“I don’t believe I’m going to recover from anything.” Understanding recovery amongst people with severe mental illness attending community health services in Spain

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"I don't believe I'm going to recover from anything."
Understanding recovery amongst people with severe mental illness attending community health services in Spain

Abstract

Purpose: The concept of recovery has become the backbone of mental health services and professional practices. However, research aimed at analysing the conceptualisation of recovery of people diagnosed with severe mental illness (SMI) has an obvious Anglo-Saxon bias. Our objective was to analyse what a sample of 51 users of mental health services diagnosed with SMI in Spain understand by recovery.

Method: The participants were interviewed in depth about their concept of recovery, and their responses were thematically analysed by three observers.

Results: Four categories of definitions of the concept of recovery were found in the analysis: Socio-Behavioural, Biomedical, Resistance, and Wellbeing-Growth. Inter-rater reliability scores ranged from 0.7 to 0.84 according to Krippendorff's alpha. While the Biomedical category essentially corresponded to the idea of clinical recovery, the Wellbeing-Growth category reproduced the concept of personal recovery (PR) that is dominant in the literature. The most frequent categories were Socio-Behavioural and Biomedical. Assimilation of the PR concept by participants was quite limited. The markedly relational character of the most frequent categories challenges the individualistic core of the classic definition of PR.

Conclusions: We advocate the need to make alternative recovery concepts and narratives visible to the mental health services' users and practitioners.

Keywords: Mental Health Recovery, Community Health Services, Severe Mental Illness, Schizophrenia, Bipolar Disorder, Culture.

Introduction

Over the past three decades, the concept of personal recovery (PR) in mental health has transformed our understanding of serious mental illness (SMI) and also health and social services. Anthony [1] defined recovery as a process specific to each person, with the aim of developing, despite the experience of illness, new meanings and purposes, and thus, achieving a meaningful life. Other authors, such as Shepherd et al. [2], described recovery as a set of values regarding people's rights to build a meaningful life with or without the presence of symptoms. It is important to differentiate clinical recovery from PR. The first refers to curing the disease or reducing symptoms from a strictly biomedical perspective. The second is intimately related to self-determination, maintaining hope, and building a meaningful life [3]. In a systematic review, Leamy et al. [4] clarified the PR concept by defining its five most therapeutically relevant processes. They state that PR is based on the "Connectedness", "Hope and optimism about the future", "Identity", "Meaning in life", and "Empowerment" processes, which they identified with the acronym "CHIME".

After analysing these different approaches to the concept of PR, we consider the elaboration of new meanings, which implies a reconstruction of identity, to be its cornerstone [5]. The diagnosis of an SMI represents a turning point that requires simultaneous re-elaboration of life stories and changes in identity. This narrative work is necessary for both improvements of health and social integration in people diagnosed with SMI. The subjective nature of PR has led to significant challenges, as its key objectives are qualitative and depend on the individual perspectives of those affected. As a result, the idea of PR has encouraged qualitative research on people with SMI's own narratives.

The definition of PR is very complex and according to some authors, ambiguous [6]. The ideas of identity resignification and reconstruction that it is based on are very abstract and sometimes hard to integrate. For example, although the canonical definition of PR is incompatible with the aim of returning to normality, some of those affected continue to use this idea as a sign of a successful journey to recovery [7].

The importance attributed to the recovery narratives of people diagnosed with SMI has led some authors to advocate the existence of a specific recovery narrative genre [6]. This narrative genre is promoted and disseminated by health and social institutions

in the belief that the construction of such narratives and their dissemination favour recovery amongst people with SMI [8].

In recent years, many researchers have tried to elucidate the main categories that people affected believe underlie recovery and the narratives associated with it [9–11]. Two ideas seem to be widely agreed upon: recovery requires achieving an acceptable quality of life and feeling better about oneself [10]. In general, their conceptualisation has been found to be similar to the CHIME model categories [4], even in different countries [11]. Although the conceptual framework on which mental health programmes are developed and recovery narratives are built are considered valid, these authors conclude that further research using more diverse research designs adapted to other non-English speaking cultures is a priority. Since the vast majority of studies on the conceptualisation of recovery are conducted in English, it is reasonable to doubt their validity in other cultures [11].

Although the recovery model is consistently present in guides, manuals, protocols and official documents, it raises several problematic questions. The definition of recovery has the individualistic bias typical of Anglo-Saxon cultures, posing recovery as a moral imperative and leaving relational, political, and social aspects in the background [6,12]. For example, O'Brien [12] through in-depth interviews with 31 women diagnosed with depression in Australia reveals the moral imperative to recover hidden by liberal discourses about recovery. The women interviewed by O'Brien felt themselves blamed and under pressure for not being able to fulfil the expectations associated with individualistic recovery discourses. In the same sense, other research has suggested that some patients diagnosed with anxiety and depression may also feel themselves under pressure to show autonomy and empowerment [13].

Offering an alternative perspective from data on family recovery, Price-Robertson et al. [14] coined the term relational recovery to emphasise the inescapable relational nature of all recovery processes within a specific social context, which are obscured by this individualistic Anglo-Saxon bias. In the same article they mention that "(i)ndividualistic recovery approaches are simply not up to the task of dealing with the full range of experiences, identities and challenges faced by many people living with mental ill-health" [14, p.117]. This perspective opposes positioning the individual at the focus of recovery, and instead proposes sensitization to the influence of the family environment [14].

Furthermore, according to Slade et al. [11], some research exploring conceptualisation of recovery has focused exclusively on PR, explicitly excluding other alternative approaches to the concept, which impedes analysis of people diagnosed with SMI's assimilation of the canonical definition. These and other drawbacks can lead to confusion, causing undesirable iatrogenic effects in implementing the PR model in health systems. For instance, individualistic approaches to the conceptualization of recovery could decrease adherence and commitment to treatment in collectivist and family-oriented communities. Moreover, a recovery approach based on perception of the person as self-sufficient, self-determining and independent risks shifting the care of people with SMI from a collective responsibility to the private responsibility of the individual, disregarding their social context, and also, the necessary consideration of cultural values and meanings [15].

Our objective was to explore the conceptualisation of recovery in a sample of users of the Spanish public social and healthcare services diagnosed with SMI. Our research design enabled the analysis of alternative definitions to PR, making it possible to explore a wider range of conceptualisations. Our specific objective was to find the essential categories that articulate this concept in a non-Anglo-Saxon population and discuss the differences. As far as we know, this is the first study of its kind in a Spanish-speaking population.

Method

Participants

The sample comprised 51 users of public mental health services in Andalusia (Southern Spain) who were diagnosed with a severe mental illness (SMI), mainly psychotic, bipolar, and/or personality disorders. All these SMI involve some deficit in social functioning and prognosis of a prolonged course of illness. Recruitment was carried out at two different mental health services in order to have a wider range of illness and treatment experiences. First, people receiving psychological treatment in a community mental health centre (CMHC) were invited to participate (n = 17). Users of an employment guidance service (EGS) specialised in supporting people with SMI were also included (n = 34). The representation of these two different populations was considered useful for the acquisition of a wide range of conceptualizations of recovery, enhancing

variability. All participants were receiving psychosocial and/or pharmacological treatment at the time of the interview.

Participants voluntarily signed their informed consent and received no financial compensation for their collaboration. Sociodemographic data are presented in *Table 1*. As can be seen, the CMHC participants were younger, mostly male, had a higher level of education, higher prevalence of psychotic disorders, fewer years since diagnosis and more hospitalizations than the participants in the other group.

Table 1.

Sample sociodemographic data.

	Community Mental Health Centre (CMHC) (n = 17)	Employment Guidance Service (EGS) (n = 34)
Mean age (*SD*)	27.9 (4.58)	41.8 (9.86)
Sex		
Male	76.5%	47.1%
Female	23.5%	52.9%
Education		
None	0%	11.8%
Compulsory	35.3%	35.3%
High school or professional school	5.9%	38.2%
University	58.8%	14.7%
Diagnosis		
Psychotic disorders	70.6%	41.2%
Affective disorders	23.5%	17.6%
Personality disorders	0%	32.4%
Other disorders	5.9%	8.8%
Years since diagnosis		
0-5 years	58.8%	29%
6-15 years	35.3%	32.3%
Over 15 years	5.9%	38.7%
Hospitalisations		
Zero	0%	29%
One	42.9%	32.3%
Two	21.4%	20.8%
Three	21.4%	16.7%
More than three	14.3%	12.5%

Instruments

The interview was designed based on the methodological premises of *community-based participatory research* after an analysis of the literature [17]. First, two of the

authors designed the interview with a focus group of people with SMI who had different diagnoses, education levels, sex, and ages. They discussed a first draft and several conceptualizations of recovery found in the literature. They were also asked to formulate the questions they considered most important for someone who has been diagnosed with a SMI and is in the process of recovering. The leader of an association of people with SMI, and two professionals, experts in community support, acted as external consultants.

A preliminary version of the interview was drafted taking this information into account. It consisted of a 12-question semi-structured interview aimed at exploring their definitions of recovery, and the obstacles and resources to considering themselves recovered (see Figure 1). It was given to two participants in a pilot test, and the questions were understood properly and elicited responses on the topics of interest to the researchers. Slight modifications were made in the expression of some questions in the final version as suggested by these participants. SPSS ver. 25 was used for sociodemographic data distribution analysis of recovery definitions in the sample.

1. Could you explain the reasons why you are attending this service?
2. Could you describe to me how your diagnosis has affected your life?
3. Has the way you think about yourself changed after your diagnosis?
4. How do you think society view people with mental disorders?
5. Can you recall an example of a situation in which you have been discriminated against for having a SMI diagnosis?
6. How would you define recovery?
7. Do you think you are in the process of recovering?
8. What aspects make you think you have, or have not fully recovered yet?
9. Could you give an example of what you have noticed to feel like you are in the process of recovery?
10. Have you come up against any obstacles or found something that has helped in this process?
11. If you were to go to a job interview, how would you convince the interviewer of your right to work, even if you are diagnosed with SMI?
12. Imagine yourself, for example, on any given day three years from now. Could you describe in as much detail as you can what your life would be like that day?

Figure 1. *Guiding questions of the interview.*

Procedure

The research was endorsed by the public health services ethics committee (opinion code: 0339-N-17/12-July-2017). Potential participants, who fulfilled the inclusion criterion of having at least one diagnosis of SMI, were first contacted by the directors of the public EGS and CMHC and explained the general objectives of the research. Then they were referred to the research team so they could participate in the study if they were interested and were given an appointment for an individual interview at the EGS or CMHC. Any doubts as to the purpose of the research were clarified. Then they were asked to sign their voluntary intent to participate, as well as consent to data transfer. They were informed that they could withdraw from the study at any time. The oral interviews, lasting an average of 29 minutes, were recorded on audio and transcribed verbatim.

Analysis

The interviews were studied by inductive thematic analysis, following Braun and Clarke [18]. The objective of this method is to identify and analyse patterns of qualitative information without trying to fit it into a pre-existing coding framework. A category or topic was defined as a statement synthesising the information related to the research questions and involves a meaningful articulation of the participants' answers.

Following this methodology, the interviews were analysed in iterative stages. The most important objectives are presented in *Figure 2*, showing the research team's independent (i) and collective (c) actions. First, each interview was read in-depth, so the researchers could become familiar with the transcripts. Each observer selected all the extracts and statements mentioning the participants' ideas of recovery and coded them according to its concept of recovery. Various monographic meetings were held in which these codes were shared. Codes were included in the study if the three observers independently selected the same extracts and agreed on their coding. Discrepancies were discussed until consensus was met. At the same time, codes that appeared to be associated were grouped together in categories. The categories were developed from the initial codes, returning to them when new categories might be possible following the emergence of new ideas during the interviews. This stage ended when saturation was reached, and no more examples were identified that could be included under these categories. Five second-level categories were identified and defined in this way.

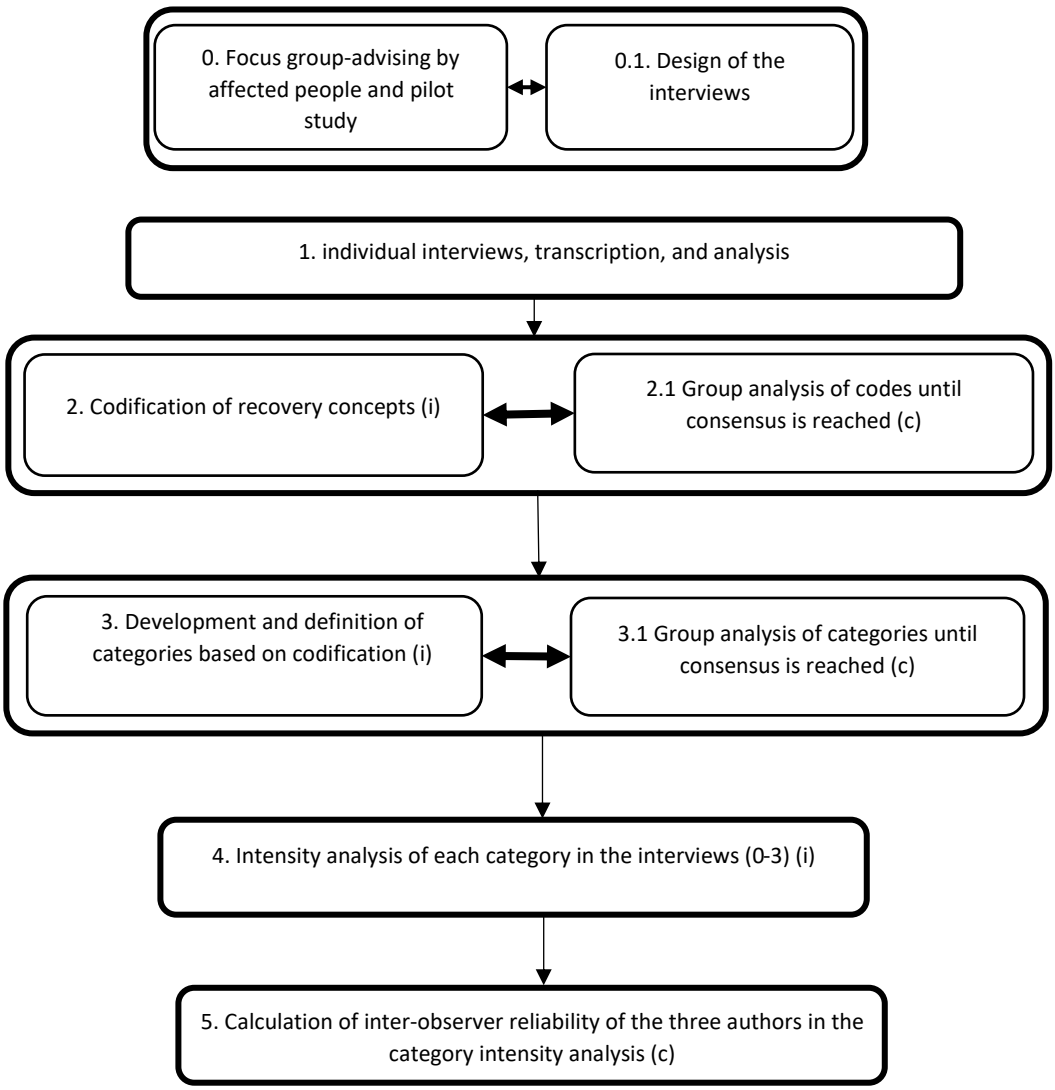

Figure 2. *Information collection and analysis procedure*

Later, three observers independently codified all the interviews using these five categories as independent dimensions, because more than one could appear in the same interview. The intensity with which each category appeared in each participant's interview was rated on a Likert scale from 0 (no intensity) to 3 (high intensity). High intensity (3) indicated that all or most of the codes in a category were identified throughout the interview, or that a few of these were developed in great depth. On the contrary, no intensity (0) in a category denoted no codes at all identified in their discourse. The intensity analysis allowed to better characterize the diversity of recovery definitions, beyond the presence or absence of each category. It also enabled to analyse the distribution of these categories in the sample using statistical tests.

Finally, the Krippendorff index was calculated for inter-observer reliability verification [19]. This analysis demonstrated that they could be systematically employed by different independent observers, in order to double check their reliability. These statistics are presented in *Table 2*. This analysis eliminated one of the categories, called "cognitive change", as there was insufficient agreement on it. This category involved a different mental state due to redefinition of life experiences. Its Krippendorff index was very low (0.59), and it overlapped with the wellbeing-growth category. Following the Krippendorff cut-off criterion [19], it was therefore eliminated from the results.

Table 2.

Summary of the results in relation to the four definition categories of recovery, including their average intensity and frequency of occurrence.

Category	Codes	*Kα*	*M*	*SD*	*f*
Socio-Behavioural	- To be active - To set goals - To have a job - To socialize (friends, family, co-workers) - To learn (New skills and capabilities)	0.74	1.52	1.07	40
Biomedical	- Absence or reduction of symptoms or disease - Return to before diagnosis or normality - Treatment and / or medication - Healing or stability	0.83	1.54	1.21	36
Resistance	- Fight, will and resistance - Ups and downs, getting up from falling down - Difficulties and obstacles - Scepticism of recovery	0.83	0.48	0.76	18
Wellbeing-Growth	- Wellbeing and quality of life (with or without symptoms) - Harmony and maturity - Identity change - Positive aspects of the disease (gift, growth)	0.69	0.53	0.93	17

In addition to these reliability analyses, Spearman correlations and Mann-Whitney *U* and Kruskal Wallis (*H*) tests, suitable for nonparametric samples, were performed to test the effect of socio demographic variables. Rosenthal's *r* and squared epsilon (ε^2) were calculated as measures of effect size. These statistics are shown in Table 3.

Results

Our general objective in this study was to explore conceptualisation of recovery in a sample of users of social and healthcare services diagnosed with a SMI. The most significant results are summarised in *Table 2*. It contains the codes that made up the four

categories, which we called Biomedical, Socio-Behavioural, Resistance and Wellbeing-Growth. For each category, the Krippendorff's alpha reliability indices (Kα), the mean intensity (*M*), its standard deviation (*SD*), and the coding frequencies (*f*), understood as the number of times that category appeared in the 51 interviews, are also included.

In the first place, we can emphasise that the agreement in the category intensity analysis was acceptable in all cases, and even very good according to Krippendorff's [19] interpretation. Two blocks showed important differences in frequencies and intensities: on the one hand, the Biomedical and Socio-Behavioural categories, and on the other, Wellbeing-Growth and Resistance. The first were more frequent, appearing in more than half of the 51 interviews, and with an intensity which, on the average, tripled that of the second block.

In the second place, we analysed whether these four categories were related to any of the sociodemographic variables. Due to the characteristics of the sample, the basic statistical assumptions of normality and non-homogeneity of variances could not be guaranteed. Therefore, nonparametric statistical analyses were carried out to verify the intensity distribution in the four categories found in the sample based on the sociodemographic variables. As shown in *Table 3*, no significant differences were found between groups based on any of the sociodemographic variables: gender, education level, diagnosis or type of centre. Their effects sizes (r and ε^2) were null or small. Neither were any significant correlations found between the intensity of the four categories and quantitative variables such as age, number of years since diagnosis or the number of hospitalizations or admissions (*Table 4*).

The four categories are described below using the *in situ* analysis of significant excerpts from the interviews. Some extracts from the interviews that can illustrate each of the categories observed are presented, attempting to represent the sample's diversity of gender, age, and diagnoses. To safeguard their anonymity, fictitious names have been used to refer to each of the participants.

Table 3.

Comparisons between sociodemographic groups considering the intensity of the categories.

	U	*H*	*df*	*p*	*r*	ε^2
Socio-behavioural						
Type of Centre	238	-	-	.368	0.13	-
Sex	304	-	-	.936	0.01	-
Educational Level	-	.202	3	.977	-	0.01
Diagnosis	-	3.86	3	.277	-	0.08
Biomedical						
Type of Centre	234	-	-	.323	0.14	-
Sex	277	-	-	.529	0.09	-
Educational Level	-	3.16	3	.367	-	0.06
Diagnosis	-	.905	3	.824	-	0.02
Resistance						
Type of Centre	262	-	-	.651	0.06	-
Sex	240	-	-	.112	0.22	-
Educational Level	-	2.61	3	.455	-	0.05
Diagnosis	-	.628	3	.890	-	0.01
Wellbeing-Growth						
Type of Centre	232	-	-	.219	0.17	-
Sex	241	-	-	.108	0.23	-
Educational Level	-	3.57	3	.311	-	0.07
Diagnosis	-	1.92	3	.589	-	0.04

Table 4.

Correlations between the intensity of the categories and age, years since diagnosis and the number of hospitalisations.

	Age		Years since diagnosis		Hospitalisations	
	ρ	*p*	*ρ*	*p*	*ρ*	*p*
Socio-behavioural	-.083	.567	-.016	.916	.065	.652
Biomedical	-.108	.456	-.021	.885	-.116	.424
Resistance	-.277	.052	.188	.201	-.122	.399
Wellbeing-Growth	.219	.126	.145	.325	.234	.102

Socio-Behavioural

This category was the most frequent. It emphasised being active, socialising, setting goals, learning, and developing skills, or making the effort to do so. While other categories were projected inward, in this one, recovery was projected outwards. When asked, “How would you define recovery and what would it be for you?”, as can be seen in *Excerpt 1*, claimed to be recovered when they can socialise and find goals:

Excerpt 1: Federico. 27-year-old male, bipolar disorder:

> "Having a job. Having a girlfriend and going out with friends. Because I don't have a job, I don't have a girlfriend and I don't go out much with friends, I have not recovered. Although right now, according to the symptoms, I have recovered." (CMHC11)

This excerpt is significant because the participant stated that he had not recovered due to social and relational issues, although he acknowledged that he had "recovered" from his symptoms. Therefore, the participant clearly differentiated between the social and the psychopathological aspects of recovery. According to Federico, there is no recovery without complete participation in the relational and social world. Therefore, he mentions work first, since financial independence makes it easier to participate in social activities, such as leisure with friends or partners. In addition, employment is an essential social context for recognition of people affected as full citizens (not only as a user of services but also as a taxpayer).

Excerpt 2: Sergio. 44-year-old male, personality disorder:

> "Recovery is related to places like this, because in psychological illnesses there is a tendency towards isolation, so you have to break down those barriers, and places like this one allow you to socialize, meet more people like you, ... And they can inspire you, and you socialize and find goals, right? For example, the goal I'm working toward now, which is to get a job. And I guess that's the important thing, right? And the power to evolve and socialize" (Are you recovering? What examples of recovery can you give me?) "Yes, look, I am a person who is capable of talking to a wall, I relate to anyone, but it has to be forced. (...) That is, if I do not have a job, if I am not in a situation that forces me to, I don't leave my house. However, by coming here, I have made four friends, and on Fridays... or that is, Monday, Wednesday and Friday, I go out with them. We eat, have a beer, non-alcoholic, of course, and we talk for a couple of hours and then we go back home. That is something I didn't do before." (EGS16)

In *Excerpt 2*, Sergio, a middle-aged man, pointed out the tendency to isolation of people with mental illnesses, and considered socialization and goal-setting as requisites for recovery. He specified the social scenarios that "force" him to socialize, such as having a job or going out with friends to have a drink. The importance of social events is demonstrated by the fact that Sergio included the context of the interview, "meeting

people like you", as a source of "inspiration" and socialization. At the beginning of the excerpt, he also stated that the EGS he attends forms part of the recovery process.

These two excerpts show the social, functional and relational character of the Socio-Behavioural category. In addition, learning new skills and setting goals are an important part of this, but the skills and goals are always directed towards the social space, for example, looking for a job, having a hobby or participating in activities.

Biomedical

The concept of recovery according to the Biomedical category is similar to a medical or healthcare point of view. Usually, it requires the absence of illness or reduction of symptoms, the idea of a return to the situation before diagnosis or to normality, reference to medical treatment or medication, and the notion of "cure" or "stability". Clinical terms or references to health professionals and mentions of adequate treatments appeared frequently in the participant interviews. For example:

> *Excerpt 3: Javier. 25-year-old male, paranoid schizophrenic:*
>
> "(To recover) is to be on the right medication, the one that is good for you, adequate, and to live in reality, to live, not to live, to live sane, not to live in madness or paranoia, not under a change, a sudden change of daily emotions, … I notice it, because I no longer have delusional ideas. I very rarely have hallucinations. It can happen, but it's very rare. I used to be used to it, and I'm not anymore." (EGS26)

Javier identified recovery with taking the "correct medication", not experiencing symptoms, such as delusions, hallucinations, or sudden mood swings. Although he acknowledged that they can still recur, because of the treatment, it is not very probable.

> *Excerpt 4: Lola. 58-year-old female, bipolar disorder:*
>
> (What makes you think you are recovered?) "I can feel it in everything. I want to do things, I am motivated, I don't forget anything when cooking, I do it well. I want to eat, to live, and before, I didn't feel like anything, nothing, nothing. … I have felt empty, very bad, very bad. Because I was very depressed. This doctor has helped me a lot, because I went to (doctor's name). And this doctor, then, ordered this treatment. I was taking Pristiq before, but it didn't work for me. And since he ordered another treatment, hey, I have evolved, improved more and more. And I said "Momma, this seems like a miracle." (EGS33)

Excerpt 4 shows a more complex conceptualisation of recovery. Lola described remission of a depressive phase of bipolar disorder. At first, she identified recovery with wanting to do things and with cognitive improvement: "I don't forget anything". Her first statement, "I want to do things", was related to the Socio-Behavioural category. Nevertheless, she later began a clinical discourse ("depression", "evolve"), mentioning clinicians and drug names. Lola claimed that it was the changes in medical treatment that had caused her "miraculous" improvement. Participants who had a biomedical conceptualization of recovery frequently referred to their psychiatrists or psychologists and their relationships with them when describing recovery.

Resistance

A third type of definition of recovery, less frequent than those above, is what we call Resistance. It is characterised by a willingness to resist disease, despite the lack of substantial changes in life. It involves being aware of the ups and downs of the process, as well as the importance of getting up after falling down. The participants are aware of the difficulties and obstacles to recovery, and in this sense, they present a more critical or sceptical perspective of the process itself.

For example, *Excerpt 5*, shows the willingness to resist in the face of what has happened to the participant:

> *Excerpt 5: Magdalena. 55-year-old female, depression and delusional thinking disorder:*
>
> "Waking up every day and erasing the day before. If everything went wrong today, if all the doors you knock on—which has happened to me—won't open… sleep. In sleep there is capacity for recovery (…) waking up every day by erasing the day before, when I get up, I start from scratch…" (EGC15)

Magdalena identified recovery with the ability to "start from scratch". She used the images of sleeping and waking up the next day as metaphors for the ability to recover. Recovery is not described as a point to be reached, not even through a process, but as falling down and continually getting back up, with the will to resist, even when "all the doors you knock on (…) won't open".

> *Excerpt 6*: Pablo. 26-year-old male, bipolar disorder:
>
> "Also, the issue of your illness being more manageable. Because until now I have not seen any mental patient who suddenly says, "I'm cured, I'm cured." No, you

always continue to have a defect, right? But that is what I think it (recovery) is. (…) Recovery… Since I'm still not recovered from this bump, I don't know how to imagine it, it's that I still haven't got out of this loop, right? Then, there will be good streaks, bad streaks, good days, bad days." (CMHS13)

In *Excerpt* 6, Pablo, despite still being quite young, showed a very sceptical outlook on recovery. He defined recovery as an illness that is more "manageable". The participant commented on never having seen a mentally ill person who said "I'm cured." For him, "You always continue to have a defect." In these two statements, apart from characteristics in the Resistance category, some qualities refer to the Biomedical category. Moreover, Pablo had problems imagining full recovery, and he understood that there are "good and bad streaks."

Other characteristics of the Resistance category are, for example, scepticism about a definitive or substantial recovery, the emphasis on obstacles, and also the cyclical nature of improvement and relapse along with a certain will to resist. Sometimes this willingness to resist is observable just in getting on with daily activities.

Wellbeing-Growth

Finally, the characteristics of the definition of recovery we call Wellbeing-Growth were related to the idea of achieving wellbeing and quality of life (with or without symptoms). It refers to finding harmony in life, feeling good about oneself, having the maturity necessary for recovery. The idea of an explicit or implicit change in identity and references to the positive aspects of the illness, understood as a capacity for growth and even as a gift, are features of this category. For example, Marcos in the *Excerpt 7* highlights how it is more appropriate for him to talk about growth than recovery. Also, he refers to a sophisticated process of self-discovery: "I'm more aware of what I am, who I am."

Excerpt 7: Marcos. 49-year-old male, bipolar and personality disorder:

"More than recovery, growth. … I appreciate all this, despite everything. … I am more in control of my life, I am more aware of what I am, who I am, my defects, my virtues, and that I can continue working, helping many people." (EGS20)

In *Excerpt 8*, Deborah, a middle-aged woman younger than the previous participant, emphasized the process of personal growth.

Excerpt 8: Deborah. 37-year-old female, personality disorder and psychotic episode due to substance abuse:

> "Recovery for me is an important personal growth process. … Well for me… the first thing is to realize that you have a problem, obviously, because if you don't realize that you have a problem, you are never going to recover. And then, you need to ask for help. It's very important to ask for help. It's therefore very important to become aware of yourself, and say "Well, let's analyse it..." What I'm doing is analysing everything, what is inside me, what is outside me, all that, and trying to take it on the path that I, the real me, my real self, deep down wants. And you need to really listen to what you are and what you are not from all the tangle of thoughts you have." (EGS22)

These two extracts show the character of discovery, change in identity and growth that recovery, understood from this point of view, implies. Cognitive verbs, such as "to analyse", "to realize", "to become aware", and nouns, such as "thought", or "real self" are frequent. This category implies identity rediscovery. As Deborah says, for recovery, "(…) you need to really listen to what you are and what you are not from all the tangle of thoughts you have."

As observed in some extracts, an important point is that different conceptualizations of recovery can coexist in participants. In fact, although according to different observers, the four categories presented clearly differentiated characteristics, the same participants frequently showed multiple interpretations and explanations. A good example of this is *Excerpt 9*.

Excerpt 9: Rosa. 46-year-old female, depression and bipolar disorder:

> "… I also understand recovery as having to return to a state that is normal. But I'm also wondering, well, what's normal? Because in my case, with bipolar, what's going on? So before when I was unwell, I was normal, and now I'm not normal? I've been living with the disease for 46 years now, so I don't think I'm going to recover from anything, but I have this disorder, that's how I am, and what I want is to live as best I can with my family and with my disorder." (EGC13)

Rosa, in addition to recognizing different definitions of recovery, was critical of some interpretations, and sought a personal explanation wondering "what's normal?" She began by identifying recovery with a return to a state of normality. This idea corresponds to a biomedical conception of recovery. But then, she reconsidered and rhetorically asked, "(A)nd now, I'm not normal?" After briefly reviewing her personal history, she angrily asserted that she is not going to recover from anything. What she wanted was good quality

of life with her family and her disorder. She used the expression "my disorder" literally, as if appropriating the diagnostic label. In this brief but intense dialogue with herself, Rosa moved from a biomedical perspective of the mental illness to a concept in which psychopathological problems were redefined and finally integrated in her identity. Thus, her concept of recovery was not limited to its medical facets but led to a conception related to the fourth category, Wellbeing-Growth. This category has a reflective character since that meaning redefinitions requires a substantial cognitive effort. The reflective nature of this category may be observed, for example, in Rosa's use of cognitive words (understand, wondering, think) or questions addressed to herself. In other words, this category, Wellbeing-Growth, requires internal dialogue.

Paradoxically, this participant stated that she understood recovery as a return to normality and thought that she was not going to recover from anything, characteristics of the Biomedical and Resistance categories, at the end, she concluded her reflection by approaching the core of the canonical definition of PR.

Discussion

In this study, we explored the conceptualisation of recovery in a sample of people with SMI in various contexts. Despite the pre-eminence of the PR model in both the academic field and in mental health services, our results show that the assimilation of this concept is very limited when participants are openly asked about it. Of the four resulting categories defining the idea of recovery, only the fourth, Well-Being-Growth, clearly fits the core of the canonical definition of PR [1,4]. In particular, this category emphasises identity change and personal growth beyond the disease. For these participants, recovery means a re-elaboration of their life stories and a resignification of their experiences, leading to an alternative perspective in life and a newly achieved personal maturity. This is the least prevalent category and the one that appears with the least intensity among the participants. In contrast, the most frequent categories are Biomedical, which corresponds to a clinical perspective of recovery, and Socio-Behavioural. The latter category is tangentially related to one of the dimensions of PR, for example, the "Connectedness" component in the CHIME model [4]. However, the emphasis of this category on adaptation, belonging and functionality limits its inclusion in the definition of PR.

Even in the Biomedical category, the abundance of references to clinicians, monitors and healthcare providers, sometimes referred to by name, reflects relational

characteristics. In fact, the Biomedical and Socio-Behavioural categories are often intertwined in the same participant. In this vein, some studies have highlighted the core function of a sense of community and feeling of belonging in the conception of recovery amongst young people who attended mental health services [13]. Moreover, as we have seen, other authors have criticized the individual bias in most definitions of recovery [14,15]. The individualist bias of PR discussed in the introduction can only be observed in the categories Wellbeing-Growth and Resistance, which were less frequent. The willingness to resist in the "Resistance" category could be compatible with PR. Nevertheless, because of its focus on obstacles and the scepticism of recovery, this category is far from the concept of PR.

The lack of significant differences between the intensity of the categories and sociodemographic variables like age, gender, diagnose or type of mental health services suggest that our categories are robust and that they are not related to those variables in our sample. However, as the sample size in our study was small for quantitative analyses, these results must be taken with caution and require further research. It would also be interesting to explore the relationship between the participants' conceptualizations of recovery and other measures of recovery, such as psychological wellbeing or social functioning. It might be expected that more sophisticated conceptualizations, such as Wellbeing-Growth category, could be related, at least partially, to better health, empowerment, recovery, and functioning [20].

The cultural and social differences in our results cannot be disregarded. In many countries, such as Spain, the PR model has penetrated later and less intensely than in the Anglo-Saxon world. Moreover, individualistic and psychological characteristics such as self-determination or empowerment are not easily grasped in an interdependent culture such as that of Southern Spain [21,22]. In this sense, some authors have coined the term relational recovery to emphasise the inescapable relational nature of all recovery processes that are obscured by this Anglo-Saxon individualistic bias [14,15]. Therefore, Anglo-Saxon service users may have been powerfully exposed to recovery narratives in public discourse and health services. They may even be led to adapt their narratives to the recovery narrative genre. For example, Hughes [13] found that their participants, young adults diagnosed with anxiety and depressive disorders, have felt compelled to "fake the change" before mental health professionals to gain a sense of autonomy and avoid letting down peers.

With respect to the Biomedical category, and practically parallel to the emergence of the PR model, biomedical aetiology has been proposed as an explanatory model for SMI, as a normalisation factor and antidote to public stigma in mental health [23]. Paradoxically, our participants have been exposed to these two hard-to-reconcile discourses. It seems evident that those participants who have been exposed more intensely to the biomedical discourse tend to have a clinical conception of recovery.

The qualitative nature of our research does not allow for the generalisation of results to other populations. For example, most of our participants were diagnosed with schizophrenia spectrum disorders and bipolar disorders. We cannot rule out that, in addition to culture, diagnosis may also influence the conceptualisation of recovery. In the future, the categories found should be validated with associated variables, such as symptom severity, social functioning, wellbeing, and others.

Summarizing, the participants understood recovery mainly from a social and biomedical perspective. The Biomedical category corresponds to the traditional concept of clinical recovery. Moreover, we did find a less frequent category, Wellbeing-Growth, that supports the ideas of identity reconstruction and creation of meanings which are the foundation of the PR. However, we also identified alternative definitions, such as the category of Resistance and Socio-Behavioural, which are only partially compatible with the concept of PR.

In view of the social and relational character of the recovery concept observed in this sample, mental health services should provide resources and scenarios to create community and sense of belonging as first strategies to promote recovery. For instance, the participation of people diagnosed with SMI in art workshops held in communitarian centres, museums, or galleries has shown efficacy in decreasing stigma and fostering social networks [24].

These results lead us to think about the recovery premises that structure mental health services. Mental health services and practitioners ought to recognise the intrapersonal and cultural diversity of conceptions of recovery. Otherwise, the overwhelming success and institutionalisation of recovery narratives and their possible individualistic bias could cause people to feel guilty for not having the resources to construct their identities according to those narratives [12]. Making visible this diversity would show that recovery is complex. It is not exclusively the product of the subjective

effort by affected people to reconstruct their identity nor it is a consequence only of the conquest of their autonomy. At the same time, it requires the existence of a healthy political, social, and relational context along with professional practices and adequate health services [25].

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Conflict of interest

The authors report no conflicts of interest.

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