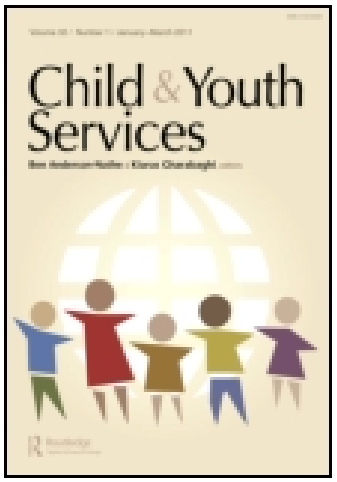

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"Is There a Getting Better From This, or Not?" Examining the Meaning and Possibility of Recovery From Mental Disorder

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The concept of "recovery" from mental disorder is widely used in the national conversation about youth and adult mental health treatment as if everyone is on the same page about what it means. Fundamental disagreements among researchers and practitioners exist, however, on a variety of issues related to the precise nature and meaning of recovery from mental, emotional, and behavioral disorder generally. Among these issues are: (a) The meaning of recovery; (b) The possibility of full recovery; and (c) Effective support for recovery. After reviewing diverging responses for each of these three issues, we then trace practical implications of competing interpretations for treatment and recovery itself. As demonstrated throughout, the stance taken on these questions can have profound and lifelong consequences for youth and children in treatment.

KEYWORDS mental illness, neuroplasticity, psychiatric treatment, recovery

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> *"You bring them home from the hospital, nurse them and dream that they will be successful . . . but then they come down with a mental illness that is there to stay lifelong. Your hopes and dreams die away."* —Mother of a 16-year-old girl

The notion of "recovery" from mental disorder is widely used among those studying and treating youth and adults—and may be taken for granted as something for which there is universal agreement. Closer examination, however, reveals disagreements that are striking and fundamental—as reflected in a report linked to the 2002 White House New Freedom Commission for Mental Health:

> It is not entirely clear what the term "recovery" means or what precisely is to be entailed in transforming America's mental health system to promote it. This lack of clarity is likely related to a deeper ambiguity about what the term recovery means as applied to mental illness. Recovery, which has been used with various connotations for the past two decades, has been the object of debate among advocates, providers, family members, and other stakeholders. The only thing about which these diverse groups appear to agree at present is that the term can be confusing and, at times, even contradictory. (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006, p. 640)

In the theoretical examination that follows, we call attention to three issues dividing the larger discourse of recovery generally, and for youth, in particular—questions about which significant divergence exists among researchers,[1] practitioners, and clients. We first consider two distinct views of what precisely it means for an individual to recover from mental disorder. Secondly, we examine different positions on the possibility of full recovery from mental disorder. Finally, we explore different views on appropriate pathways to achieving recovery.

For each issue, distinct stances and illustrations are drawn from a variety of sources—including published qualitative studies and archival data from advocacy organizations and government reports. Excerpts from our own interviewing studies are central to the inquiry, including one long-term, retrospective examination of the in-depth experience of depression treatment (Hess, 2009) and a second evaluation of the well-being of 125 youth years after treatment for serious emotional challenges (Hess, Bjorklund, Preece, & Draper, 2013).[2] Both prior analyses took a philosophical hermeneutic approach (Martin & Sugarman, 2001; Polkinghorne, 2000), which emphasizes the critical role of interpretation in both the object and process of research.[3] With these prior studies, this theoretical review shares an aim of making subtle interpretive patterns more accessible to public view—patterns and perceptions that might otherwise remain largely implicit, unconscious, and "hidden" (Slife & Williams, 1995). By surfacing and clarifying these patterns

in the broader recovery discourse, as we previously have done regarding youth treatment outcomes (Hess & Lacasse, 2011), we hope our inquiry will facilitate a more thoughtful public and professional deliberation on youth treatment itself (Schwandt, 1996).

Although these issues have a particular and critical relevance for children, they are not exclusive to youth recovery alone. We therefore cite research examples from both adolescent and adult literatures as a way to hint at the broad scope of these patterns. Likewise, because of our interest in understanding nuanced patterns across the general recovery discourse, we avoid limiting our analysis to one diagnosis alone—instead, noting examples across conditions (e.g., depression, ADHD). This variability permits a more rich and nuanced exploration of how "recovery" is being used in the treatment discourse than would be possible otherwise.[4]

NARRATING RECOVERY: KEY ISSUES

The Meaning of Recovery

So what does it mean to recover from mental disorder generally—for both youth and adults? A report of the U.S. Surgeon General (1999) states, "Recovery is variously called a process, an outlook, a vision, a guiding principle. There is neither a single agreed-upon definition of recovery nor a single way to measure it" (para. 4). Amidst the diversity of views, two general portrayals stand out—*restoring functioning* versus *deepening wellness*.

Restoring Functioning

One common way of thinking about recovery was summarized in one national study of recovery indicators: "Recovery . . . involves a personal journey of actively self-managing a psychiatric disorder while reclaiming, gaining, and maintaining a positive sense of self, roles, and life beyond the mental health system, in spite of the challenges of psychiatric disability" (Mulligan, 2003, p. 10).

Similar to recovery from a catastrophic injury, this view emphasizes the restoration of functioning that can come with sufficient support—this, despite impairments, symptoms and treatment all accepted as necessarily permanent. After describing previous hopes for his daughter's success in life, once father chided himself for ever having believed that she could recover at a deep level: "I still had in mind that she could make steady progress, go to college, develop gradual independence. In retrospect . . . sometimes I shake my head, 'what was I thinking?"' He then characterized his current understanding in this way: "How can we help her confront this illness, deal with it, manage her illness so as to enable her to realize the best objectives that *she* can reach given her disabilities—i.e., living life as a disabled person?" (176f).

The aim of such illness management to significantly reduce the impact of mental disorder as individuals develop strategies to "manage the illness." Ultimately, some kind of sustained symptom relief to the point of a functional state can be portrayed as a form of recovery (Jamison, 1997; Woolis, 2003). One psychiatric rehabilitation text, for instance, defines recovery as "managing symptoms, reducing psychosocial disability, and improving role performance" (Pratt, Gill, Barrett, & Roberts, 2006).

Deepening Wellness

In contrast to the view above, a second portrayal proposes reaching beyond symptom management to what a report of the U.S. Surgeon General (1999) calls the "restoration of a meaningful life" including "attaining meaningful roles in society" (para. 4). This view of recovery also highlights "regaining membership in society" and a renewed sense of being a "whole person"—emphasizing the possibility of a deep and enduring recovery, wherein "the person has regained a meaningful role in society, can cope with life's stresses, and is not considered sick by others around them" (Fisher, 2010a, para. 8). One woman said, "To me, knowing when you've gotten better is when you're able to really laugh—and not only laugh on the outside but on the inside too. Recovery is when you're able to find pleasure and joy. . . . And you know that you can't be happy all the time and you're okay with that" (3).

In place of attempting to manage, control, or extinguish mental symptoms, the focus may become changing one's relationship to thoughts and emotions in a way that avoids being carried away, driven, or tyrannized by them (Kabat-Zinn, 1990; Segal, Williams, & Teasdale, 2001). This type of aspiration toward deeper well-being is becoming a more generally accepted expectation of recovery—as reflected in the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Consensus Statement on Mental Health Recovery (2006):

> Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and medical treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. . . . Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles . . . with others in supportive, trust-based relationships. (pp. 1–2)

The Possibility of Full Recovery

Underlying these contrasting views of recovery itself is an even more basic question: Is it even possible to fully recover from serious mental disorder? Perhaps linked to recent major scientific shifts in how the brain and body are understood, there is wide variation in the degree to which long-term, enduring recovery from serious mental disorder is seen as possible. This question carries particular weight for youth and children, with whole lives ahead of them still. Among the varying views of appropriate prognosis in cases of serious mental disorder, there are two especially common positions: managing continued disability and cultivating eventual healing.

Managing Continued Disability

When asked: "Do you ever talk about 'getting fully better' from depression?" one individual said, "I don't think that's possible. I *want to,* but . . . I think, just a couple years ago I just faced it that I'm just always gonna have to have something" (8). Parents of children facing mental disorder often shared similar conclusions:

> Susan is just a difficult case. . . . I don't know how solvable the problem really is. (56f)

> I have come to believe that there are mental illnesses that are nearly impossible to treat. (71m)

> I don't think there's going to be a time that she's going to be well. We're going to have to stay on it, stay on it, stay on it forever. (135f)

For many, this kind of a conclusion may emerge from their own observations of long, grinding years of struggle in themselves or a loved one. When asked whether she thought recovery was possible, another person said, "No, not really. I mean . . . I just don't know. . . . I've fought with it so long that I just don't know that that'll ever happen" (9).

In other cases, this same message can come from professional helpers:

> The doctor told me, "This will be something you face the rest of your life." (18)

> My initial diagnosis—they said this is something permanent. They told me, "This isn't something that you'll ever not have." (2)

> They told us, "'This will be something your son struggles with the rest of his life." (19)

Rather than intending to convey a hopeless message, the impulse here seems often to be an attempt to help patients cultivate acceptance of the mental challenge as a potential way of coping and moving forward. By accepting the reality, and perhaps the permanence, of one's mental disability, there is a sense that an individual may potentially find greater reserves of strength and peace in moving forward.

Mental disorders thus come to be characterized as chronic diseases like type 1 diabetes—with a goal of effective management of the illness, and nothing more. A particular view of the brain can reinforce this view of recovery from mental disorder. Said one mother about her daughter:

> She's schizoaffective bipolar; the prognosis is that there is no cure—that she needs to learn to live with it the best she can. I'm expecting her to regress. . . . Her brain is wired in a way that her mental illness will be a monkey on her back the rest of her life. (64m)

As biological dysfunction is understood to be permanent, mental disorder itself also becomes accepted as largely permanent (Hess, Gantt, Lacasse, & Vierling-Claassen, forthcoming).

Cultivating Eventual Healing

Beginning in the 1980s and 1990s, a loose coalition of professionals, researchers, and former patients began advocating for greater public openness to the idea that full recovery may be possible for those struggling with mental health issues (Anthony, 1993; Frese & Davis, 1997; Gagne, White, & Anthony, 2007). With research findings during the preceding decades offering hope, the World Health Organization conducted larger-scale, systematic studies that again found surprising rates of recovery from mental disorder (WHO, 1979; see also Jablensky et al., 1992). A second, 10-country study with an even more rigorous methodological design was undertaken 10 years later, tracking patients diagnosed with schizophrenia for 5 years. Once again, the researchers found a substantial percentage of patients going on to achieve significant degrees of recovery. A fourth epidemiological study in the U.S. (Harding, Brooks, Ashikaga, Strauss, & Brier, 1987) and several, more recent, longitudinal studies in different locations (Harrow & Jobe, 2007; Whitaker, 2011) have likewise confirmed high rates of recovery from severe mental disorder. These long-term outcome studies, the U.S. Surgeon General (1999) summarized, "uncover a more positive course for a significant number of patients with severe mental illness" and "provided a scientific basis for and supported a more optimistic view of the possibility of recovering function" (para. 1, 3).

More recently, advances in neuroscience have suggested a physiological basis for this kind of hope in recovery—especially the surprising

changeability of the brain (Goldapple et al., 2004; Schwartz & Begley, 2002) and the remarkable "epigenetic" fluidity of the human genome (Handel, Ebers, & Ramagopala, 2010). Among other things, these advances suggest that mental disorder could be likened to other diseases that can eventually go away over time, given the right support and treatment. Published accounts of former patients illustrate this hopeful view of long-term recovery (e.g., Deegan 1988; Fisher, 2006), including that of Dr. Marsha Linehan, the creator of dialectical behavioral therapy (DBT), who recently made public her own account of recovery from psychosis (Carey, 2011).

Effective Support for Recovery

Laying aside the meaning and future projections for recovery, interesting differences emerge in the pathways encouraged to attain recovery.

Complying With Treatment

Families interviewed in our studies often spoke of a narrow range of "causes" for a child's problems—often centered on neurobiological aberrations. This same trend is evident in the larger mental health discourse and its unique emphasis on a static biology (Hess et al., forthcoming). When environmental and lifestyle contributors are acknowledged, they may be portrayed merely as "triggers" for the true, underlying organic problem (Zuckerman, 1999). In this way, the array of factors may be subtly deemphasized and minimized. The Web site of the ADHD advocacy organization Children and Adults with ADHD (CHADD), for instance, states that "Genetic factors and not a shared environment account for the greatest variance in ADHD symptoms ... other factors (e.g., family adversity, poverty, educational/occupational status, home environment, poor nutrition, environmental toxins, ineffective child rearing practices) do not appear to have a significant contribution to the development of ADHD symptoms" (Ellison, 2003).

Among other things, as environmental contributors are minimized, greater emphasis goes to interventions more understood to directly impact biology (Lacasse & Leo, 2006), as reflected in this former patient's comment:

> I'm a firm believer in medication because ... I think therapy is good, but it doesn't help if you're not calmed down.... You can't talk it out; it's chemical!... Like I said,... you can't get better without medication. You can talk and talk and talk but you can't get better without, if your chemicals are messed up. (7)

When recovery is seen as largely symptom-management of an enduring problem, individuals and families may essentially come to believe they

cannot directly influence, on their own, the going or coming of mental disorder. The exception to this sense of powerlessness may be in medication management—offering families and individuals a sense of control and power in relation to their experience. After emphasizing medical management as key to facing depression, one woman said, "The best change in my attitude was that I couldn't help that this happened," adding "but I can control it now, you know" (5).

Another individual emphasized, "*I'm responsible* every single day for doing this mental inventory [of] "where am I at?" and when I notice the warning signs it's *my* responsibility to do whatever it is I need to do. Whether I need to get in and see the doctor, get my medication adjusted, make an appointment, etc." (13). In this sense, the primary focus of personal choice and responsibility in the process of recovery becomes seeking and complying with treatment.

Adjusting Personal Trajectories

In contrast to this view above, a second position emphasizes a broad range both of contributors to mental disorder and options to facilitate healing. Reviews of the literature have confirmed multiple areas of risk factors that predispose severe mental disorders—with developmental psychopathologists continuing to document a multi-factorial approach to mental disorder, with multi-risk factor models of vulnerability reflecting diverse developmental pathways (Cohen & Cicchetti, 2006; Hayward et al., 2008). In one analysis of psychiatric risk across thousands of youth, authors pointed out that "the presence of multiple risk factors . . . substantially increased risk of first incidence of all disorders examined"—noting that "psychiatric disorders . . . are the product of multiple factors and these factors in turn have effects on multiple disorders" (p. 405).

As the variety of risk factors become better known, the range of intervention options simultaneously expands. This includes efforts to develop new treatments and educational curricula that focus on addressing the underlying lifestyle risk factors of various symptoms (stressful environment, sleep/eating habits, etc.) (e.g., Addis & Martell, 2004; Gordon, 2008; Null, 2008). From this perspective, no single option takes all the focus. A young man expressed gratitude that his counselor "never claimed to have a cure all. . . . He didn't say 'this is *the answer* you *do this* and you'll be fine'" (10).

When recovery becomes seen as a deep freedom potentiated from brain changes associated with mind and lifestyle shifts, individuals may naturally believe they can do something directly to influence the going or coming of mental disorder. Furthermore, severe mental disorder may be understood as hinting at deeper, underlying needs and problems that deserve attention. Like an alarm that identifies an area of danger, the symptoms alert

individuals to areas in their lives that need attention. Mental disorder and associated recovery are thus meaning-laden experiences that involve learning and teaching; to achieve these aims, it is understood that substantial personal effort is necessary—with the focus of individual action being the adjustment of personal trajectories.

The idea that nonprofessional lifestyle interventions can make a substantial impact for those facing mental disorders may admittedly be confusing within a cultural atmosphere so focused on technical, professional interventions. At a conference on ADHD interventions attended by one of the authors, a psychiatrist presented data on adverse effects from psychostimulants. At the close of his talk, an audience member asked, "But if not medication, what can we offer kids facing ADHD?" Somewhat perplexed, the clinician turned to the questioner and said, "*All of life!* Getting outside more, enjoying the sun and fresh air in nature, better nutrition, loving relationships . . . so many aspects of life could *potentially* make a difference in helping a child's attentiveness improve!"

IMPLICATIONS

The above exploration compares contrasting views regarding the nature and scope of recovery from mental disorder for youth and adults. Each issue reflects competing assumptions that may or may not be made by an individual, family, or helping professional. In practice, of course, assumptions rarely function in isolation—and instead, cluster into coherent webs of interpretation and narrative frameworks of meaning. For instance, the assumptions examined first above "hang together" as a common, overall narrative: (a) *Recovery as effectively managing continued symptoms*; (b) *Expecting enduring disorder*; and (c) *A focus on treatment compliance*. Equally so, the assumptions explored secondly often cohere as a second portrayal or narrative of recovery: (a) *Recovery as eventual healing*; (b) *Expecting deepening wellness*; and (c) *A focus on adjusting personal trajectories*.

Although different assumptions may show up in unique combinations, these two portrayals are common. Whatever the details, such narratives are not simply abstract stories told about recovery. Rather, the distinct language used in each narrative may tangibly influence practice and lived experience on a number of levels. In what follows, we consider a set of concrete implications that may flow from the foregoing assumptions and narratives as they are adopted and lived out in practice. In this final section, we move beyond interpretive, philosophical examination, to an inquiry into the practical consequences associated with different mindsets: specifically, what particular views of recovery mean for clients' own experience—beginning with (a) the degree of general hope in the future. Subsequently, we also consider (b) treatment duration and (c) the intervention effectiveness itself.

Treatment Hope

For anyone facing mental disorder, a recovery narrative that offers little hope for full recovery can tangibly heighten the awful burden—an influence not often acknowledged. One young woman recently interviewed by the lead author stated that her suicidal thoughts began when she was told by her doctor that she would likely have to face depression the rest of her life. One psychiatric nurse described many patients with little or no hope—most of whom firmly believed they were "never going to get well." She continued: "When you are already feeling hopeless and in despair, to have someone tell you that what you have is a condition you're going to have to live with the rest of your life . . . it makes you feel even more hopeless, more in despair, more worthless—and like, 'Why even try? Why even try? This pain is just going to last forever'" (C. Penney, personal communication, October 29, 2011).

A U.S. Surgeon General report (1999) notes, "Until recently, some severe mental disorders were generally considered to be marked by lifelong deterioration." Schizophrenia, for instance, was seen by the mental health profession as having a uniformly downhill course: "Negative conceptions of severe mental illness, perpetuated in textbooks for decades . . . dampened consumers' and families' expectations, leaving them without hope" (para. 1). While the implications of such a view are significant for individuals at any age, they can be particularly burdensome and terrifying for parents of a young person who is struggling. One parent who was told his daughter would "never be mainstream" reflected, "That is a knife in the heart of a parent" (18m).

For those who have endured a severe mental disorder *and* a permanent prognosis, the possibility of any sort of more meaningful recovery becomes welcome news. Several interview participants spoke fondly of the moment they first made the realization that they might be able to recover to a substantial degree. One woman who had faced both psychosis and depression was told she would likely never be able to live independently again. She spoke of overhearing the story of another woman who had recovered fully: "This was the first seed of hope. . . . I thought, 'if [she] could get well after eight years maybe I could get well after two or three'" (13).

Another participant spoke of discovering a Web site operated by the National Empowerment Center that discusses the possibility of deep, sustained recovery:

> The site is all about is all about recovery, that recovery *is real*. . . . You know, once someone is diagnosed they say "it's a lifetime illness. *Lifetime*. Never get better." Well, Daniel Fisher says "No, you *can* get better and you can *stay better*." And there's wonderful articles on there by different people who have recovered 20 years, 30 years. . . . That site

> was really *encouraging,* because until I got to that site, all you heard was drilled into people, "Lifetime, Lifetime, it's a lifetime illness, you're forever going to need meds". . . . There's no hope there for recovery. (12)

Treatment Duration

A second practical consequence of recovery narratives concerns the longevity of interventions. When full recovery from serious disorder is viewed as unlikely, and symptom control the appropriate goal, interventions and treatment understandably become accepted as a similarly permanent fixture of one's life:

> I've had lots of doctors tell me, "You will need to be on these meds the rest of your life." (2d)

> My doctor said that I could live a fairly normal life if I could stick with my medications and stay on them. [He said] "you're so far ahead, you can live a fairly normal life with the medications available." (2)

> I'm permanently going to have depression and I'll be on meds my whole life and . . . it took a mind change for me to finally get to where I could say, "I'm grateful that I was born in this day and age where I could get the medication that I need so that I wouldn't be locked up in the attic somewhere, or indisposed all the time." (7)

As reflected here, without lifelong treatment it becomes easy to assume that lifelong disorder is inevitable. In Jamison's (1997) memoir of bipolar disorder, her difficulties when coming off medication are presented as a cautionary tale against the hope that treatment will only be temporary. Given such emphases, both adults and youth interviewed were often encouraged to stay on medications indefinitely—with two participants reporting psychiatric treatment since they were two years old (121s) and since first grade (95m).

In contrast, when full and lasting recovery is viewed as possible, treatment is viewed as a temporary assistance to regain and restore well-being. Using such an approach, researchers in Finland have found impressive rates of recovery from first-episode psychosis (Seikkula et al., 2003). However, whether or not clients can reach or maintain recovery without the use of medication is an area of substantial debate—and one which could benefit from a more thoughtful collective deliberation. The point of this examination is not to establish the "right answer," as much as to trace the real-life influence of contrasting recovery narratives. We conclude, then, simply that the influence of one's chosen view of recovery extends into how long treatment is assumed to be needed.

Treatment Success

As a final implication, whether or not individuals believe that recovery is possible may have consequences for whether that recovery, in fact, occurs. There is historical evidence that rates of recovery in the U.S. improved during earlier epochs such as the early to mid 19th century when a more optimistic view of mental health recovery existed (Borthwick et al., 2001). After finding higher rates of recovery in Vermont than in Maine (Harding et al., 1987), the same research team went on to conclude that the primary difference between the states was the goals of the respective treatment systems. Whereas Vermont had self-sufficient recovery as its primary aim, Maine's system centered on maintenance, stabilization, and medication compliance (Desisto, Harding, McCormick, Ashikaga, & Brooks, 1995).

Similar discrepancies in treatment and recovery outcomes between the U.S. and other countries have been explained as a function of divergent narratives of recovery across cultures. Waxler (1979) found that in developing countries, compared with industrialized nations, "The familial and community responses to people with mental illnesses encourage normalization and discourage the disabled role" (p. 144). It is therefore perhaps not coincidental that rates of long-term recovery for schizophrenia are higher in developing countries (Jablensky et al., 1992; WHO, 1979). Indeed, despite our focus on psychiatric interventions in the U.S., there is a rising prevalence of disabling mental disorder (Torrey & Miller, 2002; Whitaker, 2011).

The idea that recovery is possible can be healing for those who have lived for years without believing such an option was even plausible. Fisher (2010a) notes, "the belief that one can recover from mental illness is well established as an important aspect of the healing experience" (para. 6). Speaking of his own diagnosis of schizophrenia years earlier, he writes that the belief mental illness means "one will *always be sick* . . . not only interferes with emotional recovery, but also prevents one from identifying as a contributing member of society . . . striving to return to work, establishing long-term relationships, etc." (para. 5).

One individual who had faced severe depression remarked, "The important thing is that I know that it won't last forever. Before, I had no hope. I couldn't see a light at the end of the tunnel" (3). Rather than just a nice way to "keep going" during treatment, the point here is that the healing process may somehow require this kind of hope, seemingly in order to catalyze the energy and actions needed to secure it. "The most important finding in our research," one study concluded, "is that people who have shown significant or complete recovery from severe mental illness . . . have cited hope as an extraordinarily important component in their recovery. Part of the recovery was being around people who saw their condition as not permanent, a condition from which they could take increasing control of their life and reestablish a place in society" (Medscape, 2005).

Amidst the pervasive disbelief in long-term recovery, one author asked, "How much of the long-term disabling effects of mental illness are due to the disease itself or to the . . . way we view severe mental illness?" (Anthony, 2007, p. 3; see also Whitaker, 2011). One mother described her daughter's emotional and behavioral struggles getting so bad that the state welfare agency was going to commit her for life, to a long-term, state-run psychiatric facility "where they put people where they are so bad they don't come out of [it]"—adding, "they felt they had done everything they could do" and concluded, "she's not going to fit into normal society." In the wake of a dismal prognosis and diagnosis with borderline personality disorder, this family made a decision to get more involved: "That's when we said, 'No, we are taking her home."'

"It was a terrifying idea to bring her home," this mother admitted. "She had been in group homes and hospitals for years . . . we didn't know if she would live, or anything. At the time, it was just terrifying. . . . She *was* like a real crazy person. Her eyes were crazed, her mind . . . she was so unkempt. I grieved the death of my daughter for quite a long time. She was just gone and there wasn't much left." And yet, she continued, "When we brought her home, that's when the acceptance came. We had been through so many things trying to fix it. . . . We just accepted, 'this is just the way she is going to be.'" She continued:

> We had been through three years-plus with her, when slowly things started to turn around. . . . It took a long-time, it was very gradual. She is doing much better—light years better. She has been holding a job [for over a year]. . . . She was suicidal for three years straight, but we haven't had any re-occurrence of that for some time. She's not the person she used to be. . . . The state was ready to commit her to life. She's gone from that to being a pretty productive member of society. . . . Doctors said that this girl's situation was one of the darkest situations and they couldn't believe she was doing better; they were totally shocked.

When asked how her daughter had recovered, this mother emphasized, "She did it all on her own . . . it was all her. . . . She made decisions internally. What we did was accept her. . . . A lot of her doing better came from inside of her, maybe from having the right environment." She continued: "I'd like to say that we did things, but we didn't do that much; we would just talk with her gently. . . . She just needed the love and support of her family. . . . When someone is willing to understand her problem and have the flexibility to work with it . . . she tends to blossom" (59m).

DISCUSSION

In the examination above, we have considered a sobering proposition—namely, the duration and nature of struggles with various mental disorders may be linked, in part, to our ways of framing, perceiving, and narrating them. Depending on the particular view of recovery taken, the practical impact on actual lives can be very real. One woman recollected an earlier moment in her treatment: "This doctor told my family that I would never be able to live independently again. . . . Even though I have made progress over the last four or five years, there's still *always* that seed of doubt that was planted; you know, 'can I really take care of myself?'. . . . That's a *long time* to have one remark [influence things]. But it was said by the doctor, so it had so much *power* and so much influence." She added, "And you know if you went back and asked him, he probably wouldn't even remember having *said that* and yet, it's had all these ripples for the last several years." This woman went on to reflect: "One of the things that I've learned since then . . . is that you can *never predict* the recovery of another individual" (13).

Many questions remain. For a subject characterized by such intense differences, ongoing openness in a thoughtful examination is crucial. Our primary goal has been to facilitate thoughtful exploration of contrasting views. Brent Slife, past president of the APA division of Theoretical and Philosophical Psychology, notes that critical thinking and decision making presuppose the presence of viable options and legitimate alternatives. Where this doesn't happen, more often than not, one prevailing view is simply taken to be "reality" (Slife & Williams, 1995). In the absence of clear exploration of competing recovery stances and interpretations, we believe recovery itself—no matter the other circumstances—will be that much harder to pursue. As contrasting ways of thinking are surfaced and openly examined, however, we believe a more thoughtful public and professional deliberation on the issue of mental health recovery is very possible.

At a minimum, our analysis calls for greater care in not limiting individual hopes in recovery—no matter the seriousness of the condition—or providing rigid boundaries or definitions of what that recovery will look like. This is especially the case with children and adolescents—who have rapidly evolving brains and their whole lives ahead of them. Indeed, depending on the narrative of recovery adopted by parents and treatment professionals, the entire course of a child's life could be substantially altered.

At the same time, depending on the context, emphasizing the possibility of full recovery may also be seen as irresponsible or reckless. In concluding this exploration, we consider the resistance that may come up on the part of professionals or surrounding families when discussing greater possibilities of recovery, before turning to what overly naïve portrayals of recovery may mean for patients. We conclude with a few simple recommendations for

helping professionals or family caregivers working to support an adult or young person facing severe mental disorder.

Skepticism About the Possibility of Recovery

In spite of evidence warranting some optimism, a view of permanence remains so widespread that sometimes those who have experienced full recovery are dismissed as unusual exceptions. Fisher (2010b) writes of a psychologist who heard his story of becoming a psychiatrist after recovering from schizophrenia: "He must have been misdiagnosed," was his response. After Fisher provided documentation for earlier symptoms which met DSM-IV schizophrenia criteria for a period of five years, the man reversed his position—saying the diagnosis must have been correct, but questioning the recovery: "We now have a case of an impaired physician." The experience, Fisher writes, reveals the extent of negative expectations that exist, such that, "anyone who appears to have recovered must not have been sick." He summarizes:

> We who have recovered from mental illness know from our personal experience that recovery is real . . . more than remission with a brooding disease hidden in our hearts. We have experienced healing and we are whole where we were broken. Yet we are frequently confronted by unconvinced professionals who . . . say that we are exceptions . . . that our experience does not relate to that of their seriously, biologically ill, inpatients. (Fisher, 2010b, para. 1–2)

From where does such unassailable certainty come, as to prompt evidence to the contrary to be immediately discounted? Whitaker's (2011) analysis of long-term outcomes hints at one sociological explanation—namely, that we know little about individuals who improve and recover, simply because they often drop out of the treatment system (Cohen & Cohen, 1984). Helping professionals working in the mental health system may therefore rarely see clients who reach full recovery, which potentially shapes their view of mental disorder as chronic, and lifelong treatment as necessary.

Naïve Expectations of Recovery

Distortions, of course, are possible in both directions. Some have also interpreted an emphasis on deep, lasting recovery to mean that with adequate will-power, faith, or choice, anyone could potentially reach such a state—and soon. One young woman with an eating disorder was told by her family, "Just eat! You just need to learn to take care of your body!" (20). When a dramatic shift doesn't happen, those facing serious mental disorder can thereby come to feel even more deeply deficient and to-blame. One woman, who

has faced mental anguish for years since suffering vicious abuse as a child, said:

> Everybody makes that promise, "it'll get better." And when it's not getting better, you know, and . . . you've been hurting alone for so long, that promise really . . . holds no weight. You know what I mean? Because you're like "no, I've been dealing with this for, you know, 10 years by myself, and hurting that long for that bad, you think you can turn it around in a few months?" (6)

Those who have found lasting relief, of course, would insist that freedom, when it comes, does not emerge quickly or through an easy fix. Nor does such recovery imply a naïve picture of zero struggle in the future as sometimes implied by the word "cure." Similar to recovered alcoholics in 12-step groups, these individuals embody a healthy acknowledgment that life will continue to involve facing some turbulence. As Maisel and colleagues (2004) point out, successful recovery from eating disorders, rather than evincing absolute, unwavering resolution, more often reflects a determination that ebbs and flows like the tides of the ocean, *as it gradually rises*: "In our experience, it is more realistic, at least initially, to think in terms of moments of anti-anorexia/bulimia clarity rather than a once-and-for-all realization . . . [and] subsequent unwavering rejection of it." They go on to speak of a "back-and-forth rhythm of recovery" that comes in waves (pp. 92, 185; see also Barker, 2008). The time required for a truly sustainable recovery highlights the crucial importance of sustained and enduring social support from friends and family along the way.

Maintaining Hope: Care in Talking About Recovery

Based on our analysis of these diverging recovery narratives, we conclude with some recommendations for those formal caregivers and parents working to assist youth and others seeking further healing from severe emotional, mental, and behavioral struggles:

1. To quote one of our participants, "never predict the recovery of another individual" (13). Allow individual youth and adults to retain hope that their situation can change (Lietz, Lacasse, Hayes, & Cheung, in press).
2. To underscore a tangible basis for hope, consider educating distressed individuals and families about neural plasticity and epigenetics—particularly for those youth or adults who feel helpless or hopeless regarding their potential for any meaningful progress. In this way, as one doctor writes, physicians and other professionals can move beyond roles as only technicians, to becoming "healers and educators as well" (Mandal, 2011).

3. Assist patients in exploring the various options available, helping them become fully informed of these different options prior to consenting to a particular treatment (Edwards & Elwyn, 2009).
4. Make clear that when it happens, recovery does not take place quickly or simply by willpower to "choose to feel differently." Instead, as the true "experts" who have achieved authentic recovery will attest, sustained practice and patient progress over time are almost always necessary.

In conclusion, it's time to broaden the conversation about mental health recovery—for both youth and adults. As clinical, neuroscience and epidemiological evidence mounts, calls have been made for "services to be structured to be recovery-oriented to ensure that recovery takes place" (U.S. Surgeon General, 1999, final para.). Over the last 10 years, governments from Canada to Australia have adopted national reforms to move mental health systems in a more recovery-oriented direction (Canadian Mental Health Association, 2003; O'Hagan, 2004). And following the White House's (2003) mental health report envisioning "a future when everyone with a mental illness will recover," many U.S. states have taken steps to "redesign their mental health systems to stress hope, healing, empowerment, social connectedness, human rights, and recovery-oriented services" (Jacobson & Greenley, 2001).

Given this growing consensus, we have argued here that the key issue for individuals, families and professionals alike is no longer *whether* to seek and support recovery, but rather: *what exactly does that mean*? As practitioners and families deliberate more carefully about the nature, scope and dynamics of recovery, greater clarity and hope may come to accompany this already arduous journey from sickness to health.

NOTES

1. The authorship team comes from diverse perspectives and backgrounds, with remnant disagreements on which stances are most accurate and valid. We share an aim, however, to comprehensively map out the interpretive options available in a way that facilitates a more thoughtful deliberation between different parties.

2. Details of these semi-structured interviewing studies are available in their respective publications. Quotations tagged by a number alone (9) come from the first study; if they have a combination number and letter (176f), they come from the second study (f = father, m = mother, d = daughter).

3. This approach shares meaningful links with interpretive phenomenology (Benner, 1994), constructionist revisions of grounded theory (Charmaz, 1990), and discourse analysis—especially, in shifting attention beyond objective experiences (e.g., of treatment) towards investigating more closely how these treatment experiences are framed and interpreted. These interpretations, rather than a mere "subjective" overlay upon our lives, are understood to be directly relevant to actual experience and "lived out" moment by moment in tangible ways (Fay, 1996, p. 178).

4. Mirroring a "maximum variation" sampling approach (Maykut & Morehouse, 2000), this permits the kind of cross-cutting exploration we intend—without artificially truncating and limiting the discussion.

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