



Reconnecting with life: personal experiences of recovering from mental health problems in Ireland

Y Kartalova-O'Doherty and D Tedstone Doherty

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Executive Summary

Background and aims

It has been recommended that Irish mental health services adopt a recovery perspective (Department of Health and Children 2006). *A Vision for Change*, the Irish blueprint for mental health policy, in a chapter pertaining to rehabilitation and recovery services describes recovery as a belief that persons with mental illness can recover their self-esteem and regain control of their lives despite their illness, and 'move towards building a life where they experience a sense of belonging and participation' (Department of Health and Children 2006: 105). However, at present there is no clearly laid-out theory of recovery to guide daily clinical practice (Care Services Improvement Partnership (CSIP) *et al.* 2007). The aim of this study was to develop a coherent theory of recovery from mental health problems from the point of view of those recovering.

The study methodology was guided by classical grounded theory (GT) which seeks to identify the main concern of the population under study (Glaser 2001). An understanding of the main concern (e.g. reconnecting with life in this study) helps services to reassess their practices to better address the needs of service users. The study involved open-ended individual interviews with 32 volunteers who had experienced mental health problems more than once over a period of two years or more and considered themselves in improvement. Most (n=23) were recruited via community mental health services, and nine via peer support/advocacy groups. This was the first classical GT study of recovery in Ireland.

An overview of findings: the theory of recovery as reconnecting with life

An analysis of the interviews identified participants' main concern as striving to reconnect with life. Thus, the core category of recovery, representing participants' main concern, was labelled as 'reconnecting with life'. It had three interactive subcategories: 1) reconnecting with self, i.e. accepting oneself as a worthy individual capable of positive change; 2) reconnecting self with others, i.e. experiencing empathic, accepting, and validating interaction with others; 3) reconnecting self and others with time, i.e. getting a glimpse of a positive future, coming to terms with the past, and planning and executing one's present. The process of reconnecting with life was open-ended, gradual and individual, and involved exploring, acknowledging and developing personal strengths and capabilities through trial and error.

Processes, tasks and strategies of reconnecting with life

The study provided a detailed description of underlying general processes, specific tasks and individual strategies of reconnecting with self, others and time. Some of the underlying processes of reconnecting with life included fighting for reconnection, developing understanding and empathy, giving back, coming to terms with the past, futurising and moving on, and turning bad days into good days. Some of the individual strategies aimed at achieving specific tasks of reconnecting with self, others and time included talking, self-talk, taking medication, exercising, studying and working.

Facilitators and barriers of reconnecting with life

Hope for the future and feeling accepted and validated facilitated development of motivation to start fighting to reconnect with life. Suitable medication and reduction or change of medication also facilitated the beginning of the fight to get better. Discovering one's strengths and capabilities and taking part in activities of interest helped reconnection with self, others and time. Positive environment was associated with friendliness, acceptance and encouragement which facilitated self-acceptance, reconnection with others, and moving on in time.

Conversely, hopelessness, seeing no future for oneself, lack of somebody to talk to, and being pushed to do something against one's will led to a lack of motivation to fight to get better and, in extreme cases, to giving up on one's reconnection with life. Pessimism of diagnosis, medication side effects, being treated as a disease rather than a person, advanced years combined with socio-economic deprivation, long stays in in-patient units, and hostility and stigma in the broader community often created barriers to reconnecting with self, others and time.

Relevance of the generated theory to recovery practice and research

Viewing recovery as a process of gradual reconnection with life embraces and synthesises diverse concepts and theories of recovery and rehabilitation into a coherent theory of mental health recovery (Anthony 1993; Onken *et al.* 2007). Such theory is also congruent with the WHO definition of mental health as 'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (World Health Organization 2007).

As the study findings show, some isolated elements of person-centred, recovery-oriented care already exist in the Irish mental health services, at least in community mental health services. Participants complimented individual psychiatrists, nurses, psychotherapists and other professionals for their understanding, empathy, sense of

humour, encouragement and listening skills which facilitated their reconnection with self, others and time. Educational and occupational activities provided by day centres were also reported by participants as facilitating reconnection with life. Such qualities and activities need to be supported and enhanced, and used as positive examples of recovery-oriented care.

This study also provided evidence that depersonalised, paternalistic and pessimistic attitudes and behaviours generally dominate over a person-centred, empathic and accepting approach within the Irish Mental Health Services. Person-centred mental health care requires a paradigm shift towards refocusing on the life goals of those recovering, and the vital importance of their input into the planning and delivery of care. Service users should be encouraged to talk at length, narrate their story, voice their concerns and aspirations, and participate in a dialogue with service providers. Standardised questionnaires should not dominate over person-centred sessions.

There are multiple options on how reconnection with life can be achieved, and both service users and service providers face the challenging task of selecting the most suitable ones in accordance with their knowledge, experience and circumstances. However, we argue that once reconnection with self, others and time is achieved, service users will be better prepared to face and control their present and their future. As a result, fewer disconnections from life will occur, which will save funds and time for the mental health services (Mead and Copeland 2000). It is hoped that the study will encourage creative innovation in mental health practice and research, and will not only improve the quality of care, but will also contribute to the morale and job satisfaction of service-providers (Hazelton *et al.* 2006).

The findings show that reconnection with life involves multiple aspects of spiritual, emotional, cognitive and physical functioning. *Development of multidisciplinary teams and community services*, as recommended by *A Vision for Change*, is essential for recovery oriented services (Department of Health and Children 2006).

This study informs the Irish public about the possibility of recovery and the important role of community in reconnection with one's life and thus can aid mental health promotion campaigns. Familiarisation with this study is recommended for mental health professionals and educators, service users, carers, researchers, policymakers and the general public.

Conclusion

The study provides a deeper level of understanding of what recovery is (i.e. reconnection with life) and guidance on how it can happen (through an active reconnection with self, others and time). Preferred individual strategies of reconnecting with life can be effectively combined with therapies and supports available in the services. In the wider community these can be allied to specific tasks of reconnecting with self, others and time. The identified underlying processes, strategies, facilitators and barriers of reconnecting with life can equip all mental health stakeholders to evaluate and develop effective recovery-oriented policy, education, practice, research and mental health promotion strategies.

1 Background and Aims

This chapter describes the background, rationale, and aims of the study. The difficulties of implementing a recovery ethos within the Irish context and internationally will be discussed.

1.1 Background to the study

As elsewhere in the world, the concept of mental health recovery originating from US mental health service users, is now central in mental health policy and planning in Ireland. *A Vision for Change* defines the principle of recovery which should underpin the work of rehabilitation and recovery teams as ‘the belief that it is possible for all service users to achieve control over their lives, to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation’ (Department of Health and Children 2006:105).

Some describe the historical development of the concepts of recovery as a continuum of at least three stages: from the bio-medical model (recovery *from* symptoms), to the rehabilitation model (recovery *in*, or despite disability or impairment), to the empowerment model (recovery *from* invalidation and disempowerment, recovery *of* active citizenship) (Andresen *et al.* 2003; Davidson and Roe 2007; Fitzpatrick 2002). Recently, the model of psychological recovery, or recovery of positive identity has also been suggested (Andresen *et al.* 2003).

Research shows that some priorities of both pure biomedical and rehabilitation models of recovery can be at odds with those of consumer recovery (Fitzpatrick 2002). The empowerment model in its extreme form rejects the need for any treatment and therefore could not guide mental health services (Speed 2006). The model of psychological recovery is based on multiple concepts, processes and stages emerging from few original studies of consumer recovery (Andresen *et al.* 2003). Such concepts and processes have not been yet conceptualised into a unified theory of recovery capable of guiding mental health practice. A more detailed discussion of the existing recovery models and their limitations is presented in a PhD thesis available from the first author.

The biomedical view of mental illness as a disease caused by brain malfunction or chemical imbalance has not been confirmed empirically (Kingdon and Young 2007). The genetic determination of mental illness has been challenged by research showing the plasticity of gene expression, influenced by multiple environmental mechanisms (Rose 1998). Whereas several genetic links associated with mental disorders have been identified, the presence or absence of such links *per se* predicts neither the incidence nor the outcomes of mental illness (Douthit 2006).

Growing evidence shows that mental health recovery is possible for persons with different diagnoses and can happen with or without medication (Anthony 1993; Ramon *et al.* 2007). Moreover, the adverse side-effects of psychotropic medication on health, associated with such life-threatening conditions as diabetes and suicidal ideation, have now been recognised (Bracken and Thomas 2005). However, medication has also been shown to be beneficial for mental health (Ludwig *et al.* 2007). Many service users view medication as helpful when their concerns and preferences are taken into consideration (Happell 2008).

One of the many barriers for developing recovery-oriented services in Ireland and elsewhere is the lack of a coherent theory of mental health recovery acceptable by service providers, family carers, service users, and the broader community (Higgins 2008). The biomedical model of mental illness and recovery has been dominant within the Irish mental health policy, and services patients' subjective experiences have been viewed as irrelevant for recovery (Hoff 2008). The rehabilitation model is largely based on the biomedical model, but allows service users to voice their concerns and choices regarding suggested treatment (Andresen *et al.* 2003). Despite the increasing evidence that people diagnosed with a 'severe and enduring' mental illness, such as schizophrenia, can recover and thrive in society (Hopper *et al.* 2007), a popular belief that mental illness is an incurable genetic disease only manageable by medication still persists both within the public domain and in the mental health services (Bag *et al.* 2006).

The lack of a recovery approach within the Irish community mental health services was highlighted in a joint study carried out by the HRB and the Mental Health Commission (MHC) (Tedstone Doherty *et al.* 2007b). In April 2009 the group tasked with monitoring the implementation of *A Vision for Change* further highlighted the continued lack of a recovery ethos within the mental health services (Department of Health and Children 2009). The authors of the report point out that a recovery ethos would have benefits to service users, society, and the economy by reducing the inappropriate use of inpatient care and prescribed medication, thus lowering the costs incurred by services (Department of Health and Children 2009).

The next section outlines previous findings on concepts and processes of recovery emerging from mental health service users, or persons who identify themselves as having experienced mental health problems (Crossley and Crossley 2001).

1.2 Concepts and processes of recovery emerging from service users

The concept of consumer, or service user recovery emerged from the consumer movement in the USA during the 1980s (Andresen *et al.* 2003). Since that time, service user recovery has been increasingly gaining the attention internationally of mental health practitioners, researchers and policymakers. For example, the importance of service users' perspectives on recovery has been underlined by the UK National Institute for Clinical Excellence guidelines for schizophrenia (National Institute for Clinical Excellence 2002).

A widely accepted definition of psychological recovery is 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness.' (Anthony 1993:16). Service users view emotional, spiritual, physical and cognitive aspects of self as equally important in recovery (Borg and Davidson 2007; Tooth *et al.* 2003). Among factors identified by persons with schizophrenia as important for recovery were: an active sense of self, determination to get better, and self-control of their illness (Tooth *et al.* 2003). Work, exercise, and art were reported as helping recovery, by promoting self-esteem, self-confidence, social contact, temporal structure, and distracting from illness (Crone and Guy 2008; Goodwin and Kennedy 2005).

Several dimensions, or stages of recovery have been identified by international studies, such as the reawakening of hope after despair; breaking through denial and achieving understanding and acceptance; moving from withdrawal to engagement and active participation in life; active coping rather than passive adjustment (Ridgway 2001). A review of five previous publications describing service user experiences of recovery summarised four key processes, including finding hope, re-establishment of identity, finding meaning in life and taking responsibility for recovery (Andresen *et al.* 2006). Service users argue that not all dimensions and stages identified so far in the literature need to happen for recovery to take place (Ralph *et al.* 2000). For some, recovery may be about overcoming symptoms; for others, it may be living well despite the symptoms. The goals of recovery should be defined by personal contexts, wishes, and capabilities (Higgins 2008).

Concepts and processes of recovery that were part of international policy documents were based on only a few original studies of first-hand evidence of service users, and extensive reviews of these studies (Higgins 2008; Mental Health Commission 2005). Some suggest that there is a danger that by using the word 'recovery', adopting the 'recovery-oriented' prefix and some general 'universal' concepts of recovery, mental health services may simply repackage their services without properly understanding the major principles of recovery (Ralph *et al.* 2000). Moreover, mental health services which

are not fully cognisant of the recovery goals of their service users may inadvertently create barriers to their recovery (Lilja and Hellzen 2008; Tooth *et al.* 2003). Original research aimed at synthesising and documenting service users' recovery experiences is needed in order to build a coherent theory capable of guiding innovative mental health practice.

The concept of mental health recovery has been described as a vision, belief, philosophy, ethos and stance (Mental Health Commission 2005). We argue that until recovery has been thoroughly explored, understood and accepted by mental health practice, education, and research, it would be challenging for the whole Irish mental health system to become recovery-oriented. In addition, a nationally driven combined effort of Irish service providers, service users and policymakers is needed to implement recovery-oriented services.

To date, no in-depth research on the experiences of those recovering from mental health problems in Ireland has been published. We need to identify their main concern and the key processes of recovery by asking open-ended questions in simple neutral language, relatively clear of medical, ideological, or political terminology.

1.3 Study aims and objectives

The main aim of the study was to generate a theory of recovery based on the first-hand experiences of persons with mental health problems living in Ireland. Specific objectives of the study were to:

- 1 explore what recovery means and how it happens from the point of view of persons recovering from mental health problems in Ireland;
- 2 build a theory of mental health recovery in an Irish context;
- 3 inform recommendations for mental health services, carers and policymakers.

2 Methodology

This chapter will describe the study design, method and procedures. Included also is a discussion of quality criteria applicable to this study, and an overview of the study sample.

2.1 Design, method and recruitment

Following its objectives, the study was designed as qualitative, open-ended and data-driven, aimed at providing an understanding of what recovery is and how it happens from the point of view of those recovering. The inclusion criteria for study participants were self-nominated volunteers with recurrent mental health problems who considered themselves in improvement (Appendix A). Recurrent mental health problems were defined as having been experienced more than once during at least two years.

We selected a classical grounded theory (GT) approach as it assists theory building (Glaser and Strauss 1967). Whereas various concepts of recovery were described in the literature, few original studies synthesised concepts into a unified theory capable of providing conceptual understanding of broader shared patterns underlying the existing diversity of concepts (Andresen *et al.* 2006). Generating a coherent theory of recovery that would provide understanding and guidance was viewed as essential for this study.

Glaserian classical GT aims at a systematic generation of theory through systematic procedures leading to the emergence of conceptual categories. Such categories should be related and linked to each other, and as a whole provide a theoretical explanation of striving behaviour of the participants aimed to resolve their main concern (Glaser 2001). Participants' main concern of which they may not be immediately aware (e.g. 'reconnecting with life' in this study) and its constant resolution should be reflected by the core category, which should explain all the variance in the striving behaviour of the population under study (Glaser 2001). The core category should emerge directly from the participants, as opposed to being predetermined by the previous research or interests of a professional community (Glaser 2001). A more detailed discussion of classical GT methods and procedures is presented in a PhD thesis based on this study, and is available on request from the first author of the report.

The service users consulted during the scoping stage commented that individual interviews were preferable to focus groups, as people might feel uncomfortable speaking about their sensitive experiences in a group. Therefore, in-depth interviews were chosen. The original interview schedule was designed as open-ended and flexible and was drafted during consultations with service users and service providers. The schedule started with an open-ended question: 'So tell me about your experiences

with mental health problems and recovery, anything that you think is important.’ The sampling criteria and the interview schedule were constantly modified in accordance with the emerging findings (Glaser 2001). For example, when the open code of ‘fighting to get better’ emerged from the first six interviews, questions about its relevance and essence in the recovery context were included in the next interview schedule. Participants’ suggestion to measure recovery separately on bad days, good days and in the desired future also emerged from the first six interviews and was further explored and refined in all subsequent interviews (Appendix B).

For descriptive purposes, all participants filled out a questionnaire where they stated their age, gender, education, employment, marital status, the nature of their mental health problems (diagnosis if known), the duration of their mental health problems in years, and the use of various mental health services and peer support groups. This was completed at the end of the interviews so as not to influence open-ended responses (Glaser and Strauss 1967). The main purpose of collection and reporting of demographic data was to demonstrate that the underlying processes of the generated theory were shared by diverse groups of participants, and that the core category and its subcategories explained all the variance in the data (Glaser 2001).

The study received ethical approvals from the Research Ethics Committee of the HRB in March 2007, from the relevant mental health services authorities in March 2007, and from the CEOs of the mental health peer support organisations GROW and IAN in June and November 2007, respectively. During all stages of recruitment, the study information letter (Appendix A) was distributed to service providers, service users, and members of the peer support organisations. Volunteers contacted the researcher directly to agree on the time and place of the interviews. All participants signed a consent form prior to the interviews, which informed them that their participation was voluntary and confidential and could be terminated at any time throughout the interview. The first author conducted all of the interviews, which lasted for between 30 minutes and 2 hours. All interviews were audio-recorded and transcribed verbatim.

The study underwent three iterative stages of recruitment, interviewing and analysis. These included the first six interviews with participants recruited via day centres¹ in April 2007 in suburban and rural areas, nine interviews with participants recruited via peer support organisations in urban areas in June–November 2007 and 17 interviews with new participants recruited via day centres¹ in suburban and rural areas in April–May 2008.

1 Day centres are part of public community services and are attended by users of diverse services, including users of inpatient and community residences, and day care, day hospital, and rehabilitation services. The functions of day centres include provision of nursing care, administration of medication, participation in work and self-management skills programmes and other activities facilitating integration in the wider community.

Data analysis progressed from open coding of narratives to the synthesis of open codes into broader categories. The categories were further refined through their constant comparison between new and previous interview transcripts and within parts of each transcript, until the core category and its subcategories explained all data variance and the theory was generated (Glaser 2001). As in any classical GT study, the emergence of the core category was iterative, non-linear and time- and effort-consuming (Christiansen 2007), and involved coding, categorizing, group discussions and consulting dictionaries. At the final stage of theory-building an extensive literature review of previous findings relevant to the generated theory was conducted in order to test how the theory complemented previous research on recovery (Glaser 2001). Due to space limitations, only a brief discussion of previous findings relevant to the current theory will be presented in the report. A thorough discussion of multidisciplinary findings relevant to the generated theory is laid out in a PhD thesis based on the study, available from the first author. Anonymised field notes and memos, coding sheets and diagrams, revised interview schedules and interview transcripts can also be made available on request.

2.2 Criteria to assure quality in grounded theory

The classical GT quality criteria include relevance, fit, workability, and modifiability of the generated theory (Glaser 2001). The following section shows how the quality criteria were met within this study.

Relevance refers to the applicability of the theory to a specific field (Glaser 2001). The generation of the core category of reconnecting with life and its subcategories of reconnecting with self, others and time were discussed with the members of the research team comprising two psychologists, one psychiatrist, and two mental health nursing academics. The preliminary theoretical framework of recovery was also discussed with one ex-service user. All involved identified with the core category and its subcategories and considered the theory relevant and useful for their respective fields.

Fit refers to how adequately the categories express patterns in the data (Glaser 2001). The categories were constantly compared and refitted within and between narratives, until a coherent theory of recovery that explained all data variance was developed.

Workability stands for the ability of the theory to not only explain the main concern of the study population, but also to predict what may be happening with the population in the future (Glaser 2001). We believe that the current theory can explain and to some extent predict what is and will be happening when a person is recovering from mental health problems, in terms of what phenomena can facilitate or slow down the process of recovery.

Modifiability refers to the flexibility and durability of theory application to practice and research (Glaser 2001). The current theory could be modified should new data emerge. For example, if the influence of the present economic downturn on individual recovery emerged from further research, such an issue could be further incorporated in the subcategory of reconnecting with self and others with time.

Therefore, the study theory of recovery based on participants' main concern, defined as reconnecting with life, met the classical GT quality criteria of relevance, fit, workability, and modifiability.

2.3 Overview of the sample

The sample comprised 32 volunteers with recurrent mental health problems who considered themselves in improvement. More than half (n=18, 56.3%) were male, and 14 (43.8%) were female. Most (n=23, 71.9%) were recruited via mental health services and nine (28.1%) via peer support/advocacy groups. Slightly more than half of the interviewees (n=17, 53.1%) resided in urban or suburban areas, and 15 lived in rural areas (46.9%). The majority (n=29, 90.6%) used some professional help in the last 12 months. Three participants did not use any professional help but participated in peer support/advocacy groups.

Half of the participants (n=16, 50%) lived in community residences, nearly half (n=14, 43.8%) lived independently, and two resided with parents/relatives. The average age of interviewees was 47 years (SD = 11.4; min=25; max=68). More than half (n=18, 56.3%) were single, seven (21.9%) were married/cohabiting, and seven (21.9%) were separated/divorced/widowed. Over one-third (n=12, 37.5%) had children. Over one-third (n=13, 40.6%) were unemployed, and six (18.7%) were in mainstream employment. Seven participants (21.9%) were in sheltered employment or training provided by the day centres, three (9.4%) were retired, and three (9.4%) were homemakers.

Half of the participants (n=16) reported that their main diagnosis was depression or bi-polar disorder; about one-third (n=10, 31.2%) had been diagnosed with a schizophrenic illness, and six (18.8%) reported being diagnosed with unspecified anxiety. All participants reported having been given at least two different diagnoses over time. The reported average duration of recurrent mental health problems was 20.2 years (SD = 13.2, min=2, max=54). The majority of participants (n=24, 75%) reported that they were currently using prescribed psychotropic medication, with a quarter (n=8) reporting no use of such medication in the last 12 months.

The concepts of good and bad days emerged directly from participants of this study as possible measures of self-perceived fluctuating degree of reconnection with and disconnection from life. Questions pertaining to self-perceived highest level of recovery on a good day, lowest on a bad day, and the desired highest level were added to the interview schedule (Appendix B). All participants reported self-perceived scores of recovery ranging from 0 to 100. The average highest score on a good day was 81.8 (median = 80.0, SD = 17.2), ranging from 30.0 to 100.0. The average lowest score on a bad day was 34.6, ranging from 0 to 100.0 (median = 32.5, SD = 24.2). The average desired score in the future was 93.8, ranging from 50 to 100 (median 100.0, SD = 11.5).

Despite the differences in the reported duration of illness, diagnoses, employment, residential, marital statuses and other factors, there were shared underlying patterns evident in the accounts of all participants. The identified shared processes and tasks underlying the resolution of the main concern of participants (i.e reconnecting with life in this study) formed the basis of the generated theory laid out in the next chapter.

3 Findings and Theory

This chapter presents an overview of the theoretical framework of recovery from recurrent mental health problems developed by this study. We will describe the phase of disconnection from life as a symbolic starting point of recovery. We will also describe the core category of reconnecting with life and its subcategories of reconnecting with self, others and time.

3.1 Disconnection from life: disconnection from self, others and time

The phase of extreme disconnection from life was described by participants as a symbolic starting point of recovery. This phase was associated with an awareness that persons were somehow different or distanced from others and not moving on with their lives. It was perceived as being ‘disconnected from the whole’, ‘sitting at the side of people’, ‘being stuck’, or ‘being trapped’:

But the next thing was an awareness that I was sitting at the side of people, people appeared to be talking about things that were plain and getting on with living and I felt that I was somehow stuck at the side just looking, that was an awareness I was coming up with about myself ... I didn't seem to function like them, in that ordinary way, I was inhibited or if you want, retarded or undeveloped in that area, it depends on how you want to put it. I was sitting at the side ... (14).

Figure 3.1 illustrates the key characteristics of the phase of extreme disconnection from life emerging from the participants (as opposed to the perceived underlying reasons behind such disconnection):

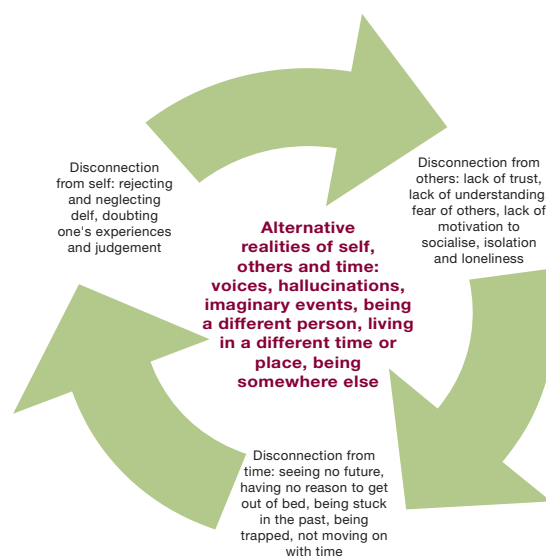


Figure 3.1 Disconnection from life: disconnection from self, others and time

The phase of disconnection from life was characterised by the inability to face one's responsibilities, such as work, study or household duties; seeing no reason to get up in the morning, and unwillingness to socialise:

You lie in the bed all day and you won't want to get up and you won't want to talk to anybody and you're so low, that no matter who talks to you, you won't want to talk to them. I've had so many people that said, 'If you ever feel low like that and feel suicidal or anything, just please give me a ring.' But when you feel low you don't want to give anyone a ring. You are in a hole and you just want to be on your own, you don't want to talk to anyone, not your parents, family, friends (7).

Often it was emotionally unbearable for a person to face the 'here and now' due to loss of a significant other, physical injury, bullying or abuse, or stress at work. Alternative realities of self, others or time could take over the reality of 'here and now' and become difficult to control:

And then I was working on landscaping and building and I got sick, there was lads hammering floorboards and it started playing on my mind and I thought it was a woodpecker ... And I got all jumbled up in my mind, I couldn't concentrate on my work and I was trying to do it too quick, and I was climbing ladders and trying to hold on to a bucket of cement climbing a ladder, and I was afraid of my life I'd fall because I wasn't thinking right, you know, things were playing on me, you know, the boss was playing on me and I was imagining things (31).

Persons can stay emotionally and spiritually 'trapped' in the negative past or present and become incapable of seeing a positive future:

I signed myself in, as far as I can remember, I was just totally destroyed, I couldn't think straight, I didn't know what the future held for me you know (26).

3.2 Core category: reconnecting with life

The core category of recovery, representing participants' main concern, was a gradual progression from disconnection from life to reconnection with life:

And I joined [peer support group], I got some counselling and gradually I became more connected with myself and the world around me ... Suddenly I was talking to people who I thought were far superior to me, and they would listen, and for the first time things began to change, so that you can see a pattern there. So, from a lack of connection to a connection (15).

The core category of reconnecting with life had three interrelated subcategories: 1) reconnecting with self through accepting the self as a worthy human being capable of positive change; 2) reconnecting self with others through experiencing accepting, non-judgemental and validating connection; 3) reconnecting with self, others and time through getting a glimpse of a positive future, coming to terms with the past, and

actively shaping and executing one's present. Synchronising self with others and time was achieved by talking, doing things with others or for others, and getting positive and constructive feedback.

The interrelated subcategories of reconnection with life did not represent linear stages, but could occur in any order or simultaneously. For example, reconnecting with self and others was sometimes triggered by reconnecting with time as in gaining hope for a positive future; reconnecting with others through experiencing accepting and validating connection could trigger self-acceptance and hope inherent in reconnecting with self, and so on.

Figure 3.2 represents the three interdependent and interconnected subcategories of reconnecting with life.

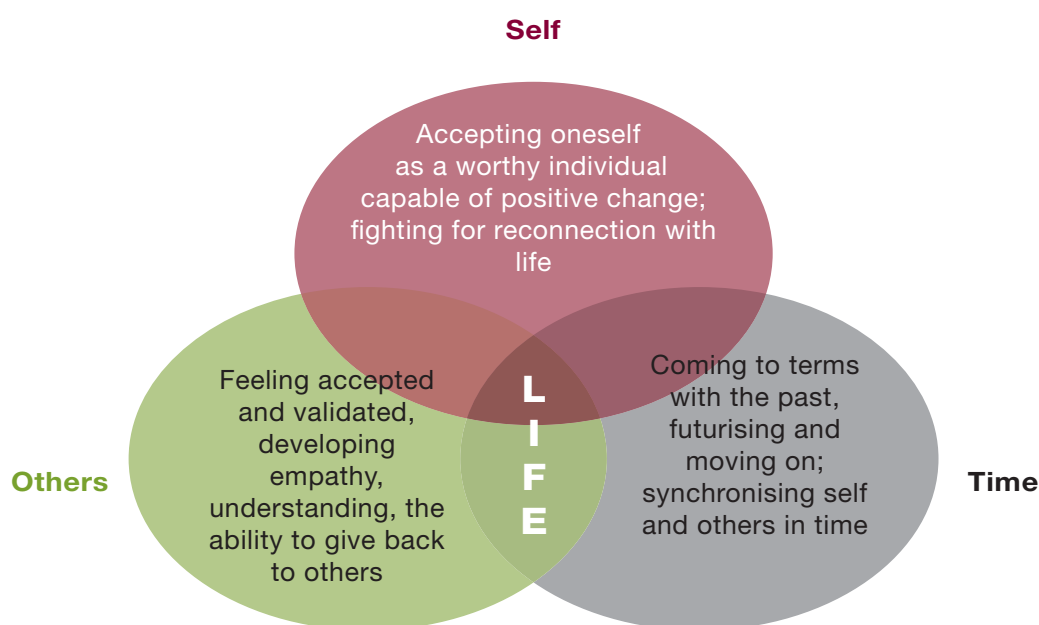


Figure 3.2 Reconnecting with life: reconnecting with self, others and time

There is no final stage of reconnecting with life, but a qualitative progression which allows the person to feel more in control of his/her life:

It's about discovery, recovery is about discovering yourself, and for me it's about being honest with yourself ... I may well be recovered, if I'd got to a certain stage, when the less I panic when I come to a problem in my life, the less I am distressed, and the more I feel in control, and think like, 'I can handle this' ... Once I do something about it and not just sit and worry about it ... (9).

The processes, tasks and strategies of subcategories of reconnecting with self, others and time will be described in the next three sections.

3.3 Reconnecting with self

Table 3.1 represents the underlying processes, tasks and individual strategies associated with reconnecting with self.

Table 3.1 Processes, tasks and strategies of reconnecting with self

Processes	Tasks	Strategies
Getting back to oneself: getting back to here and now	Physical reconnection with self in here and now: awareness, focus, concentration	Getting sleep and rest, nutrition; taking medication; calming down
Reawakening of hope and will to get better	Believing that positive change is possible; developing self-determination and motivation to get better; making a decision to start fighting for reconnection with life	Imagining one's future life; finding reasons to get better; seeing oneself as a human being capable of positive change
Fighting for reconnection: designing and executing own recovery	Designing own recovery through trial and error; development of self-esteem, self-confidence; activating and strengthening own cognitive, emotional, physical and spiritual resources	Talking, self-talk, reasoning, explaining, learning, doing things with others, taking medication, getting advice; exercising; strengthening memory, concentration, physical fitness

Getting back to oneself: getting back to 'here and now'

The initial reconnection with self for all participants of the current study started with 'getting back to oneself' through medication or admission to hospital. As the 'fog' of disconnection was partially cleared, physical, cognitive and emotional functioning began to improve slowly:

[What does recovery mean to you, what would it mean for you to be recovered?] Starting to feel better, maybe be able to, I'm not sure, I was going to say to think clearer, I'm not sure that is true. To think clearer (30).

Hospital provided safety, rest and regular meals which contributed to physical reconnection with self:

Well the good things were that you were fed, you know, I didn't have to worry about getting a meal for myself, which I am capable of doing anyway but I got balanced food, that's on the plus side, and it was handed to me three times a day ... (14).

Medication helped to calm down, relax and 'clear one's head':

Ah sure I've had psychosis, and it was terrible, it was ... accusing other people of different things, the doctors and other people, all people, I thought everyone was involved. Everybody was guilty. But when I got the tablets it took it away from me, I spent 10 weeks here in [name] ward and the tablets, I was on them for 10 weeks for it to clear it away from me (25).

Reawakening of hope and will to get better

Reconnecting with self spiritually was associated with reawakening of hope and making a conscious decision to get better. Some persons recalled that they had always had hope that their life could get better, whereas others needed to communicate with others to reawaken hope and to find some meaning or purpose to their existence:

I suppose, I've always held a lot of hope that things would get better, you know (9).

The first improvement, I come here. To the day centre. I was talking to [peer name] and nurse. It's nice to know what you're around for, that you're not a burden on anyone or anything like that (16).

Participants felt that self-determination played a major role in recovery. The decision to get better came from within the self through realising the need for change. Non-judgemental support was very important, but the 'push' had to come from within the person:

But definitely, if you're not going to fight, nobody, nobody can do it for you, absolutely not, but every little bit helps, you know really just a little bit of support here and there really helps you know (23).

Sometimes, through comparison of themselves with other people who gave up hope on their recovery participants realised they wanted to recover:

Within a couple of days I was sent to [hospital name] and while I was there, spent the first couple of weeks not really knowing where I was and very deeply depressed, and then I started to realise that there were a lot of patients within the hospital who did not want to get better, they were waiting for the pills to do that, and I knew pretty quickly that the only way for me to recover was for me number one to want to, so that was my first step. I saw other people who didn't want to recover and I didn't want to be like them (8).

Reduction of medication or change to a more suitable medication was also reported as helping with spiritual reconnection with self and contributing to the desire and energy to fight to get better:

That's what happened to me like, the lower the medication went, the better I got. The more energy I had and the more I got back into my hobbies and activities. Then I got back to my old self ... So, medication halved; that was the big turning point for me (7).

The advice participants gave to others was to fight for reduction of medication, but under supervision, as otherwise it may lead to relapse:

I'd fight against getting more medication off doctors. Because medication makes you very tired. Don't let the doctors give you too much medication. I'd say to them, here, listen, I'm staying in bed all day, so I can't take that, you'll have to give me something else that might be better, some smaller dosage. Don't go off your medication without your doctor's advice.

Because you'll just end up in hospital again. Because that's what I did, and I ended up in hospital (28).

Once the process of fighting to get better started, persons felt relief, freedom, and confidence. Participants claimed that whereas 'giving up' could turn into fighting at some stage, the process of fighting was unlikely to reverse itself back into 'giving up':

[Some people told me that you have to fight to get better, not to give up, would you agree to that?] I would agree totally to that. I would agree with that yeah. [Explain this to me please.] It's hard to, you just feel like ... you just want to get better in yourself, and you try everything to get better in yourself ... Force yourself, it's like a brick thrown on you, and you try and get it off you, and you are relieved then, the heavy brick is off ... And the same with your illness, you have to push it and fight it. Don't let it block you. [And can fighting turn into giving up?] No. Because if you are fighting, you know you'll get there (29).

However, if self was seen as something negative and non-modifiable, 'giving up' could not turn into fighting:

I think it's just ... the personality I was given at birth. I can't relate to other people. And I have a rather negative personality. [And how do you feel about that?] Well there's nothing I can do about it. I mean it's not a thing you say to a doctor, you can't have a pill for talking. [And why can't you say it to your doctor?] Because it's only a, eh ... my problem. A doctor can't help me really ... [Some previous people told me that it's important to fight for your recovery, not to give up?] Yes ... I would say I'm the nearest to it [giving up] of the people I know. The others are coping well with their own problems (24).

Lack of concentration combined with advancing years and limited financial resources also made it hard to start the 'fight' for reconnecting with life:

I think I'll still be in the hospital because I can't afford a house, and I haven't the concentration for work, and I'm 61 anyway (2).

It was also very easy to give up on your life when you were in hospital too long:

But definitely, keep from long-term in the hospital, you know. [And what happens if you stay too long in the hospital?] Well you begin to get kind of ... you want to stay there, just don't see any other way, you know, just stay there (5).

Fighting for reconnection: designing and executing one's own recovery

After the reawakening of hope and making a conscious decision to get better, the fighting for reconnection with life evolves. By trial and error, people come to realise what strategies, medication, therapies are available, and what works and what does not work for them:

Well, once I made the decision that I wanted to get better, I asked how could I get better, and so they spoke about CBT [cognitive behavioural therapies] and they spoke about

psychoanalysis and they spoke about psychotherapy, so I said okay, where is it, and it took a couple of weeks of me banging down the door to get an appointment with a psychologist. So I got an appointment with a psychologist and continued to see the psychiatrist and continued to, you know, speak with the psychiatric nurses, continued to engage with the other patients, continued to engage with the occupational therapists and I suppose I've designed my own recovery and I was very active (8).

Participants thought that professionals should allow them to have a dialogue and support them in designing their own recovery, rather than being treated as passive recipients of medication or available therapies:

I think patients should be given an option for what they want to do for your care plan. It involves them in the care plan, so they can do things they enjoy, not what the doctor thinks will work for them. Because everyone is an individual and everyone knows their own body and what works for them ... Maybe at some stage you mightn't even know what you want, because you are really unwell. Then you might need some guide, someone to give you some options ... Then eventually you are going to know what will work for you (7).

Sharing ideas and advice with their psychiatrists, nurses or peers was viewed as very helpful:

The doctor I go to in [hospital name] is very good doctor ... Because I go in and I'd say such thing and he'd say, 'Did you try it, did you try it that way or did you try it this way?' And maybe I wouldn't have thought of it, and you find yourself trying to do that and it works, you know, he's very good like that ... (6).

Gradually becoming aware of one's interests and capabilities helped to develop one's self-esteem and self-confidence and start the fight for reconnection with life:

So they [peer support group] discovered I could play the guitar and sing, not through hearing me, just a friend of mine told them, so I couldn't sing in front of people, I didn't know what to do, so they got a get-together with the group, and they got me to sing one song and play my guitar with the light out, now who else in the world would understand that? So eventually, bit by bit, we practised every week, and then I sang without the light out, and just to cut past that, I now sing voluntarily, solo (11).

Get something you like doing, work at something you like doing, don't work at something you're not happy at, work at something you're happy doing, you have an interest in (31).

If a person has not made their own decision to get better, trying to talk them into their own recovery could sound judgemental and condescending, like 'pull up your socks':

I remember one time I went to facilitate a group in a day hospital in a psychiatric unit ... and started talking to them about recovery, and one of the ladies in the group in about 10 minutes started screaming at me and shouting at me, 'And you think you can come here, talk to us and we get all fixed, and we'll all be recovered?' and the nurse had to take her out ... And in

fact it was an affront to her, because she thought, it's like saying, 'Well why haven't you', you know, 'I'm going to teach you about recovery' (9).

Making somebody do something against their will was perceived as traumatic and slowed down reconnection with life:

[What was the most difficult period of your experience?] I think when I was in [hospital], I was up on a ward and I wasn't eating at the time and they made me eat, put my hand behind my back and ... I'll always remember that (19).

Fighting for reconnection with self occurred on four levels: spiritual, emotional, cognitive, and physical:

I have a physical recovery, I have an emotional recovery and I have a spiritual recovery and they're all different, they're all at different stages ... I am a bit better emotionally than I used to be, and I would say that my recovery spiritually is the most consistent, so even on a bad day I would be spiritually okay with it, I'd be okay to have a bad day and recognise that having a bad day is part of the process ... If I'm having a bad day physically I'm exhausted, I just have to sleep and even emotionally I'd be low, in a very low mood ... Obviously I want to get to about ninety in terms of physical, I want to go back and play rugby again (8).

Spiritual reconnection involved hope, self-determination, will, motivation, courage, self-confidence, and realising one had some purpose in one's life. Reconnecting with self emotionally involved allowing oneself to feel and take control of one's emotions. Reconnecting with self cognitively involved changing negative emotions into neutral or positive by self-talk, talking to others, and activating cognitive resources such as memory, concentration and reasoning through talking, reading, studying, or writing. Training and learning new things brought energy, concentration, and self-confidence:

I'm in here at the moment till a course comes up and when that comes up then it will give me the mood and the confidence and the energy then to do part-time work so I'm looking forward to that (22).

The computer [classes] helped a lot. Because sometimes there's no work and you just feel stupid (4).

Reconnecting with self physically entailed getting out of bed, walking, exercising, relaxing, improving diet and so on. Often when spiritual, emotional and cognitive aspects of self improved, physical health improved too:

It [recovery] was gradual, thinking back it was gradual, because I thought I was physically sick, I didn't realise I was mentally sick. I just felt in pain ... So it's in my head and I've put down some expectations I'm achieving, but physically I feel well, I had hypertension and she [doctor] had me on tablets for the blood pressure, and the first time I went back to her after coming out of my own place, it was back to normal again, and she couldn't believe it. Everything, the whole lot, the physical body, mentally and physically I'm much better (23).

However, the long-term side effects of medication could interfere with physical and other aspects of self:

I'm on an injection and I'm on a blood pressure tablet, I take it, and I've a stomach problem, I take it, but I have refused to take two of my tablets because, I'll tell you why, they interfere with my life, and I've been off them, I've been putting them down the sink for a month, and I feel in great form. I used to be feeling sleepy, stiffness in the legs and headaches with these two tablets, and since I gave them up I'm grand, so that's my life story ... It's a good day if I'm able to get up in the morning and dress myself and get my breakfast and walk down to the bus and wait on the bus, and not be feeling tired or hardly able to stand up, and nowhere to sit down at the bus stop, my legs would be so weak and tired, I blame that on the two tablets, since I stopped taking them I'm grand (31).

Becoming dependent on medication could affect spiritual reconnection with self and lead to a lack of self-confidence when facing daily tasks:

But I did become very dependent on the tranquilisers ... and I needed them, you know, for every small task I had to do, and I continued on for another few years in that state, it was like being in a fog [laughed] you know, I was just about getting through life (10).

Some participants commented that medication did not do anything for their reconnection with life, and that they could function effectively without it:

I'm not taking anything now, although they continue, the hospital services that I have been attending, continue to think that I should because they think that I have a chronic illness that needs medication for life ... Then the debate arises, do I need the tablets to work, and since the beginning of this year the answer to that is no, because I'm functioning very well in work and I'm doing the work well (14).

Summary of subcategory of reconnecting with self

Reconnecting with self started with physical reconnection with the here and now, which was triggered by rest, sleep, medication, nutrition, or calming down. It entailed reawakening of thoughts, emotions and perceptions, and an increase of energy. Reconnecting with self spiritually was associated with the reawakening of hope for the future and the will to get better. It included such concepts as motivation and self-confidence. Reconnection with self also involved making a conscious decision to get better and saying to oneself that one would be ready to fight to get one's life back. Fighting for recovery involved trying different activities and supports and choosing the ones that helped to stay connected with life. Fighting for recovery was associated with gradual activation and strengthening of one's own spiritual, cognitive, emotional and physical resources.

3.4 Reconnecting self with others

The crucial stage of reconnection with life included experiencing meaningful connection with others, which led to further reconnection with life. Table 3.2 shows the underlying processes, tasks and individual strategies associated with reconnecting self with others.

Table 3.2 Processes, tasks and strategies of reconnecting self with others

Processes	Tasks	Strategies
Experiencing meaningful connection: feeling accepted and validated	Encountering somebody friendly, funny and helpful; calming down, getting positive energy from others; seeing oneself as a human being through another person's eyes	Focusing, looking, listening, relaxing, concentrating, speaking, expressing oneself to others
Learning to understand self and others better: developing trust and empathy	Developing trust, opening up; developing understanding and empathy	Listening, talking, dialogue, synchronising eye-contact, speech, body language; humour, joking
Giving back to others: re-establishing the meaning and purpose of one's life	Becoming aware of a possibility to give back something positive to others	Doing something with others or for others; getting positive, supportive and constructive feedback

Experiencing meaningful connection in clinical settings: feeling accepted and validated

Experiencing meaningful connection with others was triggered by refocusing on somebody accepting, helpful, positive, familiar, or funny:

But eh, sometimes if you are having a bad day as in like you are not in good form or just a bit low, or you are paranoid, you might change if you are out in public and somebody you really get on with really sparks a bit of life into you. Somebody who you really click with. And somebody that you can bounce off and have a bit of fun with will cheer you up. Somebody that's funny. Like one guy, he was in hospital with me, and he used to cheer me up in hospital and try to make me laugh and stuff like that even though I was in a catatonic state, I was barely blinking ... I was in a zombie-like state, and he'd still get half a smile out of me ... I do believe that laughter is the best medicine, you know, at times (7).

Reconnecting with somebody made persons feel that they were not alone, that there were other people like them out there:

I enjoy coming here [day centre]. A bit of company and a bit of independence ... Then I meet other people who are not well or sick or whatever. Whatever problems they have, I'm not the only one that comes here so ... (3).

Empathic, warm, caring interaction, often combined with humour, brought feelings of calm, warmth and happiness:

He's nice [psychiatrist], he's really nice, he's real calm, calms you down, you know. Sometimes he has a laugh with you. [And is it good to have a laugh?] It's good, yeah. Because I feel happy inside (28).

Conversely, when faced with formal and impersonal attitudes of service providers, service users did not develop trust in them and refused to discuss their thoughts and feelings:

You have to trust the doctors. When I first started, I really didn't trust her [psychiatrist] at all, so I didn't tell her anything. [Why didn't you trust her?] Because she was very rude, she didn't say 'How are you?', she'd say 'Now what's the mood like?' and I thought 'I'm not telling you anything', she shut me down, she stopped me from talking. Then I saw Dr [name] and he'd say 'Are you anxious?' or 'Are you down?' but nobody, nobody once said to me, 'What are you thinking about [name]?', it was all mood, high, low, like a robot, you know (23).

Continuity of meaningful connection also helped to develop trust:

I talked to Dr [name], now he is fabulous, I could trust him, trust is very important, do you know what I mean ... [And how do you know you can trust a person?] I don't know really, how can I trust them, because you probably get to know them. I used to meet Dr [name] every month, every six weeks. He just listened I suppose, he didn't really do anything much, he just listened, which is important enough (26).

Constant change of service providers made development of trust and meaningful connection difficult:

You see the doctors change all the time, registrars change all the time, the consultant stays the same, but the trainee doctors come here, you know, and they don't really know much about you, they change around your tablets, that's all they do (19).

Being in hospital was described as a lonely experience due to a lack of 'normal' human interaction. Service users often felt that they were treated as a 'disease' rather than individuals by service providers:

I always have the impression that they treat you as an illness rather than a person. Like, you are schizophrenic, we are going to give you this, this and that, you take them all and see if it works. You are a manic depressive, take this, this, just like I gave the last manic depressive, and see if it works for you. I know they are not psychologists and not counsellors, not there to listen as such, but at the same time I'd like to be treated like a person and not just like a guinea pig, like a guinea pig that you just throw pills into (7).

A perceived lack of person-centred care and being identified by one's illness and prescribed medication only was associated with both public and private sectors:

It reminded me of One Flew Over the Cuckoo's Nest, [hospital name], I mean it's a beautiful facility, and even when you're inside the rooms are really nice, the staff are really nice, but your name gets called out over the Tannoy for you to come and take your medication. And you queue up in the corridors like Jack Nicholson ... It was, it was exactly like One Flew Over the Cuckoo's Nest (8).

According to participants, service providers often lacked listening skills and preferred to talk themselves:

Well the doctor wouldn't let you talk to him, he wants to talk on, he wouldn't listen to me, will turn his back on you and walk away and say he'll see you (31).

Meaningful connection outside clinical settings: positive and negative energy

Both within clinical settings and in the broader community, feeling accepted and validated as a person and not as somebody 'strange' or 'nuts' helped to establish trust in others and reawakened hope that one was capable of positive change:

I was terrified to sit down, because I was afraid that I'd fall off the chair, because I was so nervous going in. The first impression of [peer support group] was, they don't think I'm mental, you know, they don't think I'm nuts, they said, 'Yeah, no problem, of course you can sit on the floor.' So I think the first thing that hit me was, here's people who accept me for where I am, who I am, they don't really care whether I want to stand on me head, once I'm here, and they're going to help me, you know (11).

The main characteristics of a good environment emerging from study participants were friendliness, acceptance, joyfulness, and positive energy:

[Do you think environment is important for recovery?] I think so. Good environment. Feel good in [hostel]. Because the nurses are good and the people are good (16).

What I liked about it [peer support group] was an underlying joyfulness, even though people were dealing with, you know, very profound issues, everybody was obviously there for a reason, but beneath it there was an underlying joyfulness, which I know was there beneath all the sorrow, and it seemed to be alive in that setting. People were listening to each other, taking each other seriously, etc., and there was a form of community, sort of a gathering of people that could have some interaction (14).

A lack of normal interaction in the community due to stigma associated with mental health problems was often seen as preventing further reconnection with others:

I think I'd socialise a bit more with normal people, but the trouble is you see in society, whether we like it or not, if you've a mental illness there is a lot of stuff about you ... I mean the only reason I'm doing so well is because I don't give a damn what they think, and I

behave proper when I'm out, I don't do anything strange or, I have a good name so everybody is very nice (23).

Some participants commented that medication side-effects can make people look 'strange', which could affect their image in the eyes of others in the community:

And I don't like the side effects of the medications ... they're the only reason why people do look like they have mental illnesses, because they are pale, they put on weight, their eyes are zonked out, they are sitting around, they are not walking like, their speech is slurred (7).

Hostility and badmouthing could lead to disconnection both from self and from others, and in extreme cases, to aggression and further readmissions:

I know what motivates people to get sick – people talking about them, and calling them names. Then they get it into their heads that there's something wrong with them, you know what I mean, there's some bad people out there you know. What got me sick this time was a fellow badmouthing me, he called me a paedophile. [Did he?] He did, and we had a row. He was a big fellow from [suburban town], I was in the pub and he called me a paedophile, which there's no truth in it, and I caught him by the throat and then [the fight] was broken up. He was a lucky man because I get terrible if I get vexed. Well I think that triggered it off, triggered me getting sick, that row I had, I got sick after that (31).

Learning to understand self and others better: trust and empathy

The establishment of meaningful connection was accompanied by recognition of one's own and others' feelings and emotions through talking and listening, and by the gradual development of empathy:

[Do you think you've changed as a person since your most difficult time?] Yeah, I've learnt about my heart. [What do you mean?] I started to recover in my heart. Became more understanding. [And how did you do that?] Well you have to be able to talk (27).

Further reconnection with others was possible through realising that all people were equal, that they shared the same humanity:

Another thing they teach you in [peer support group], in a subtle way without you realising that you're being taught it I suppose, is that everyone is equal. I mean, I believe that the President is as equal as the man on the street with the can of beer, because you know, they're both people of, if there is a God, I believe there is, but if there is, they're both people of some higher universe or God, you know, so who is to say one person is better than another? So like I do believe everyone is equal, you know, so that keeps everyone grounded, doesn't it? (11).

Giving back to others: re-establishing meaning and purpose of one's life

Reconnecting with others brought some 'positive energy' and made it possible to start giving back something positive:

When I had my negative energy everything was black ... When the opposite happens, you know, when I realise I have a purpose here, when I can connect with other human beings, when I can use all of the talents that I've been given (8).

A person can start feeling that he/she can make a difference by being there for somebody, by working, studying, and helping, creating something of practical or intellectual use to others:

[So how do you know it is a good day?] Well I'm studying at the moment and if I get something done with my study, as you probably know yourself I'm sure ... I mean it makes the whole world shift focus from one small little life of your own to something ... [Bigger?] A lot bigger, a lot more varied and a lot more interesting (15).

[What would recovery mean to you?] Working, filling in my day properly instead of walking around calling for friends and complaining ... It makes me feel really angry, makes me feel lazy. Working is good, because it's helping people. It makes you feel good about yourself (28).

Encouragement and support from others helped to get further reconnected with life:

I want to get well and I was determined to get well and that was [what the nurse] was saying, 'You look better today', and I used to say, 'Yeah, I'm getting better, you know, great' ... A bit of encouragement, oh you have to have that, just a word makes all the difference, just one kind word, it's amazing how it makes you feel, well, you know, when you want to make people feel good, you do say nice things don't you, you don't ask if your mood is up or down (23).

Occasionally people needed guidance and constructive feedback to help them find out what could be done better:

Well I've always kind of tried to help myself as much as I can, but there are times I need help. There are times, I don't know whether it's a frailty of the human condition or something, I much prefer people that tell me, you know, you're doing this wrong, you're doing that wrong, point it out, than not suggest or not say anything (1).

One peer support group had a special system of positive and constructive feedback on completed tasks:

We're all given tasks on a weekly basis, and hopefully you'll achieve that by the following week ... Then there're special activation reports, whereby after a period of time, say seven months, we get a report by at least two members of the group, who will tell us what they think of us. Mostly on a positive basis, 75 per cent on a basis that would be positive. The other 25 per cent on what we can improve on, to help us have a better state of mind (13).

Summary of subcategory of reconnecting self with others

The significant turning point of reconnection with life included experiencing meaningful connection with others, and further reconnecting with self through reconnecting with others. Reconnecting with others involved focusing on somebody positive, feeling accepted and validated as a person capable of positive change, getting involved in interaction and dialogue, developing empathy towards and understanding of others and self, giving back to others, and developing self-esteem and self-confidence through doing things and getting positive and constructive feedback.

3.5 Reconnecting self, others and time

An important dimension of the core process of reconnecting with life, closely intertwined with the previously discussed subcategories of reconnecting with self and others, included reconnecting with changing time. Reconnection with time could be triggered, achieved or maintained through accepting and encouraging support from others, or through reconnecting with self by getting a glimpse of positive future, or imagining a negative future for oneself and resisting it. Thus, reconnection with time included getting hope for a positive future, coming to terms with the past, and actively shaping and executing one's present and future. Table 3.3 shows the underlying processes, tasks and individual strategies associated with reconnecting self and others with time.

Table 3.3 Processes, tasks and strategies of reconnecting self, others and time

Processes	Tasks	Strategies
Getting a glimpse of a positive future: hope	Becoming aware of a positive future	Starting to believe that positive change is possible
Coming to terms with the past: reliving and explaining the past	Re-establishing the meaning of major events of one's past in the present and future	Remembering and explaining one's past to others; linking past experiences with the present and future
Synchronising self with others and time	Maintaining meaningful connection with others; developing understanding and empathy; giving back	Dialogue, eye-contact, body language; doing things together with others: work, study, arts, sports, etc.; doing things for others: working, helping others
Futurising and moving on	Futurising: planning and executing short and long-term future; doing, changing: moving on	Comparing self in the past with self in the present and image of self in the future; making decisions and following them through
Turning bad days into good days	Recognising signs of disconnection and fighting for reconnection with life	Seeking help from others; futurising, music, exercise, deep breathing, prayer, working, medication

Getting a glimpse of a positive future: hope

Reconnecting with time could be triggered by getting a glimpse of a positive future, either through believing in it oneself or through encouragement from others:

I talked to Dr [name]; now he is fabulous, he said, I was ok, I'm going to live (26).

Being given a diagnosis of a serious mental illness with no hope for recovery caused hopelessness, anxiety and could negatively affect motivation to reconnect with time:

Well I was diagnosed with paranoid schizophrenia which is quite a frightening diagnosis for a young fellow to have on his shoulder ... And I felt I was a reject, I was rejected from family, friends, the whole world and somehow, you know, distanced from the whole ... And with this diagnosis they don't offer, they didn't offer me any hope, they didn't say you can do this and you'll be alright. Nothing really, they said 'medication' (15).

Schizophrenia, that's what I suffer from. And they said, 'It's a lifelong disease.' And I don't like that ... I'd like to be fully recovered, that's why I don't like the idea that this is a lifetime (4).

Coming to terms with the past: reliving and explaining the past

After getting a glimpse of a positive future, persons felt the need to face the past, to come to terms with the past, and to take responsibility for one's future life:

It was about facing myself, facing my own fears and, you know, moving from that kind of helpless child who took himself off in his head and really didn't take much responsibility for himself, to somebody who maybe would eventually take responsibility by facing his past, you know, so that was my kind of major advancement in recovery up to that point (9).

Negative past experiences had been viewed as something too scary, or too risky to disclose. In some cases past experiences were disregarded by mental health professionals as not relevant to the current situation:

I'm just thinking about what I went through ... Like I'd just tell them [nurses], like I want to hang myself, can I talk to you for a few minutes but we'd be talking about like, that situation you know, so I didn't really talk to anybody about my past. [Do you think it could have helped to talk to somebody about your past?] Yeah it would have. I'm screaming inside, do you know what I mean? (28).

One of the shared things from the past was a lack of empathic, accepting and validating connection. In addition to a lack of emphatic connection, there was often bullying, violence, or emotional, physical or sexual abuse:

For many years I was bullied emotionally, denigration of my personality, withdrawal of affection, shouting. Shouting and silence. [Kind of, a lack of contact, is it? Or is it too much contact?] Well deliberate withdrawing of emotional contact, I would call it emotional bullying ... We had an emotionally compressed home, so there wasn't much emotion shown, the only

emotion shown I'd say was anger from my father, so my mother was quiet, my father was angry (8).

The main damaging effect of abuse, violence or emotional neglect was the perceived loss of persons' confidence and ability to make active choices in life:

When I'm out now, I'm in fear all the time, I'm kind of looking behind me a bit ... I'm always kind of wary, you know, like I remember one time when my own daughter, she was only five or six and we were at the beach and she stepped on some stones and she was sliding deeper in, but I didn't go to her, I just froze, my niece was with me ... You see, when you get a bad fright, you would like, you know ... (6).

Telling one's story to somebody helped persons to see what had been missing in the past and thus needed to be addressed in the future in order to start moving in time with others. However, in order to open up to others and retell the negative or upsetting past one had to find an accepting, empathic and non-judgemental audience:

I was able to mention it in the [peer support] group, I was able to talk about the experience of what actually happened, to engage with the emotions and the feelings and the fears of what happened, in a group where people seemed to be listening to me and ... the normal feedback without analysing you or whatever ... I came down off the cross, I was able to come down and out, in a sense of that freedom to engage with people and to come into the world (14).

Synchronising self and others in time

Synchronising self with others in time was achieved through talking and doing things with others or for others.

And sometimes, when I'm just going to play golf with a friend, it just takes away a lot of stuff, just by doing that, just being involved in something else, and being with somebody (9).

Starting to understand other people and becoming aware of a possibility to give back led to the development of new friendships, which further contributed to reconnection with time:

I get a sense of satisfaction, job satisfaction, seeing people get well ... It's really great, you know, because when you see what friendship in a group does to one person, and how they recover, because people are accepting them, you know, I mean it's fascinating to see, they're like a flower that's closed, and you see them nearly opening up, you know, and then six months later, they're running a group, they're an organiser of a group, you know (11).

Futurising and moving on

Futurising involved looking forward to new things and becoming a part of life that is constantly moving and changing. It entailed comparing positive present with the negative past, and finding positive things in the past which could be linked to the future:

Move on, put the experience behind me, so that if I meet these people [bullies from previous job] three or four years down the road, that I'm not kind of cowering in a corner, that I'm not getting palpitations, I'm not feeling anger and resentment, that I've risen above that, and I've moved on ... Basically full recovery would be, for me, to put this traumatic experience behind me, by that I mean that I would like to be re-employed again, in a job which, monetary terms has never been a huge influence on me, more a satisfaction of doing a job well, and it being recognised. To try and re-ignite my marriage, I have a great relationship with my children. I love my children dearly, and I get a great kick out of them growing up, and seeing how they're developing (13).

One of the main tools and goals of future changes was developing decisiveness, proactiveness and the ability to make choices rather than hesitating or doubting:

[How would you see yourself as 100% recovered, what would you like to be?] Not afraid of taking decisions on the spot and then following them through, rather than hesitating and thinking about this, that and the other (26).

As people became stronger and more in control, they started thinking about bigger chunks of time ahead: next day, next week, next month, next year, next decade:

[How would you know you're completely recovered?] Well I mean, a proper health, like be able to go to work, to be able to go out, to be able to deal with myself, you know, and just keep going, the way I'm going ... When I get older, you know, to be able to cope, and hope I don't get any sickness that will stop me doing what I'm doing now, like, does that make sense? Like I mean, life in general, just to be happy in myself, and content with what I've got (12).

Service providers who were perceived to be focusing on maintenance of the present state rather than on positive change could cause anxiety and even weaken one's connection with life:

There haven't been bad days, I'll tell you recently when I was under, when the appointment at the hospital came up again and I had to begin to think about that, and maybe the fear of going down there and trying to articulate, you know, how I was, and what my hopes, if you want, towards a recovery were, rather than being maintained with medication and just going on that way ... I was trying to figure out whether that was a cause of anxiety, because I'm seeing that as something of a distraction at this stage. I see it as a distraction from a busy life (14).

Deprived environment could also slow down reconnection with time:

I suppose in my own recovery, my environment has changed from kind of very deprived upbringing to where I am now, I kind of departed from that stagnant, depressed, deprived environment, which would only kind of keep you in your place sometimes (9).

Turning bad days into good days

The concepts of good and bad days emerged from participants as a possible measure of the process of reconnecting with life. Good days were described as effortless, easy-going, joyful, whereby persons felt optimistic, energetic, proactive, confident and happy about themselves:

On hard days lots of things are an effort, driving the car is an effort, you know, cooking the dinner is a real effort, everything is just dissipated ... But on a good day ... there's effortlessness about the day. It's effortless (8).

Bad days were characterised by the slowing down or acceleration of time, low mood or anxiety, tiredness, and loneliness. Multiple internal and external factors were suggested as causing bad days: stress, bad weather, judgemental or hostile interaction with others, flashbacks from the negative past and so on. Poor physical health also threatened connection with time by curtailing meaningful activities:

[Do you think there is anything slowing you down?] Well at the moment there is, because I've to go in for an operation ... I'm having an operation on my foot ... Yeah, so I'll be off [day centre classes] ... What's worrying me, what I'd love, someone to come up to the house and do the classes at that time you know. A tutor (18).

An important step in one's reconnection with time was accepting that there will always be bad days, as life can throw up problems unexpectedly:

But the bottom line is that we are strong because we know we're weak, we're kept afloat because we know we're weak, that's an aspect really of functioning, and we can be strong, but it is because of some sort of an awareness within us, within ourselves, that we can be weak ... It is a paradox (14).

Reconnection with time on bad days was maintained through futurising small units of present, living one hour or one day at a time. The more vulnerable a person felt on a bad day, the more specific, short-term and structured the future needed to get:

I did plan my day, and if it's a bad day, I said, 'I'll get another shower', and then I'll clean my teeth, you know what I mean, and I had a very structured day and I found that it was the easiest way (23).

Turning bad days into good days was achieved by positive self-talk, thinking of something positive, exercising, writing a diary, praying, listening to the music, or having a conversation with somebody positive:

[So what would be a bad day?] When I'm worried about myself again. Sometimes the cancer and stuff like that, I'm getting over it, that is just the worst case scenario you know. I do my best to keep it minimised, the effect, I'll pray, I'll get in contact with my Christian friends and they'll pray, I'm able to talk to them about my problems (26).

Some suggested that as reconnection with life progressed, they encountered fewer bad days and they were not as 'bad' as they used to be. The more good days a person had in life, the more progress they had made in their recovery. Therefore reconnection with life could be evaluated by two factors: frequency of occurrence of bad days in the last year or month, and the degree of disability, or disconnection from life on bad days:

I had just six months of bad days, and the last six months have been nothing but good days. I'm fully recovered like, I don't have any bad days anymore (7).

If a person achieved good quality connection with self, others or time, even if it was not 100% perfect, it was still possible to be happy and feel connected with life:

[So what would be your highest score of recovery on a good day?] I'd say we'll put down 80, will we? See if things have changed in my life, in terms of if I met somebody, in terms of if I had a relationship with someone, it might go up a bit, but some days like today, if I'm quite happy to be me today, it is not a bad day ... You feel you're not different basically, you're a part of something, you're a connecting link or whatever in the community (15).

[You were saying that you're probably a totally different person now?] Oh yeah. Well I'm back to what I was, but better than I was. [Better, how better?] Well to be having a life of my own is better, getting the house on my own is better, everything is better, everything that most people take for granted I now have, so it's like winning the lotto, going into [town] or [city], it's given me a sense, it's great happiness (23).

Summary of subcategory of reconnecting self and others with time

From an empathic connection in the here and now, whereby persons felt accepted and validated as they were, came a glimpse of hope that a positive future was possible. After the decision to get better was made, persons were ready to start remembering and coming to terms with the past. They were then ready to set up future goals and to gradually execute them, which further contributed to their feeling of reconnection with life. Synchronising self with others and time emerged as a helpful tool and goal of reconnecting with life, and was achieved through dialogue, discovering one's strengths and capabilities, and doing things with others or for others, such as sports, educational activities, or work.

Summary of the core category of reconnecting with life

The core category of recovery, representing participants' main concern, was identified as 'reconnecting with life'. It had three interactive subcategories: 1) reconnecting with self through accepting oneself as a worthy individual capable of positive change; 2) reconnecting self with others through empathic, accepting, and validating connection; 3) reconnecting with self, others and time, through getting a glimpse of a positive future, coming to terms with the past, and planning and executing one's present and future. The core process of reconnection with life had no clear-cut final outcome but represented a gradual strengthening of connection, sometimes involving repeated cycles of disconnection and reconnection.

Facilitators and barriers of reconnecting with life

Hope for the future and feeling accepted and validated facilitated development of motivation to start fighting to reconnect with life. Suitable medication and reduction or change of medication also facilitated the beginning of the fight to get better. Discovering one's strengths and capabilities and taking part in activities of interest helped reconnection with self, others and time. Positive environment was associated with friendliness, acceptance and encouragement which facilitated self-acceptance, reconnection with others, and moving on in time.

Conversely, hopelessness, seeing no future for oneself, lack of somebody to talk to, and being pushed to do something against one's will led to a lack of motivation to fight to get better and, in extreme cases, to giving up on one's reconnection with life. Pessimism of diagnosis, medication side effects, being treated as a disease rather than a person, advanced years combined with socio-economic deprivation, long stays in in-patient units, and hostility and stigma in the broader community often created barriers to reconnecting with self, others and time.

4 Discussion of Findings

This chapter discusses the relevance of the generated theory of recovery to mental health practice and research.

4.1 Relevance of the theory to mental health practice and research

This study explored, synthesised and documented the views of Irish persons with recurrent mental health problems on recovery, and built a coherent theory of recovery. The study adds to both national and international understanding of what recovery is and how it can happen from the point of view of those recovering.

The view of recovery from recurrent mental health problems as reconnection with life – defined as an active effort to establish and maintain meaningful connection with self, others and time – is suggested by this study as helpful for recovery-oriented services. It is hoped that this study will contribute further to facilitation of understanding, promotion and implementation of the recovery ethos within the Irish mental health care in accordance with *A Vision for Change* (Department of Health and Children 2006). Familiarisation with this study is recommended for mental health professionals and educators, service users, carers, researchers, policymakers and the general public.

The findings suggest that through re-establishing and maintaining a dynamic connection with self, others and time one can regain the feeling of meaningfulness of one's life, which was found to be crucial for physical and mental health (Urry *et al.* 2004). As everybody's life circumstances are unique, it may be challenging to apply standard measurement criteria for recovery. However, it is possible to improve people's connection with self, others and time through accepting and validating connection and by encouraging people to tell their story when they are ready and to define their own goals of recovery according to their life circumstances, wishes and capabilities (Higgins 2008). We argue that once active self-driven reconnection with self, others and time is underway, persons are better prepared to face their 'bad days' in the future. This will lead to fewer disconnections from life, which will not only save time and funds for the mental health services (Mead and Copeland 2000), but also improve service-providers' morale and job satisfaction (Hazelton *et al.* 2006).

The theory of recovery as reconnecting with life fits with other concepts and processes of recovery, such as a way of living a contributing life (Anthony 1993), living well despite disability (Deegan 1996), and taking control of one's life (Department of Health and Children 2006). Such complex concepts as hope, self-esteem, and self-determination emerging from the current study are also congruent with previous

recovery research (Onken *et al.* 2007). An extensive literature review performed at the final stage of the study confirmed that the core category of reconnection with life complemented and clarified the previously identified processes of spiritual reconnection of self and others (Higgins 2008), reconnection of spiritual, cognitive, emotional and physical aspects of self (Forchuck *et al.* 2003), and the importance of active coping and resilience in recovery (Ridgway 2001). The theory of reconnecting with life can explain and to some extent predict what is and will be happening in mental health recovery, in terms of which phenomena can facilitate or slow down reconnection with self, others and time. For example, being listened to, being accepted and not being judged can trigger self-acceptance and reconnection with others, which can lead to further reconnection with life. Conversely, being treated as a disease as opposed to a unique individual capable of positive change can lead to further disconnection from others, lack of trust in self and even a lack of motivation to move on in time.

The study core category is also congruent with the WHO definition of mental health as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community ... This core concept of mental health is consistent with its wide and varied interpretation across cultures.' (World Health Organization 2007). It can be argued that the view of recovery as reconnection with life is shared across the globe, whereas some underlying values of life may be culturally specific. For example, the importance of work, independent accommodation, and family in one's life have been inherent in the Western system of values (Onken *et al.* 2007). Not surprisingly, work, family and independent accommodation were among the key goals of reconnection with life in participants' narratives in this Irish study.

The study provides a deeper level of understanding of what recovery is (i.e. reconnection with life) and guidance on how it can happen (through an active reconnection with self, others and time). Preferred individual strategies of reconnecting with life can be effectively combined with therapies and supports available in the services. In the wider community these can be allied to specific tasks of reconnecting with self, others and time. The identified underlying processes, strategies, facilitators and barriers of reconnecting with life can equip all mental health stakeholders to evaluate and develop effective recovery-oriented policy, education, practice, research and mental health promotion strategies.

4.2 Study limitations

The theory of mental health recovery generated by this study cannot claim to capture the full complexity of recovery. The study theory is based on 32 interviews and can be further explored and modified by research and practice. Other interviewees may have identified additional issues and categories not captured by the current theoretical framework.

The majority of the sample (90.5%) were in contact with mental health services or professionals at the time of the study, and very few recruits did not use any professional support. As such, current sample could have been early in the recovery process or more compliant than those not using any professional support.

Other researchers could have viewed the data from a different angle and could have arrived at a different theoretical framework. As in any study, subjectivity and previous background of researchers could have influenced the design, data collection and the analysis. The rigorous quality guidelines of classical GT, frequent discussions of the analysis by the researchers, verification of identified concepts by further participants and in the literature may have helped to reduce subjectivity and to improve theory building.

We did not always have direct control over recruitment as some participants were invited via representatives of peer support groups and mental health services. Distribution of the information letter and clarification of selection criteria may have helped to ensure consistency of recruitment.

5 Study Implications

The study's implications for mental health policy, practice, research and health promotion are presented in this chapter.

5.1 Implications for mental health policy and services

A Vision for Change recommends that all staff within rehabilitation and recovery teams should be trained in *recovery-oriented competencies and principles* (Department of Health and Children 2006). The work of recovery-oriented services can be guided by a vision of recovery developed in this study as a gradual progression of reconnection with life through reconnecting with self, others and time. In addition, the study provided an explanation of the underlying processes, tasks and individual strategies associated with reconnecting with life and demonstrated these to be flexible, modifiable, and therefore adaptable to any mental health practice (see Tables 3.1–3.3).

This study provides further clarification of the concept of person-centred *care* highlighted by *A Vision for Change*. Person-centred care requires a paradigm shift towards refocusing on the aspirations and goals of those recovering, and the vital importance of their input in care. Personally defined life goals should map the starting point of one's recovery journey, as opposed to being mapped according to the views of service providers (Connecticut Department of Mental Health and Addiction Services 2006).

With regard to mental health services, the findings show that reconnection with life involves multiple aspects of spiritual, emotional, cognitive and physical functioning. Development of *multidisciplinary teams and community services*, as recommended by *A Vision for Change*, is essential for recovery oriented services (Department of Health and Children 2006).

Day centres were highly valued by participants for providing space for development, education, training, and peer support. Day centres assisted with reconnection with self, others and time by providing social, educational, artistic, and physical activities. The work of recovery-oriented community rehabilitation services should be supported, funded and further expanded to make reconnection with life in the community possible. The guidelines for recovery-oriented care developed by Yale University, and echoed in the results of the present study, can be a useful guide for further improvement of community mental health services (Connecticut Department of Mental Health and Addiction Services 2006).

The contribution of other expertise beyond specialised professional knowledge should be welcome in the treatment context. Such *multiple expertise* could include peers, peer support groups, carers, religious groups, primary care providers and others supports available in the community. The benefits of voluntary and community support groups should not be underestimated, as their work may result in reducing the need for, and potentially the cost of, mental health services. This requires further exploration and cost/benefit analysis.

The study showed that peer support groups such as GROW are not readily available in most rural areas, with most of them located in urban or suburban areas. It may be helpful to explore geographical distribution of peer support groups and community services in order to identify areas where both, either, or neither are within easy reach.

Quality and effectiveness of recovery-oriented services can be monitored through independent and anonymous audit of service users' and their carers' satisfaction with a specific service or therapy. Such audits can employ a mixed methods approach aimed at eliciting both satisfaction scores and qualitative reasons behind satisfaction or dissatisfaction.

5.2 Implications for recovery-oriented mental health practice

The underlying processes, tasks and individual strategies associated with reconnecting with self, others and time laid out in tables 3.1–3.3 of the report can be a useful tool for mental health practitioners to tailor their services to a specific person-centred recovery-oriented treatment context. In addition, some key study implications applicable to all recovery-oriented treatment contexts are presented below.

Facilitating reconnection with self

The work of service providers should be focused on active reconnection of service users with self through developing hope, *self-determination and self-confidence*. Individual strategies of reconnecting with self emerging from the participants included self-talk, learning, exercising, deep breathing, taking medication and reasoning. Such individual strategies facilitated underlying processes of reconnecting with self, such as getting back to here and now, reawakening of hope and will to get better, and designing and executing own recovery. Service providers should actively discuss and support the tasks and strategies of individual recovery and provide positive and constructive feedback on the achievements of agreed tasks of reconnecting with self and life (see Table 3.1).

Facilitating reconnection of self with others

The underlying processes, tasks and individual strategies associated with reconnecting self with others are laid out in Table 3.2. This study provided evidence that elements of person-centred, recovery-oriented care already exist in the Irish mental health services. Participants complimented psychiatrists, nurses, psychotherapists and other professionals for their *understanding, empathy, encouragement, sense of humour, and listening skills*, which facilitated their reconnection with self and others. Such qualities need to be supported and expanded, and used as positive examples of elements of recovery-oriented care.

This study also provided evidence that depersonalised and pessimistic attitudes and behaviours often dominate over a person-centred, empathic and accepting care within the Irish mental health services. Service users should be encouraged to talk at length, narrate their story, voice their concerns and aspirations towards recovery, and participate in a dialogue with service providers. Standardised questionnaires should not dominate over person-centred methods.

Belief in recovery needs to be shared by both service users and professionals. To be able to nurture and support recovery, service providers may need to question some pessimistic assumptions likely to have been acquired during their training, and paternalistic relationships with patients which were so prevalent in the past (Mead and Copeland 2000). Curiosity, benevolence and self-reflection can help service providers to refocus on the recovery of their service users (Buchanan-Barker 2009).

Acceptance and validation, the key characteristics of meaningful connection emerging from this study, are essential in many evidence-based talking therapies, including cognitive behavioural therapies (CBT) and dialectical behavioural therapy (DBT) (Hazelton *et al.* 2006). Principles of DBT such as acceptance, validation, mindfulness and change can facilitate reconnection with others and promote the trust and motivation necessary for reconnection with life. Our study suggests that such principles should underlie recovery-oriented service provision at all levels and times, regardless of the immediate availability of CBT or DBT in a specific treatment context.

Facilitating reconnection with self, others and time

The underlying processes, tasks and individual strategies associated with reconnecting with self, others and time are laid out in Table 3.3. Such underlying processes as seeing a positive future, coming to terms with the past and planning and executing one's present should be supported by the mental health services through talking, listening, and planning of activities with service users. Recovery-oriented mental health services should aim to help the person to find reasons behind being 'stuck' or 'trapped', and to become aware of what needs to be changed in order to start 'moving on'. For example,

the initial assessment can start with simple yet powerful questions such as ‘What happened? And what do you think will be helpful? And what are your goals in life?’ (Connecticut Department of Mental Health and Addiction Services 2006, p.11).

The Tidal model of nursing developed in the 90s on the basis of what patients and their families needed from and valued in nursing (Stevenson *et al.* 2003) fits with the current theory and could be effectively used in mental health education (Buchanan-Barker 2009). Among the 10 Tidal commitments of caring are: developing genuine curiosity about the person and his life; becoming the apprentice rather than master of healing while learning from the person what needs to be done. The Tidal model is congruent with the claims of the study participants that they had to design their recovery themselves, but needed the support from other people to formulate their specific needs and goals and to follow them through trial and error.

Subjective scores of recovery on good and bad days, shown in Appendix B, can be a helpful tool for setting person-centred goals, selecting the best available and suitable therapies and activities, and measuring individual progress of recovery. In this study participants rated their scores on a scale of 0 (complete disability) to 100 (complete recovery) and provided qualitative descriptions of their current and desired states. The effectiveness of suggested scores for personal recovery planning should be evaluated in mental health practice. Individual strategies for turning bad days into good days, as discussed in the study, and thus avoiding crises should be also explored and evaluated by the mental health services. More detailed recommendations for mental health education and practice development are laid out in a PhD thesis based on this study available from the first author.

Towards recovery-oriented pharmacology

Appropriate recovery-oriented use of medication should be based on *shared decision-making* between service users and service providers, and aimed at agreed goals of reconnecting with the daily life of service users. A guide for service users, carers and practitioners on medicine management published by the UK Department of Health can be useful for applying a person-centred approach to the use of medication (NIMHE National Workforce Programme 2008).

Service users’ subjective experiences of the positive, negative, or neutral effects of medication on their reconnection with self, others and time should be explored, evaluated and taken into consideration for future planning of recovery-oriented care.

5.3 Implications for mental health research

Studying mental health, recovery and resilience in addition to mental illness and distress will benefit the population health knowledge base and should be included in the national research agenda. Mental health and resilience can contribute to positive health outputs and protect from the negative consequences of an economic downturn (The European Commission 2009).

The identification of the main concern of service providers regarding the implementation of recovery principles within the Irish mental health services could facilitate policymakers' understanding of how better to structure and support recovery within mental health care. A study involving focus groups or individual interviews with psychiatrists, nurses, and other professionals could highlight further directions for policy planning and streamlining of funds.

Subjective scores of reconnection with life on good days, bad days and in the desired future could be further explored and tested as potential measures of personal recovery progress. In addition, existing constructs fitting the identified subcategories of reconnecting with self, others and time, such as hope, self-determination, spirituality, empathy, temporality and others could be explored in terms of their potential application to measuring a degree of achieved or desired reconnection with life, or a current level of disconnection from life.

Qualitative research findings should be included in evidence-based medicine and systematic reviews as they lead to creative and innovative practices (Glasby and Beresford 2006). In addition, narratives are highly effective in health promotion campaigns (Davidson *et al.* 2008).

5.4 Implications for mental health promotion

It is hoped that this study will aid mental health promotion by informing the Irish public about the possibility and reality of recovery, and will help to reduce the stigma associated with mental health problems. Notwithstanding the influence of biological, genetic, social or other factors, mental health problems can affect anyone during difficult times (World Health Organization 2007). The *HRB National Psychological Wellbeing and Distress Survey* showed that in Ireland approximately 12% of people were experiencing distress at any given time (Tedstone Doherty *et al.* 2007a). Public attitudes to mental health should therefore be refocused on viewing persons experiencing mental health problems as part of 'us', rather than the genetically or socio-economically predetermined 'them'. Services and supports should therefore be designed to be able to accommodate any of us, as opposed to some of 'them'.

The good news about seeing recovery as a gradual reconnection with life is that with proper support, it is open to all who are ready to start fighting for such reconnection. We would like to conclude this report with a message from one of the study participants:

It's good to be recovered. And everybody will recover sooner or later ... It's very important to believe.

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Appendices

Appendix A Information letter for participants



Improving health through research and information

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Recovering from recurrent mental health problems: What does it mean to you?

Dear Sir/Madam,

The Health Research Board is carrying out a study to find out what 'recovery' means for different people who have experienced recurrent mental health problems. '*Recurrent mental health problems*' for our study means that a person has experienced mental health problems more than once over a period of two or more years. An example of recurrent mental illness could be serious depression or schizophrenia.

Please note that you do not have to be a user of mental health services in order to participate in this project. We are looking for any persons who have experienced mental health problems more than once over a period of two or more years prior to the study, consider themselves to be in improvement and feel relatively well to tell us about their experience in a confidential interview.

What has this got to do with you?

We would like to hear about your personal experience of recovering from mental health problems, what difficulties you have had at different times, and what helped you

to get through them. Such information will help to make recommendations to service providers and policymakers and combat stigma by letting the public know real stories about mental health difficulties and recovery.

How do you tell us about your experiences, needs and recovery?

You are invited to have a private interview with Yulia Kartalova-O'Doherty, who is an HRB researcher. The interview will be completely *anonymous*, this means that no-one else will find out what you have said, and no personal information (e.g. personal names, addresses, organisations, etc.) will be included in the study report. Please also note that participation in this study does not form part of your treatment. If you take part in this study you are covered by an approved policy of insurance in the name of the Health Research Board. It is also entirely *voluntary*, so if you feel like stopping at any stage you can do so.

To be involved you need to contact us:

If you want to find out more or are willing to help with this study, or even if you have questions or comments, please phone Yulia Kartalova-O'Doherty:

- Phone [01 234 5144] or [mobile phone number]
- E-mail ykartalova@hrb.ie

What will be involved in the interview?

- The interview will take between 45 and 90 minutes.
- It will be arranged in a place that suits you.
- The information you share with us during the interview will be available to the researcher only and no identifying details will be disclosed.

If you know any other persons who have recurrent mental health problems and who might be interested in the study, please feel free to give them the contact details.

With your help, the findings of the study will be published by the HRB and made available to the public. We appreciate your time and effort; your experience is very important to us.

Yours faithfully,



Yulia Kartalova-O'Doherty
Researcher

Appendix B Three self-assessed scores of recovery

- 1) Imagine you are having a good day.

On a scale from 0 '*complete disability*' to 100 '*complete recovery*', how would you rate your current level of recovery on a good day? What would be your highest score on a good day?

Please write down your score here: _____

Please describe your feelings, thoughts and actions on a good day.

- 2) Imagine you are having a bad day.

On a scale from 0 '*complete disability*' to 100 '*complete recovery*', how would you rate your current level of recovery on a bad day? What would be your lowest score on a bad day?

Please write down your score here: _____

Please describe your feelings, thought and actions on a bad day.

- 3) On the scale from 0 '*complete disability*' to 100 '*complete recovery*', how would you rate your desired level of recovery? Where would you like to be in the future, what would be your desired score?

Please write down your score here: _____

How would you like to feel, what would you like to be able to do when fully recovered?

