

Power

Recovery is an ongoing act of expressing power and has been described as “a manifestation of empowerment” (Jacobsen & Curtis, 2000, 334). It involves the rejection of labels linked to psychiatric disabilities and the acknowledgement and recognition of the personhood retained by the individual through the process of being ill, diagnosed, and in treatment, suffering and gaining control over symptoms (Davidson et al., in press; Harding & Zahniser, 1994). An outgrowth of the re-authoring process is the recognition that personhood entails the experience and expression of emotions as a normal part of the human experience rather than a mechanism of the illness (Deegan, 1996; Fisher, 2004). Information and education about the illness, available treatments and the possibility of recovery are forms of information that lead to choice, hopefulness and power (Deegan, 1996). Participation in consumer self-help and mutual aid teaches new coping skills and methods of self-advocacy and encourages situations of mutual acceptance, support, mentorship and socialization (Salzer et al., 2002; Smith, 2000).

Recovery “has a political as well as personal implication – to recover is to reclaim one’s life” (Jacobsen & Curtis, 2000, 334). Connections among peers allow a non-pathologizing community discourse, less susceptible to judgement, fostering expressions of power and collective social action (Spaniol & Wewiorski, 2002; Vodde & Gallant, 2002). These efforts serve to counteract the stigma imposed by society and internalized by individuals while instilling meaning in life pursuits. Political action and community organizing are routes that individuals take to enhance the degree to which their lives have meaning by challenging discrimination and improving the lives of others (Fisher & Ahern, 1999; Onken et al., 2002).

Choice Among Meaningful Options

The ability to freely choose how to live one’s life in areas that are important to the individual is the cornerstone of achieving a self-determined life and a crucial element in the recovery process (Cook & Jonikas, 2002). A related necessity is tangible supports that meet basic human needs – a safe place to live, sufficient funds to survive, and access to transportation and effective services (Baxter & Diehl, 1998; Long, 1994; Onken et al, 2002) – that grant an individual room to consider further choices in all aspects of life: a university or training program to enroll in, a job to apply for, a person to date, a child to care for (Dornan, Felton & Carpinello, 2000). Real choice is not possible,

however, without meaningful options, and the wider community plays a critical role in self-actualization through the provision of such opportunities and tangible resources.

What supports need to be in place for an individual to be able to make sound choices that promotes wellness, mental health, and the fulfillment of potential? Information about the psychiatric disability and treatment options is necessary. A lack of needed resources – community supports, family, friends, and providers – is a barrier to recovery. The notion of “effective freedom” comes into play. Effective freedom, first conceived by Nobel Prize Laureate Amartya Sen (1999), is the notion that freedom, even when legally codified, is effectively restrained when there is a lack of psychological, social and monetary resources available to achieve goals and live a meaningful life. Effective freedom is predicated on individual values and preferences, and in this regard it is mediated by the capacity a person has to develop and act on meaningful choices. Effective freedom is increased by creating a support system that is as flexible as possible, while providing the assistance necessary for the person to obtain critical and deserved resources, including social and psychological resources as well as financial and other material resources. The notion of effective freedoms – that freedoms guaranteed by law are not necessarily an accessible part of life unless the environment is one that includes access to the benefits of such freedoms – is one that reflects the critical role of social circumstances in the pursuit of recovery (Sen as cited in Cook, Terrell & Jonikas, 2004).

Within the treatment setting, it is indicated that consumers must have the freedom to design their own treatment plans – often referred to as an individual, consumer-driven, or personal recovery plan – and to choose with whom they work towards their goals. However, some advocates have called into question the extent to which choices are provided in most community treatment models (Unzicker, 1999; Fisher & Ahern, 1999), particularly for people of color (Neighbors, Elliot et al., 1990; Snowden & Lieberman, 1994). Too often, freely chosen options that are self-determined are viewed as a privilege to be earned rather than as a right (Chamberlin & Powers, 1999). People are often “rewarded” for treatment compliance by being given “opportunities” for self-determination and choice (Unzicker, 1999). The recovery process is entwined with and moved forward by the establishment of options in the treatment setting and all areas of life that extend beyond notions of illness or impairment and are not circumscribed by stigma and discrimination.

Community-Centered Elements of Recovery

Supportive social relationships, circumstances and opportunities must be in place for recovery to be fully actualized. Recovery is quite reliant on an environment that provides opportunities and resources for new or resumed social roles, engagement in relationships with others and meaningful integration in the larger society. Efforts toward integration are performed by the individual and by those in relationship with the individual, be they family, friends, partners, employers or mental health professionals.

Social Connectedness/Relationships

Human connection plays a large role in the healing process and recovery (Ahern & Fisher, 1999; Baxter & Diehl, 1998; Beale & Lambric, 1995; Deegan, 1998; Onken et al., 2002). It is important for the individual and her or his network of family, friends, and service providers to recast the healing process in a way that promotes further functioning. Support of others in the form of relationships built on love, patience, and trust are a requisite to recovery as well as an outgrowth of the recovery process, as individuals are able to (and wish to) rebuild relationships and take on responsibilities associated with familial and partnership roles (Curtis, 1998; Deegan, 1998). Intimacy is a necessary element in a socially connected lifestyle, and can signal a level of recovery achieved as well as foster further steps towards recovery (Andreasen, Oades & Caputi, 2003; Baxter & Diehl, 1998; Harding, 1994; Liberman & Kopelowicz, 1994; Spaniol & Wewiorski, 2002; Townsend, Boyd & Griffin, 1999). The wider environment is critical in offering opportunities for such relationships to develop.

Social Circumstances/Opportunities

None of the elements of recovery are possible in a vacuum of valued opportunities. To consider the steps necessary to achieve a modicum of control over one's symptoms, basic needs must be met in terms of safe housing, adequate food and clothing, sustainable income, and adequate health care in order to free the individual and helping professionals to focus on building a healthy life and approaching complex dreams and goals (Baxter & Diehl, 1998; Long, 1994). The environment must include some amount of social supports in the form of friends, family and peers, as well as opportunities to access alternative therapies and formal supports including medications and mental health providers as well as peer groups (Curtis, 1998; Jacobsen & Greenley, 2001; Onken et al., 2002). A sense of trust that the mental health provider, family member or community group be

open regarding the possibility of life progressing beyond the current constraints of the illness is a part of an effective partnership (Ahern & Fisher, 1999; Deegan, 1998; Ralph, 1999). Conversely, a lack of trust linked to having been treated disrespectfully or differently due to the illness creates a barrier to positive change (Deegan, 2004; Johnson, 2000; Markowitz, 2001; Onken et al., 2002).

Stigma is a barrier to social opportunities on many levels. The stigma association with mental illness may keep an individual from a deserved job opportunity, a romantic relationship, or an apartment (Beale & Lambric, 1995; Onken et al., 2002). Furthermore, stigma can be internalized, compromising the individual's self-esteem, and leaving her or him with the idea that she or he is lesser than others, unworthy of various protections, and belongs outside the bounds of community life (Markowitz, 2001). On the other hand, it is also possible that the experience of being stigmatized can inspire a greater determination to beat the illness and the societal restrictions on behavior (Spaniol, Koehler & Hutchinson, 1994). One may speculate that are periods of time when an individual is motivated by the experience of being stigmatized and other times when stigma becomes a hurdle difficult to overcome (Townsend, Boyd & Griffin, 1999).

Integration

The ability to participate fully in the community by building on strengths and reintegrating is another facet of recovery (New Freedom Commission on Mental Health, 2003; Johnson, 2000), and one's close social network and the community at large become resources in the recovery process (Miller, 2000). Integration is necessary - both of the illness into a sense of self and of the individual into a welcoming community (Harding, 1994; Onken et al., 2002). 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 (Stephenson, 2001). The ability to live among (and interact with) others, mutual positive interdependence, is a hallmark of community and an underpinning of the recovery process (Johnson, 2000; Lapsley, Nikora & Black, 2002). Conversely, community sanctioned otherness and labeling are dehumanizing forms of oppression and violence (Deegan, 2004).

Further Reflections regarding Recovery

There is tension between the importance of self-determination to recovery and the impact of ongoing social stigma faced by individuals with psychiatric disabilities. Stigma persists that casts

people outside the bounds of normalcy, inscribing their life stories with expectations of failure, and a lack of future possibilities. The description of recovery as a unique process generated by the willing and strong individual who combats the illness and emerges in society able to function inadvertently perpetuates the myth that those who are psychiatrically disabled must earn their way back into the mainstream of society.

While much of the recovery literature exhorts the power of the individual in the face of insufficient services and outdated treatment philosophies, there is tension between the hope and promise of self-directed recovery, and the weighty responsibility for developing a successful self-care plan borne disproportionately by the individual. The lives of people contending with overwhelming symptoms and the role of the larger community in fostering the recovery process are topics that must be examined if we are to accurately represent the shared effort involved in recovering from a psychiatric disability - and overcoming the barriers imposed not only by the disability but by the stigma linked to the disability.

The "New Paradigm" of disability in the field of rehabilitation (DeLong & O'Day, 2000) views disability as an interaction between characteristics of an individual and features of his or her cultural, social, natural and built environments (Hahn, 1999). In this framework, disability does not lie within the person but in the interface between an individual's characteristics, such as their functional limitations or impairments or personal or social qualities, and the features of the environment in which they operate. While the old paradigm of rehabilitation generally views an individual with a disability as someone who struggles to function because of a limitation, the new paradigm views the individual as someone who needs an accommodation in order to function and views accommodations as civil rights. Using the new disability paradigm shifts the focus away from recovery solely being the responsibility of the individual to one that makes equally strong demands of the environment. It highlights how the environments of people with psychiatric disabilities often are socially inaccessible, economically unaccommodating, legally exclusionary, and emotionally unsupportive (Cook & Jonikas, 2002). It also directs the search for solutions and remedies away from "fixing" individuals or correcting their deficits to removing barriers and creating access through accommodation and promotion of wellness and well-being. Achieving recovery moves from being measured by the quantity of tasks one can perform by the person, to that of the quality of life one can have with supports (Zolla 1986). Concomitantly, the source of intervention is no

longer predominantly or exclusively mental health professionals and clinical/rehabilitation service providers but emphasizes peers, mainstream providers and consumer advocacy and information services. Most importantly, in the new disability paradigm the role of the person with a psychiatric disability shifts from being an object of intervention or a patient to one of a customer, empowered peer and decision-maker.

The lack of consensus regarding the definition of recovery and the abstract nature of the concept is in part due to the lack of consensus regarding what is mental illness. This ambiguity compounds the myriad of continued relevant questions: What is the role for formal services in recovery? Does the recovery process have a specific endpoint? Are certain accomplishments required to consider a person recovered? It is possible that recovery will remain a flexible term to be fleshed by each person who encounters the word and gives it his or her own interpretation.

Conclusion

This paper has endeavored to map the core elements of recovery onto an ecological outline of the recovery process, beginning with hope and expanding to fulfilling social roles integrated with the community. Individuals meet challenges associated with each element of recovery throughout the process, drawing on their internal and external resources to continue to propel themselves between and among the various elements of recovery as they navigate the challenges imposed by both the residual effects of the illness and the persisting societal inequality.

In closing, we evoke the words of recovery visionary Patricia Deegan, "Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again... The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution" (1988, p.15). To which we add that this personal disposition toward positive recovery must be complemented by a facilitating environment. Much of the challenges that the disability encompasses are those incurred through living in a society which remains largely hostile to the needs of people who are in recovery. Recovery relies not only on the individual's emerging sense of integrity and purpose (first order change) but also on society's increasing ability to acknowledge and support that integrity and purpose (second order change).

References

- Ahern, L. & Fisher, D. (1999). *Personal assistance in community existence*. National Empowerment Center, Inc. 1-33.
- Allott, P., Loganathan, L., & Fulford, K. W. M. (2002). Discovering hope for recovery, *Canadian Journal of Community Mental Health*, 21(2), 13-34.
- Andreasen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*. 37: 586-594.
- Anthony, W. (2003). Expanding the evidence base in an era of recovery. *Psychiatric Rehabilitation Journal*, 27 (1), 1.
- Anthony, W.A. (1993). Recovery from mental illness: Guiding vision of mental health service system in 1990's. *Psychosocial Rehabilitation Journal*, (16)4, 11-23.
- Baxter, E.A., & Diehl, S. (1998). Emotional stages: Consumer and family members recovering from the trauma of mental illness. *Psychiatric Rehabilitation Journal*. 21(4): 349-355.
- Beale, V. & T. Lambric (1995). *The recovery concept: Implementation in the mental health system: A report of Community Support Program Advisory Committee*. Ohio Department of Mental Health, OH.
- Carver, C.S. (1998). Resilience and thriving: Issues, models, and linkages. *Journal of Social Issues*, 54(2), 245-266.
- Chamberlin, J. & Fisher, D. (2004, November). Presentation and Materials. Measuring the Promise: Assessing Recovery and Self-Determination Instruments for Evidence-based Practices Conference, Boston, MA.
- Copeland, M. E. (2004). *Self-determination in mental health recovery: Taking back our lives*. In J. Jonikas & J. Cook (Eds.), UIC NRTC's National Self-Determination and Psychiatric Disability Invitational Conference: Conference Papers (pp. 68-82). Chicago, IL: UIC National Research and Training Center on Psychiatric Disability.
- Contra Costa County Mental Health Recovery Task Force. (1999). *The recovery model: A conceptual framework and implementation plan*. Martinez, CA: Author.
- Corrigan, P.W. & Ralph, R.O. (Eds.). (2004). *Recovery and Mental Illness: Consumer Visions and Research Paradigms*. Washington, DC: American Psychological Association Press.
- Crowley, K. (2000). *The Power of Procovery in Healing Mental Illness*. San Francisco, CA: Kennedy Carlisle Publishing Co.
- Curtis, L.C. (1998). *Recovery - Old wine in new bottles?* Burlington, VT: Center for Community Change through Housing and Support.

Davidson, L., O'Connell, M.J., Tondora, J., Steaheli, M. & Evans, A.C. (in press). Recovery in serious mental illness: Paradigm shift or Shibboleth? *Professional Psychology Research and Practice*.

Davidson, L. & Strauss, J.S. (1995). Beyond the biopsychosocial model: Integrating disorder, health, and recovery. *Psychiatry* (58), 44-55.

Davidson, L. & Strauss, J.S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology* (65), 131-145.

Deegan, P. (2004). *Rethinking rehabilitation: Freedom*. Presented at the 20th World Congress of Rehabilitation International, Oslo, Norway.

Deegan, P. (1998). *Some common themes of the recovery process*. Lawrence, MA: National Empowerment Center.

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, (19)3, 91-97.

Deegan, P. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, (11)4, 11-19.

DeLong, G. & O'Day, B. (2000). The new paradigm of disability. In *National Institute on Disability and Rehabilitation Research's (NIDRR) Long-Range Plan*. Rockville, MD: NIDRR.

Dixon, L. (2000). Reflections on recovery. *Community Mental Health Journal*, (36)4, 443-447.

Dornan, D.H., Felton, C., Carpinello, S. (2000, November 14). *Mental health recovery from the perspectives of consumer/survivors*. Presentation at the American Public Health Association Annual Meeting, Boston, MA.

Farkas, M., Gagne, C. & Kramer, P. (2002, October). Handouts presented at the Innovations in Recovery and Rehabilitation: The Decade of the Person Conference, Boston, MA.

Fisher, D. (2004). Presentation and Materials. Measuring the Promise: Assessing Recovery and Self-Determination Instruments for Evidence-Based Practices Conference, Boston, MA.

Fisher, D. B., & Ahern, L. (1999). Ensuring that people with psychiatric disabilities are the leaders of self-determination and consumer-controlled initiatives. In Proceedings from the National Leadership Summit on Self-Determination and Consumer-Direction and Control (pp. 195-203). Portland, OR: National Alliance for Self-Determination.

Foucault, M. (1980). The confession of the flesh. In C. Gordon (Ed.), *Power/knowledge: Selected interviews and other writings by Michel Foucault* (pp. 194-228). New York: Pantheon.

Foucault, M. (1979). *Discipline and punish: The birth of the prison*. New York: Vintage.

- Freire, P. (1990). *Pedagogy of the oppressed* (32nd ed.) New York: Continuum.
- Hahn, H. (1999, October). The movement for independent living and disability rights: Origins and objectives. In *Proceedings from the National Leadership Summit on Self-Determination and Consumer-Direction and Control*. Sponsored by the National Alliance for Self-Determination, Oregon Health Sciences University, Portland, OR.
- Harding, C.M., & Strauss, J. S. (1992). Chronicity in Schizophrenia: Revisited. *British Journal of Psychiatry*, 161, 27-37.
- Harding, C.M. (1994). An examination of the complexities in the measurement of recovery in severe psychiatric disorders. In R. Ancill (Ed.). *Exploring the Spectrum of Psychosis*.
- Harding, C.M., & Zahniser, J.H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatr Scand*, 90 (suppl. 384). 140-146.
- Hatfield, A. (1992). Recovery from mental illness. *The Journal of the California Alliance for the Mentally Ill*, (5)4: 6-9.
- Hatfield, A., & Lefley, H.P. (1993). *Surviving mental illness: Stress, coping and adaptation*. New York: Guilford Publications, Inc.
- Hilburger, J. & Lam, C. S. (1999). Readiness for change among people with severe and persistent mental illness in a rehabilitation program. *Rehabilitation Counseling Bulletin*, (43)1, 12-19.
- Ivey A.E., & Ivey, M.B. (2003). *Intentional interviewing and counseling Facilitating client development in a multicultural society*, (5th ed.). Pacific Grove, CA: Brooks/Cole – Thomson Learning.
- Jacobsen, N. & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, (23)4, 333-341.
- Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, 52(4):482-485.
- Johnson, E. (2000). *Recovery principles: An alternative in Maricopa county for individuals who experience psychiatric symptoms*. META services.
- Jonikas, J.A., Cook, J.A., Rosen, C., Laris, A., & Kim, J.B. (2004). "A program to reduce utilization of physical restraint in psychiatric inpatient facilities." *Psychiatric Services*, 55(7), 818-820.
- Karakashian, M. (1998). Armenia: A country's history of challenges. *Journal of Social Issues*, 54(2), 381-392.
- Kramer, P. (2002, October). Handouts presented at the Innovations in recovery and rehabilitation: The Decade of the Person Conference, Boston, MA.

Kurtz, P.D., & Tandy, C.C. (1995). Narrative family intervention. In A.C. Kilpatrick & T.P. Holland (Eds.), *Working with families: An integrative model by level of functioning* (pp. 177-198). Boston: Allyn & Bacon.

Lapsley, H., Nikora, L.W. & Black, R. (2002). "Kia Mauri Tau!" *Narratives of recovery from disabling mental health problems*. Wellington: New Zealand Mental Health Commission.

Lecount, D. & Koberstein, J. (2000, August). *SOAR Case management services*. Keynote address at the Mental Health Services Conference, Wellington, New Zealand.

Liberman, R.P., & Kopelowicz, A. (1994). Recovery from schizophrenia: Is the time right? *The Journal of the California Alliance for the Mentally Ill*, 5(4): 67-69.

Long, A. (1994) "Reflections on recovery" in *Recovery the New Force in Mental Health*, Ohio Department of Mental Health.

Lunt, A. (2000). Recovery: Moving from concept toward a theory. *Psychiatric Rehabilitation Journal*, (23)4, 401-404.

Markowitz, F.E. (2001). Modeling processes in recovery from mental illness: Relationships between symptoms, life satisfaction, and self-concept. *Journal of Health and Social Behavior*, (42) March, 64-79.

Mead, S. & Copeland, M.E. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal*, (36)3, 315-328.

Miller, A. (2000). *CROS the consumer recovery outcomes system*. Paper prepared for The 16 State Performance Indicator Grant Meeting, Austin, TX.

National Alliance for Self-Determination. (1999, October). Proceedings from the National Leadership Summit on Self-Determination and Consumer-Direction and Control. Oregon Health Sciences University, Portland, OR: Author.

National Mental Health Association. (n.d.) *Making the journey of recovery*. Alexandria, VA: Author.

New Freedom Commission on Mental Health, (2003). *Achieving the promise: Transforming mental health care in America. Final report*. DHHS Pub. No. SMA-03-3832. Rockville, MD.

O'Hagan, M. (2003, Winter/Spring). Why we nearly didn't adopt 'recovery'. *Balance, the Journal of the Mental Health Association Queensland, Inc.*, 10-12.

Onken, S.J., Dumont, J.M., Ridgway, P., Dornan, D.H., & Ralph, R.O. (2002). *Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators. Phase One Research Report: A National Study of Consumer Perspectives on What Helps and Hinders Recovery*. Alexandria VA: National Technical Assistance Center for State Mental Health Planning.

Prochaska, J. O. & DiClemente, C. C. (1983). Stages and processes of self-change in smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51, 390-395.

Recovery Advisory Group (Ralph, R. O., Risman, J., Kidder, K., Campbell, J., Caras, S., Dumont, J., Johnson, J. R., Kaufmann, C., Knight, E., Loder, A., Penny, D., Townsend, W., & Van Tosh, L.). (1999, May). *The recovery advisory group recovery model: A work in process*. Paper presented at the National Conference on Mental Health Statistics, Washington, DC.

Ridgway, P. (2001). ReStorying Psychiatric Disability: Learning From First Person Recovery Narratives. *Psychiatric Rehabilitation Journal*, (24)4, 335-343.

Ridgway, P. (1999). *Deepening the recovery paradigm: Defining implications for practice. A Report of the Recovery Paradigm Project*. Unpublished Manuscript. Lawrence, KS: University of Kansas, School of Social Welfare, Office of Mental Health Research and Training.

Rogers, J., & Rogers S. (2004). Self-determination for people with psychiatric disabilities: Personal obstacles and facilitators. In J. Jonikas & J. A. Cook (Eds.), *UIC NRTC's National Self-Determination and Psychiatric Disability Invitational Conference: Conference Papers* (pp. 7-23). Chicago, IL: UIC National Research and Training Center on Psychiatric Disability.

Rothman, J., Smith, W., Nakashima, J., Paterson, M.A., & Mustin, J. (1996). Client self-determination and professional intervention: Striking a balance. *Social Work*, 41(4), 396-405.

Roe, D. & Chopra, M. (2003). Beyond coping with mental illness: Toward personal growth. *American Journal of Orthopsychiatry*, (73)3, 334-344.

Russinova, Z. (1999). Providers' hope-inspiring competence as a factor optimizing psychiatric rehabilitation outcomes. *Journal of Rehabilitation*, 4, 50-57.

Saakvitne, K.W., Tennen, H. & Affleck, G. (1998). Exploring thriving in the context of clinical trauma theory: Constructivist self development theory. *Journal of Social Issues*, 54(2), 279-299.

Salzer, M. S., & Mental Health Association of Southeastern Pennsylvania Best Practices Team. (2002). Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines, *Psychiatric Rehabilitation Skills*, 6(3), 355-382.

Sen, A. (1999). *Development as Freedom*. New York, NY: Alfred A. Knopf, Inc.

Snodgrass, S.E. (1998). A personal account. *Journal of Social Issues*, 54(2), 373-380.

Spaniol, LR, Koehler, M., Hutchinson, D. (1994). *The recovery workbook*. Center for Psychiatric Rehabilitation, Boston, MA.

Spaniol, L. & Wewiorski, N. (2002). *A conceptual model for understanding and researching recovery*. Presented at: Innovations in recovery and rehabilitation: The decade of the person. Boston, MA.

Srebnik, D. S., Russo, J., Sage, J., Peto, T. & Zick, E. (2003). Interest in psychiatric advance directives among high users of crisis services and hospitalization, *Psychiatric Services*, 54(7), 981-986.

Stephenson, A. (Ed.) (2000, December/2001, January). *Recovery outcomes*. Tacoma, WA: Empower Alliance.

Sullivan, W.P. (1994). A long and winding road: The process of recovery from severe mental illness. *Innovations and Research*, 3(3): 19-27.

Sullivan, W. P. (1994). Recovery from schizophrenia: What we can learn from the developing nations. *Innovations and Research*, (3)2, 7-15.

Tooth, B.A., Kalyanasundaram, V. & Glover, H. (1997). *Recovery from Schizophrenia: A consumer perspective*. Centre for Mental Health Nursing Research, Queensland, Australia.

Torrey, W.C. & Wyzik, P. (2000). The recovery vision as a service improvement guide for community health providers. *Community Mental Health Journal*. (36)2, 209-216.

Tower, K.D. (1994). Consumer-centered social work practice: Restoring client self-determination. *Social Work*, 39(2), 191-196.

Townsend, W., Boyd, S. & Griffin, G. (1999). *Emerging best practices in mental health recovery*. The Ohio Department of Mental Health, OH.

Vodde, R., & Gallant, J.P. (2002). Bridging the gap between micro and macro practice: Large scale change and a unified model of narrative-deconstructive practice. *Journal of Social Work Education* (38) 3, pp. 439-458.

Walsh, D. (1999). Coping with a journey toward recovery: From the inside out. In R. P. Marinelli & A. E. Dell Orto (Eds.), *The psychological and social impact of disability* (4th ed. pp. 55-61). New York: Springer Publishing Company.

Watzlawick, P., Weakland, J., & Fish, R. (1974). *Change: Principles of problem resolution and problem formation*. New York: Norton.

White, M. (1991). Deconstruction and therapy. *Dulwich Centre Newsletter*, 3, 22-41.

White, M. (1989). The externalizing of the problem and the re-authoring of lives and relationships. In *Selected Papers* (pp. 5-28). Adelaide Australia: Dulwich Centre.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Williams, C.C. & Collins, A.A. (1999). Defining new frameworks for psychosocial interventions. *Psychiatry*, (62) Spring, 61-78.

Zola, I.K. (1986). The medicalization of aging and disability: Problems and prospects. In C. Mahoney, C. Estes & J. Heumann (Eds.), *Toward a unified agenda*. Berkeley: World Institute on Disability.
