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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 about 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 were 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 about mental health services they felt contributed to their recovery. Thematic analysis uncovered seven 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, other illustrations contrasted the mandate put forth ten years ago by the New Freedom Commission on Mental Health (2003). Findings suggest more efforts should be made to evaluate the degree to which current mental health services adhere to practice principles that are strengths-based, person-centered, 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
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 highlights the important role human relationships serve in facilitating successful outcomes, fosters empowerment and self-determination in decision-making, and is founded on the idea that recovery is indeed possible (Anthony, 1993; Barber, 2012; Jacobsen & Greenley, 2001; Rapp & Gosha, 2006; Whitley & Drake, 2010). Although a decade has passed since this mandate, evidence suggests that the recovery model has been implemented heterogeneously, and that some portions of the mental health system have been slow to fully embrace recovery as the guiding principle in mental health 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 were previously diagnosed with Serious Mental Illness but are currently functioning well, to understand what about mental health services are helpful from the perspective of those who are successfully navigating the process of recovery.

**Literature Review**

Roughly 450 million people suffer from a mental disorder worldwide (World Health Organization, 2003), and within the U.S., almost half of all adults will meet criteria for a mental disorder in their lifetime (Kessler, Berglund, Demler, Jin, Merkiangas, & Walters, 2005). The number of U.S. citizens receiving disability payments for SMI has risen dramatically in recent years (Whitaker, 2010). Despite the prevalence of these problems and the extensive resources
dedicated to treatment, research suggests many consumers are not satisfied with the mental health services they receive. A review by Hagen and Nixon (2011) concludes, “more than 50% of mental health consumers report poor satisfaction with and/or adverse experiences within the mental health system” (p. 48). Clients report that this dissatisfaction stems from a variety of sources, including overuse of psychiatric medication, 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). Additionally, concerns about stigma lead many clients to avoid professional services when possible (Frese & Davis, 1997).

Perspectives offered within traditional mental health services have historically offered little hope to adults who are 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 demonstrates 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 what are considered the most severe mental disorders.

In a longitudinal study of chronic state hospital inpatients discharged into the community, Harding (1987) documented that 34% 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 as SMI demonstrated functional recovery at 15-year follow-up. Similarly, Bellack (2006) reports 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, raising intriguing questions regarding expectations for those so diagnosed. Importantly, there is likely a relationship between the types of services and treatments received and outcomes; for instance, 79% of people diagnosed with first-episode psychosis treated using a unique approach in Finland were asymptomatic at 5-year follow-up, with only 20% receiving disability payments (Seikkula, 2006).

As research has accumulated contradicting previously held beliefs about expectations for those diagnosed with SMI, an increasing discontent has developed within the population of service recipients. Some of the concerns cited by consumers include a sense of oppression stemming from the diagnosis/labeling process, troubling interactions with providers that range from disrespect to coercive and even traumatizing practices, and a general sense that consumers are not heard (e.g., Hagen & Nixon 2011). Fueled by the consumer/survivor and independent living political movements as well as more general changes in social welfare policy (Spaulding-Givens, 2011), there was a call to transform the mental health system towards 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 U.S.

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 et al., 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, Gifford, Rashid, Leary, & Okeke, 1999; Corrigan & Phelan, 2004; Gagne, White, & Anthony,
Finally, the underlying principle guiding a recovery orientation is the premise that recovery is possible, offering a hopeful outlook not previously asserted within mental health services (Anthony, 1993; Bonney & Stickley, 2008; Borg & Kristiansen, 2004; Gagne, White, & Anthony, 2007).

Although ten years have passed since the commission report asserted all mental health services within the U.S. should become recovery-oriented, some leaders within this field believe this transition has not been fully embraced (e.g., Jacobsen & Curtis, 2000). Davidson et al. (2006) conclude 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, Tondora, Croog, Evans, & Davidson, 2005; Tsai, 2010). At the micro level, Torrey and Wyzik (2000) cite 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, and practitioners may resist relinquishing a position of power within the professional helping relationship. Also, consumers who recover often leave services provided as part of the mental health system, meaning that most clinicians will spend most of their time working with chronic clients who have not recovered – which understandably shapes their view that recovery is rare. Given these issues and in conjunction with the changing philosophy regarding the ideal approach to services, additional research is needed that incorporates the voice of consumers within 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 as SMI who
reported they were functioning well at the time of the study. Their study identified the helping relationship as the most critical aspect of care, citing the value of empathy, respect, availability, and the development of a collaborative relationship as important. Hagen and Nixon (2011) conducted a qualitative study of 18 consumers who discussed their concerns with the mental health system. Specifically, these consumers felt the system remains too focused on labeling, fails to validate the concerns of consumers, and engages in an overuse of coercive practices that hinder consumer choice. Research participants identified the interactions and support received from other consumers as the most positive aspect of mental health treatment. Young and Ensing (1999) conducted semi-structured interviews with 18 participants to explore the process of recovery from the perspective of consumers. These findings emphasize 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 that the experience of stigmatization and disrespectful treatment made recovery difficult; however, participants felt the presence of hope in the context of supportive relationships fostered the process of recovery.

Despite these important contributions, it is important to acknowledge that a handful of existing studies do not adequately fill the gap in the literature. Jacobsen and Curtis (2000) specifically cite a need for more research conducted from the perspective of consumers that examines what fosters and hinders the process of recovery. Additionally, many of these studies are not well represented within 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 their ability 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 A 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 research 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 describe their experiences with mental health services as helpful or not helpful in facilitating a process of recovery. The study was monitored by the IRB of the first author’s institution.

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 which 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 non-clinical 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 $\geq 3.5$ on the Recovery Assessment Scale (RAS) was required. There is no empirically established cut-off for the RAS, but a mean score of 3.5 on the 1-5 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). This measure 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 under this cut-off is unlikely to currently meet criteria for a mental disorder such as depression.

The research team collaborated with a peer-run community agency in the southwest that provides mental health services to adults who have been designated as SMI to identify potential research participants. One agency staff member who is also a peer was included as a co-principal investigator on the research and managed study recruitment. This agency employee presented details about the study at several staff meetings and invited 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 honor confidentiality, staff members were not asked to send referrals directly to university researchers. Instead, staff encouraged people they knew who might meet eligibility to make self-referrals directly to the agency employee. She then explained the study purpose, risks, and benefits, and invited those who were interested to consider enrollment. Potential participants were then screened for inclusion by completing the measures either as a hard copy that was returned to the agency employee or through a link to the scales.
available through Qualtrics, a web-based survey. The surveys were scored and when respondents met inclusion criteria, the agency employee invited those eligible to participate in interviews conducted by the researchers at the agency. None of the participants were current service recipients from the agency coordinating study recruitment.

Thirty-seven people completed the screening tool. Of those, 20 met study criteria and participated in an interview. Despite meeting study criteria at the point of screening, four of these participants later disclosed information in the interview that contradicted their responses on the screening tools suggesting they did not meet study criteria. Therefore, these four interviews were excluded from analysis. At this point, the sample included 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, men ($n = 4$) and people of color ($n = 5$) were included 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 four to 41 years ($M = 22.06$ years; $SD = 11.42$). Regarding type of service, all participants reported they received some form of psychiatric treatment, and 13 reported at least one inpatient hospitalization. Half 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. All participants indicated they participated in mental health services some time during the five years preceding these interviews.

Regarding diagnoses, all participants reported a diagnosis of mood disorder, and 15 reported one or more additional category of diagnosis. All self-reported they had been identified as SMI. The RAS mean score 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 under the clinical cut-off of 0.4 (see above).

Table 1: Description of Sample (N = 16)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Female</th>
<th>12 (75.00 %)</th>
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<tr>
<td></td>
<td>Male</td>
<td>4 (25.00 %)</td>
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<table>
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<tr>
<th>Race/Ethnicity</th>
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<tbody>
<tr>
<td>European American</td>
<td>11 (68.75%)</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>2 (12.50%)</td>
</tr>
<tr>
<td>Multiracial</td>
<td>3 (18.75%)</td>
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<table>
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<tr>
<th>Self-Reported Psychiatric Diagnoses</th>
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<tbody>
<tr>
<td>Mood Disorders</td>
<td>16 (100.00 %)</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>8 (50.00 %)</td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>7 (43.75 %)</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>8 (50.00 %)</td>
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<table>
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<tr>
<th>Services Received</th>
<th></th>
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<tbody>
<tr>
<td>Case Management</td>
<td>7 (43.75 %)</td>
</tr>
<tr>
<td>Psychiatric Treatment</td>
<td>16 (100.00 %)</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>13 (81.25%)</td>
</tr>
<tr>
<td>Counseling</td>
<td>16 (100.00 %)</td>
</tr>
<tr>
<td>Peer Support</td>
<td>8 (50.00 %)</td>
</tr>
<tr>
<td>Self Help</td>
<td>11 (68.75 %)</td>
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<table>
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<tr>
<th>Current Functioning</th>
<th></th>
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<tr>
<td>Recovery Assessment Scale</td>
<td>$M = 4.46; SD = .48$</td>
</tr>
<tr>
<td>SCL-90 GSI</td>
<td>$M = .04; SD = .03$</td>
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Qualitative Data Collection

Semi-structured interviews were conducted by two researchers with experience in qualitative interviewing. The interviews ranged from 45 to 90 minutes, averaging 70 minutes per interview. This time period only includes the time of the interview that was recorded and analyzed. It does not include a 10 to 15 minute orientation that occurred prior to initiating taping and 10 to 15 minutes of processing that occurred post-taping. During the orientation, the purpose of the study was explained and informed consent was achieved. This time period is important, because it allowed for the development of rapport 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 A). 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, but fostered in-depth responses. Although all six questions were asked in each interview, not all follow 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 was of particular interest to these participants. To demonstrate the in-depth nature of these interviews, a word count was conducted of the transcripts in NVivo software. The mean word count for the interviews was $M = 10,549.81$ ($SD = 2213.06$).

This article presents responses to questions 2c and 5a (appendix A), which focused specifically on participants’ descriptions of their experiences with mental health services. For the purpose of this paper, 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. Because another article discusses participants’ perspectives about psychiatric medication (Author 2 et al., in progress) quotes related to the impact of medication on recovery are not included in this article. 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, 2006; Floersch, Longhofer, Kranke, & Townsend, 2010). To conduct thematic analysis, first, 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 that led to agreement that seven themes emerged from the initial coding. Two of the coders then went back into the data and coded all meaning units a second time 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 involved creating seven documents through NVivo9 that included every meaning unit (sentence or multiple sentences) that were coded according to each of the seven themes. Two researchers analyzed these quotes looking for consistencies and contradictions to uncover ways participants
felt similarly about the theme “safety” and ways their thoughts about “safety” were contradictory, for example. Individual reflection and group dialog amongst the coders allowed for increased understanding regarding the meaning of the comments shared by these participants. Once the preliminary analysis was complete, a summary of the findings was put into a 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 to which any research team member could contribute 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, 2008), was evident throughout the research process and is again 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 to manage 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 allowed them to freely comment on the initial findings allowing 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 [referring to our summary of the service-related findings] is excellent and exactly describes the kind of services that were most beneficial to me,” while another stated, “Great summary, and I agree that all parts [referring to the description of their 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 differences in 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 appraisals, all participants also identified service experiences that were not helpful. Seven themes emerged from these data as participants discussed what about services helped to facilitate the process of recovery. Essentially, participants felt that services 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) grounded services in a shared experience were most helpful. Each theme will be illustrated through quotes provided by participants.

Establish Safety

When participants discussed what about services facilitated the process of recovery, they consistently discussed establishing safety as essential. For some, safety referenced a sense of emotional safety established through respect demonstrated by a number of professionals.
Although some primarily discussed emotional safety, others also spoke about concern for their physical well-being during services. In many cases, concerns for emotional and physical safety were concurrent. Illustrating this point was one woman 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 by which she was expected to abide. 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 may 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. She described it stating:

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 due to risk of harm to self, not others. She perceives her attempt 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. Similar to this story, the consumers who participated 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 felt 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 explained:
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 five 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 agreed stating, “There is an unspoken message that if you ask too many questions…there could be consequences 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 did solicit their feedback and incorporate their voice into decision-making. For example, one participant stated:

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.” When participants 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 the value of self-determination was the idea that services should be adapted to fit the individual. Participants felt having a “one size fits all plan” did not work for them, but when services were adapted to fit their preferences and when self-determination allowed their choices to become known, growth and development was possible. Related to this was the idea
that service recipients desire to be treated in a way that honors 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 highly valued this experience and often found it contrasting many of their other interactions with mental health professionals. For example, one participant stated:

But I was very lucky. I had a doctor for ten 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 one’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, service recipients 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.

If consumers felt service providers communicated that recovery was not possible, this prompted a sense of helplessness and discouragement. For example, one service recipient talked about her initial diagnosis of a mental health disorder and described it as:

…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 this 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 like these highlight the important role expectation exerts in one’s process of recovery.

**Validate Experiences including a Trauma History**

Although having a trauma history was not a criterion for inclusion in this study, 12 of the 16 study participants reported a history of trauma or abuse. When discussing their trauma histories, participants shared how important it was that mental health providers asked about their
trauma history and validated their 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. She stated:

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:

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 is cited as an essential part of the
recovery process. When service providers do not validate trauma histories, as in the story of the second participant in this section, 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 one who stated, “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 them. 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 talked 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, ‘ok, 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 about 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,” while another stated peer-run services are 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 that as a result of recent budget cuts, her peer support services were eliminated. When discussing this, she explained:

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
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 perspective of being a service recipient, participants also talked about how helping others was an important part of their own recovery. For example, one participant talked about the mutuality of the process of recovery. He described a time when he was mentoring another young man who was working on his own recovery, and the participant explained:

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, but 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 how mental health services fostered the process of recovery for this sample of consumers.

Similar to other studies, the findings suggest consumers at times felt re-traumatized by the mental health system. This was reportedly caused by a range of factors, from physical restraint to disrespectful communication patterns. This is consistent with previous research reporting that many clients felt “invalidated and unheard” (Hagen & Nixon, 2011) and resented coercion (see also Gilburt, Rose, & Slade, 2008; Newton-Howes & Mullen, 2011). Participants noted that some service providers communicated in ways that were demeaning, intrusive, or suggested a mental health diagnosis represented a downward spiral with little hope for one’s future. These negative service experiences did not foster opportunities for rehabilitation and on occasion, seemed to hinder progress rather than facilitate it. Considering the mandate that mental health services adopt a recovery perspective has been in place a full decade, stories like these that contrast a recovery orientation are concerning. 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 (NASW, 2008). Considering 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 this population.

Although several interviews offered descriptions of services that contrasted 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; Gilburt, Rose, & Slade, 2008), participants discussed process-oriented aspects of services as meaningful. For example, incorporating voice into mental health decision-making fostered 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 consumers to feel valued and heard. Simple things like being “remembered” or feeling providers were “sincere,” were meaningful to these consumers. Many aspects of these stories suggested the process of how services were delivered was just as important as the content or what services were offered. This 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 (TIC), 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, included but not limited to CBT, DBT,
Acceptance and Commitment Therapy (ACT), and mindfulness (e.g., Bach & Hayes, 2002;
Fava, Ruini, Rafanelli, Finos, Conti, & Grandi, 2004).

Participants also attached a high value to peer-run or peer support services, as services
implemented by people with similar experiences were seen as validating. Consumers appreciated
the unique insight and understanding that comes from a provider who “has been there”; rather
than only working 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, Chinman, Kloos, Weingarten, Stayner, & Tebes, 1999; Davidson, Chinman, & Rowe,
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 put limits on their potential. People were told they would require
psychiatric medication for their lifetime. These consumers were also told they would never work
and could expect to be on disability for a lifetime. 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, White & Anthony, 2007) as well as the longitudinal data on recovery (e.g., Harding, 1987), and should be avoided by practitioners.

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 them, and fundraising events are scheduled to support research to combat their 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 wrap around these individuals with support, providing further evidence of how stigma impacts this population (see Holley, Stromwall, & Bashor, 2012). Participants in this study found messages that limited potential as damaging, and instead of fostering recovery these messages 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, consistent with principles established in the strengths perspective (Saleebey, 2013), participants felt empowered by the hope of what their future could be. These findings suggest more training may be needed for clinicians to increase understanding regarding the meaning 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: empathic responding, listening, relationship building, recognizing strengths, facilitating and respecting self-determination, evidence-based awareness of the data demonstrating that
recovery is possible, and knowledge 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 broadly adopted a recovery orientation, social work could distinguish itself by doing so, and this could result in substantial benefits for clients. Despite macro-level barriers that hinder genuine adoption of the recovery model (e.g., Gomory, Cohen, Wong & 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 DSM-5 to critical assessments of bioreductionism (Whitaker, 2010; Kirk, Gomory, & Cohen, 2013). In the wake of such discourse, mental health clinicians and researchers will likely 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 to treatment-as-usual) would be a valuable contribution to the literature. This might be accomplished through specialized training of clinicians. Importantly, “full implementation” of the recovery model should be confirmed from the perspective of consumers.

There are limitations to this study. The sample represented only the perspective of consumers who identify themselves as currently in recovery. 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 Caucasian participants, highlighting the need for more research that raises the voice of men, due to the potential that gender bias shaped these
findings, and people of color who are diagnosed with SMI. The perspectives of service providers were also not included.

Although the experiences of these individuals cannot be extrapolated to all consumers of mental health services, findings can offer transferability in that the in-depth descriptions provide insight into how some consumers perceive their service experiences. Transferability refers to the degree to which findings can be applied to other contexts or settings (Padgett, 2008). Because these participants received services at multiple agencies on average for over 20 years, we feel their descriptions move beyond one setting and offer implications for many service providers. In addition, their findings offer implications for social work practice and recovery-oriented services considering many stories contrast social work values and the recovery model, suggesting social service agencies further evaluate the degree to which services are adherent to the recovery model and social work values. The consistency across stories from these participants was quite 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 about services recipients see as most helpful to 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. Findings suggest more research is needed to evaluate the degree to which programs are
implementing a recovery orientation. Training may be needed across disciplines interacting with this population to increase awareness regarding how best to facilitate the process of recovery. These findings lend support to treatment programs that move beyond medication-only intervention, to programs that offer 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 A: 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 “c”).
      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 “d”).
      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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