

RE-STORYING PSYCHIATRIC DISABILITY: LEARNING FROM FIRST PERSON RECOVERY NARRATIVES

PRISCILLA RIDGWAY

PRISCILLA RIDGWAY, MSW, IS A DOCTORAL STUDENT AT THE UNIVERSITY OF KANSAS, SCHOOL OF SOCIAL WELFARE, LAWRENCE, KANSAS, AND A PROGRAM ASSISTANT WITHIN THE SCHOOL'S OFFICE OF MENTAL RESEARCH AND TRAINING.

FOR INFORMATION CONTACT THE AUTHOR AT THE UNIVERSITY OF KANSAS, SCHOOL OF SOCIAL WELFARE, TWENTE HALL, 1545 LILAC LANE, LAWRENCE, KANSAS 66044-3184. TEL.: 785/864-4720; FAX: 785/864-5277; AND E-MAIL: PRidgway@ukans.edu.

This qualitative study examines first person accounts of recovery from psychiatric disability. Common themes and patterns are identified and findings are linked to narrative and resiliency theories. Implications for policy, practice, and research are provided.

Until recently, the fact that people who experience prolonged psychiatric disability can grow beyond the limits of their condition and reclaim full lives was rarely mentioned in professional literature, perhaps because the idea of recovery is heretical within the dominant biomedical model (Jimenez, 1988; Anthony, 1993). Most programs continue to be primarily oriented toward either short-term treatment or life-long supportive maintenance. This is true, despite the fact that rigorous outcome studies from across the globe consistently demonstrate a substantial proportion of people with prolonged psychiatric disabilities either recover or improve significantly across major life domains over time (Harding, Brooks & Ashikaga, 1987; Sullivan, 1997).

Research on the process of recovery and conceptualizations of recovery facilitating practice are only slowly beginning to emerge, even though strong empirical evidence of positive outcomes has been available for many years. While some view recovery as an exciting new framework for organizing the mental health

field (Anthony, 1993; Sullivan, 1994, 1997) it remains a formative or emerging concept. There is growing concern that recovery may become the latest catch phrase used merely to reframe traditional activities, rather than evolving into a well constructed paradigm that can effectively guide policy and practice. The need for clarity has become even more pressing since the Surgeon General's (1999) landmark report on mental health called for every mental health system to assume a recovery orientation.

The field of psychiatric disabilities requires an enriched knowledge base and literature to guide innovation in policy and practice under a recovery paradigm. We must reach beyond our storehouse of writings that describe psychiatric disorder as a catastrophic life event and depict people who experience significant and prolonged psychiatric problems as progressively deteriorating, persistently impaired, and in need of life-long care (Harding, Zubin & Strauss, 1987; Jimenez, 1988; Anthony, 1993; Marsh et al., 1996; Sullivan, 1997).

First person recovery narratives are important source materials that can help us refocus our thinking beyond the myopic and outdated deficit perspective. Autobiographical accounts serve as strong testaments to the existence of recovery and the inherent strengths of people who face the challenge of psychiatric disability. Such writings document and detail the lived experience of recovery in people who were told they should hope for no more than a life of prolonged disability. Recovery narratives intersect growing interest in narrative in mental health theory and practice.

Narrative psychotherapy challenges people to broaden or change the stories that they tell themselves about themselves, which shape their lives (White & Epston, 1990). Questioning and reformulating one's life story can renew a sense of meaning and possibility (Kelley, 1995). Deconstruction and reconstruction of one's personal narrative has been called "reauthoring" or "restorying" the life project. Movement from a "problem-saturated" personal narrative that emphasizes pathology and victimization to one that accentuates latent strengths can mobilize an individual to fight against negative life events (Kelley, 1995; White & Epston, 1990). Narrative practice has been used successfully with people experiencing many challenging conditions. Individuals with chronic medical problems, for example, have been helped to externalize their condition and come to view their illness as something that effects but does not constitute the self (Wynne, Shields & Sirkin, 1992).

Narrative is also an important element of contemporary social science theory (Begun, 1993; Borden, 1992; Hartman, 1994; Kelley, 1995; Saleebey, 1994; 1997). Narratives help practitioners understand and respect diversity within the value base, culture, lived experience and life context of people served (Holbrook, 1995; Kelley, 1995;

Kleinman, 1988). Stories of individuals' lives can contradict and serve to overturn "master narratives"—the socially constructed stereotypic accounts that serve to stigmatize and marginalize groups of people within the social world (Saleebey, 1994). When the previously disqualified voices of people whom the dominant society has marginalized are honored, submerged issues of justice, power and abuse of privilege commonly come forth (Foucault, 1980; Hartman, 1994; Holbrook, 1995; White & Epston, 1990). A revision of discourse may then occur that serves to empower the oppressed group (Foucault, 1980; Hartman, 1994).

This paper describes exploratory research centered on four accounts of women who experienced prolonged psychiatric disability and recovered. The inquiry was undertaken to learn important lessons from individual narratives, and to determine whether common patterns exist within the lived experience of recovering individuals. Knowledge gained in this effort can contribute to the development of a more complete conceptual understanding of recovery that may inform theory, policy and direct practice. The primary questions associated with this inquiry are: "What do first person accounts reveal about the process of recovery from prolonged psychiatric disability?" and "What common themes or patterns emerge from a systematic analysis of such narratives?"

METHODOLOGY

Qualitative research methods were used in this study. Qualitative inquiry is the appropriate approach when knowledge is sought concerning complex, little-understood personal, interpersonal and social processes. Document analysis of published topical autobiographies and constant comparative and narrative data analytic methodologies were employed.

Because the study sought to develop grounded theory (Glaser & Strauss, cited in Lincoln & Guba, 1985) major research concepts were not defined nor operationalized *a priori*. Instead, the recovering persons' own terms shaped the character and content of the final set of critical concepts.

First person accounts were found through computer literature searches, augmented with searches of two journals known to have published such material. Other recovery narratives were identified through reference lists contained in published and unpublished materials. Over 25 recovery narratives were found. This preliminary inquiry samples from the universe of published studies and concentrates on four narratives (Deegan, 1988; Leete, 1989; Lovejoy, 1982; Unzicker, 1989). These narratives were selected because they were "early" or seminal accounts, written prior to a strengthened general interest in recovery, and each provide rich details and thus could serve as an exemplary narrative. The remaining accounts of recovery were held for future study.

The constant comparative method was used to analyze the narratives (Lincoln & Guba, 1985). This procedure involved identifying and extracting significant statements or "meaning units" from the narratives; initial identification of manifest themes (clusters of meaning or motifs); returning to the data to verify themes; and, the formulation of an exhaustive set of descriptions of the phenomenon under study. Data were manually coded and then grouped by theme within each narrative. Next, data were compared, contrasted, and synthesized across the four accounts. Relationships between themes and appropriate ordering were then determined; some elements were subsumed under larger dimensions, and a final parsimonious set of major themes was developed.

Mishler's (1986) narrative analytic method was employed to augment the thematic analysis. This approach identifies the "core narrative." A core narrative is the global theme—an interpretive summary, stripped of all details—drawn inferentially from an examination of full texts (Mishler, 1986). This method protects temporal ordering and the "plot," rather than fragmenting a complex unified meaningful story into many segmented elements. Mishler's is one among many approaches available in the emerging field of narrative research (Berg, 1995; Lieblich, Tuval-Mashiach & Zilber, 1998).

FINDINGS

The accounts of recovery from prolonged psychiatric disability were found to share many critical themes and a common core narrative. The core narrative shifted from one in which people felt stuck in chronic disability and relegated to a stagnant life situation, to a much more complex and dynamic life story that can best be understood using the metaphor of an ongoing journey. People had been told, and came to believe: *I have a mental disorder and will never get better*. Once the process of recovery was set in motion the core narrative shifted to: *I am a unique individual, struggling with a psychiatric disorder, and through my attitudes and daily actions, with the help of caring others, I can and have reclaimed a meaningful life. I tell the story of my ongoing journey of recovery so that others may recover as well*. Common themes follow; each segment includes illustrative paraphrases and direct quotations from the narratives under study.

Recovery Is the Reawakening of Hope After Despair

A period of despair often follows the diagnoses of psychiatric disorders and the negative expectations and stereotypes that accompany such conditions. Deegan (1994, in Anthony & Spaniol) describes the shattering of her world, hopes and dreams when she was told she had an "incurable illness"—schizophrenia. She was informed she would be disabled for life and should learn to cope and adjust. Deegan tells us that she gave up, because "giving up seemed like a solution when one lives without hope" (Deegan, 1994, p. 153). She characterizes her deep sense of despair as "a wound with no mouth, a wound so deep that no cry can emanate from it" (p. 153). Unzicker (1989) talks of spending 10 years in such a state, and describes this period as "a lifetime of pills, shrinks, labels, powerlessness, and hopelessness" (p. 71).

Recovery is characterized by a renewed sense of hope. Deegan (1994, p. 153) says she does not remember "the specific moment when the fragile flame of hope illuminated the darkness of [her] despair." She describes the spark of hope as "a mystery" and as "grace" (p. 154). Lovejoy (1982) found her hope renewed in a program that employed people who had formerly received the program's services. There is proof, in the presence of other recovering individuals, that it is possible to regain control over one's life and become independent. In a third narrative, breakthrough from hopelessness came through exposure to another person's powerful story of suffering and survival in the mental health system. Here hope manifested itself largely as an upsurge of righteous anger. Unzicker calls her "spirit of defiance. . . a perpetual birthday present [she is] still uncovering" (p. 71).

The reawakening of hope after hopelessness does not mean that all doubt or

suffering is overcome. People in recovery come to endure suffering as part of their transformation, according to Deegan (1994). Lovejoy (1982) came to accept that it is all right to feel bad, all right to feel anger as part of recovery, that such feelings are not symptoms, but a natural part of life.

Recovery Is Breaking Through Denial and Achieving Understanding and Acceptance

Prior to recovery, it is common for people to deny their psychiatric problems or avoid contending with them. Deegan (1994, p. 152) calls denial "an important stage of recovery," and "a normal reaction to an overwhelming situation." In recovery, people learn to understand and accept the challenges posed by their condition. Several of the narratives describe how people educated themselves about psychiatric disorders and became involved with educating others. On the other hand, Unzicker (1989) completely rejects a medical model explanation for her experiences and feels discouraged when people call mental health problems "their illness" as though mental health were not "inextricably linked to the human spirit" (p. 75). It is clear that one does not have to accept an "illness model" in order to recover. Having a way to think about and understand one's experiences and challenges seems crucial, the specific content of the explanatory structure appears to be less important.

Recovery Is Moving from Withdrawal to Engagement and Active Participation in Life

Prior to recovery, most narratives tell of a period of extreme social withdrawal and a quality of frozen inactivity. During this time people actively isolate themselves and/or experience social segregation in closed program environments. Deegan (1994, p. 154) sat for months in a chair chain-smoking one cigarette after another between bouts of "drugged,

dreamless sleep.” She describes this period of her life as “a dark night and a paralysis of the will to do and to accomplish” (p. 153). Unzicker (1989, p. 71) describes this experience as “numbness,” and “a perpetual suspended animation that is better than never-ending pain.” “To be a mental patient,” she writes, is to “become a no-thing, in a no-world, and you are not” (p. 77). Lovejoy’s self-isolation began in childhood, when others saw her as “different” and rejected her. Later, as a “chronic mental patient” she felt “overwhelmed by the emptiness of her future” (Lovejoy, 1982) and “immobilized by defeat and despair” (p. 608). She linked her profound withdrawal to feeling ashamed, helpless, useless and frightened (p. 606).

In recovery, people break through this frozen state of suspended animation and begin to participate actively in life once again. We learn from these narratives that people often have to push themselves to move beyond social withdrawal and into relationship with others. “I often have difficulty interacting with others socially and tend to withdraw... I feel more comfortable, however, if I socialize with others who have similar interests or experiences to my own” says Leete (1989, p. 197). According to Deegan (1994, p. 156) responsible action includes being “willing to try and fail and try again” to involve oneself in life.

Employment serves as one important form of active participation in life. Leete (1989) relates how work motivates her, provides positive structure for her life, gives her new skills and something to look forward to on a daily basis; and work increases her sense of being accepted and a part of her community. A part-time job and having her own money were important aspects of early recovery for Deegan (1994). Later, she returned to school to earn advanced degrees as a mental health professional in

order to be of assistance to others. Unzicker (1989) and Lovejoy (1982) also went to work, although Lovejoy’s treatment with heavy psychiatric drugs made it difficult for her to work.

Recovery Is Active Coping Rather than Passive Adjustment

One hallmark of recovery is the movement from a position of passive adjustment to a stance of active coping. Active coping has seldom been promoted in traditional mental health programs. Formal helpers often encourage passivity and adaptation to permanent disability. Lovejoy (1982), at age 19, was told by her psychiatrist not to ever think of returning to academic pressures or working. She was directed to “regard [herself] as retired and in need of a long, long rest” (Lovejoy, 1982). She was trained to view herself as “incurably ill,” as someone who would “always have to be taken care of by others” (p. 606).

Recovery involves a resurgence of a sense of personal responsibility for one’s own state of being and the return to active self-help. As part of the recovery journey, people learn to make decisions and choices that are real, take risks in order to experience growth, and assume primary responsibility for their own recovery process (Lovejoy, 1982). “I began to learn I had to be more than a passive, cooperative patient to recover,” wrote Lovejoy (1982, p. 607). People must become “active and responsible participants in their own recovery projects” according to Deegan (1994, p. 149).

Active coping requires a high degree of self-awareness, including acute attentiveness to both sources of stress and positive resources in one’s environment. People learn to actively self-monitor their own state of mind. “I attempt to keep in touch with my feelings and attend immediately to difficulties,” says Leete (1989, p. 197). Over time, people improvise and try out a variety of means

to contend with challenging aspects of their disorder. Ultimately, each person comes to develop a dynamic and highly personalized set of self-help strategies, resources and coping skills. They learn to self-monitor and self-control their psychiatric symptoms, build important supports and contend proactively with stress and challenge, so that symptoms lessen or do not recur.

Leete (1989) weaves more than 20 personalized coping strategies throughout the story of her recovery. Her coping strategies include: checking out reality with trusted others and assertively requesting unambiguous communication. She structured and limited her leisure time; organized her environment to reduce distracting stimuli; and learned to identify warning signs of potential decompensation. Leete cultivated concentration and list-making and suppressed or masked symptoms, such as responding to voices, through concerted practice. Lovejoy (1982) participated in a program that helped her learn to identify stressors and devise her own unique set of coping skills or “tools.” In order to develop personalized coping strategies people become investigators in an active self-discovery process and practice intensive self-discipline. Self-care becomes an increasingly important activity. Leete (1989) tells us that over time, active coping efforts improve the sense of mastery and control one has over one’s challenging life circumstances.

Recovery Means No Longer Viewing Oneself Primarily as a Person with a Psychiatric Disorder and Reclaiming a Positive Sense of Self

Prior to recovery people were often treated as though they were their diagnoses, felt defined by their disorder, and came to view themselves almost exclusively in terms of their psychiatric problems. “Your label is a reality that never leaves you; it gradually shapes an identity that is hard to shed” wrote Leete (1989, p. 199). These women tell us

that, for a time, they lost a sense of their own strengths and unique personality and experienced a deep loss of self-esteem. Power inequities that exist within the treatment system only serve to compound this problem. The use of controlling power by staff members engenders a sense of powerlessness that steals courage and harms self-respect, according to Lovejoy (1982, p. 607). "Power games create winners and losers; I was a loser" she writes (p. 607).

Over the course of the recovery journey, a renewed sense of self emerges, a positive sense of self that exists beyond the disorder or in spite of the disorder. Psychiatric problems become a fact of life, but not the whole of one's life, not the core of one's life. Leete (1989) for example, speaks of becoming increasingly self-confident after a return to work. She moved from feeling "vulnerable, weak and incompetent" to feeling "important" and "grownup" (p. 197). Attainment of a more positive sense of self does not mean that the challenges people face are ignored or forgotten. In fact, acceptance of certain personal limitations or vulnerabilities is a valuable aspect of recovery. Deegan (1994, p. 155) writes: "in accepting what we cannot do or be, we begin to discover who we can be and what we can do."

Recovery Is Moving from Alienation to a Sense of Meaning and Purpose

A profound sense of alienation is apparent prior to recovery. Deegan (1994, p. 152) felt like "a ship floating in a sea with no course or bearings." Her future seemed "a barren place, where no dream could be planted and grow into reality" (p. 152). Alienation comes, in part, from receiving treatment in environments that are barren, boring, and lifeless, where life itself seems like a "numbing succession of meaningless days and nights" (Deegan, 1994, p. 152). Unzicker (1989) describes her long inpatient experience as "tedious and bor-

ing" rounds of volleyball, ceramic mug making and the taking of "enormous quantities of drugs" (p. 74).

Alienation also arises from being told by mental health professionals that one has no positive future and will never recover (Unzicker, 1989, p. 74) and feeling "discredited by stigma" (p. 77). Leete describes being discounted, going unheard and not being taken seriously after being given a psychiatric label. She writes "Ultimately we must conquer stigma from within. As a first step... it is imperative... to look within ourselves for our strengths. These strengths are the tool for rebuilding our self-image and thus our self-esteem" (Leete, 1989, p. 199). In recovery, people struggle to overcome self-doubt and begin to honor themselves once again. They reclaim their strengths and talents and sense of dignity and come to believe that they are making an important and valid contribution to others and to their communities. Life takes on new meaning and people reclaim a sense of purpose.

The women who wrote these recovery narratives are all moved by a sense of altruism and survivor mission. Their recovery journey extends beyond finding personal meaning and achieving personal goals. They find a deep source of meaning through being actively involved in a process of giving back, in helping other people who experience psychiatric disabilities to have an opportunity to begin their own journeys of recovery. Lovejoy (1982, p. 608) tells us that her life's purpose is to create "hope for others who may never have seen someone who has 'been there and back.'"

Recovery Is a Complex and Nonlinear Journey

These narratives tell us a good deal about the recovery journey itself. People do not make the recovery journey in one grand leap, they learn to feel good about taking very small concrete steps. Leete (1989) found crossing things off a

"to be accomplished" list gave her small successes that built her confidence to try other things. Deegan (1994, p. 154) began her recovery journey by achieving "small triumphs" through "simple acts of courage" like riding in a car or talking to a friend for a few minutes. The recovery journey becomes a way of life, made up of "many small beginnings and small steps" (Deegan, 1994, p. 154).

Most of the narratives point out that recovery is not a sudden conversion experience; it is a slow process that takes substantial ongoing commitment. Recovery is not linear; the journey is not made up of a specific succession of stages or accomplishments, and it does not follow a straight course (Deegan, 1994, p. 155). Instead, recovery is an evolving process, one that sometimes spirals back upon itself, and may result in a frustrating return to active disorder after periods of positive functioning. Deegan (1994, p. 155) says "At times our course is erratic and we falter, slide back, regroup and start again." Setbacks are accepted parts of the journey; they are common. In fact, while all these women ultimately attained substantive recovery, most face ongoing challenges.

Each person's journey of recovery is individual and unique. Recovery processes cannot be forced into a preset mold or formulated as a cookbook full of recipes for everyone to follow. In fact, recovery holds a quality of chance, a measure of mystery, and often involves transpersonal events and spiritual passages. Unzicker (1989, p. 75) says her recovery journey relied upon "a thousand events, people, challenges, and mysteries" while Deegan (1994, p. 154) honors the importance of grace in her recovery and life.

Recovery Is Not Accomplished Alone—The Journey Involves Support and Partnership

People do not claim to recover on their own; they describe recovery as a process that involves many other people. While

no one can change another person, or force him or her to recover, other people strongly influence the process. Deegan (1994, p. 153) tells us of people who “loved her and did not give up,” who “remained optimistic despite the odds.” Their love was “a constant invitation... calling [her] forth... to be more than [she] was” (p. 154). Support and help flow from many people, including family members, spouses, and caring informal helpers. Unzicker (1989) describes a loving family who, though strangers to her, took her into their home for a year and did not treat her like she was “crazy.” Later, she actively chose people to become a part of what she calls her “real family,” including those who “believed in [her]... supported [her]... loved [her]” (p. 75). Reliable social support is “invaluable” to recovery says Leete (1989).

Peers can spark and support recovery through formal self-help, informal encounters, mutual assistance and exposure to their stories of recovery. The self-help movement gives people a sense that they are the primary experts in their own recovery process and can solve their own problems. Invaluable practical information, insight and support are available through peer groups (Leete, 1989). Self-help also provides a powerful sense of solidarity and a sense of purpose focused on changing unhelpful or abusive practices in the mental health field.

People employed in the formal helping system also help engender recovery. Lovejoy (1982, p. 607) tells us of a time when staff members inspired her with the idea that she was responsible for changing her own life and peer practitioners showed her that recovery was really possible. Recovery does not mean people stop using formal helping services, but people are no longer passive recipients of expert services. They seek out professional helpers who will honor their authority to make their own deci-

sions. Practitioners can help facilitate a self-directed recovery process. Some narratives describe the active search for formal helpers who are able to work from a position of partnership. “I ‘did therapy’ one more time” Unzicker tells us (1989, p. 75)... “but this time it was different. I carefully selected my therapists, knowing never, ever again to believe that another human being could fix me, heal me, or set me free.” Through trial and error, Leete (1989) found medications that work for her in very small doses. She determines when she needs to take somewhat more medication for a period of time to contend with particularly stressful life events.

Another important passage on the journey of recovery involves working to reduce the sense of internalized stigma and addressing external stigma. Over time, people begin to heal their sense of separateness, and the pain of being cast into the role of “Other” or “outsider.” Unzicker (1989), Lovejoy (1982), and Deegan (1994) all call for breaking down the artificial walls that are constructed between formal helpers and people who are mental health consumers that promote and perpetuate an “us versus them” mentality. We are not “worlds apart,” but are “all struggling and wounded” writes Deegan (1994, p. 160). “We are not only like you,” writes Lovejoy (1982, p. 609) “we are you—your sons, daughters, husbands, sisters and fathers.”

DISCUSSION AND IMPLICATIONS

Recovery narratives strongly contest the dominant discourse in the mental health field, which provides only a “decline narrative,” focused upon the inevitability of chronic disorder, a downwardly spiraling course, poor prognoses and life-long disability. Recovery stories serve as “quest narratives” that open

new pathways and present positive trajectories for a life course of discovery and personal growth after the experience of prolonged psychiatric disability.

This exploratory qualitative study supports the proposition that a multifaceted recovery process exists for people who experience prolonged psychiatric disabilities. It reveals that the recovery journey, while unique for each person, has many broad passages that are held in common. These conclusions are reinforced by findings of other informal and formal research on recovery. Blanch and colleagues (1993), for example, report on forums that included peer-practitioners—those who have experienced serious psychiatric disorders who are now formal helpers. Forum participants describe recovery as an active ongoing process relating to overcoming assaults of stigma, discrimination, and abuse; developing a renewed sense of free will and self-control; undertaking self-directed coping strategies; participation in valued activities and important human relationships; feelings of hope; and a sense of personal meaning. All of these processes were found in the four narratives studied.

Sullivan (1994) conducted semistructured qualitative interviews with 46 people who were currently receiving mental health community support services, who had remained out of the hospital and involved in productive activities for an extended period, despite the experience of severe and persistent psychiatric disorders. These respondents identified strong relationships with caring and encouraging helpers; self-will/self-monitoring; stress management; medications; vocational activity and schooling; spirituality; knowledge and acceptance of illness; self-help and mutual assistance; and relationships with significant others as crucial for their success. All these elements were found in the first person accounts examined in this study.

This concordance of research findings leads to the conclusion that recovery from prolonged psychiatric disability is far from an anomalous experience attained by a few very special individuals. Rather, recovery appears to be an example of resilience. Resilience is the ability to withstand, or rebound from, and prevail over adverse life circumstances (Marsh et al., 1996). Innate self-righting capacities and supportive environments facilitate resilience. The concept of resilience focuses attention upon restorative powers, mastery, constructive change, and the potential for growth that remains inherent within very challenging life circumstances.

Resilience is being studied in at-risk children and adults facing crises, stress, and trauma (Anthony & Cohler, 1987; Flach, 1988; Higgins, 1994; Lerner, 1996; Lifton, 1993; Marsh, et. al., 1996; Wolins & Wolins, 1993). Systematic research focusing on resilience among mental health consumers is just beginning to be published (Marsh, et. al., 1996). Marsh and colleagues (1996) found more than three in four family group members who responded to their survey could identify qualities of resilience in their family member who experiences psychiatric disability. These include positive personal qualities, recovery, and positive contributions they make to family, other consumers, the mental health system and society.

LIMITATIONS OF THE STUDY

This study may be critiqued on the basis that data were abstracted from a small number of published narratives and may represent atypical recovery processes found only among extraordinary individuals (Lefley, 1994). Documentary research, which includes this analysis of narratives, can generally be challenged on the basis of questionable representa-

tiveness and lack of objectivity and validity (Lincoln & Guba, 1985). To contend with such problems we can test the material against known facts, examine the internal consistency and coherence of the documents, and scrutinize the credibility of the writer (Lincoln & Guba, 1985). The fact that these narratives were published in credible journals, that they independently describe similar phenomenon, that the narrators are well respected leaders within the consumer movement, that their stories are highly consistent with findings from other forms of recovery research, serve as checks to such problems. In any event, the narrative research tradition is less concerned with transcription of literal historical facts than with remembrance, personal meaning, identification of important themes interwoven within stories, and the sense people make of their lives (Borden, 1992; Hollway, 1989; Spence, 1982).

Questions of credibility are routinely leveled against people in groups that have carried social stigma, especially people labeled with psychiatric diagnoses, whose life experiences, standpoint and preferences are too often discounted or completely ignored (Leete, 1989; Ridgway, 1988; Unzicker, 1989). To understand and facilitate processes of resilience and recovery, we must end the silence imposed on people with psychiatric disabilities, attend much more carefully to their personal and collective voices, and value and honor their stories.

Further, qualitative research is not concerned with "representativeness," as the term is used in quantitative research—that findings may be generalized to all people in similar circumstances. The test of qualitative research is whether an inquiry identifies patterns and concepts that advance collective thinking. In this instance, careful examination of four self-reports serves to improve our understanding of patterns common in the



lived experience of recovery. Knowledge gleaned through triangulation of the findings of several studies can help the mental health field elaborate an adequate and empirically grounded recovery paradigm.

Narrative research provides the mental health field with another means to respectfully listen to and learn from consumers. Storytelling is an inherently social act. The story is complete only when what is said is heard by one or more other people whose thinking and future actions may evolve as a result.

IMPLICATIONS FOR RESEARCH, POLICY, AND PRACTICE

Research on recovery and resiliency in psychiatric disability is in its infancy. This exploratory study provides tantalizing pieces of a puzzle. Many efforts to learn from consumers about the process of recovery and more adequately define recovery are underway. A single clearly delimited recovery construct remains to be achieved; the multi-faceted recovery process remains too complex to be operationalized in any simple manner.

The ultimate goal of recovery research should not be the creation of a set of parsimonious research constructs or indicators. Nor should we seek only a deeper understanding and appreciation of the life experience of those who have experienced recovery, even though their stories are fascinating and inspirational. Instead, we must continuously work to identify the processes, attitudes, skills, and supports employed by persons who are initially most resilient, in order to create useful means, models, and maps to assist people who continue to struggle with the challenge of psychiatric disability. Our primary goal should be to build applied knowledge that evokes the potential for recovery in many more lives.


“WE MUST SUPPORT
 THE GREAT ADAPTIVE
 STRENGTHS PEOPLE HAVE,
 AND HONOR THE
 HEALING POWER OF
 ACTIVE COPING, SYMPTOM
 SELF-MANAGEMENT,
 AND PEER SELF-HELP.”


Narrative accounts challenge the field to critically examine institutional structures and processes. Resilience and recovery are highly contextual. Helping systems can either amplify resilience and support recovery, or suppress these processes and induce what Harding, Zubin, and Strauss (1987) have called “careers of chronicity.” Many practices that are common within the mental health field forcefully restrain recovery. Unwarranted negative messages about prognoses continue to accompany psychiatric diagnoses; people are still being inducted into the status and role of “chronic mental patient” (Harding, Zubin & Strauss, 1987). Socially segregated programs frequently serve as entrapping niches that reinforce social stigma, reduce access to normative feedback and resources, encourage passive adjustment, and solidify social withdrawal (Rapp, 1998; Sullivan, 1997). Pathology-focused rather than strengths oriented interventions provide deviancy-amplifying feedback that discourages recovery (Rapp, 1998; Saleebey, 1997; White, cited in Hart, 1995). Many social

policies continue to reward permanent disability and provide disincentives for engagement in meaningful activities including competitive employment.

We must learn to identify and guard against messages, practices, and policies that demoralize people, reinforce despair, engender unnecessary dependency, and prolong disability. Because context strongly influences resilience, barriers standing in the way of self-healing processes must be identified, uprooted and removed. We must collectively work to end an era in which people find it more difficult to recover from the mental health treatment they receive than from a psychiatric disorder itself.

A recovery orientation will demand fundamental shifts in the way psychiatric disorders are understood, and in the mission, design, and delivery of mental health services (Sullivan, 1997). The full implications of recovery-oriented practice are beyond the scope of this paper. Anthony (1993) and Rapp (1998) suggest administrators and practitioners can learn from recovery narratives and create environments and practices that trigger and nurture the recovery process. If we believe recovery is based in the natural self-righting capacities of resilience that are open to all people, formal helpers must be educated and dedicated to nurturing its unfolding.

Professionals must become realistically hopeful and avoid messages that serve as self-fulfilling prophecies of decline (Lovejoy, 1982). Messages of hopefulness, and interesting and challenging programs are needed to give people the encouragement and opportunities they need to risk and grow. Increasing the emphasis placed on consumers’ individual strengths, goals, and preferences is obviously important (Rapp, 1998; Saleebey, 1997). We must support the great adaptive strengths people have, and honor the healing power of active coping, symptom self-management, and

peer self-help. People who are farther along the path of recovery must be available in all programs as mutual self-helpers and peer-providers so they may serve as guides, living exemplars and role models of recovery. Other natural helpers, including family members, must be supported to facilitate the processes of recovery and resilience.

Recovery narratives are an important resource that should be transmitted to staff members and consumers in every psychiatric treatment and psychosocial rehabilitation program. These stories provide an alternative “counter plot” that challenges and overturns the master decline narrative, the story of inevitable life-long disability that holds the outmoded “chronicity” or “deficit paradigm” in place. First person accounts amplify the message that a positive life course is attainable for persons with serious and prolonged psychiatric disabilities. We must appreciate, recount, and add to our storehouse of recovery narratives. Sharing first person accounts of recovery is important because “We live with each other in a world of...narrative, and we understand ourselves and each other through changing stories and self-descriptions” (Anderson & Goolishian, 1988, p. 380). Recovery narratives can engender a “contagion of hope” (Deegan, 1994, p. 159) and reorient both staff members and people with psychiatric disabilities toward alternative and more rewarding life paths, by restorying the possibility for positive growth after destabilizing life events.

REFERENCES

- Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, 27(4), 371–393.
- Anthony, E. J., & Cohler, B. (Eds.) (1987). *The invulnerable child*. New York: Guilford.
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11–23.
- Begun, A. L. (1993). Human behavior and the social environment: The vulnerability, risk and resiliency model. *Journal of Social Work Education*, 29(1), 26–35.
- Berg, Bruce L. (1995). *Qualitative research methods for the social sciences* (2nd Ed.). Boston, MA: Allyn & Bacon.
- Blanch, A., Fischer, D., Tucker, W., Walsh, D., Chassman, J. (1993). Consumer practitioners and psychiatrists share insights about recovery and coping. *Disability Studies Quarterly*, 13(2).
- Borden, W. (1992). Narrative perspectives in psychosocial interventions following adverse life events. *Social Work*, 37(2), 135–141.
- Deegan, P. E. (1994). Recovery: The lived experience of rehabilitation. In W. A. Anthony, & L. Spaniol (Eds.), *Readings in psychiatric rehabilitation* (pp. 149–162). Boston: Boston University, Center for Psychiatric Rehabilitation.
- Flach, F. (1988). *Resilience: Discovering a new strength in times of stress*. New York: Fawcett/Columbine.
- Foucault, M. (1980). *Power/knowledge: Selected interviews and other writing*. New York: Pantheon.
- Greenberg, J. S., Greenley, J. R., & Benedict, P. (1993). Contributions of persons with serious mental illness to their families. *Hospital & Community Psychiatry* (45), 475–480.
- Harding, C. M., Brooks, G.W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness. I: Methodology, study sample, and overall status 32 years later. *American Journal of Psychiatry*, 144(6), 718–726.
- Harding, C. M., Zubin, J., & Strauss, J. S. (1987). Chronicity in schizophrenia: Fact, partial fact, or artifact? *Hospital and Community Psychiatry*, 38(5), 477–484.
- Hart, B. (1995). Re-authoring the stories we work by: Situating the narrative approach in the presence of family therapy. *Australian and New Zealand Journal of Family Therapy*, 16(4), 181–189.
- Hartman, A. (1994). In search of subjugated knowledge. *Reflections and controversy: Essays on social work*. Washington, DC: NASW Press.
- Higgins, G. O. (1994). *Resilient adults: Overcoming a cruel past*. San Francisco: Jossey-Bass.
- Holbrook, T. L. (1995). Finding subjugated knowledge: Personal document research. *Social Work*, 40(6), 746–751.
- Hollway, W. (1989). *Subjectivity and method in psychology: Gender, meaning and science*. Newbury Park, CA: Sage.
- Jimenez, M. A. (1988). Chronicity in mental disorders: Evolution of a concept. *Social Casework*, 69(10), 627–633.
- Kelley, P. (1995). Integrating narrative approaches into clinical curricula: Addressing diversity through understanding. *Journal of Social Work Education*, 31(3), 347–357.
- Kleinman, Arthur (1988). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.
- Leete, E. (1989). How I manage and perceive my illness. *Schizophrenia Bulletin*, 15(2), 197–200.
- Lefley, H. P. (1994). Thinking about recovery: Paradigms and pitfalls. *Innovations & Research*, 3(4), 19–23.
- Lerner, M. (1996). *The politics of meaning: Restoring hope and possibility in an age of cynicism*. Reading, MA: Addison-Wesley.
- Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis and interpretation*. Thousand Oaks, CA: Sage.
- Lifton, R. J. (1993). *The protean self: Human resilience in an age of fragmentation*. New York: Basic Books.
- Lincoln, Yvonne S., & Guba, Egon, G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage.
- Lovejoy, M. (1982). Expectations and the recovery process. *Schizophrenia Bulletin*, 9(4), 604–609.
- Marsh, D. T., Lefley, H. P., Evans-Rhodes, D., Ansell, V. I., Doerzbacher, B. M., La Barbara, L., & Paluzzi, J. E. (1996). The family experience of mental illness: Evidence for resilience. *Psychiatric Rehabilitation Journal*, (20)2, 3–12.
- Mishler, E. G. (1986). The analysis of interview-narratives. In T. R. Sarbin (Ed.) *Narrative psychology: The storied nature of human conduct*. New York: Praeger.
- Rapp, Charles A. (1998). *The strengths model: Case management with people suffering from severe and persistent mental illness*. New York: Oxford University Press.
- Ridgway, P. A. (1988). *The voice of consumers of mental health services: A call for change*. Burlington, VT: Trinity College, Center for Community Change Through Housing and Support.
- Saleebey, D. (1994). Culture, theory, and narrative: The intersection of meanings in practice. *Social Work*, 39, 351–359.
- Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work*, 41(3), 296–305.
- Saleebey, D. (1997). *The strengths perspective in social work practice* (2nd ed.). New York: Longman.
- Spence, D. P. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis*. New York: Norton.
- Sullivan, W. P. (1994). A long and winding road: The process of recovery from mental illness. *Innovations and Research*, 3(3), 19–27.
- Sullivan, W. P. (1997). Strengths, niches, and recovery from serious mental illness. In Saleebey, D. (Ed.), *The strengths perspective in social work practice* (2nd ed.). New York: Longman.
- Surgeon General (1999). *Mental health: A report of the surgeon general*. Department of Health and Human Services, Bethesda, MD: United States.
- Unzicker, R. (1989). On my own: A personal journey through madness and re-emergence. *Psychosocial Rehabilitation Journal*, 13(1), 71–77.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton.
- Wolins, S. J., & Wolins, S. (1993). *The resilient self: How survivors of troubled families rise above adversity*. New York: Villard.
- Wynne, L. C., Shields, C. G., & Sirkin, M. I. (1992). Illness, family theory, and family therapy: Conceptual issues. *Family Process*, 31, 3–18.