An Analysis of the Definitions and Elements of Recovery: A Review of the Literature

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The concept of mental health recovery has been evident in consumer/survivor self-help since the 1930s and gained prominence in mental health consumer/survivor writing in the late 1980's (Ralph, 1999). The lived and shared experience of mental health consumers provided growing testament to an innate ability and resiliency that allow rebound, growth and transformation after the outset of the psychiatric disability, and overlooked and ignored by a mental health system enmeshed in a deficiency orientation (Ridgway, 1999). "Recovery" was coined as a way of acknowledging that people can successfully contend with severe mental illness and go on to live full and productive lives. Recovery thinking has generated new ideas and different truths that are being fashioned into a new paradigm, a paradigm with its own integrity and distinct values, beliefs, practices, and terminology. Recovery has now been the subject of discussion for nearly two decades, and many people have put forward definitions, including those that are philosophical, those that were based on grounded theory from lived experience, and those that involved operational definitions that shaped practices and research studies. These definitions, which view recovery as vision, process and/or outcome (or set of outcomes), have remained diverse, and few attempts have been made to create a dimensional analysis that assesses the growing consensus about what recovery is, or what its definition should entail.

An ecological framework helps us to organize and interpret the phenomenon of mental health recovery that is emerging across these writings. Ecological perspective incorporates both the individual and the environment and focuses on the relationships between both, with greater emphasis on interactions and transactions. Thus recovery can be viewed as facilitated or impeded through the dynamic interplay of many forces that are complex, synergistic and linked (Onken, Dumont, Ridgway, Dornan & Ralph, 2002). The dynamic interaction among characteristics of the

individual (such as hope), characteristics of the environment (such as opportunities), and characteristics of the exchange between the individual and the environment (such as choice) can promote or hinder recovery.

Embedded in recovery writings is the notion of change. Recovery is about change, and to better understand the forces of change, it is useful to articulate the difference of first order and second order change. First order change is one that occurs within a given unit of a system but the system itself remains unchanged (Watzlawick, Weakland, & Fish, 1974). When an individual recognizes that recovery is possible, a first order change has occurred. The occurrence of a second order change brings about a change within the system itself (Watzlawick et al, 1974). Incorporating and honoring advance directives as a routine component of care and treatment would constitute second order change. The ecological framework adds the interactional dimension, that is, change in one part will have an impact on other parts of the system and potentially the system itself.

Recovery is often described as a process undertaken differently by each unique individual, he or she confronting challenges using his or her composite of strengths and vulnerabilities and the resources that are available (Crowley, 2000; Deegan, 1996; Jacobsen & Curtis, 2000; Kramer, 2002; Lecount & Koberstein, 2000; National Mental Health Association, n.d.; Tooth, Kalyanasundaram & Glover, 1997; Spaniol & Wewiorski, 2002). Recovery is often said to be a non-linear process that involves making progress, losing ground, and pressing forward again (Anthony, 1993; Crowley, 2000; Kramer, 2002; National Technical Assistance Center, 2000; Tooth, Kalyanasundaram & Glover, 1997). Ralph (2004), incorporating a spiral model, reports that "consumers indicate that one may move from any stage to any other stage, both backward and forward, depending on where individuals are in their mental health journeys" (p.137). These subjective and experiential qualities of recovery have made it challenging to objectify and measure.

Understanding recovery must also entail a discussion and definition of what people are recovering from and it is at this nexus that the large schism appears in the literature. Some theorists focus on the challenge associated with recovering from the illness itself or overcoming disabling symptoms (Harding & Zahniser, 1994; Jacobsen & Greenley, 2001; Kramer, 2002) while others regard overcoming the impact of and eliminating the deviant status imposed by the greater society as the larger task of the recovery process (Lapsley, Nikora & Black, 2002). When recovery form the

psychiatric disability is identified as the primary challenge, recovery is defined as a process of gaining mastery over the illness that is largely accomplished by the individual and results in the elimination or alleviation of symptoms. The deviance status and the accompanying stigma of mental illness imposed by the greater society, however, carries with it a host of barriers to successful recovery, including poverty and social marginalization. In this sense, the recovery process emphasizes social inclusion and meaningful roles that the person with the psychiatric disability is able to inhabit, along with building inclusive communities (Markowitz, 2001; Smith, 2000).

There is the constant interweaving of the elements of one's life context (such as psychosocial, cultural, spiritual and economic experiences) and the meanings attributed to these, as they occur (Davidson & Strauss, 1995). This paper incorporates such a perspective by taking the individual's life context into account and views as important both the reestablishment of one's mental health by alleviating symptoms (i.e., first order change) and the mitigation of the oppressive nature of barriers imposed by the greater community (i.e., second order change) so that people may experience social integration and community inclusion. Multidimensional, fluid, nonsequential and complex, recovery permeates the life context of the individual, with some elements linked primarily to the individual and other elements that are more deeply infused with the role of the community to provide resources and opportunities to individuals as they embark on a recovered journey. And all elements of recovery involve interactions and transactions between the individual and community and within larger society.

Person-Centered Elements of Recovery

In our analysis of the literature, we have identified elements of recovery that are primarily associated with the individual and that draw heavily on individual motivations. These elements include hope, self-determination, agency, meaning/purpose, and awareness/potentiality. These elements also involve interaction with others – with family, friends, and/or mental health professionals – and these interactions can help or hinder the ability of the individual to access hope, take action in self-determined ways, develop agency and create meaning and purpose in life pursuits (Onken et al, 2002). Clearly, each of these elements is a cornerstone of the recovery process that must be incorporated into an individual's life in order to engage in the work of recovery.

Hope

Hope is central to recovery, as consumers must have hope for themselves and their futures in order to rally the resources necessary to surmount the challenges that the psychiatric disability imposes. Writings from the perspective of one in the process of recovery identify self and other's hopefulness as critical in launching journeys from despairing about life situations to hoping for a better future (Anthony, 1993; Dornan, Felton & Carpinello, 2000; Onken et al., 2002; Russinova, 1999; Stephenson, 2001; Torrey & Wykiz, 2000), and for this reason the establishment of particular hopes and aspirations can be seen as one initial step in the process of recovery (Andreasen, Oades & Caputi, 2003; Crowley, 2000; Curtis, 1998; Deegan, 1996; New Freedom Commission on Mental Health, 2003; Long, 1994; Miller, 2000; Ridgway, 2001). It is often the expectation of better things – reduction of symptoms, better physical surroundings or emotional support – that propels a person toward an improved life situation and incites the desire to take steps in that direction (Jacobson & Greenley, 2001; Lunt, 2000). But others have accessed a feeling of hopefulness at seemingly the least likely points: when caught in a bitter round of coercive treatment or in response to an abruptly worded statement by a provider about the changeless and chronic nature of their illness (Dornan, Felton & Carpinello, 2000; Miller, 2000). Just as the process of recovery is a winding spiral loop, an individual may be able to sustain hope only for brief periods.

The development of a sense of hope is accomplished by the individual through interactions with others in the environment, whether those interactions foster or obstruct the establishment of hopefulness (Onken et al., 2002). Hope may be expressed by someone in the individual's natural support network (family member, intimate partner, or friend) or by someone in the formal support network (mental health professional or peer advisor) (Anthony, 1993). Spirituality is cited as a pillar of many individual recovery journeys and is aligned with the notion of recovery with its implicit expectation of better things and faith both in the individual and in the presence of meaning and purpose in each life (Contra Costa County Mental Health Recovery Task Force, 1999; Corrigan & Ralph, 2004; Kramer, 2002; Onken et al., 2002; Recovery Advisory Group, 1999; Spaniol, Koehler & Hutchinson, 1994; Spaniol & Wewiorski, 2002; Sullivan, 1996). Conversely, statements made by mental health professionals that express the supposed chronic nature of the illness and profess limited prospects in life are detrimental to an individual's recovery process (Deegan, 2004; Johnson, 2000).

Agency

Recovery is often characterized as rooted in agency (i.e., goal-directed determination) and most often in self-agency (Spaniol, Gagne & Koehler, 1999; Walsh, 1999). The notion of recovery is founded on an assumption of competency of the individual to surmount the challenges posed by a psychiatric disability (Chamberlin & Fisher, 2004; Contra Costa County Mental Health Recovery Task Force, 1999; Davidson & Strauss, 1992; Dornan, Felton & Carpinello, 2000; Harding & Strauss, 1992; New Freedom Commission on Mental Health, 2003; Johnson, 2000; Lapsley, Nikora & Black, 2002; Lunt, 2000; Miller, 2000; Onken et al., 2002; Roe & Chopra, 2003). The process of recovery springs from the internal and external resources of those most affected by the psychiatric disability: the individual and close unit of family and/or friends. The sense of agency of an individual (and in some cultures and traditions, the family or tribe) to endure through the challenges imposed by psychiatric disability can be augmented by an environment that fosters positive change, but can also occur as a person surmounts obstacles imposed by a hostile environment (Deegan, 2004; Harding & Strauss, 1992; Lapsley, Nikora & Black, 2002; Onken et al., 2002).

A too narrow focus self-agency, however, highlights what can be seen as a limitation, an emphasis on the value of Western individuality and the overriding power of the individual (O'Hagan, 2003; Sullivan, 1994). The recovery paradigm must allow room for more cooperative approaches to recovery that rely less on solitary paths of recovery and instead include the notion that within some cultures and traditions, a family, tribe, or community may collectively approach the task of creating meaning from psychiatric disability and establish meaningful roles that the individual will assume within the larger social structure (Lapsley, Nikora & Black, 2002).

Self-Determination

Agency is related to another core tenet of recovery, the primacy of self-determination, and this element ripples throughout various aspects of the recovery process (Cook & Jonikas, 2002). Because it is the individual with the psychiatric disability who recovers, it is this person who must direct his or her own goals by identifying a life path and determining desired steps to take along that path, choosing from various options and designing a unique life journey (Tower, 1994).

Self-determination rests on the freedom to make basic decisions with far-reaching consequences, such as a choice of where to live, how to spend one's time and with whom to spend it. It is reliant on the availability of resources necessary to create a good life and to make responsible decisions that are best for the individual and those close to the individual (Rothman, Smith, Nakashima, Paterson & Mustin, 1996). Entwined with these decisions are those regarding accessing (or declining to access) support and assistance for mental health problems if and when needed. Thus people must have the freedom to choose the types of supports they deem necessary, such as a choice of therapists, psychoeducational programming and the ability to make educated decisions regarding the use of medications (Curtis, 1998; Davidson et al., in press, Deegan, 1998; Mead & Copeland, 2000; Tooth, Kalyanasundaram & Glover, 1997).

Gaining control of one's illness entails driving one's formal treatment as well as taking responsibility for symptom management, self-care and wellness (Curtis, 1998; Davidson et al., in press; Deegan, 1998; Mead & Copeland, 2000; Tooth, Kalyanasundaram & Glover, 1997). Self-determination encompasses the consumer'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 (Jonikas, Cook, Rosen & Laris, 2004). This highlights the need for advance directives in treatment to thwart the use of constraining measures such as forced medication, seclusion, and physical restraints (Srebnik, Russo, Sage, Peto & Zick, 2003). 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 the consumer'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 (National Alliance for Self-Determination, 1999). This implies an overarching shift that emphasizes moving from passive adjustment to active coping, that requires the ability to self-advocate and to define and use personal coping mechanisms (Ridgway, 2001; Tooth, Kalyanasundaram & Glover, 1997) and that demands the responsiveness of mental health professionals and the broader community to consumers as they "direct [their] own lives like their non-diagnosed brethren" (Anthony, 2003).

As a basic human right, self-determination extends beyond notions of illness and impairment to encompass the liberty to determine one's own actions according to personally-developed life goals (Ahern & Fisher, 1999; Anthony. 2003; Beauchamp & Childress, 1983). People can be in the

process of recovery, however, and still lack many of the basic civil rights indicated by self-determination. Thus, self-determination not only involves the rebuilding of a life beyond the limitations imposed by psychiatric disability (Anthony, 1993) but also incorporates addressing larger social issues that sometimes co-occur with mental illness, such as poverty, coercion and social marginalization.

Meaning and Purpose

Recovery is partly dependent upon the ability of the individual to find and pursue meaning and purpose in his or her life, and this ability is derived through the interaction of the individual's internal drive within an environment that offers valued supports and opportunities (Ahern & Fisher, 1999; Andreasen, Oades & Caputi, 2003; Davidson et al., in press; Deegan, 1998; Jaconsen & Curtis, 2000; Lecount & Koberstein, Onken et al., 2002; Tooth, Kalyanasundaram & Glover, 1997). It becomes a given that an individual with a psychiatric disability can pursue and undertake productive activities of interest, such as education, employment, hobbies, family life, parenting, intimate partnerships, community involvement and activism (New Freedom Commission on Mental Health, 2003; Miller, 2000; Onken et al., 2002; Townsend, Boyd & Griffin, 1999). As noted above, spirituality plays a role in the achievement of a sense of meaning as well, infusing meaning in daily life and linking one to broader contexts of humanity and nature (Contra Costa County Mental Health Recovery Task Force, 1999; Corrigan & Ralph, 2004; Kramer, 2002; Lapsley, Nikora & Black, 2002; Onken et al., 2002; Recovery Advisory Group, 1999; Spaniol, Koehler & Hutchinson, 1994; Spaniol & Wewiorski, 2002; Sullivan, 1996). Further, recovering individuals may have a heightened awareness to oppression and a desire to challenge the status quo in ways that free them to think creatively and imbue their lives with meaning and purpose (Cook & Jonikas, 2002).

Awareness and Potentiality

Engaging in recovery requires an individual with a mental illness to develop awareness that change is possible and to embrace the idea that the future can be different than current circumstances (Farkas, Gagne & Kramer, 2002; Hatfield, 1992; Onken et al., 2002; Spaniol, Koehler & Hutchinson, 1994; Stephenson, 2001; Torrey & Wyzik, 2000). This also involves potentiality, that what you seek/desire is achievable through an awakening of a sense of personal capability and the ability to seek out opportunities to change (Andreasen, Oades & Caputi, 2003; Jacobson & Greenley, 2001; Townsend,

Boyd & Griffin, 1999). Glimpses of potentiality can happen following a moment of utter despair - hitting rock bottom and deciding that forward was the only way to move (Lapsley, Nikora & Black, 2002; Recovery Advisory Group, 1999; Smith, 2000). Although much of the struggle to seek change is an act of the solitary self, a supportive network, including formal and informal supports, can foster such a shift by pointing to or helping to create opportunities for change (Davidson et al., in press; Johnson, 2000; LeCount & Koberstein, 2000). Conversely, a hostile environment can obstruct such strivings towards a better life (Johnson, 2000; Onken et al., 2002). Clearly, opportunities that expand activities and provide an arena that tests one's capacities are necessary in order to build on existing and to discover new strengths and build new capabilities.

Recovery involves acknowledgement not only that personal change is possible but also awareness that one may be at various stages in the change process (Cook, Terrell & Jonikas, 2004). The Transtheoretical Model developed by Prochaska and DiClemente (1983) provides a useful heuristic device for conceptualizing how recovery can vary on the individual level. The stages of change model views the change process as incorporating five stages: precontemplation (no yet thinking seriously about change), contemplation (beginning to desire to change), preparation (taking small steps toward change), action (taking necessary steps to realize change) and maintenance (sustaining change over time). This model also takes into account relapse and recycling through stages. In thinking about recovery, it can be useful to consider the person's current stage in the change process, and to offer support and assistance that is appropriate and flexible for moving to later stages. This is important because, historically, most treatment programs are designed for persons who are at the later stages of the model (Hiburger & Lam, 1999). In considering the recovery process of diverse groups of consumers, it is important that a wide range of services options and supports be available, in accordance with the individual's stage in the change process, as well as their values, preferences, and stated goals.

The Re-Authoring Elements of Recovery

Personal narratives reflective the ways in which people organize their lives around particular meanings they ascribe to their experiences (Kurtz & Tandy, 1995). Evident in personal narratives are the larger power relations and social-cultural forces embodied in dominant discourses (White, 1989). These forces gain the status as norms and truths, experienced as the ways things are (White, 1991). Interiorization refers to the ways in which individuals accept these dominant discourses as

methods for being, a means of internalized social control (Foucault, 1979, 1980). Such embedded dominant discourses become objectifying, subjugating, stigmatizing and oppressive for people whose experiences have led to being defined as "deviant other"– not normal, not healthy, not sane (Foucault, 1980; White, 1991). Through questioning and externalizing, reflecting directly and critically through self-narrative, one begins to take back one's right to define the world, to reclaim one's life (Freire, 1990). Dialogical action - telling one's narrative, uncovering the strengths and assets embedded within it, untangling and externalizing the negative dominant discourses, results in a transformative re-authoring of one's experience, triggering new meanings and personal and political growth (Freire, 1990, White & Epston, 1990, Ivey & Ivey, 2003).

For people with psychiatric disabilities, the act of telling one's narrative can facilitate a healing process that increases coping ability as one integrates the trauma experienced in conjunction with symptoms and stigmatization into a sense of self broadened rather than limited by the experience (Williams & Collins, 1999). Re-authoring is a pivotal task in the recovery process, perhaps the primary mechanism of personal growth, and is itself a nonlinear process as backsliding may occur throughout the endeavor of contextualizing one's experiences. It is a collaborative process accomplished through the interaction of the individual with the network of family friends and service providers (Williams & Collins, 1999). Recovery involves replacing a view of the self as centered on a psychiatric disorder to that of one who is a whole person facing challenges, thus broadening the telling of one's life story through the transformation of suffering into a significant life experience (Ridgway, 2001; Deegan, 1998).

The notion that there is meaning and value in the experience of psychiatric disability itself is a central task in the re-authoring process and the recovery literature considers emotional distress, psychiatric disability, and psychiatric rehabilitation as part of the continuum of life experiences within the framework of human experience that are integral to the self and to be learned from (Ahern & Fisher, 1999; Davidson & Strauss, 1995; Deegan, 1998, 1996; Lunt, 2000). Thus a life complicated by a psychiatric disability is enriched by the experiences involved in both the ongoing encounter with the disability and the act of recasting those encounters. An outgrowth of re-authoring is reshaping of one's personal identity though a holistic sense of self that includes the psychiatric disability but does not center on the psychiatric disability as a defining aspect of life (Davidson et al., in press; Ridgway, 2001; Smith, 2000).

The re-authoring process incorporates the elements of coping, healing, wellness and thriving, each of which can be seen as a staging ground for the next element to take root even as some vacillating between stages is likely to occur. The Recovery Advisory Group Recovery Model (1999) identifies the creation of an action plan, a determined commitment to be well, wellbeing and empowerment as stages that closely parallel the tasks involved in the re-authoring process.

Coping

Recovering from a mental illness clearly entails the development of coping skills and the ability to recognize when to access various resources to sustain one's mental health, whether those are formal services, alternative treatments, friends or solitary time spent engaged in creative activities (Curtis, 1998; Tooth, Kalyanasundaram & Glover, 1997; Williams & Collins, 1999). The availability of resources on which to draw is critical in the development and use of coping mechanisms, indicating a strong role for the environment in promoting the healing process (Onken et al., 2002; Spaniol, Koehler & Hutchinson, 1999). Coping skills provides one with a set of techniques to take steps towards wellness and allows one to begin to frame one's experience in a newly integrated way. Linked to coping with the stresses of daily life is the necessity of spending time engaged in enriching or playful activities (Lapsley, Nikora & Black, 2002; Smith, 2000). This sense of rejuvenation is a necessary part of any life lived with mental health as a goal, and can be achieved through meaningful hobbies and activities or through intimacy with others (Ahern & Fisher, 1999; Baxter & Diehl, 1998).

Healing

Coping creates opportunities for healing, primary focus of the recovery process. Recovery involves an ongoing process of healing mind, body and spirit (Lecount & Koberstein, 2000) as a part of self-managing one's life and mental health to reduce psychiatric symptoms and achieve higher levels of wellness (Ridgway, 1999). It is often a painful healing process of adjustment, movement and growth beyond the catastrophic, multiple and recurring traumas of mental illness (Anthony, 1993; Ralph, 1999; Spaniol, Gagne & Koehler, 1999). The healing process incorporates not only a new way of living with and controlling symptoms, but also an increasing adeptness of navigating social realms to overcome stigmatizing and discriminatory social-structural beliefs and practices. Re-authoring hinges on reclaiming a positive self-concept and mitigating the damage done by stigmatization and

involves an externalizing recast of both the internalization of stigma and experiences of discrimination (Markowitz, 2001, Vodde & Gallant, 2002). Indeed, "recovery from the consequences of illness is sometimes more difficult than recovering from the illness itself" (Anthony, 1993, 19).

At this juncture it is important to realize that are two perspectives contextualizing recovery in light of symptomatology: those who believe recovery is the absence of symptoms (Davidson & Strauss, 1992; Tooth, Kalyanasundaram & Glover, 1997) and those who view recovery as a positive sense of self achieved in spite of continuing symptoms or in recognition of one's surmounting the social impact of the illness (Crowley, 2000; Deegan, 1996; Onken et al., 2002). Symptom self-management entails the identification of internal and external resources for facilitating recovery, including strategies such as identification of early warning signs and creation of wellness and crisis plans, as well as healthy diet, exercise, sleep patterns, and pursuit of adult life roles (Baxter & Diehl, 1998; Copeland, 2004). Self-management is highlighted as a cornerstone of recovery by many without calling for the absence of symptoms, and recovery is widely regarded as not a cure but an ongoing healing process (Anthony, 2003; Crowley, 2000, Deegan, 1996; New Freedom Commission on Mental Health 2003; Kramer, 2002).

Wellness

Wellness is a central concept in self-management and is viewed as facilitating recovery (Allott et al., 2002). The active use of coping skills and engagement in the healing process sets the stage for wellness to foster in the individual's life, and recovery clearly implies that a higher of wellness has been achieved. Often recovery implies that the symptoms of the psychiatric disability have been mitigated to the point that they are not debilitating or overwhelming and the person has gained a sense of control over the condition (Davidson et al., in press; Deegan, 1998). As indicated, mental wellness implies more than the mitigation of symptoms, encompassing the development and use of coping skills to promote health and navigate the challenges presented by the psychiatric disability as it fluctuates in severity and through encounters with life stressors (Hatfield & Lefley, 1993; Jacobson & Greenley, 2001; Liberman & Kopelowicz, 1994; Smith, 2000).

Wellness strategies are as varied as people themselves, but some common techniques include: writing or talking about problems, contacting or visiting friends, exercising, prayer, meditating,

engaging in creative endeavors, practicing good nutrition, and self-advocating (Rogers & Rogers, 2004). Physical health involves the ability to care for oneself in a holistic way, awareness of the effects that one's sleep patterns, diet and exercise have on symptoms and increasing the overall quality of life that result from caring for one's physical health (Kramer, 2002). Treatment approaches involving coercion, such as forced medication or physical restraints, often impinge on physical health and mental well-being and hinder the recovery process (Onken et al., 2002). In a broader sense, the lack of resources in the wider environment can likewise serve as an obstruction to the realization of positive states of wellness (LeCount & Koberstein, 2000; Townsend, Boyd & Hicks, 1999).

Thriving

Jonikas and Cook (2002) speak of the psychological process of thriving, in which individuals rebuild lives with qualities that exceed those they had before the beginning of their difficulties. Thriving is a process in which individuals' experiences of dealing with traumatic life events lead them to become better off than they were beforehand (Carver, 1998). A large body of research confirms that individuals can thrive after coping with an array of adversities such as warfare and torture (Karakashian, 1998), physical and sexual abuse (Saakitne, Tennen et al., 1998), and life-threatening illness such as cancer (Snodgrass, 1998). If psychiatric disability is a test of one's resources and a challenge to overcome with creativity and drive and ambition to be well, then recovery is an expression of one's ability not to survive but to thrive in the midst of strikingly difficult circumstances. Certainly, those with psychiatric disabilities are awash in challenges outside the realm of 'normal' experience and with those challenges come opportunities to learn and grow in profound and unique ways (Lapsley, Nikora & Black, 2002). Thriving can be viewed as a natural extension of the re-authoring process and is borne of the successful navigation of the unique challenges posed by the experience of living with psychiatric disability in the context of an often-hostile environment. Thus, a central question for the person is whether and how self-determination can help to ensure a recovery process that includes thriving (Cook & Jonikas, 2002).

Exchange-Centered Elements of Recovery

The re-authoring process enables the individual to function in the realm of the larger society with a firm sense of agency, purpose and meaningfulness built upon an integrated and positive

understanding of self. Recovery advances into the strengthening of social functioning, power and choice that is central to the nature of the exchange relationship between self and the larger community that he or she inhibits. These critical exchanges result in the person's involvement in new or resumed social roles and fuller engagement in the larger society.

Social Functioning and Social Roles

The literature reveals that peer support can play an integral role in promoting positive social functioning (Johnson, 2000; Mead & Copeland, 2000; Ralph, 1999; Townsend, Boyd & Griffin, 1999), as can self-directed involvement in formal services (Smith, 2000). The role of advocate and supporter of others with psychiatric disability is prominent in the literature as well, as many individuals recognize their ability to influence others' perceptions of the possibility of recovery, serving as guides and mentors. Indeed, engaging in peer support is as an outgrowth of their own recovery journey, often helping to sustain their own recovery (Ahern & Fisher, 1999; Baxter & Diehl, 1998; Smith, 2000). Indeed, connecting people to other like people can dissolve the isolation that accompanies pathology-bound experiences, engaging and encouraging authentic re-authoring (Vodde & Gallant, 2002). "It is this collective act of accessible individuals engaging in dialogue (reflection-action) with each other that leads to transforming the world" (Vodde & Gallant, 2002, p. 447, referencing Freire, 1990).

The role of "patient" accompanying the diagnosis of mental illness is not a primary life role. It is a descriptor that is unable to capture the whole person, as the illness is merely one facet of the person and does not frame or delimit his or her abilities and expectations (Deegan, 1998; Fisher, 2004; Ridgway, 2001). Re-authoring one's experience of mental illness and related stigma grounds individuals in a new sense of personhood and social functioning, which facilitates individuals' movement into positive social roles (Harding & Zahniser, 1994). Recovery involves active involvement in such social roles, either by regaining those roles that were lost through the treatment, severity of the illness or stigma, as family and friends retreated, or through the genesis of new social roles (Ahern & Fisher, 1999; Davidson et al., in press; Kramer, 2002). Thus, the individual engages in familiar social roles that may have been suspended for a time. Or the individual may embark on new life roles: as intimate partner or spouse, employee, parent, caregiver, or peer advisor. The ability to parent, work, or relate intimately to another person are indications of positive social functioning (Jacobsen & Curtis, 2000; Liberman & Kopelowicz, 1994).

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 disproportionally 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).

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