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The Role of Services in Mental Health Recovery: A Qualitative Examination of Service Experiences Among Individuals Diagnosed with Serious Mental Illness

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ABSTRACT Mental health services are provided to people diagnosed with mental disorders to foster rehabilitation by enhancing emotional and behavioral functioning. The purpose of this project was to understand from the perspective of service recipients what aspects of services they found most helpful in facilitating the process of recovery. Using a sequential explanatory design, a quantitative screening tool was used to identify a criterion sample of people who had been diagnosed with serious mental illness and reported they achieved functional recovery. A sample of 16 adults who met study criteria participated in qualitative interviews to understand what aspects of mental health services they felt contributed to their recovery. Thematic analysis uncovered 7 themes that emerged from their stories of service experiences describing both the content and process of services they found most beneficial. Although some descriptions of services were consistent with recovery-oriented practice principles, others contradicted the mandate put forth 10 years ago by the New Freedom Commission on Mental Health. Findings suggest more efforts should be made to evaluate the degree to which current mental health services adhere to strengths-based, person-centered practice principles and offer a hopeful outlook regarding the possibility of recovery from mental disorders.

KEY WORDS: psychiatric, community mental health services, consumer participation, mental disorders, recovery

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In the late 1990s and early 2000s, U.S. policymakers concluded the mental health system was in need of a dramatic overhaul. Adopting a recovery orientation was cited in the New Freedom Commission on Mental Health (2003) as

the “single most important goal” guiding the needed transformation of mental health services. The recovery model is a strengths-based, person-centered approach to treatment that is grounded in the idea that recovery is indeed possible, and it not only highlights the important role human relationships play in facilitating successful outcomes, but also fosters empowerment and self-determination in decision making (Anthony, 1993; Barber, 2012; Jacobsen & Greenley, 2001; Rapp & Gosha, 2006; Whitley & Drake, 2010). Although a decade has passed since the mandate to transform mental health services, evidence suggests the implementation of the recovery model has been inconsistent, with some portions of the mental health system slow to fully embrace recovery as the guiding principle in service delivery (e.g., Davidson, O’Connell, Tondora, Styron, & Kangas, 2006; Jacobsen & Curtis, 2000; O’Connell, Tondora, Croog, Evans, & Davidson, 2005; Tsai, 2010). The purpose of this research was to examine the service experiences of people who had received a diagnosis of serious mental illness (SMI) but are currently functioning well. Moreover, our investigation aimed to understand which elements of mental health services are helpful from the perspective of those who are successfully navigating the process of recovery.

Literature Review

Roughly 450 million people worldwide suffer from a mental disorder (World Health Organization, 2003), and within the United States, almost half of all adults will meet the criteria for a mental disorder in their lifetime (Kessler et al., 2005). In recent years, the number of U.S. citizens receiving disability payments for SMI has risen dramatically (Whitaker, 2010). Despite the prevalence of SMI and the extensive resources dedicated to the treatment of these problems, research has suggested many consumers are not satisfied with the mental health services they received. A review by Hagen and Nixon (2011) concluded, “more than 50% of mental health consumers report poor satisfaction with and/or adverse experiences within the mental health system” (p. 48). Clients report their dissatisfaction stems from a variety of issues, including overuse of psychiatric medication, providers’ poor or cold communication styles, lack of shared decision making, an overemphasis on bioreductionism, and coercion (e.g., Baker, Lovell, Easton, & Harris, 2006; Laugharne & Priebe, 2006; Newton-Howes & Mullen, 2011). In addition, many clients avoid professional services when possible because of their concerns about the stigma associated with mental illness (Frese & Davis, 1997).

The perspective from which traditional mental health services have historically been provided offers little hope to adults diagnosed with mental disorders. Particularly for individuals diagnosed with SMI, conditions are conceptualized as chronic and debilitating, suggesting patients have little hope of recovery (Borg & Kristiansen, 2004; Gagne, White, & Anthony, 2007). Despite these longstanding views, a

substantial body of research has demonstrated that many people diagnosed with mental disorders do recover (e.g., Hagen & Nixon, 2010; Jablensky, 1992; Zanarini, Frankenburg, Hennen, & Silk, 2003). In fact, the potential for recovery exists even among those diagnosed with conditions considered as the most severe mental disorders.

In a longitudinal study of chronic state hospital inpatients discharged to the community, Harding (1987) documented that 34% of the patients experienced full recovery, meaning they were employed or otherwise productive, asymptomatic, and had good social relationships. More recently, in a federally funded prospective study, Harrow and Jobe (2007) found that 45% of clients previously diagnosed with SMI demonstrated functional recovery at 15-year follow-up. Similarly, Bellack (2006) reported that 50% of people diagnosed with schizophrenia returned to premorbid levels of functioning. Research evidence has failed to support the common assumption that a diagnosis of SMI results in chronicity or disability, which raises intriguing questions regarding the expectations of those diagnosed with SMI. Equally important, a relationship likely exists between the types of services and treatments received and outcomes. For instance, a study in Finland showed that 79% of people diagnosed with first-episode psychosis who were treated using a unique approach were asymptomatic at 5-year follow-up, with only 20% of the sample receiving disability payments (Seikkula, 2006).

Alongside the accumulating research that contradicts long-held beliefs about outcomes for those diagnosed with SMI, an increasing discontent has developed in the population of service recipients. Some consumers of mental health services have cited concerns such as a sense of oppression stemming from the diagnosis/labeling process; troubling interactions with providers, ranging from disrespect to coercive and even traumatizing practices; and a general sense that consumers' concerns are not heard by service providers (e.g., Hagen & Nixon 2011). Fueled by these concerns of consumer/survivors and independent living political movements, as well as general changes in social welfare policy (Spaulding-Givens, 2011), a call emerged in several sectors demanding efforts to transform the mental health system toward a more consumer-oriented approach. In 2003, the New Freedom Commission Report called for the adoption of a recovery orientation as essential to the transformation of mental health service delivery within the United States.

Recovery-oriented services take a strengths-based, person-centered approach to mental health services (Jacobsen & Greenley, 2001; Rapp & Gosha, 2006). The recovery model is consumer driven and supports empowerment of client autonomy (Anthony, 1993; Davidson, Chinman, Sells, & Rowe, 2006). Social support is highly valued in this perspective, which raises peer support and egalitarian relationships with professionals as the preferred context for helping (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999; Corrigan & Phelan, 2004; Gagne et al., 2007). Finally, the

underlying principle guiding a recovery orientation is the premise that recovery is possible, offering a hopeful outlook not previously put forward in mental health services (Anthony, 1993; Bonney & Stickley, 2008; Borg & Kristiansen, 2004; Gagne et al., 2007).

Although 10 years have passed since the Commission report called for all mental health services within the United States to become recovery oriented, some leaders in the field believe this transition has not been fully embraced (e.g., Jacobsen & Curtis, 2000). Davidson et al. (2006) concluded that some organizations are simply looking at a recovery model as an add-on service rather than an overarching philosophy guiding all services (on implementation, see also O'Connell et al., 2005, and Tsai, 2010). At the micro level, Torrey and Wyzik (2000) have cited problems with implementation, explaining that clinicians often experience difficulties moving toward a recovery perspective. Many professionals fear they will offer consumers false or inflated hopes about the future, whereas some practitioners might resist relinquishing a position of power within the professional helping relationship. Ironically, practitioners' perceptions of recovery as a relatively rare event is fueled by the situation created when consumers do recover. Consumers who recover often leave services that are provided as part of the mental health system, meaning that most clinicians will spend the greater part of their time working with chronic clients who have not recovered, thus shaping their view that recovery is rare. Given these issues, in conjunction with the changing philosophy regarding the ideal approach to services, additional research is needed that incorporates the voice of consumers in the mental health literature to understand how best to move forward (Borg & Kristiansen, 2004; Mead & Copeland, 2000; Repper, 2000).

Although more research is needed, a few in-depth qualitative studies have examined the process of recovery from the perspective of consumers. For example, Borg and Kristiansen (2004) conducted a phenomenological study of 15 people previously diagnosed with SMI who reported they were functioning well at the time of the study. These researchers identified the helping relationship as the most critical aspect of care, citing the most important aspects as the value of empathy, respect, availability, and the development of a collaborative relationship. Hagen and Nixon (2011) conducted a qualitative study of 18 consumers who discussed their concerns with the mental health system. Specifically, consumers reported they felt the system remained too focused on labeling, failed to validate the concerns of consumers, and engaged in an overuse of coercive practices that hindered consumer choice. The research participants identified the most positive aspect of mental health treatment as the interactions and support they received from other consumers. Young and Ensing (1999) conducted semi-structured interviews with 18 participants to explore the process of recovery from the perspective of con-

sumers. The findings from their study emphasized the role of spirituality, self-empowerment, and social support when progressing through a process of recovery. Finally, Davidson (2003) conducted qualitative interviews with people who recovered from schizophrenia and found the process of recovery was made more difficult by experiences of stigmatization and disrespectful treatment; however, participants reported feeling the process of recovery was fostered by the presence of hope in the context of supportive relationships.

Despite these important contributions, a handful of existing studies do not adequately fill the gap in the literature. Jacobsen and Curtis (2000) specifically cited a need for more research conducted from the perspective of consumers that examined what fosters and what hinders the process of recovery. In addition, many of these studies are not well represented in the social work literature, meaning these contributions may not be framed within a social work perspective, and they remain relatively unincorporated into social work education, hindering the ability of this research to inform practice.

Method

The objective of this project was to examine the process of mental health recovery from the perspectives of consumers. The larger study examined several aspects of recovery, including the role of psychiatric medications (see Appendix for the entire interview protocol). This article presents findings related specifically to participants' experiences with mental health services. The research question framing the study asked, "What about mental health services do people diagnosed with SMI find helpful or not helpful in fostering the process of recovery?" To answer this question, the researchers chose a sequential explanatory research design; this mixed-methods approach is well-suited for research projects that seek to identify a sample based on criteria established in measures (Creswell, 2009). The design involved administering standardized measures to identify a purposive sample of participants who met eligibility criteria. Once the sample was identified, semi-structured qualitative interviews were conducted to examine how people previously diagnosed with SMI described their experiences with mental health services as helpful or not helpful in facilitating a process of recovery. The study was monitored by the Arizona State University Institutional Review Board.

Sampling

Criterion sampling was used to identify a sample of adults who had been diagnosed with SMI and reported they were functioning well at the time of the study. Participants completed a questionnaire that included their psychiatric history, the Recovery Assessment Scale (RAS; Corrigan, Salzer, Ralph, Sangster, & Keck, 2004), and the SCL-90 (Derogatis, Lipman, & Covi, 1973). The RAS is a 24-item instrument

that has been found to produce reliable and valid data measuring five components of recovery (McNaught, Caputi, Oades, & Deane, 2007). The SCL-90 is used extensively as a clinical self-report instrument and has good properties in terms of its ability to distinguish clinical from nonclinical cases (e.g., Schmitz, Kruse, Heckrath, Alberti, & Tress, 1999). Inclusion in the study required a previous diagnosis of SMI and qualifying scores on the two instruments. First, a mean score ≥ 3.5 on the RAS was required. No cut-off for the RAS has been empirically established, but a mean score of 3.5 on the 5-point Likert scale means that the participant generally endorses components of recovery such as hope for the future and goal/success orientation. Second, participants were required to score < 0.4 on the SCL-90 General Severity Index (GSI). The GSI has been found to have a negative predictive value of 0.81 in primary care (Bland, 2005; Schmitz et al., 1999), meaning that any participant scoring below this cut-off is unlikely to currently meet criteria for a mental disorder such as depression.

To identify potential research participants, the research team collaborated with a peer-run community agency in the Southwestern United States that provides mental health services to adults who have been diagnosed with SMI. One agency staff member who was also a former consumer of mental health services was included as a co-principal investigator on the research, and this agency employee managed study recruitment. In addition, this agency employee presented details about the study at several staff meetings and invited co-workers to refer potential participants to her for screening. Staff members attending local meetings with other mental health agencies announced the study and invited other community professionals to make referrals to this employee for study screening as well. To maintain confidentiality, rather than asking staff members to make referrals directly to university researchers, the staff encouraged potential participants to make self-referrals directly to the agency employee. When a client self-referred, the agency employee then explained the study purpose, potential risks and benefits of participation, and invited those who were interested to consider enrollment. Potential participants were then screened for inclusion by completing the measures either on paper that was returned to the agency employee or through a Web-based survey hosted by Qualtrics, which used the same measures. The surveys were scored, and the agency employee invited those meeting inclusion criteria to participate in interviews, which were conducted by the university researchers at the agency. None of the study participants were current service recipients from the agency coordinating study recruitment.

The study screening tool was completed by 37 people, 20 of whom met study criteria and participated in an interview. Despite meeting study criteria at the point of screening, 4 of the 20 participants later disclosed information during their interviews that contradicted their responses on the screening tools and suggested they did not meet study criteria. Therefore, these four interviews were excluded

from analysis. These exclusions yielded a final sample of 16 cases that met study criteria, and the researchers met to determine whether further interviews were needed. A preliminary review of these data indicated new themes did not emerge after completing the first 12 interviews. The four additional interviews included data that corroborated these themes, suggesting saturation was achieved. Therefore, data collection was closed at this point. This decision was consistent with a study by Guest, Bunce, and Johnson (2006) indicating their study reached 92% of the total codes after 12 interviews.

As seen in Table 1, the sample identified primarily as female and European American; however, some men ($n = 4$) and people of color ($n = 5$) participated in the study. All participants reported they received various forms of mental health services off and on since their initial diagnosis; time since first diagnosis ranged from 4 to 41 years ($M = 22.06$ years; $SD = 11.42$). All participants reported they had received some form of psychiatric treatment, and 13 reported at least one inpa-

Table 1
Description of Sample (N = 16)

	<i>n</i>	<i>%</i>
Gender		
Female	12	75.00
Male	4	25.00
Race/Ethnicity		
European American	11	68.75
Latino/Hispanic	2	12.50
Multiracial	3	18.75
Psychiatric Diagnoses		
Mood disorders	16	100.00
Anxiety disorders	8	50.00
Psychotic disorders	7	43.75
Personality disorders	8	50.00
Services Received		
Case management	7	43.75
Psychiatric treatment	16	100.00
Inpatient hospitalization	13	81.25
Counseling	16	100.00
Peer support	8	50.00
Self-help	11	68.75
Current Functioning		
Recovery Assessment Scale	$M = 4.46$; $SD = .48$	
SCL-90 General Severity Index	$M = .04$; $SD = .03$	

tient hospitalization. Half of the sample participated in peer support services, which included receiving support from others with similar experiences, whereas 11 reported self-help, which included engaging in their own self-directed efforts such as reading or attending lectures. It is important to note that 14 of the 16 participants indicated they participated in mental health services sometime during the 5 years preceding these interviews.

All participants reported a diagnosis of mood disorder, and 15 reported one or more additional category of diagnosis. All participants self-reported they had been identified as SMI. The RAS mean score for the sample was 4.46, suggesting participants perceived they were experiencing recovery. The mean GSI score was 0.04, with 0.12 being the highest score attained by any participant in the study, meaning all participants scored well below the clinical cut-off of 0.4.

Qualitative Data Collection

Semi-structured interviews were conducted by two researchers with experience in qualitative interviewing. The interviews ranged from 45 to 90 minutes ($M = 70$ minutes), which included only the time of the interview that was recorded and analyzed. In addition to the time of the actual interview, participants engaged in a 10–15-minute orientation before the interview started and 10–15 minutes of administrative processing after the interview. During the orientation, the interviewer explained the purpose of the study and obtained the participant's informed consent. The orientation period was important because it provided an opportunity for rapport to develop between the interviewers and the participants, allowing the interviews to progress quickly into relatively involved content.

A semi-structured interview guide that included six questions with follow-up prompts was used to draw out the participants' experiences in greater detail (see appendix). Despite the structure created by the interview guide, participants were given time to expand on the six primary questions based on their preferences. In this way, the interviews remained focused on the research questions while fostering in-depth responses. Although all six questions were asked in each interview, not all follow-up prompts were initiated. This decision was based on the preferences of the interviewee regarding which areas each preferred to offer extensive content. Over time, it became clear that the two follow-up prompts related to mental health services were of particular interest to these participants. To demonstrate the in-depth nature of these interview responses, a word count was conducted of the transcripts in NVivo software. The mean word count for the interviews was 10,549.81 ($SD = 2,213.06$).

This article presents responses to questions 2c and 5a (see text box below; see Appendix for full interview protocol), which focused specifically on participants' descriptions of their experiences with mental health services.

2. Can you think back to the time of your life when you first remember struggling with mental health problems and describe this time for us?
 - c. did you receive social services (e.g. individual or group counseling, peer support) to address these problems? (If yes, move to following prompt. If no, move to "d").
 - i. What services did you receive?
 - ii. What about these services did you find helpful?
 - iii. What about these services were not helpful to you?
5. Considering your history with mental health problems and how you feel about your current situation, can you tell us what was important in managing these problems?
 - a. What about you, the people in your life, and/or your services helped you?

For the purpose of this article, mental health services included any discussion by participants related to case management, counseling, peer support, crisis intervention, and psychiatric hospitalization. The mean percentage of content coded as "services" and analyzed for each interview was 38.38%, suggesting a substantial proportion of these interviews related specifically to the topic of services. This article does not include participant quotes regarding the effect of medication on recovery because the participants' perspectives about psychiatric medication have been reported elsewhere (Lacasse, Hayes, Lietz, & Rider, in progress). All interviews were audiotaped, transcribed, and loaded in NVivo 9 software to prepare for analysis.

Qualitative Data Analysis

Thematic analysis was used to analyze the data from the interviews that focused specifically on services. Thematic analysis involves identifying and labeling patterns within qualitative data that help to describe a phenomenon or experience (Fereday, & Muir-Cochrane 2006; Floersch, Longhofer, Kranke, & Townsend, 2010). To conduct thematic analysis, three coders used inductive open coding (Boyatzis, 1998; Charmaz, 2006) by reviewing and attaching labels to all meaning units in the transcripts. After open coding was complete, the researchers held a coding meeting that included the agency collaborator to create a protocol to guide secondary coding procedures. This meeting involved extensive discussion and led to consensus on seven themes that emerged from the initial coding. Two of the coders then conducted a second round of coding using the coding protocol similar to the template approach (Crabtree & Miller, 1999). Meaning units were then collapsed under each theme and analyzed for consistencies and contradictions within the quotes representing that theme. This process required creating seven documents through NVivo9 that included every meaning unit (sentence or multiple sentences) that was coded according to each of the seven themes. Two researchers analyzed these quotes looking for consistencies and contradictions to uncover, for example, how participants felt similarly about the theme of safety and whether or in what

ways their thoughts about safety were contradictory. Individual reflection and group dialogue among the coders enabled increased understanding regarding the meaning of the participant comments. Once the preliminary analysis was complete, a summary of the findings was posted to an online discussion board and all participants were invited to comment on the findings as a member check.

Strategies to Manage Research Reactivity and Bias

The research team engaged in several strategies described by Padgett (2008) to increase the trustworthiness of the findings. First, an audit trail was kept throughout the research project by creating a document in Google Docs that allowed research team members to add to the document at any time. The audit trail recorded the research procedures and created a place to record reflexive conversations that occurred throughout the process. Reflexivity, an active attempt to make known the researchers' sociopolitical positions in reference to the research topic and participants (Lietz & Zayas, 2010), was evident throughout the research process and was documented in the audit trail. One example of an outcome of the reflexive procedures involved the early decision to collaborate closely with a local agency and to include an agency employee as a member of the research team as a means of managing research bias and reactivity. This research member offered peer debriefing not as an expert researcher but as a member of the community we were studying. She assisted in the study design, facilitated study recruitment, and served as a consultant at research meetings.

To further manage bias, preliminary findings were posted to an anonymous online discussion board as a member check. This discussion board was accessible only to the research participants and encouraged participants to freely comment on the initial findings, which in turn, allowed their comments to inform the final analysis. All of the comments from the discussion board suggested participants were in agreement with the findings reported in this article. One participant posted, "The list here [our summary of the service-related findings] is excellent and exactly describes the kind of services that were most beneficial to me," whereas another stated, "Great summary, and I agree that all parts [the description of service preferences] have to be present." During analysis, triangulation by observer was used by three coders for the open coding and two coders for the secondary coding. Meetings were held with the coders and all research team members to reflect on any disagreements regarding coding, providing an opportunity for further analysis that resulted in consensus.

Findings

As participants spoke of their experiences with mental health services, their appraisals of services were mixed. All participants found some services helpful and shared stories regarding positive helping relationships. Despite these positive ap-

praisals, all participants also identified service experiences that were not helpful. Seven themes emerged from the data as participants discussed what aspects of services helped to facilitate the process of recovery. Essentially, participants reported feeling the most helpful services were those that (a) established safety, (b) facilitated self-determination, (c) offered an individualized and humanizing approach, (d) fostered hope, (e) validated experiences including a trauma history, (f) promoted positive thought patterns and esteem, and (g) were grounded in a shared experience. Each theme is illustrated with quotes provided by participants.

Establish Safety

When participants discussed the aspects of services that facilitated the process of recovery, they consistently discussed establishing safety as an essential element. For some, safety referenced a sense of emotional safety established through respect demonstrated by the various professionals involved in their services. Although some participants primarily discussed emotional safety, others also spoke about concern for their physical well-being during services. In many cases, participants reported concurrent concerns for emotional and physical safety. This point was illustrated by the comments of one woman who was hospitalized for the first time in her early twenties. She explained that hospital staff members often assume patients know how to behave in an inpatient mental health facility, but she in fact was not aware of the written and unwritten rules that she was expected to follow. She described the moment she woke up for the first time in the hospital after being sedated and discussed how a simple question from the nurse might have avoided what became a high-risk situation. She stated,

And I woke up, and she [nurse at psychiatric hospital] yelled at me, because I was sitting in a quiet place trying to be okay with being in the hospital 'cause it was very scary . . . She wanted me to go where all the people were, and there was a lot of noise over there. So, I asked her if I could just stay where I was, and she said, "No you need to move over there." She yelled at me . . . and it just frightened me . . . so, I did run away from the hospital at that very moment, which is scary and uncharacteristic of me. And then they caught me, and I got the pleasure of experiencing restraint because I wouldn't sit on the other side of the room. You should know that all it would've taken her to say is, "You seem like you don't want to sit over there. Can you tell me why?" I could've said, "Because there's no bars in the windows here, and there's too much noise over there, and I'm just trying to be safe."

The participant then explained that the man who sexually abused her as a child used to drive her by the state hospital and threatened if she told anyone about the

abuse, he would send her to the “nut house; liars go there.” She remembers it as a frightening building behind a large fence, making the bars on the windows at the current facility feel particularly threatening.

Later in the interview this participant described what it was like to experience the physical restraint that resulted from this incident:

I think that the restraint in the hospital was one of the—a huge trauma in my life that I can cry from talking about. And of all the things I’ve experienced [referring to her history of childhood sexual trauma], I wouldn’t expect myself to cry about that [the restraint], but it was so demeaning and horrible . . . It was totally, totally unnecessary for me, and it brought back huge trauma memories of being held down. You know, I was 104 pounds at that time and five men tied me down.

It is important to note that this participant was hospitalized because of risk of harm to self, not others. She perceives her decision to sit “in a quiet place” as an attempt to cope with her extreme fear about being hospitalized for the first time. She believes the attempt to run away and the use of restraint could have been avoided had someone simply asked why she felt more comfortable at one side of the room than the other. The participants in this study consistently identified emotional and physical safety within mental health services as fundamental to the process of recovery.

Facilitate Self-Determination

When participants discussed how to establish safety, facilitating self-determination was consistently identified as critical. When self-determination was supported, participants felt their capacity for growth and rehabilitation was fostered. However, several participants reported feeling subject to both frank and tacit coercion, ranging from involuntary hospitalization to subtle and sometimes direct messages that they “should just do as they’re told” when interacting with professionals in the mental health system. For example, one woman shared her experience, explaining,

And pretty much most of the psychiatrists that I ran into, and the case managers, and everybody else that I dealt with, their attitude was “Do what the doctor tells you.” The doctors would give me 5 minutes, and if I raised any objections they’d go, “Look, you’re court ordered, I know more about this than you do. I’m the expert; this is what you’re going to do.” That was their attitude.

Another participant shared a similar dehumanizing experience, stating, “There is an unspoken message that if you ask too many questions . . . there could be conse-

quences and those consequences could be scary like gettin' put in the hospital. Some of your humanity is taken away."

Just as participants shared stories of feeling they should not question professionals, they also identified how meaningful it was when a professional solicited their feedback and incorporated their voice into the decision-making process. For example, one participant incorporated,

It helped me a lot when a therapist worked with me when I made my wellness recovery action plan. She trusted that I actually knew, and I was really surprised how much I knew how to take care of myself.

When speaking about one of his service providers, a participant explained, "That's what I would say about him, he just thinks outside the box, and he listens to me, and makes me feel like my opinion matters." Participants reported that when they felt they could assert their opinions about their own recovery, they felt the process of rehabilitation was fostered.

Offer an Individualized and Humanizing Approach

Following self-determination as a critical element of helpful services, participants most frequently mentioned the concept of services adapted to fit the individual. Participants reported feeling that a "one-size-fits-all plan" did not work for them. However, when services were adapted to fit their preferences and when self-determination allowed them participants to make their choices known, participants said growth and development were possible. Related to the concept of adaptability was the idea that service recipients desired to be treated in a way that honored their human worth and dignity. One story that helps to illustrate what it can feel like when individual preferences are not considered was shared by a Muslim woman who tried to speak to her doctor about psychotropic medication-induced sexual dysfunction. She described how challenging it was as a woman and as a Muslim to speak to a doctor about sexual intimacy. She recounted what she explained to the doctor:

I can't have sex right. Can that be a side effect? And she [the doctor] said, "Well, at least you're not a man and you can just lay there." And for a Muslim woman to bring up sex is—took a lot. For me with my history, took a lot. Just as a human being to talk to someone about this thing, took a lot. And then I got totally shamed—like [I felt like the doctor was saying] "You stupid idiot. Why would you ask about that? Take your meds and be quiet," is the message I got.

When service recipients felt they were treated in a way that honored human worth and dignity, they reported they highly valued the experience and often

contrasted these positive experiences with many of their other interactions with mental health professionals. The following comments of one participant were typical of those shared by many participants:

But I was very lucky. I had a doctor for 10 years in the system. She was my doctor . . . and, she listened. She used to sit me down; she used to keep me in there *half an hour*. And she used to ask me all kinds of things, like, “How was your day? How’s your job? How’s your daughter?” you know, “How’s your relationships? How are your friends?” I don’t know if she kept notes, or what she did, but she remembered *me*. I wasn’t just a number. She remembered me.

Similarly, another participant felt professionals “stood out” as going “above and beyond” when they were “sincere.” When discussing what it meant to be treated like a human being, participants identified experiences such as being “remembered” or providers who expressed care and concern for them. When these positive examples were provided, they were often juxtaposed against service experiences that were “demeaning” or caused a participant’s “humanity to be taken away.” Being treated humanely was described as essential if services seek to foster recovery.

Foster Hope

Consistent with a recovery perspective is the idea that recovery from a mental disorder is possible. This idea was asserted when one participant stated,

I think one of the really important things about fostering recovery is having an expectation that people can recover. The expectation is so often that you can just manage your symptoms . . . I don’t have any symptoms. I have bad days. I sure don’t have any symptoms. And I think that’s the secret that we don’t talk about and we’re dancing around that, that people really can recover.

When service providers communicated a sense of hope that recovery is possible, participants reported they were motivated to take steps toward making positive changes in their lives. For example, one participant recalled, “At some point, people started to say ‘Well, you can do this, and you can do this,’ and I started to say, ‘Yeah, I *can* do that.’” Highlighting how valuable it was to have a service provider who communicated a sense of hope, another participant explained, “What she [service provider] conveyed to me was that I was not hopeless . . . it’s probably the most important thing we can tell anybody who has any kind of mental illness or mental condition—there are no hopeless cases.” Another participant stated his

recovery was fostered when he got a new caseworker who said, “What is it that you’ve always wanted to do?” He replied, “I’ve always wanted to go to school.” She said, “Let’s go,” and went with him to sign him up for classes. He describes this moment as a turning point in his recovery because he began to believe his dreams might be possible.

When consumers felt service providers communicated that recovery was not possible, they reported feeling helpless and discouraged. For example, one service recipient talked about her initial diagnosis of a mental health disorder and shared the following description of receiving the diagnosis:

. . . a very, very negative experience, because they made me feel that there was no hope for me. They essentially said, “You’re gonna be on medication for the rest of your life. You’re never going to be able to work, and you’re not going to be able to resume a normal lifestyle. You’re basically going to be in the public health, mental health system, and your life is over. Go away, take this medicine.”

Speaking of the issue of hope, another participant stated,

When the doctor told me along with his diagnosis, “You get to never work again,” that felt hopeless to me. So how a label is put on you and how that person delivers that message to you, is really, really important.

Concurring with this sentiment, another consumer stated,

Expectation is really important. When service providers don’t expect that you recover, even if they don’t say it, it’s the message that’s conveyed in everything they offer, and that was all I got was you know, “Just take your medication and shut up.”

Stories such as these highlight the important role expectation exerts in the process of recovery.

Validate Experiences Including a Trauma History

Although having a trauma history was not a criterion for study inclusion, 12 of the 16 study participants reported a history of trauma or abuse. When discussing their trauma histories, participants shared the importance of having the mental health provider ask about the person’s trauma history and validate his or her experiences. One participant reported she was sexually abused for years by a stepfather and described how meaningful it was to have a person validate her experiences.

He referred me to his counselor, and I told her [the service provider] the truth. And for the first time in my life—it's not the first time I told, but for the first time in my life this woman looked at me, and she put her hand on mine, and she said "I am so sorry that happened to you. You did not deserve that," and I just burst into tears because nobody—I mean my mother was like "How dare you accuse him?" and nobody had ever even really believed me before. So that was really powerful. And then . . . I was ready to work. And I mean, things really changed for me, and it felt like for the first time in my life I felt hope. I didn't feel that constant despair. So that was a really major turning point.

Although one participant described being validated as a "turning point" in her recovery, another described a story to emphasize how hurtful it was when her history of sexual abuse was not respected. She explained, saying

So when the psychiatrist started asking me questions, I started sharing a little bit more with her, and I said something about abuse issues—and she was from another country—and she said, "In this country you guys make too much a big deal over sexual abuse. There was probably nothing that happened, and if it did, you over exaggerate it. You have weak genes. You have borderline personality disorder. Don't think about it. We need to find something to make you less impulsive. You were born with weak genes." Like end of story.

For consumers who have a history of trauma, having mental health professionals who ask about their history and are willing to validate and address these issues was cited as an essential part of the recovery process. When service providers do not validate trauma histories, as illustrated above, the system can re-traumatize those who have already suffered a painful, abusive experience.

Promote Positive Thought Patterns and Esteem

In addition to processing a trauma history, participants also related the importance of skill building through treatment models such as cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT). Although some participants named these treatments during their interviews such as, "a counselor I saw did mindfulness-based cognitive therapy that was helpful," others talked more generally about "changing unhealthy thoughts" or "building skills." In either case, it was striking to observe participants speak about the benefits of these treatments without being asked specifically about treatment approaches. For example, one participant described her experiences, stating,

And in DBT therapy I had a very good therapist, and she was that turning point for me. She was the one that I started to relate [to] people, saying “Well, okay. I’m not the only one out there. People like me are out there that have the same thought patterns.” I found out through the interview that I had no boundaries. They gave me a test and found out I had none, and then they put me in DBT therapy . . . I would have to say my [DBT] therapist is the one who made the biggest difference in my life, because she got me to see things from a completely different perspective than I had learned growing up.

Speaking of the benefits of changing unhelpful thoughts, another participant who grew up in an abusive home spoke about the need to stop the negative messages internalized in childhood. The participant explained,

I said I would never talk to my children like that, so I’m going to pay attention to and counteract that, and then the therapist helped me with, ya know, some cognitive-behavioral about what’s an actual real thing . . . and she taught me to say, “Okay, where’s the truth in that?” . . . She gave me some tools that I used . . . at the time, I used them intensely.

Similarly, another participant talked about a group she attended and explained, “We learned here’s distorted thinking, here’s the rational mind, and how your thinking is not necessarily reality, so you have to learn how to stop your thinking . . . Now I can turn it around, and understand why I think that way.” Although the interview guide did not ask questions about any specific treatment program, it is important to note that participants found the ability to change maladaptive thinking patterns helpful to their recovery process.

Ground Services in Shared Experiences

Finally, as participants discussed what aspects of services helped foster recovery, they were careful to emphasize the benefits of peer-run services that grounded services in shared experiences. When discussing why peer support services are helpful, one participant explained, “They [peers] were telling me things they lived through. They didn’t feel sorry for me, they understood me,” whereas another participant stated peer-run services were helpful “because they [peers] understand exactly what you’ve been through.” For many, the shared experience seemed to foster increased insight and understanding about recovery from the perspective of the provider.

Another participant explained recent budget cuts had eliminated her peer support services:

I was getting peer support. Like a mentor who would come out, somebody holding me accountable . . . I really miss that portion. They were peers who also had been dealing with mental health issues, but they were trained, and you know, were just there to kind of do a check.

Participants consistently spoke highly of their experiences with peer-run services and were concerned about the possibility that such services might be eliminated.

In addition to discussing the benefits of peer-run services from the service recipient's perspective, participants also relayed that helping others was an important part of their own recovery. For example, one participant spoke about the mutuality of the process of recovery, and described a time when he was mentoring another young man who was working on his own recovery:

That's what "recovery" means to me for the both of us. You know, we were having a mutual learning experience. I could have all the books, and I could do all the talks and the presentations, but if there is not another person receiving recovery with me, it's just empty . . . for me recovery is to have meaningful relationships in my life.

For this participant, helping others created an opportunity to foster quality, meaningful relationships he had not previously experienced in his life. Another participant also talked about the benefit of helping others while being a provider of peer support services. She stated,

Recovery has been the most rewarding because now I have purpose. I have meaning, and what I'm doing right now is trying to relate to those people that are like me and paying it forward, and saying, "Hey, it can be done. You can recover. You can have meaning. You can have joy."

For the participants who had served as peer mentors or worked in peer support, peer-run services created an opportunity to focus on their own recovery as they concurrently used their experiences to help others.

Discussion and Implications

This qualitative research study examined interviews of a criterion sample of participants who were previously diagnosed with SMI and were functioning well at the time of the study. This article discusses the findings from a thematic analysis of comments related to participants' descriptions of services. Specifically, seven themes emerged from these data that describe the aspects of mental health services that this sample of consumers found helpful in fostering the process of recovery.

Similar to other studies, our findings suggest consumers were sometimes re-traumatized by the mental health system. This re-traumatization stemmed from a number of factors, ranging from physical restraint to disrespectful communication patterns of service providers. This finding is consistent with previous research reporting that many clients felt “invalidated and unheard” (Hagen & Nixon, 2011) and resented coercion (see also Gilbert, Rose, & Slade, 2008; Newton-Howes & Mullen, 2011). Participants noted that some service providers communicated in ways that were demeaning or intrusive, or suggested a mental health diagnosis represented a downward spiral with little hope for the individual’s future. These negative service experiences did not foster opportunities for rehabilitation, and on occasion, seemed to hinder progress rather than facilitate recovery. Given that it has been a full decade since the mandate was issued for mental health services to adopt a recovery perspective, stories like these that contrast a recovery orientation are troublesome. Such findings indicate the need for further evaluation regarding whether current mental health services adhere to the principles of a recovery model (e.g., Corrigan et al., 1999; Jacobsen & Greenley, 2001). These stories are also inconsistent with social work’s ethical principle that social workers respect the human worth and dignity of all people and the ethical responsibility to promote client self-determination (National Association of Social Workers, 2008). Because social workers are the providers of many of the mental health services described in these stories, these findings suggest further efforts are needed to better prepare social workers to intervene effectively with clients diagnosed with SMI.

Although several interviews offered descriptions of services that contradict the principles of a recovery perspective and social work values more generally, all research participants also identified positive aspects of services to which they attributed their ability to navigate the process of recovery successfully. Similar to previous research findings (Borg & Kristiansen, 2004; Gilbert et al., 2008), participants in this sample discussed process-oriented aspects of services as meaningful. For example, incorporating the consumers’ voice into mental health decision making fostered their self-determination and was seen as an important part of establishing emotional and physical safety in services. Validating individuality, and when necessary a trauma history, helped these consumers to feel valued and heard. Consumers in this study reported that simple things such as being “remembered” or feeling providers were “sincere” were meaningful to their recovery process. Many aspects of these stories suggested the process of *how* services were delivered was equally important as the content or *what* services were offered. This finding echoes calls from researchers to prioritize the therapeutic relationship as a mechanism of positive change (Kondrat & Teater, 2012). The findings also lend support to practice models such as trauma-informed care, which “recognizes the profound multidimensional impact of trauma and incorporates that understanding into services and treatment approaches” (Huckson &

Lebel, 2013, p. 65). These descriptions remain consistent with a social work perspective demonstrating clients' appreciation for services that display social work values.

Beyond process, participants also cited preferences about the content of services. This sample discussed valuing mental health services that moved beyond the traditional first-line treatment of medication-only and offered skill building. Particularly for consumers who were raised in unhealthy and abusive circumstances, the cognitive patterns they developed throughout their childhood posed a barrier to recovery. Services that helped consumers develop increased understanding about themselves and their situations were cited as highly valuable. Essentially, participants discussed increases in self-esteem, based both on the way they were treated by some service providers and through replacing negative thought patterns with more positive views of themselves, as an important part of their recovery. These findings offer support for evidence-based approaches grounded in cognitive theory, including but not limited to CBT, DBT, acceptance and commitment therapy (ACT), and mindfulness (e.g., Bach & Hayes, 2002; Fava et al., 2004).

Participants also attached a high value to peer-run or peer support services, because services implemented by people with similar experiences were seen as validating. Consumers appreciated the unique insight and understanding that come from a consumer/provider who "has been there," rather than working only with professionals who are well-educated but lack the ability to relate to the experiences of consumers on a personal level (e.g., Hagen & Nixon, 2011). These findings support the continuation of peer-run services as a critical component of the system of care (see Davidson et al., 1999; Davidson et al., 2006).

Finally, while discussing helpful aspects of the process and content of mental health services, participants suggested services must be framed in a way that prompts a hopeful outlook (Borg & Kristiansen, 2004) regarding what is possible for people diagnosed with mental disorders. All of the participants shared examples that illustrated moments in their lives when they were given messages that imposed limits on their potential. People were told they would require psychiatric medication for their lifetime, they would never work again, and could expect to be on disability for the rest of their lives. A college student was told she might as well drop out of college because having a career was not in her future. Such statements are incongruent with the principles of recovery (Anthony, 1993; Gagne et al., 2007) as well as the longitudinal data on recovery (e.g., Harding, 1987), and should be purged from practitioners' discussions with clients.

One participant summed up this point when he explained that when people are given a diagnosis of cancer, they are told the medical community will do anything possible to fight for their life. Friends and family rally behind the cancer

patient, and fundraising events are scheduled to support research to combat the disease. When a person is diagnosed with SMI, the medical community instead says these patients need to be “realistic” about what they are capable of and can only hope for a life of managing symptoms. Family and friends often step away rather than step forward to provide the individual with support, offering further evidence of how stigma affects this population (see Holley, Stromwall, & Bashor, 2012). Participants in this study found messages that limited potential as damaging and hindered progress. Yet, when service providers asserted a genuine belief in the ability of consumers’ capacity to grow, learn new skills, and live a full life—which is consistent with established principles of the strengths perspective (Saleebey, 2013)—participants felt empowered by hope regarding what their future could be. These findings suggest clinicians might need additional training to better understand the meanings consumers attach to service experiences that foster a hopeful outlook for their future.

Of particular interest to social workers, the characteristics of positive clinician engagement that emerged from this study reads much like a description of ideal social work practice: responding empathically, listening, building relationships, recognizing strengths, facilitating and respecting self-determination, being aware of evidence-based data demonstrating that recovery is possible, and being knowledgeable of well-validated cognitive treatment strategies. Social workers may be particularly well-suited to provide the types of services that participants found helpful. Although the mental health field has not yet broadly adopted a recovery orientation, social work could distinguish itself by doing so, which could result in substantial benefits for clients. Despite macro-level barriers hindering genuine adoption of the recovery model (e.g., Gomory, Wong, Cohen, & Lacasse, 2011), social work advocacy efforts should address this issue on both the practice and policy levels.

The conventional psychiatric model is increasingly subject to empirical critique, ranging from well-publicized debates regarding the reliability of the *Diagnostic and Statistical Manual of Mental Disorders* criteria to critical assessments of bioreductionism (Kirk, Gomory, & Cohen, 2013; Lacasse, 2014; Whitaker, 2010). In the wake of such discourse, mental health clinicians and researchers are likely to be looking for ways to move the field forward. In light of previous research (Davidson, 2003; Young & Ensing, 1999) and the present findings, full implementation of the recovery model represents an attractive possibility. In the future, a longitudinal quantitative study tracking outcomes resulting from careful implementation of the recovery model (perhaps as compared with the treatment-as-usual model) would be a valuable contribution to the literature. Such comparison might be accomplished through specialized training of clinicians. More important, full implementation of the recovery model should be confirmed from the perspective of consumers.

This study had some limitations. The sample represented only the perspective of consumers who identified themselves as currently in recovery; therefore, the perspectives of other types of consumers, such as those currently receiving disability for SMI, were not included. The sample was also composed primarily of female and European American participants, highlighting the need for more research that raises the voice of males and people of color who are diagnosed with SMI given the potential that gender or race bias shaped these findings. In addition, this study did not include the perspectives of service providers.

Although the experiences of these individuals cannot be extrapolated to all consumers of mental health services, the findings might be transferable because the in-depth descriptions provide insight into the ways in which some consumers perceive their service experiences. Transferability refers to the extent to which findings can be applied to other contexts or settings (Padgett, 2008). Because these participants received services at multiple agencies on average for more than 20 years, we believe their descriptions move beyond one setting and offer implications for many service providers. In addition, the findings have implications for social work practice and recovery-oriented services because many stories contradicted social work values and the recovery model, suggesting an urgent need for social service agencies to further evaluate the extent to which services adhere to the recovery model and social work values. The consistency across stories from these participants was striking, offering corroboration between cases. The member check, peer debriefing with a mental health consumer and current provider, reflexivity, and triangulation by observer increased the ability to present a trustworthy representation of the perspectives of these participants. Considering the mandate that mental health services move to a recovery orientation, this study offers an important contribution regarding what aspects of services recipients perceived as most helpful in fostering their recovery.

Conclusion

Findings from this study offer important implications about what mental health consumers who are successfully navigating the process of recovery find helpful about services. Consumers discussed aspects of the process and content of services that supported their recovery. The findings suggest more research is needed to evaluate the extent to which programs are implementing a recovery orientation. Additional training might be needed across disciplines interacting with this population to increase providers' awareness of how best to facilitate the process of recovery. These findings lend support to treatment programs that move beyond medication-only intervention to offer programs that provide opportunities to increase skills and replace negative thoughts with more productive patterns. Similarly, peer support and peer-run services were a highly valued component of mental health services.

Appendix. Semi-Structured Interview Guide

The purpose of our project is to explore the concept of recovery for people who were given a mental health diagnosis.

1. Can you tell us if you have ever been given a mental health diagnosis or substance abuse problem? (If yes, move to follow up prompts. If no, participant is not eligible for participation in this study.)
 - a. When were you first diagnosed?
 - b. What diagnoses were you given?
 - c. Can you describe how you felt about being given a mental health diagnosis?
2. Can you think back to the time of your life when you first remember struggling with mental health problems and describe this time for us? (If yes, move to follow up prompts. If no, move to question #3).
 - a. How did your problems affect your life at that time?
 - b. Was there anything that precipitated these problems?
 - c. Did you receive social services (e.g. individual or group counseling, peer support) to address these problems? (If yes, move to following prompt. If no, move to “d”).
 - i. What services did you receive?
 - ii. What about these services did you find helpful?
 - iii. What about these services were not helpful to you?
 - d. Were you prescribed psychiatric medication to manage your mental health problems? (If yes, move to following prompt. If no, move to “e”).
 - i. What psychiatric medications have you been prescribed?
 - ii. What psychiatric medications did you take?
 - iii. Were you informed of the risks and benefits of taking psychiatric medication?
 - iv. Did you find your use of psychiatric medication helpful?
 - v. Did you experience side effects as a result of the medication?
 - vi. Are you currently taking psychiatric medication?
 - vii. What are your current thoughts about the role of psychiatric medicine prescribed for people given a mental health diagnosis?
 - e. What else would you like to tell us about this time frame of your life?
3. How would you describe your current mental health functioning?
 - a. Are you currently satisfied with your social relationships?
 - i. What about your social relationships do you find satisfying or not satisfying?
 - b. Are you currently satisfied with your employment situation?
 - i. What about your work situation is satisfying or not satisfying?
 - c. What else would you like to tell us about how you are currently doing?

4. Do you consider yourself “recovered” from these mental health problems? (If yes, move to following prompt. If no, move to #5).
 - a. If so, what does “recovery” mean to you?
 - b. What about your current functioning leads you to feel that you have “recovered”?
5. Considering your history with mental health problems and how you feel about your current situation, can you tell us what was important in managing these problems?
 - a. What about you, the people in your life, and/or your services helped you?
 - b. Can you describe how your life has changed since your diagnosis to now?
 - c. How do you feel about the progress you have made?
 - d. What else would you like to tell us about how you are currently doing?
6. Before we finish, is there anything else you would like to tell us about being diagnosed with a mental health problem, your experience with social services, and/or how you feel about the ability to recover from these problems?

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