever it occurs. Support hope. We must believe that this person's life can get better...Celebrate the small victories of each client. Support strengths. It is easy to find things that the person is not doing well. Rather, focus on what is going a bit better, even a small bit better... Start with the client's own goals. We need to support strengths and support risk taking when appropriate. What does the client want, in his or her own words? ...We may not agree with all of the client's goals, and the client may not agree with all of ours. Focus on the goals that we share...[and] support activities that the client can undertake to promote recovery.

The Use of Peer Services in Recovery-Orientated Care

The use of peer support in the treatment of mental illness has risen alongside the implantation of recovery-orientated care. While no precise definition of what peer support entails, how to structure these programs or the role they should serve in the treatment plan exists, it generally refers to a person with severe mental illness who uses mental health services themselves and who has reached a farther point in the process of recovery that has a role in the provision of mental health services to other consumers (Resnick and Rosenheck 2008). Peer support can take place in self-help agencies run by persons with a history of lived experience with mental illness, independent of other mental health services, within traditional mental health services or in the form of support groups led by peers (Vayshenker et al. 2016).

Resnick and Rosenheck (2008:1307) describe peer support:

Most peer-provided mental health services believe that consumers can benefit from interacting with people who have themselves experienced similar difficulties, learned to cope with them, and found reasons for hope for the future. Peer services are founded on core values, such as empowerment, taking responsibility for one's own recovery, the need to have opportunities for meaningful life choices, and the valuation of lives of people with disabilities as equal to those of people without disabilities.

Fekete (2004:192) speaks of the importance of peer services in recovery-orientated care:

The Peer Specialist is a recognized member of the treatment team that also shares the whole depth of experience that the client is undergoing. The Peer Specialist has a special understanding of the drives that cause isolation after the disorientation of psychosis. As “one who has been there,” the Peer Specialist can foster a solidarity with the person being served. With this special bond of mutual understanding, the Peer Specialist recognizes the disorientation that can occur during recovery and stays in the moment with the person being served, waiting in the darkness, speaking through the turmoil. The Peer Specialist can thus supply needs for community that go beyond ordinary friendship, until the person being served passes through the recovery period and is ready again to strike up those endearments that so enrich our lives. Here, mutual camaraderie becomes a therapeutic tool.

Benefits of Peer Services

Peers who provide services to others with mental illness model recovery to other consumers less far along the journey of recovery. While at best mental health professionals can tell consumers about the potential for recovery, peers can demonstrate—by sharing their own stories of experiencing symptoms and disability and speak of how they came to manage their symptoms and regain a positive sense of self, quality of life and accomplish goals—that recovery does happen. Having a role model who has had similar experiences with mental illness fosters hope for the future in the consumer and encourages her to learn how to cope with and manage her own illness (van Gestel-Timmermans et al. 2012). The participants in Lewis, Hopper and Healion (2012:64) exemplify the value of peer support: “Many members claim that having peers as providers gives them role models. For Mike, ‘Hiring people who are also in recovery is key. ... It's inspiring. They are productive; they want to be part of society. It makes me feel like I can do it, too.’”

In addition, the consumers providing the peer support benefit because they have a chance to act as helpers, a contrast to the role of the one helped in traditional mental health care (Pettie

and Triolo 1999). This role of helper in the peer support relationship can increase self-esteem and self-worth among participants and can teach them skills over the course of leading support groups or programs that help them understand their own illness and recovery and use these skills to better cope in their lives (Corrigan 2006; Perry et al. 2013).

The relationships forged and the accountability in peer support, for both the consumer giving and receiving the care, promote recovery (Lewis, Hopper and Healion 2012; Young and Ensing 1999). Persons who partook in a peer-run course saw improvements in empowerment, hope and self-efficacy beliefs—elements necessary to start the process of recovery (van Gestel-Timmermans et al. 2012). Other benefits of peer support include “sharing the positive and challenging experiences of mental illness, validating one's own and others' strengths through supportive discussions, and bolstering motivation toward recovery” (Fukui, Davidson and Rapp 2010:944). In addition, “peers can provide more empathic support and make participants feel more comfortable about discussing experiences and feelings [and] may have more influence on clients' attitudes, values, and behavior” (van Gestel-Timmermans, Brouwers and van Nieuwenhuizen 2010:945).

Participants in Firmin et al. (2015) specifically expressed an interest in assisting other persons with mental illness by working in peer services or taking part in self-help groups and in ways such as helping others to combat external and internalized stigma or sharing the skills they learned to self-manage their illnesses. Helping others also helped the recovery process for these participants because it helped them manage their own illness—it provided structure and a sense of normalcy to their lives, and volunteering kept them active and potentially paved the way for a return to the workforce (Firmin et al. 2015). Participants who talked of helping others “described

the confidence and hope they experienced when engaging in helping behaviors... helping others became an important aspect of how they saw themselves—as someone capable of giving back to others” and “had significantly greater quality of life, insight, recovery, hope, illness management, patient activation, and medication adherence and lower overall, negative, positive, and cognitive symptoms” (Firmin et al. 2015:338-339)

Lewis, Hopper and Healion (2012) describe an example of recovery-orientated, consumer-run services—what they call Open Arms, a center that provides help to members with their housing, employment and advocacy needs, as well as recovery-orientated psychiatric treatment. Members of this center support each other in their recovery, building authentic relationships with mutual accountability for their peers, which helps members to stay sober or stick with treatment because they do not want to let down their peers (Lewis, Hopper and Healion 2012). Services at the center revolve around psychosocial goals that members set when they start at the center.

Other peer-led group programs created to help consumers in their recovery involve peer instructors who lead discussions and lessons relevant to recovery. Perry et al. (2013:929) ran a pilot program that taught certified peer specialists recovery-orientated cognitive therapy, which “emphasizes individualized goal attainment: long-term goals are broken down into intermediate and short-term goals, and specific strategies and techniques are then used to overcome obstacles (such as low energy and positive symptoms) to goal achievement” and “peers learned to use recovery-oriented cognitive therapy strategies to enhance and support consumers’ recovery efforts”—to provide them with skills to work with persons with schizophrenia.

Dalgin et al. (2011) present another form of peer-run mental health services—a “warm” line for consumers to call if they need support, but are not in a crisis, when other service providers are closed. Peer specialists run the warm lines and can “can offer hope, strength, and knowledge gained from their own personal experience of the recovery process” and are “trained in active, empathic listening, disclosure, providing possible ideas for coping strategies and how to bridge to crisis services should it be necessary” (Dalgin et al. 2011:66). The majority of callers to the warm line reported that the warm line made them less likely to need crisis services and that they discussed coping strategies with the peer on the warm line. The participants also felt the peer support on the warm line improved their well-being, gave them a sense of security to know they could access that service, helped them feel more empowered, and a majority indicated that the program contributed to their recovery process.

Benefits of Recovery-Orientated Care

Better recovery outcomes as a result of recovery-orientated care, including trusting, collaborative and person-centered psychiatrist-consumer relationships, reflect the importance of its use. Chang et al. (2013:83) conclude that “people who receive services that are viewed as adhering more to recovery principles tend to have better recovery statuses. Therefore, it is recommended that mental health professionals, administrators, and policy-makers implement recovery principles in their work. Greater adaptation of recovery-oriented services is likely to lead to greater recovery among people with psychiatric disabilities.” Green et al. (2008:19) find that “individuals with serious mental illness who receive recovery-oriented, patient-directed care in the context of long-term, close, collaborative relationships with their clinicians are more

satisfied with their care and have fewer psychiatric symptoms, better recovery outcomes, and enhanced quality of life.

CHAPTER 7: RECOVERY-ORIENTATED MENTAL HEALTH SYSTEMS

The shift toward making mental health services recovery orientated forced changes in the provision of mental health services at all levels—from the day-to-day interactions between mental health professionals and consumers to the organizational structures that provide these services. Recovery cannot take hold from declaration of policy alone—it requires commitment at the systems level and the work of individual service providers to understand and carry out recovery values. Recovery-orientated mental health systems incorporate the values of recovery with a goal of helping the consumer manage their illness; see the consumer as an individual with needs, values and goals; allow service users and their families meaningful opportunities to design services; incorporate language that focuses on strengths and the potential for recovery, and all services work together to promote the individual achievement of personally identified recovery goals (Anthony 2000). Restructuring mental health care to be recovery orientated, to include services and service providers who can support consumers in their recovery, reflects at the policy and system levels the shift to promote mental health along with treating mental disorder. This chapter addresses how mental health services have and can become inclusive of recovery values in practice and orientated toward recovery.

Putting Recovery into Practice

A recovery-informed mental health system should differ from previous models of mental health care; whereas older systems had a purpose of maintaining the consumer through services professionals control, recovery models work with the individual consumer to support her

in managing her illness and building a meaningful life in the community (Davidson et al. 2007). The implementation of recovery-orientated care often involves the reworking of entire mission statements of organizations, a change of the specific services offered, changes in sources of funding, changes in the structure of organizations and the culture of mental health service providers. The latter necessitates dissemination of knowledge of recovery and training in how to deliver recovery-orientated care. Places that have designed and put into practice recovery have had commonalities in their experiences.

Becker et al. (1998) wrote about the experience implementing Individual Placement and Support (a supported employment program with the goal of putting consumers in jobs of their choosing) and Pascaris, Shields and Wolf (2008) about the Work and Recovery Project—both conveyed the need when transforming a system for a clear vision and set of policies, strong leadership that believes in the values of recovery, training staff in how to do recovery-promoting strategies and having a system to self-evaluate progress. Davidson et al. (2007:24) addressed their experience transforming Connecticut's mental health system, which involved:

- a) developing core values and principles based on the input of people in recovery;
- b) establishing a conceptual and policy framework based on this vision of recovery;
- c) building workforce competencies and skills through training, education, and consultation;
- d) changing programs and service structures;
- e) aligning fiscal and administrative policies in support of recovery; and, finally, f) monitoring, evaluating, and adjusting these efforts.

Jacobson and Curtis (2000) discuss how the states have gone about putting recovery into policy and practice. They argue the introduction of recovery has emerged alongside managed care approaches—which views recovery as a way to achieve cost-effective mental health care and as requiring measurable outcomes. The process implementing recovery begins with

creating a vision statement that defines recovery, underscores the important role it will have in mental health care and recommends how to bring recovery into practice. In some cases, and demonstrating a lack of understanding of recovery, states have just renamed current services—now calling them “recovery orientated.” In the cases in which states actually try to make the shift toward the actual incorporating of the values of recovery, strategies include educating consumers, families and service providers; involving consumers in designing and researching mental health services; creating consumer-run services and focusing on preventing relapse and planning for crises.

Putting recovery into practice so it can receive funding and be held to standards of accountability also required turning the abstract into a measurable concept—thus the need to determine the different aspects of recovery to be included in an instrument (Jacobson and Curtis 2000). At all levels, policy makers, administrators and service providers review their practices to make them compatible with recovery and to ensure the implementation of best practices for recovery-orientated services. Since recovery has entered the mainstream and has been turned into the quantifiable, some consumer advocates worry it detracts from the original essence of recovery or will end up as a fad that will ultimately fail to truly change the delivery of mental health care.

Hunt and Resnick (2015) have a similar concern. They argue that in the adoption of recovery in mental health systems, professionals inadvertently co-opted the language of the original recovery movement. Hunt and Resnick (2015:1235) write about the origin of the recovery movement:

We trace the recovery movement back to the social justice movements of the 1960s and 1970s, exemplified by expatient survivor activist groups such as the Insane Liberation Front. These activists, motivated by a shared experience of outrage after distressing encounters with the professional mental health system, sought to develop support networks and a voice independent of professional mental health services. These early efforts were decidedly out of the mainstream, excluded professionals, and were, at their heart, social justice movements that rejected the medical model of care's emphasis on symptoms and on power imbalances in the relationships between health professionals and care recipients.

Since then, recovery has entered the mainstream, which has also led to efforts to “define and operationalize recovery to pursue the worthy goals of the recovery movement”—the work of SAMHSA to define recovery, the creation new mental health interventions to support recovery and changes in mental health systems—what they call the “professionalizing of recovery” (Hunt and Resnick 2015:1235). Because of the professionalization of recovery, Hunt and Resnick (2015:1235-1236) argue:

Recovery could no longer be a radical social justice movement because professionals, who by definition are part of the established system, make changes within the boundaries of the financial, legal, and structural rules of a medical model health care system. Professionalizing recovery created dissonance with the original goals of the recovery movement. Initially the recovery movement attacked the very notion of diagnosis as unnecessary labeling; professional recovery maintains diagnoses but uses person-first language to minimize labeling and stigma. Leaders in the early recovery movement rejected professional guidance, learning through trial and error regardless of risk; mainstream service systems minimize risk and maximize safety... This well-meaning theft-through-adoption of recovery not only has poorly represented the original goals of the movement but also has overpowered the voices of recovery calling for radical changes to the system.

They propose a solution to the problem they have observed that mental health professionals should return the term “recovery” to consumers, “permitting individuals with lived experience to reclaim the definition, process, and experience of recovery as their own” (Hunt and Resnick 2015:1236). Mental health professionals should then join the larger patient-centered care

reform effort in the medical community. Patient-centered care has similar values as professionalized recovery, and joining a unified movement with other medical specialties will address the problematic divide between general and mental health services, which they think will reduce stigma and disparity in mental health care.

Piat et al. (2016) write about another way designed to improve recovery-orientated practices: recovery communities of practice. This article talks about a Canadian context, but SAMHSA also has Recovery to Practice. They describe the community of practice as “a group of diverse stakeholders who work together to share and transfer knowledge; support diverse practices, strategies, and solutions; develop a culture of collaboration; mobilize opportunities for quality improvement; and influence decision-making bodies” (Piat et al. 2016:10). Members include consumers, service providers, family members and researchers—who all share the goal of sharing knowledge of recovery and turning what they learn into changes within actual mental health settings.

In 2010, SAMHSA initiated Recovery to Practice to provide service providers with the training they need to practice recovery-orientated care in their everyday work with consumers (del Vecchio 2015). SAMHSA worked with the service organizations in the fields of psychiatry, psychology, psychiatric nursing, addiction specialists, peer specialists and social work to create specialized training programs to teach recovery to the members of each organization. The training programs for each of these organizations focused on addressing the needs of each organization’s members for implementing recovery-orientated care in their respective fields. The organization then developed their own strategies to disseminate the training curricula,

and Recovery to Practice created an online resource center with a collection of training materials and a training series on various recovery-orientated care strategies (SAMHSA 2016; del Vecchio 2015:751).

Training Service Providers in Recovery

Proper training about recovery principles improves provider knowledge and hopefulness about recovery and helps them see recovery beyond clinical measures, which stresses the importance of giving mental health professionals in-depth training about what recovery means and how to provide recovery-orientated care (Crowe et al. 2006; Feeney, Jordan, McCarron 2013). Mental health professionals may have encountered negative messages about the prognosis of serious mental illness and thus do not believe in recovery, do not understand how to implement recovery in their practice, may not have had any past formal training in recovery models and some might not understand how to work with consumers to achieve their goals. Chen et al. (2014) studied a recovery competency education program designed specifically for providers in an inpatient setting; participants in the study reported that they found the skills useful for potential practical application. To evaluate from the point of view of the consumer the degree to which service providers use recovery-promoting skills, Russinova et al. (2013) designed the Recovery Promoting Relationship Scale. The scale rates the extent to which providers promote hope, empowerment and acceptance and build a relationship with the consumer.

Davidson and Chan (2014) argue that training for service providers in recovery-orientated practices should directly teach how to establish a healing relationship with the

consumer, that, in fact, the evidence base for the recovery-orientated case lies in the effectiveness of consumer-provider relationships. Service providers should thus receive training in how to “instill hope and raise expectations; how to empathically and nonjudgmentally listen, accept, and understand the people they serve on their own terms; and how to provide accessible and useful information about a range of topics (including, most prominently, strategies for self-care) and encourage and support the person in using this knowledge to pursue his or her own recovery” (Davidson and Chan 2014:676).

Problems with Implementation

Service providers in Piat and Lal (2012) discuss challenges service providers encountered during the shift toward recovery-orientated mental health systems. Service providers had trouble understanding what exactly recovery meant, such as the comment, “What's recovery? I still have trouble to really understand it. It's a process, we know that it's this idea of a process, and I want to say, we've seen all sorts of definitions. I've seen many in my time...what's the difference between empowerment and recovery?” (Piat and Lal 2012:293). They did not understand how to focus on recovery in settings such as hospitals, crisis interventions or with populations that lack basic necessities such as housing and food. Service providers took issue with the bureaucratization of recovery, which made them have to do extra paperwork and get approval for recovery-orientated practices they say they would have done anyway. Some service providers thought that leadership did not really know or care about the implementation of recovery, but pushed it on the service providers without providing necessary support or consulting with them about recovery practices. Finally, providers found they ran into stigma among service providers

in the community whom they encountered while trying to help consumers with their recovery, which made their jobs supporting recovery more difficult.

Diversity in Recovery-Orientated Services

Ida (2007) writes about the experience of recovery in diverse populations. Citing the New Freedom Commission on Mental Health (DHHS 2003:49), she writes that the “current mental health system has neglected to incorporate, respect or understand the histories, traditions, beliefs, languages and value systems of culturally diverse groups,” arguing that recovery-orientated services need to include culturally competent care. This care includes “helping an individual reclaim one's culture and community as part of feeling whole again” and “respect[ing] the importance of culture” (Ida 2007:51-52). Mental health systems must also have service providers who match the diversity of the populations they serve, and training for service providers must “adequately address cultural or linguistic competency, ethnic identity, or sexual orientation” (Ida 2007:51).

In addition, people from diverse backgrounds may also have different meanings of recovery and relations to the word that service providers need to take into account (Das 2012). Service providers in this case, when the term “recovery” does not fit with the person's experience, must aid the person within the framework of their personal understanding (Das 2012). People of color, LGBT people and foreign-born people may face additional trauma, which mental health care must also address (Ida 2007).

Recovery in the context of people marginalized by the stigma of mental illness and by their ethnicity, language and sexual orientation goes beyond recovering from the illness and its

effects on their lives—it must take into account the larger, external social forces. Jacobson and Farah (2012:335) give the meaning of recovery in this sense:

Recovery thus refers not just to the processes of hope, healing, empowerment, and connection occurring at the individual level, but also to the need for these processes to work at other levels. Hope encompasses not only an individual's belief that a better life is possible for himself, but a broader sense of opportunity for an entire cultural-linguistic community. Healing means not just that an individual's distress is lessened, but that his extended family is able to move toward better health and functioning.

CHAPTER 8: DISCUSSION

The Representation of Recovery

The psychiatric discourse on recovery centers on four major themes—defining and elaborating upon the major components of recovery, describing the development of recovery-orientated mental health programs and their effectiveness, contextualizing the role of service providers in recovery and the implementation of recovery into structures of mental health care (Table 6). The articles that define what it means to recover include analyses of recovery narratives that seek to determine the important elements of recovery for the sake of adding clarity to definitions. Knowing what consumers want to gain from their recovery process can help mental health professionals know which services to include in recovery-orientated care, how to shape these programs and how service providers should relate to consumers. The services created, or adapted in some cases, to promote recovery teach skills that reflect aspects of recovery—responsibility for life, empowerment, hope, pursuit of goals. Interactions between consumers and service providers should adhere to these principles of recovery as well—relationships with providers who see them as individuals not diagnoses, allow them some control over their treatment and offer them hope. Finally, the transformation of mental health systems ideally reflects the goals of recovery and methods shown to support consumers in recovery.

Table 6. Main Themes in the Representation of Recovery

	Description
Theme	
Constructive Elements of Recovery	Hope Responsibility for Life Rights of Consumer Meaningful Activities Empowerment Life in the Community Moving Beyond Illness Identity Acceptance of Illness Symptoms Control Social Support Religion/ Spirituality Activism
Treatment Methods that Promote Recovery	Wellness Recovery Action Plan (WRAP) Illness Management and Recovery (IMR) Assertive Community Treatment Medication Role of Coercion Psychiatric Advance Directives (PAD) Housing as a recovery-orientated service First Episode Psychosis Programs
Role of Service Providers	Professional Services: Provider-Consumer Relationships Person-Centered Care Supporting Recovery Peer Services: Modeling Recovery
Recovery-Orientated Mental Health Systems	Building Recovery-Orientated Mental Health Systems Training Mental Health Professionals in Recovery Values Problems with Implementing Recovery Diversity in Recovery-Orientated Services

My study agrees with what other studies have found about the discussion of recovery in psychiatric journals *Psychiatric Services* and *Psychiatric Rehabilitation Journal* extensively publish articles with recovery as the main focus (that is, with recovery in the title)—articles examining recovery from the perspective of consumers using their accounts to determine how they define and experience recovery, which services they consider most valuable to the recovery process and rigorous studies that test the effectiveness of recovery programs—while *JAMA Psychiatry* and the *American Journal of Psychiatry* do not publish articles that talk of recovery in any such way. When discussing recovery, they frame it solely as an outcome of an intervention, a result in a longitudinal study (Strakowski et al. 1998; ten Velden Hegelstad et al. 2012; Wunderink et al. 2013) or in the context of another topic (Drake et al. 2013)—mentioning

recovery in the text of the article but not including it in the title. As an effect perhaps of other studies, these journals do acknowledge the need to include a functional recovery component in any clinical definition of recovery and the benefits of psychosocial interventions to recovery (Penn et al. 2005; Wunderink et al. 2013).

Recovery entered into the psychiatric discourse when service users voiced their lived experience of recovery, orientating their own lives in the context of problems and the potential for change they saw in the mental health system (Deegan 1988; Lovejoy 1984). Researchers, such as Anthony (1993), took the narratives of these consumer-survivors and called for further understanding of the experience of recovery and for mental health systems to take up this “vision” of person-centered services. This call, along with psychiatry’s realization of the heterogeneity of outcomes, led to the increasing number of studies looking at various aspects of recovery, further established as a subject of interest by its eventual acceptance into the mainstream. As evident in all the journal articles, researchers responded to the need to better define recovery and recovery-orientated services and later design programs and methods to promote recovery in the mental health system, while others described their experience putting these recovery-orientated services into practice, so its contribution could extend beyond the theoretical discussions within the journals. The prevalence of articles about recovery in *Psychiatric Services* and *Psychiatric Rehabilitation Journal* shows the significance of the concept in psychiatry and the commitment to it by these mental health professionals and researchers.

Similar to original conceptions of recovery—such as Antony’s (1993:15) claim that “recovery is what people with disabilities do. Treatment, case management and rehabilitation are

what helpers do to facilitate recovery”—the representation of recovery here presents recovery as emerging from an interplay of an individual’s internal state and the social context in which this person experiences mental illness. For instance, hope, one of the defining elements of recovery, triggers a willingness to engage in the process of recovery, but hope and a desire to take part in the community, employment or other activities mean little in a system without opportunities to do so. For recovery to happen, the mental health system will need to have certain attitudes and services, but consumers must also engage with these services.

Recovery—as the individual-level process and outcome and the phenomena at the larger level—depends upon the provision of resources that encourage recovery. The creation of these recovery-orientated mental health systems depends upon an attitude—recovery as a guiding force. Recovery, as laid out here and built into policy, requires that consumers have access to the services they need, which requires proper funding of services, which has never quite happened; proper training and retention of mental health professionals; concern for carrying out recovery values at all level of care; and perhaps even re-evaluating legal standards for involuntary care.

Recovery has marked the beginning of a shift away from psychiatrists and other mental health professionals defining the meaning, potential and life course for a person with severe mental illness. The acceptance of non-clinical definitions of recovery within the psychiatric discourse parallels the acceptance of non-clinical voices, such as the individual with the mental illness oneself and peers, into the creation and implementation of treatment plans. Journals publish as articles first-person accounts of recovery. Consumers who went on to work as mental health professionals use their own experiences with the mental health system and recovery to inform their writing and practice. Consumers now in part shape the discourse, and shape policy

to the extent non-consumer policy makers take their presence in decision-making bodies seriously.

For individuals to pursue recovery, they must reframe their own view of themselves from diagnosis to person. In this same way, the mental health system must change the way it conceives of persons with mental illness and their potential in order to become recovery orientated. Recovery as a concept in the discourse around severe mental illness sought to change the meaning attached to a diagnosis, challenging the pessimism and inevitability of loss and severe limitations and pushing for hope and for mental health services that support that hope.

Recovery Puts “Mental Health” in the Treatment of Mental Illness

Prior to recovery as the goal, mental health care would have predominantly focused on removing the disorder. Whereas recovery expands outcomes and the services needed to reach them beyond the sphere of eliminating symptoms to factors similar to Keyes’s (2002, 2005) criteria for mental health. Keyes (2002, 2005) gives a definition that sees mental health as subjective well-being, an individual’s self-evaluation of one’s life and functioning and lays out “diagnostic criteria” for mental health. He includes as “symptoms” that represent positive functioning self-acceptance, personal growth, purpose in life, positive relations with others and social integration, which are similar to components of recovery (Keyes 2009:541).

Self-acceptance resembles the shift in identity that comes with recovery from that of mental patient to a positive view of the self where the mental illness is accepted as a single aspect of the person. Consumers in recovery must have hope for themselves and their futures, grounded in a belief in their own potential and strengths, which is like Keyes (2005:541) criteria

for personal growth. Recovery offers consumers the opportunity for a life that does not revolve solely around their mental illness and entails gradually coming to believe in oneself, working toward goals and gaining a different direction than a life controlled by mental illness, much like personal growth. Additionally, many people with mental illness find meaning in their lives from spirituality or religion or have as a purpose to advocate for and help other people with mental illness pursue recovery like they have. Environmental mastery reflects the idea in recovery that consumers can take responsibility for their own lives, whether it be in following their treatment plan, taking care of their everyday needs, having an active role in their treatment or creating and pursuing goals. In recovery, consumers consider supportive relationships with others, whether it be mental health professionals, peers, family or friends, invaluable to the recovery process, like Keyes's (2005) positive relations with others. Finally, social integration is like the elements of recovery that describes how consumers should be able to live and take part in personally meaningful activities in their communities.

Recent research on and conceptualization of mental health have challenged the long-standing assumption that the absence of a mental illness signified mental health. Payton (2009:223) supports the argument that mental health and mental illness do not represent "opposite poles of a single continuum" and thus, mental health is composed of more than the lack of a diagnosable mental disorder. Furthermore, Payton (2009:224), testing the relationship between the distinct yet related constructs of mental health and mental illness, suggests "disorder has no clear directional association with mental health...this result indicates that the absence of disorder may be neither a necessary nor sufficient condition for mental health." Recovery can perhaps explain this relationship. Consumers in recovery will for the most part live everyday

with mental illness and face the potential for an exacerbating of symptoms, but through access to recovery-orientated services, they can gain elements of mental health as well.

People who have a mental illness and who fit few of the criteria for mental health have the lowest levels of psychosocial functioning (Keyes 2005:546). People whose hopes and dreams, ability to take care of and trust themselves, functioning in work, school or social environments and their very sense of self have been damaged by mental illness and who have not received recovery-orientated care could fall into this category. Both the presence of the symptoms of mental illness and the absence of mental health disrupt functioning. Recovery then would need to address them both, which it does as evident by the components of recovery symptom control and the services included to reach that end and the components of recovery that reflect mental health and the adoption of services that promote achieving these states into mental health programs.

Keyes (2002:220) concludes “Mental health promotion should be the preeminent treatment objective,” an objective much in agreement with recovery. The objective of a recovery-orientated mental health system would be to reduce or eliminate the symptoms of mental illness (the clinical aspect of recovery) while also building within the person the positive elements of mental health (the not strictly clinical aspects). Recovery affords people with mental illness a chance for mental health, moving them from languishing with symptoms of mental illness to better mental health and lessened symptoms of mental illness. Similar to how the absence of a diagnosable mental illness does not necessarily mean the presence of mental health, the treatment of the symptoms of mental illness does not necessarily mean recovery. The goal of

recovery would thus be to not have any person with mental illness languishing with symptoms of disorder but pursuing mental health.

CHAPTER 9: CONCLUSION

The concept of recovery as constructed within the psychiatric literature represents a shift in expectations and priorities within mental health care to a focus of not solely treating the symptoms of mental illness but also promoting mental health. In freeing consumers from the inevitability of a life limited by mental illness, it allows them the possibility of creating a life filled with the positive symptoms of mental health. The psychiatric discourse within these journals lays out the components of recovery and describes and evaluates recovery-orientated services, the role of mental health professionals in these services, and the ways in which the mental health system can transform its services to reflect the recovery orientation.

The inclusion of recovery into the discussion and care of mental illness has altered what it means to be mentally ill. What recovery means, and how that meaning is acted toward from service providers to the policy makers who decide which services are provided, can change the meaning of mental illness. The meaning, and thus expectations, of a diagnosis of severe mental illness has ramification at all levels of mental health care, from interactions between consumers and providers to the services and opportunities built into the structure of the mental health system. A mental health system that does not consider recovery a potential will not provide the services needed to support it, and a society that does not will have trouble overcoming negative views about mental illness.

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