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Questioning the professionalization of recovery: a collaborative exploration of a recovery process

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ABSTRACT

While the recovery concept strongly resonates in clinical mental health care today, it first arose in service user-led contexts. A major risk of this professionalization shift is that recovery primarily becomes defined by treatment providers. This study aims to keep the debate on recovery alive through a collaborative exploration of Pete's recovery process by means of a bricolage approach. This resulted in an idiographic portrait of Pete's experiences of recovery and treatment, clustered around four themes: life rebuilding, identity, continuity of care and the role of drugs. His experiences illustrate a number of contradictions in the operationalization of the recovery ethos in today's mental health care; whilst recovery appears as a hopeful vision of empowerment, it also risks being reduced to a tokenistic model that fails to address the social realities of people in recovery and in which the assumption that mental illness is chronic is still latently present.

Points of interest

- This article has been co-written by a service user and an academic.
- Everybody in mental health is talking about recovery. This concept originated in the service user movement but has since been taken over and redefined by professionals and academics.
- The perspectives and opinions of service users are essential if we are to assess the success or failure of professionally led treatment programs that aim to support recovery processes.
- Currently in Flanders, people with mental health problems are being actively encouraged by staff to identify themselves as having a mental vulnerability ('psychische kwetsbaarheid'). The authors resist this top-down labeling of all people with a psychiatric diagnosis as necessarily disabled.

Introduction

Today, recovery is a central guiding principle in international mental health care (Braslow 2013). Moving away from a biomedical approach to mental illness, recovery has been described by Deegan as:

> a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. [...] The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution. (1988, 15)

The origin of the recovery concept traces back to the 1960s, when psychiatric institutions were increasingly criticized for their collectivist work regime that disregarded the embeddedness of mental illness in people's lives (Goffman 1968). During the 1970s, the anti-psychiatry movement gained ground and stood up against seemingly endless psychiatric admissions and a medicalized view of mental illness and treatment. The American survivor movement advocated the acknowledgment of depriving living contexts as the primary cause of mental health problems (Morrison 2013). These developments led to a wave of deinstitutionalization and a shift toward a more person-centered treatment approach (Rissmiller and Rissmiller 2006). Gradually, recovery was presented as a fundamentally new way of thinking about mental illness, challenging the assumption of chronicity and the belief that mental health problems always lead to life-long dependency on the mental health system (Anthony 1993; Price-Robertson, Obradovic, and Morgan 2017; Braslow 2013).

During the 1990s, the recovery ethos gradually found its way into the American mental health care system, and in a later movement also into European mental health care. Especially during the last decade, the recovery concept has increasingly been adopted by professionals, policy-makers and academics in the field. For example, in search of the clinical utility of the recovery philosophy, Leamy et al. (2011) composed a synthesizing framework of recovery based on a narrative synthesis of first-person accounts. According to this CHIME framework, recovery comes about through the interplay of five central processes: Connectedness, Hope and optimism about the future, Identity, Meaning and purpose, and Empowerment (Leamy et al. 2011). Later, Stuart, Tansey, and Quayle (2017) added 'Difficulties' to this framework (CHIME-D), to include struggles and challenges that persons in recovery face. However, Duff (2016) argues that such a conceptual model, despite being based on first-person accounts, fails to grasp 'real' recovery experiences as they merely offer an abstracted idea of possible recovery experiences, thus resulting in a generic model that pays insufficient attention to idiosyncratic and contextual recovery dimensions (Price-Robertson,

Obradovic, and Morgan 2017). Moreover, reducing the recovery framework to a model risks overlooking disabling structural factors and social realities (e.g. material deprivation, homelessness, judicial problems) that often play a central role in the emergence and course of mental illness in people's lives (Hopper 2007). Related to this, Stuart, Tansey, and Quayle (2017, 302) warn for unintended side-effects of the 'professionalization' of the recovery ethos; that is, 'the danger of imposing professional ideas of recovery onto what was originally a service-user-led concept'. Indeed, recent studies show that there often reside subtle gaps and contradictions between the recovery discourse and its implementation in everyday mental health care practice (Khoury and del Barrio 2015; Lietz et al. 2014; Slade et al. 2014). A major risk of this professionalization trend is that recovery becomes predominantly defined by treatment providers and leaves little room for a person-centered approach (Pilgrim 2009; Hyde, Bowles, and Pawar 2015). Consequently, it is far less seen as a personal journey that only makes sense in terms of the challenges and contexts one is confronted with in life. In light of this shift, several authors have warned of mainstreaming (Rose 2014), theft through adoption (Hunt and Resnick 2015), colonization (O'Hagan 2009), popularization (Stuart, Tansey, and Quayle 2017) and hijacking (MHRSWG 2009) of the recovery concept, all referring to the danger of recovery becoming a surrogate specialist discourse that is shaped by practitioners and policy-makers and no longer reflects the original user-led concerns (Pilgrim 2009). In other words, professionalizing recovery runs the risk of pushing people with mental health problems back into a more passive role: the role of the ones who need to accomplish targets that others have imposed.

As a result of these developments, recovery has become a floating signifier, an umbrella concept that can be interpreted in many different ways but fails to grasp the actual underlying mechanisms that ebb and flow in the lives of people in recovery (Hopper 2007; Duff 2016; Price-Robertson, Obradovic, and Morgan 2017). Experiential knowledge is essential to fill this knowledge gap and to critically discuss if and how professionally led, recovery-oriented treatment and support programs actually support recovery processes or rather impose societally valued targets onto people (Pilgrim 2009). First and foremost, to do justice to the ethical imperative inherent to the recovery discourse – that is, that persons with mental health problems themselves hold the authority to talk about recovery – service users should be acknowledged as experts by experience (Pilgrim 2009, Beresford 2005). Moreover, Stanhope and Solomon (2006) argue that experiential knowledge, even when it is rooted in micro-level processes, has the potential to address larger social, structural and political developments. However, until today, the perspectives and involvement of service users have largely remained in the

margins of academic discourse and disability research (Faulkner 2017; Roets et al. 2007; Jones and Brown 2012; Beresford 2005) or have been used in a strategic way, 'to represent and speak for an essentialized group of others whose interests are wide and varied' (Voronka 2016, 198). Such an approach reduces persons with lived experience to a homogeneous group, reinforcing epistemic inequalities between professional and experiential expertise (Voronka 2016).

In contrast, the aim of this study is to capture, in all its complexity, what it means to be in recovery and how (recovery-oriented) treatment and support are experienced. Following the statement by Faulkner and Thomas (2002) that research into mental health services should always be a marriage between expertise by experience and expertise by profession, this article is the result of a co-production between an academic researcher and a person with lived experience. More precisely, this article is the result of a journey of 'bricolaging' that Pete (an expert by experience) and Clara (an academic researcher) have traveled together, aiming to draw a portrait of Pete's recovery process and treatment experiences. During this collaborative journey, they were confronted with a number of tension points and entrenched assumptions regarding the conceptualization and operationalization of recovery in today's mental health care system. Based on the premise of Roberts and Boardman (2013) that an emphasis on recovery in mental health care can only be of value as long as it remains open to debate, this article aims to provide an experience-based contribution to this debate by discussing Pete's experiences and challenging these assumptions.

This study is part of a larger research project that has been granted ethical approval by the Ethics Committee of Ghent University Hospital (EC UZG 2016/0530). As an expert by experience who openly talks and writes about his experiences in psychiatry as part of his profession, Pete has full understanding of the fact that this publication, in which he also shares these experiences, is publicly available and might have an impact on his life.

Methods

Context

This study took place in Flanders (Belgium), where the recovery concept has gained dominance in mental health care during the last 10 years. Pete and Clara met for the first time at Villa Voortman, a community-based meeting place for persons with dual diagnosis in Ghent, in January 2013 (De Ruysscher, Vanheule, and Vandevelde 2017). Villa Voortman offers a welcoming shelter for persons with co-occurring psychosis and addiction problems

who have lost connection to regular treatment. Besides a safe haven, Villa Voortman is also a creative hub where a wide range of activities (e.g. sports, cooking) and workshops (e.g. poetry, philosophy, music, art-making) are organized, both by staff members and visitors (as service users are called). Clara got to know Pete as a daily and enthusiastic visitor to Villa Voortman who organized philosophy and poetry workshops for fellow visitors and started thinking about becoming a peer worker at the center where he was treated for depression and for alcohol and cannabis addiction. From November 2013 to September 2015 Pete suffered a paranoid delusional psychosis, the first of his life, that led to a series of further (involuntary) admissions and the loss of contact with his social network – especially the (temporary) loss of contact with his teenage daughter. Since September 2015, Pete frequented Villa Voortman again, which is where Pete and Clara picked up again. From then onward, and especially during the last year, Clara increasingly started sharing and discussing thoughts and questions regarding her research on recovery with Pete. In turn, Pete let her read the poetry and texts he was writing at that time about his recovery and treatment experiences. Writing poetry has always been a crucial aspect of Pete's recovery process:

> I wrote my way into this mess
>
> Into this crisis of self and reality
>
> The intentionality was mine all along
>
> I resolve to write my way out again
>
> To take control of the process
>
> To assert my will that way
>
> To get it all down
>
> With the intention to publish
>
> (20 September 2015)

During the writing process of this article, Pete and Clara have had lengthy discussions about the necessity to include details on Pete's diagnosis and treatment history. Initially, it seemed self-evident to include this information as background to understand the article. Additionally, adding details on Pete's treatment history would stress the individuality of his experiences and would anticipate the question: recovery from what? Most importantly, Pete considered it crucial to include details on his diagnosis and treatment history in the text, as they serve as proof that persons who experience(d) something as life-changing as psychosis are capable of (co-)writing academic papers. Based on these arguments, the decision was made to include details on Pete's treatment history.

In this article, Pete draws on his whole experience of three years (from November 2013) staying in four different hospitals plus Villa Voortman.

Research process

To do justice to both the complexity of recovery processes and the versatility of experiential knowledge, we have adopted a collaborative case-study design, starting from a bricolage approach (Kincheloe 2001; Baxter and Jack 2008). Building on the work of Denzin and Lincoln (2011), Kincheloe describes bricolage as a hermeneutic process that allows the researcher to move toward more complex and layered ontological insights, as it starts from the assumption that:

> any social, cultural, psychological or pedagogical object of inquiry is inseparable from its context, the language used to describe it, its historical situatedness in a larger ongoing process, and the socially and culturally constructed interpretations of its meaning(s) as an entity in the world. (Kincheloe 2001, 682)

In other words, bricoleurs allow for contextual contingencies to prompt the questions that should be asked and combine empirical methods and materials creatively in search of answers to these questions (Rogers 2012; Van Hove, De Schauwer, and Platel 2017).

Gillard et al. (2012) emphasize the importance of applying methodological flexibility in such a process of knowledge co-construction, to create space to situate and challenge entrenched assumptions and existing professional practices. Therefore, during the entire bricolage process, which took place between May 2016 and January 2018, Pete and Clara worked closely together as they combined the following information sources:

- A series of nine in-depth conversations between Pete and Clara over a wide range of topics including the concept of recovery, Pete's experiences of psychiatric treatment, the role of substance use in psychosis, and the organization of the mental health care system. To keep track of the topics discussed, all conversations were audio-recorded and transcribed verbatim as they went along. The conversations took place in Dutch, and the excerpts used were translated into English by Pete himself, who is a native English-speaker.
- 'From the Inside: My Escape from Paranoid Delusional Psychosis', a poetry bundle by Pete that he describes as a view of 'material parts of my psychosis and […] a large part of the therapeutic work I have done to stay out of psychosis and deal with the wreckage of my life'.
- Email conversations between Pete and Clara.
- Pete's recovery story, which he wrote as part of a course he followed to become a peer worker.

- Conversations with the third and fourth authors. Being Clara's supervisors, they were involved in the research process from a further distance. Their 'outsider' perspective gave Pete and Clara multiple opportunities to discuss their ideas on the professionalization of recovery, which helped facilitate the research and writing process.
- Existing recovery (research and policy) literature.

Data analysis

During the bricolage process, Pete and Clara engaged in an iterative process in which data collection and analysis alternated. After each conversation, Clara conducted an initial thematic analysis following the guidelines of Clarke and Braun (2014). Secondly, this analysis was extensively discussed and checked with Pete, generating new questions to discuss in the following conversations, which were in turn analyzed. This process was repeated until a saturation point was reached and no further questions came up. During this iterative process, the emerging themes were also linked to poetry extracts from Pete's bundle. In a later stage, a group meeting was organized with the third and fourth authors to discuss interpretive perspectives and identify themes which remained untouched in the analysis (Gillard et al. 2012). This way of working resulted in an elaborate idiographic portrait of Pete's experiences regarding his recovery and treatment trajectory, which was clustered around four key themes (see earlier).

Results

Pete describes his recovery in the following way:

> It is getting a life back after the destruction caused by the illness. Essential to my personal recovery is going back to not living in isolation. Recovery is also a therapeutic process, of getting to know yourself better, of becoming better informed and of overcoming symptoms by understanding and tackling them. Recovery after mental illness is especially the restoration of a sustainable and sufficiently positive emotional life after the prolonged suffering associated with illness and [forced] admissions to hospital. I think that deinstitutionalization ['*vermaatschappelijking*'] should be seen in terms of so complete possible psychosocial reintegration of the mental hospital population into general society for patients who want that. Empowerment means being accepted as we really are by public opinion. People should not need a collective name for people who have been in mental hospital because outcomes are so diverse.

During their conversations about recovery and Pete's treatment experiences, Clara and Pete were repeatedly confronted by dilemmas and tension points, which they clustered around four themes: life rebuilding, identity, continuity of care and the role of drugs. Each of these themes will be discussed in detail.

'Some people really believe I would recover by having a TV installed': *life rebuilding*

During their initial conversations, Pete and Clara gave a central position to the concept of recovery as such. However, they soon noticed that they were constantly fluctuating between different interpretations of the concept, which prevented them from touching the core of Pete's experiences. In search of a new common language, they started talking about 'life rebuilding', described by Pete in the following way:

> To have a life again. A better life than recently, you know. Definitely full working days – paid or voluntary. A relationship. More friends. Interesting things to do with others. Finally succeeding in getting my poetry published, which will probably never happen, but I still put it on the list, why not. Maybe a bit Utopian, but for me … My ideal world, my ideal existence is one in which I am constantly engaged in a fascinating conversation, with company whenever I want it.

One aspect that Pete considers crucial in this process of life rebuilding is to lead a life with responsibilities in which leisure time alternates with meaningful activities (such as having a job, writing poetry), and to always have plans and be learning new things. He calls this 'self-realization', another concept he prefers to recovery:

> I prefer the discourse of self-realization to recovery. I know it's old-fashioned, but it appeals more to me because it is more social. […] Recovery is getting better after something … which implies a norm, yes. But self-realization does not. You relate it to yourself. […] A lot of people achieve their goals. They graduate from college, or they find a job they want and a relationship … Of course their lives will not be perfect, they will have their disasters, loved-ones who die, divorce, that kind of thing … That's life. And yet they still feel good about who they are in society. That's the feeling I'd like to have.

What stands out in Pete's description of both life rebuilding and self-realization is the importance of rebuilding a social network and having a family life. In this respect, two aims are especially high on his agenda: to restore a positive contact with his daughter and to find a romantic partner. However, this is a very arduous process, because of how difficult it is to overcome the stigma caused by his psychotic episode ('I have been a very public lunatic') and his psychiatric admissions. To explain how he felt on returning home after a series of admissions, Pete used the metaphor of moving to a different country where you have to start all over to build a network:

> I have experience in moving around a lot. As an immigrant, I have been faced a number of times with situations where I had lost everything. My life is fragmented. […] I have learned that it takes a very long time to make friends. Years. If you find one or two new friends in a year, to put it simply, you are doing well.

However, the conversations about life rebuilding and self-realization were often in stark contrast to moments in which Pete's experiences in residential

psychiatric treatment were discussed. In his perception, people become seriously mentally ill because of the problems in their lives and go into hospital when they cannot function any more. However, when Pete was admitted, he felt as if he was in limbo, in a sort of vacuum space where he was not actively working toward rebuilding his life, and that the ideas and effort to recover came entirely from himself:

> When I'm in mental hospital, it feels like I am normally there, that hospital is my real life, the continuity in my life. Such thoughts do not make you happy. Sometimes you go into hospital highly motivated, but often, once you are there … Your motivation falls away. It is very difficult to explain. […] You are not really recovering, you are not really improving, you are not really getting worse either. You're just there.

He attributes this state of limbo to a lack of contact ('non-contact', see earlier) between the psychiatric context and the real world. He experienced residential psychiatry as a sort of 'waiting room', a place to stabilize one's life rather than to actively pursue a different life. Pete describes how psychiatric admissions can even become integrated into destructive and hard-to-break cycles:

> We come from mental hospital. We are depressed because we have no money. Because we have no life. Many of us have no friendships with people who have never been admitted to mental hospital. And … then they begin to use illegal drugs, often for the first time during an admission. In the beginning it's all right, I mean … it seems to help, but in the end these drugs always lead to new problems with money or mental instability or illness, and then they go to ground in mental hospital. You get ill enough to need residential treatment when your problems become unbearable, for example, with money. I ran up debts of 3000 euros in six months during my illness. Only the intervention of a friend prevented me from becoming homeless. Many of my fellow patients are not lucky enough to have such a friend. They lose their accommodation, because they didn't pay the rent when they were ill. Poverty makes you ill, then the illness makes you poorer. Such vicious circles are cruel. They can break a person.

In Pete's experience, this lack of contact *('non-contact')* between residential psychiatry and the real world also extends to a lack of insight from staff into his personal lifeworld. For example, in his recovery story, Pete describes how social isolation remains a daily struggle for him:

> I spend 75% of my waking hours alone. This has been the situation since I came home from hospital in May 2016. I am a very social person and I do not like being alone, so this extended, deep solitude, forced on me by the fall-out from my illness (broken relationships), is something I have learned to live with – a very difficult but extremely educational experience. Not being able to be alone is a psychological vulnerability which I have overcome. I will not consider myself recovered until my life changes dramatically.

To counteract this social isolation, however, Pete has been advised by one psychiatric staff member to install a television in his apartment. This

advocacy of passivity is in sharp contrast to how Villa Voortman positively challenges him. In this meeting place, visitors are encouraged to elaborate a sense of identity and to engage in dialog with others, expressing who they are by different means. In line with this personalized approach, Pete learned how to play the drums and organizes weekly philosophy and poetry workshops at the meeting place, because those roles in those activities suit him. He feels that these opportunities and activities help him rebuild his life, both because they fill his days with meaning and because they help him move away from his identity as psychiatric patient.

'Are we strong people with difficult lives, or weak people who can't handle life?': identity

Pete's identity has many facets: he is a father, he is a poet, he is a philosopher, he is a peer worker, he is an (ex-)psychiatric patient. In his poetry, Pete describes how these different facets are often intertwined and alternately play a central role in his life:

> For many years
>
> If asked who or what I was
>
> The answer came easily and immediately
>
> I am a father
>
> The rest of my existence
>
> I built up and held together
>
> In function of this primary responsibility
>
> To make my fatherhood possible
>
> Now that's had to change
>
> She's still number 1
>
> But no longer my centre
>
> That is being a writer
>
> (11 September 2015)

However, the one aspect of Pete's identity that was discussed the most was that of (ex-)patient, as he felt that during treatment his identity was primarily defined by his illness ('first and foremost, we are people with an illness'). In the current recovery discourse in the Flemish mental health care system, persons with mental health problems are no longer called 'patients' but 'persons with a psychological vulnerability' ('*psychische kwetsbaarheid*'). However, this new wording can prompt one to make a number of flawed assumptions. Firstly, using 'persons with a psychological vulnerability' as a

name suggests that there exists a category of people without a psychological vulnerability. Pete has reservations about this categorization, because it appears as if psychological vulnerability is something that coincides with and defines yourself as a person, thus implying that it is something entirely about the individual. However, Pete clearly attributes his psychosis to traumatizing experiences in his childhood and his social situation at the time. Also, since he clinically recovered from his psychotic episode, he sees his vulnerability especially becoming visible in interaction with others, rather than within himself:

> Then a psychological vulnerability is just a euphemism for an incurable sickness. But for me, my vulnerabilities are more social. It is how people react to me, how they see me since the madness. I was a very public lunatic, you know, a lot of people recognize me. And that is in fact more than one problem […] I am a vulnerable person, yes, but not for psychosis. Am I more vulnerable than the average person? I don't think so. I think others have had better luck. […] I am not so much a vulnerable person, I am a person with average vulnerability and a lot of problems. My daughter is gone, because of the illness. Am I ever going to get over that? I don't know. As a patient you are expected to simply accept those things.

Secondly, psychological vulnerability is often assumed by staff to be something which is always permanent and incurable, and thus chronic. As a consequence, labeling people with a 'psychological vulnerability' implies a constant expectation of relapse. Because of this expectation, psychiatric staff put patients under pressure to lower their expectations of recovery. Pete sees this being reflected in the daily practice of some residential psychiatric wards where he has stayed:

> There are no group talking therapy sessions, because the whole emphasis is on keeping people as calm as possible. We have pills to make us calm, we follow therapies which relax us. There is the routine, the structure. But I do not necessarily see recovery as a process of calming down. For me, you have to tackle the problems, don't you think? For example, you have to say why you refuse to talk to staff, if that is a problem.

Although Pete himself is opposed to this assumption of chronicity, he does think there are persons with chronic mental health problems who need long-term treatment. What he finds problematic is how other aspects of people's identity are overshadowed by their illness identity:

> Clara: Do you think chronic patients exist?
>
> Pete: Well yes, I think so. But it is what that means, do you see? Because you can also say … 'OK. I am a chronic patient.' But what does that mean? It is the limits on my life that the staff think I have. It is always down, down, down, down.

In the same vein, Pete told Clara that some staff members have asserted that after he recovered from his psychosis, he should only expect a life in which he mainly has contact with other (ex-)patients. Pete links these low

expectations toward patients with his perception that residential psychiatry is a deeply entrenched system, in which thinking in terms of the deficits rather than the strengths of people to recover is still latently present:

> They are far too unambitious when it comes to the life-prospects of patients. You come under a lot of pressure to be passive, that's what it amounts to. It is the whole system and the medication which pushes you in that direction […] I have the feeling that people are deeply entrenched. That attitudes in psychiatry are dyed in the wool, you know. Certainly with respect to the whole chronicity thing, that in the last analysis, we have fallen out of society because we are inadequate in some way and there is not much you can do to help us.

This attitude from staff members refers only to one aspect of Pete's identity, namely his 'psychiatric' identity, relegating other aspects of his identity to relics from the past. As a consequence, it is difficult to reconcile such an approach with the future that Pete pictures for himself:

> I have fifteen years to go to retirement. If I just take this time. I don't see why they can't be the fifteen happiest years of my life. Why not? I don't say that is going to happen. Why not? But the assumption is that it is not possible.

Pete refers to these low expectations from staff members as 'diagnostic overshadowing', a concept originally used to describe the negative bias of clinicians toward symptoms and behavior of patients with mental illness (Jones, Howard, and Thornicroft 2008). In Pete's sense, this negative bias also extends to patients' capabilities and plans for the future. According to him, diagnostic overshadowing is the way that, once someone knows you have a diagnosis (e.g. psychosis), all your behavior is interpreted as being related to the diagnosed disorder. Frequent diagnostic overshadowing is counterproductive in supporting patients' recovery processes, especially because patients are often prone to internalizing these low expectations (leading to self-diagnostic overshadowing).

'Sometimes it felt like I was sitting on a conveyor belt': continuity of care

During conversations about what constitutes good treatment, Pete unhesitatingly put continuity of care forward as an indispensable component. However, during a large part of his treatment trajectory, Pete has missed this continuity, in the sense of having long-term contact with one or a few staff members. In one of his poems, he describes his therapists as 'pass-the-patient-parcel therapists' who fail to truly connect to his life story and long-term needs:

> As a patient in the mental health system, I feel like I'm sitting on a conveyor belt. I pass on from one psychology expert to the next. They all do their required interventions, then I pass on to the next. No one tries to stop the line. No-one tries for or expects a full recovery.

In that sense, we came to the realization that the non-contact Pete experienced between psychiatry and the outside world (life rebuilding) also extends to the contact between himself and the psychiatric staff, manifesting itself in a distant attitude from staff members and a lack of personal(ized) (talking) therapy. This non-contact became eminently visible during Pete's three involuntary admissions:

> You arrive, you've been sectioned, and nobody says anything to you, you are treated from a distance. You're completely crazy, of course, but nobody tries to bring you back to reality. No-one tries to … Nobody talks to you about your delusions and the like. You can talk to the psych's but if you don't talk about your illness, they don't. And that is not enough. Because if you … In my opinion, talking and thinking about delusions and discussing them does have value. Analyzing delusions helped me, why shouldn't it help some others?

He partially attributes the lack of talking therapy to the fact that, in the psychiatric wards where he stayed, a group approach was applied to treatment. In Pete's case, this meant that most therapeutic activities – apart from a weekly 30 minutes of individual therapy with the psychologist – took place in the group and that the many hours of spare time were spent just hanging around in the ward. However, as our conversations progressed, we touched the core of Pete's frustration: patients are insufficiently approached as individuals with their own life stories, problems and personalities. This has far-reaching consequences; looking back at this period in his life, Pete goes as far as identifying the distant attitude of some psychiatric staff and the lack of attention to his personal story as important causes of the stigma he experienced during and after his admissions.

> When you are there, you are merely a member of the group. You lose half your personality when you go into mental hospital. And then, when some staff are more personal, more direct, then you really appreciate it. Those are the positive memories I have. But between those moments … Mental hospital is mostly hanging around. It is mostly waiting.

Pete believes that continuity of care can only be realized when staff connect with patients over a longer period of time and across different settings, without losing the link to patients' personal lifeworlds. In his view, continuity of care is interwoven with a made-to-measure treatment approach that is flexible in addressing the different needs that patients have at different times. This flexibility is something Pete experiences in Villa Voortman, which he visits almost daily:

> Homeless? Eat and sleep in the bed. Staying in mental hospital? Come to the Villa as a stepping stone to going home and to keep in contact with the outside world. Dying of boredom? Take the initiative and organize or do something for yourself or others. In crisis? Welcome. During my psychosis, I came back to the Villa repeatedly and was very well received, despite my behavior at that time.

'I call it chemical company': the role of drugs

The role of drugs in Pete's life and recovery is a topic that was only discussed during Clara and Pete's later conversations. The use of cannabis has been an integral part of Pete's daily life since before his psychotic episode and continues to be so today. The primary functions of his cannabis use are to fight boredom and to fill up the void caused by loneliness, as he describes in his recovery story:

> Both in company and alone, I pursue my three passions: philosophy, writing and drumming. These are how I fill most of my time. These and cannabis, which I smoke alone in the evenings. It is my way of dealing with the loneliness, I call it 'chemical company' and it has helped me therapeutically, for example by freeing me to have animated conversations with myself. Because I smoke cannabis, I do not need heavy sedative medication such as second generation anti-psychotics or benzo's. […] I have never taken other drugs. I will not consider myself recovered until my cannabis problem is of a lower order.

What stands out in this excerpt is that Pete finds it a necessary condition for his recovery to deal with his cannabis use. For quite some time, Pete did not consider his daily cannabis use to be a problem and found it very convenient that the staff on the ward where he stayed were oblivious to it, as this gave him the space to continue using. However, recently he started seeing his use as a problem and worrying about the damage it brings to his physical health and financial situation. Also, now he realizes that it would benefit his recovery process if he could find a suitable alternative to face the 'challenge of solitude':

> Drugs are very important to me and a very conscious aspect of my life. I rely on them. If I want to stop, I'll need an alternative, but they really don't have an alternative, except other medication. I could stop tomorrow by going over to heavy medication.

As a consequence of his recent concerns regarding his drug use, Pete considers it his moral obligation to begin speaking about it to his therapists:

> But it's not good for my therapy. I'm in therapy at hospital X, and there I do not talk about drugs. This is not good […] I am still a bit worried about my mental health and there are a couple of symptoms I get, especially when I have smoked. And I want to discuss these things with someone. But I can't do that without talking about my drug use, do you understand?

However, part of him still feels reluctant to talk about it to his psychiatrist, for a number of reasons. First, he points out that drug use remains taboo in certain treatment settings. Second, he is scared of patronizing conversations from a lack of understanding of the function of Pete's cannabis use and, in a broader sense, his lifeworld. Third, Pete is scared that his drug-related worries will be misunderstood because drug use is often seen as a trigger for

psychotic thoughts. In other words, he is concerned that the psychiatrist might suspect him of turning psychotic again:

> I used [cannabis] before my psychosis, during my psychosis and I still use and have no psychosis. So, in my case … but I can understand what they mean. It can provoke certain phenomena, voices and the like. But to become really psychotic, you have to start interpreting these phenomena. If you experience but don't interpret the experiences, you don't become full-blown psychotic.

Discussion

While the concept of recovery arose first in activist, personal and social justice contexts, it currently strongly resonates in clinical mental health care settings (Roberts and Boardman 2013; Hunt and Resnick 2015). This mainstreaming shift might imply that the personal perspectives of persons with mental health problems get somewhat neglected. To counteract this, this study aimed to keep a critical debate about recovery alive by means of a collaborative exploration of Pete's recovery process. In so doing, a number of tension points and ambiguities were identified and clustered around four themes: life rebuilding, identity, continuity of care and the role of drugs. Discussing these themes exposed a number of gaps between the original recovery ethos and the professionalized translation of the concept and its operationalization in today's mental health care. In other words, it became clear how Pete's individual meaning of recovery is in tension with a professional enactment of recovery as mental health care policy and practice (McWade 2016). In what follows, we will elaborate on these gaps and situate them in the wider debate on recovery and recovery-oriented care.

Recovery: a never-ending journey?

Recovery is generally described as a personal, unique and non-linear journey toward living a meaningful and contributing life, even with limitations caused by mental illness (Anthony 1993; Deegan 1988). Built on the idea that people with mental health problems strive to live a meaningful life in fundamentally similar ways to those without mental health problems, Slade (2012, 702) argues that the role of recovery-oriented treatment is to 'support everyday solutions to everyday problems'. Contrary to this statement, however, Pete experienced residential psychiatry as a 'waiting room' in which his everyday life was put on hold and in which he was reduced to a member of a group, rather than an individual with unique needs and aspirations. Moreover, driven by a reflex of diagnostic overshadowing, he was often urged by psychiatric staff to lower his expectations for his further life (e.g. by suggesting that his social network would mainly consist of other [ex-

]patients) (Jones, Howard, and Thornicroft 2008). These low expectations of staff members toward Pete's further aspirations carry a sense of chronicity in them, as they seem to assume that being in recovery implies being condemned to a never-ending journey (Gordon 2013). In this respect, Khoury and del Barrio (2015) suggest that it is precisely the unique nature of recovery processes, characterized by intense ups and downs, that is often misread by psychiatric staff as a sign of chronic illness. Pete's experiences show that, while the recovery movement openly rejected thinking in terms of deficits, the medical gaze still remains the norm in daily mental health care practice (Lietz et al. 2014). A consequence of this underlying belief in biomedical treatment is that it discourages people with mental health problems from finding their own creative and non-coercive ways of recovery (Howard and Voronka 2012; McWade 2015). Hopper (2007) offers a promising alternative to this hidden assumption of chronicity by putting forward a capabilities approach to recovery. Rather than (implicitly) focusing on a process of 'getting better' or 'healing', a capabilities approach is built on the principle of equality, as 'recovery asks not what such people should be content with but what they should be capable of, and how that might be best achieved and sustained' (Hopper 2007, 875).

Recovery: a personal process?

A capabilities approach to recovery also acknowledges the embeddedness of a person in a social context and the contribution of structural and social factors to both mental health problems and recovery (Harper and Speed 2014; Hopper 2007). During the bricolage process, Pete's social vulnerabilities and aspirations continuously permeated our conversations; we talked about his daily fight against social isolation (which is directly related to his drug use), the disabling effect of the stigma from psychiatry, and his desire to have a family life and to fulfill a meaningful role in society. In contrast, Pete experienced that these vulnerabilities and aspirations were insufficiently understood and addressed during his psychiatric admissions. The distant attitude from psychiatric staff and the fact that he was primarily seen as a 'person with an illness' (rather than a father, artist, citizen) made him feel disconnected from his lifeworld and society. Pete's experiences provide a striking illustration of a growing body of critique on individual conceptualizations of recovery that give insufficient weight to the social and interactional nature of both mental illness and recovery (Vandekinderen et al. 2012; Price-Robertson, Obradovic, and Morgan 2017, Topor et al. 2011, Schön, Denhov, and Topor 2009). For example, in the commonly used CHIME-D framework, Connectedness is listed as one of five central recovery processes (Stuart, Tansey, and Quayle 2017; Leamy et al. 2011). Considering the centrality of

the social struggles in Pete's story, however, this framework falls short in two ways. Firstly, lining up Connectedness alongside four intrapersonal processes (Hope, Identity, Meaning and Empowerment) suggests that the latter processes take place in a vacuum space that is sealed from one's social context (Price-Robertson, Obradovic, and Morgan 2017). Secondly, picturing Connectedness as one of five processes gives the impression that the social context and social interactions are a mere contributing aspect, rather than a vital facilitator of recovery processes. Pete's experiences show how his social context is the very medium through which processes such as finding meaning in life, rebuilding a new sense of identity and feeling empowered come about. Moreover, when thinking in terms of the CHIME-D framework, nearly all of the Difficulties that Pete faces are of a social nature (e.g. overcoming stigma, fighting social isolation).

In other words, an individual recovery approach fails to fully address the complex social realities of people in recovery. Even more so, Vandekinderen et al. (2012, 3) argue that such an individual approach promotes a neoliberal interpretation of care and citizenship, as it entails 'a socially constructed norm of the self-managing, self-sufficient, and independent consumer-citizen who is fully responsible for his/her own choices'. Instead, it proves more valuable to start from a relational recovery approach that is characterized by interdependence rather than individualism (Price-Robertson, Obradovic, and Morgan 2017). From a relational perspective, care takes the shape of a continuous dialog between persons with mental health problems and professionals, characterized by a shared responsibility and the constant renegotiation of rights (Vandekinderen et al. 2012; Hopper 2007).

Recovery: a tokenistic model?

The original recovery movement rejected thinking in terms of diagnoses and reducing people to a psychiatric label (Hunt and Resnick 2015). This aversion to labeling people has found an echo in today's mental health care system in the sense that a deficit-oriented language (e.g. 'disorders', 'diagnosis', 'patients') is increasingly being replaced by person-first language that aims to minimize (self-)stigmatization. In the Flemish mental health care system, people with mental health problems are referred to as persons with a psychological vulnerability instead of as patients. However, Pete's experiences showed that, notwithstanding the good intentions of this new wording, it still risks becoming the next categorization of people with mental health problems ('the psychologically vulnerable'), with its own predefined characteristics and expectations. Although Pete describes his own vulnerabilities primarily as social and of a passing nature, these vulnerabilities were often perceived and treated by psychiatric staff as intrapersonal (rather than

interactional), chronic and something that fundamentally differentiates him from people without mental health problems. The problem with such preset expectations is that they make psychiatric staff unable to understand the perceptions of people with mental health problems and the way psychiatric symptoms are embedded in their lives (Vanheule 2017). Consequently, they stand in the way of a personalized treatment approach that is tailored to the lifeworld, personality, needs and wishes of each person. In his recovery story, Pete also expressed this need for personalization and differentiation by saying that the 'psycho-social reintegration of the mental hospital population into general society [is desirable] for patients *who want that*' (original emphasis), thus pointing out the need for a particularizing approach that starts from the personal meaning of recovery for each person with mental health problems (De Ruysscher, Vanheule, and Vandevelde 2017).

To prevent the recovery discourse from being reduced to a tokenistic or superficial model, it is necessary to rethink the roles and aims of mental health care treatment and therapy. Rather than a deficit-oriented approach to diagnosis that categorizes symptoms into disorders and results in a psychiatric label, it would be more valuable to focus on the way one's problems and symptoms are embedded in one's life and functioning. Such a functioning-oriented approach to diagnosis results in an organized narrative that offers personal starting points for support (Vanheule 2017). As a consequence, professionals in the field no longer function as labeling experts but as '*compagnons de route*' who continuously search for the most appropriate support through engaging in a dialogical process together with the person with mental health problems. Such a dialogical and equal partnership only becomes possible when continuity of therapeutic contact is guaranteed.

The initial, service user-led recovery movement pursued high ambitions with regard to fighting stigma, rejecting unnecessary labeling and redressing power imbalances in the mental health care system (Roberts and Boardman 2013). However, our bricolage journey showed that the translation and operationalization of the original recovery ethos into today's mental health care system contains several contradictions (Khoury and del Barrio 2015). It simultaneously appears as a hopeful vision of person-centeredness and empowerment, and an expert-driven discourse in which diagnoses still have a major impact and low expectations of recovery are still latently present. The findings from this collaborative case study are in line with insights from authors in the field of Mad Studies who warn for mechanisms of epistemic violence in psychiatry (Liegghio 2013). Through these mechanisms, the personal meanings which service users have of their recoveries remain overshadowed and even marginalized by professional recovery discourses, based on the hidden assumption that persons with mental health problems' own perceptions are a symptom of mental illness and invalidated as necessarily flawed

(Costa et al. 2012; Faulkner 2017; Russo 2016; Voronka 2016). Instead, professionals need to (re)connect with the activist spirit of the original user-led recovery movement and adopt a more ambitious attitude regarding the lives of people with mental health problems.

Limitations and future directions

The bricolage journey that Pete and Clara traveled allowed them to make the professionalization trend of recovery tangible and visible through Pete's experiences. However, as these findings are situated within a specific (Belgian) mental health care context, they cannot simply be generalized to other (international) contexts. Also, the wards where Pete stayed during his admissions are currently in transition toward a more explicitly recovery-oriented approach (e.g. by abandoning the practice of daily staff meetings). The question arises of whether and how these recent developments might affect the experiences of people who are currently staying there. Therefore, and also considering the idiosyncrasy and diversity of recovery processes and treatment experiences, it would strengthen our findings to combine Pete's experiences with other experiences of persons with mental health care problems.

In short, it is now time that people with mental health problems are given back ownership of a philosophy that was originally theirs (Pilgrim 2009). Within an academic context, this means that more ethnographic and collaborative research into recovery and recovery-oriented treatment is much needed, as it is precisely the first-person perspectives of service users that raise the most relevant questions and hold the potential to address assumptions that otherwise remain unchallenged.

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