

ABSTRACT

RECOVERED VOICES, RECOVERED LIVES: A NARRATIVE ANALYSIS OF PSYCHIATRIC SURVIVORS' EXPERIENCES OF RECOVERY

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The discourse of the medical model of mental illness tends to dominate people's conceptions of the origins and treatments of psychopathology. This reductionistic discourse defines people's experiences of psychological distress and recovery in terms of illnesses, chemical imbalances, and broken brains. However, the master narrative does not represent every individual's lived experience, and alternative narratives of mental health and recovery exist that challenge our traditional understandings of normality and psychopathology. Using the method of interpretive interactionism, I examined how psychiatric survivors position themselves in relation to the medical model's narrative of recovery. In its inception, the psychiatric survivor movement created a counter-narrative of protest in opposition to the medical model's description and treatment of psychopathology. Since then, the movement has moved beyond the counter-narrative and has constructed an alternative narrative; one that is not defined in opposition to the master narrative but instead participates in an entirely different discourse.

RECOVERED VOICES, RECOVERED LIVES:
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SURVIVORS' EXPERIENCES OF RECOVERY

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Table of Contents

Introduction.....	1
Narrative Psychology.....	1
History of Psychiatric Survivor Movement	5
Narratives of Recovery	9
Survivors’ Perspectives on Recovery	12
Medical Model as Master Narrative	17
Researcher’s Positioning in Relation to Current Study	20
Method.....	22
Interview and Recruitment Procedure	22
Analysis of Narratives.....	23
Results.....	25
Dialogical Positioning of the Researcher’s Voice	25
Presentation of Results.....	26
Recovery as a Process.....	27
Recovery from the Mental Health System.....	29
Surviving Trauma	34
An Epiphany of Human Compassion	35
Recovered Voices, Recovered Lives	37
The Myth of Incurability.....	41
Deconstructing Recovery.....	44
Recovery and the Good Life.....	46
It’s Not All About Me: Destiny and the Good Life	51
Consciousness-Raising and Participation in Counter-Cultural Communities	53
Discussion.....	59
Traditional Constructions of Recovery: Recovery as a Process, Recovery from the Mental Health System, and Surviving Trauma.....	59
Turning Point: An Epiphany of Human Compassion.....	61
Revisioning Recovery: Recovered Voices, Recovered Lives, and the Myth of Incurability	62
Turning Point: Deconstructing Recovery	63
Re-Constructing Recovery: Destiny and the Good Life	64
The “Empty Self,” American Psychology, and the Good Life.....	67
References.....	71
Appendix A.....	75
Appendix B.....	77
Appendix C.....	78

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Recovered Voices, Recovered Lives: A Narrative Analysis of Psychiatric Survivors' Experiences of Recovery

People live in a storied world filled with many discourses, narratives, archetypes, metaphors, and knowledge with differing degrees of privilege within various societies. In order to organize their existence within this world, persons narrate their experiences and in doing so create life narratives that relate their past to their present and imagines possible storylines of the future. The organization and structure of a person's life narrative provides insight into one's psychological meaning-making processes. People's life narratives are never static, changing constantly in relation to new experiences and interactions. My interest in narrative analysis grew out of wanting to understand why people tell their stories in a particular way. I look at what cultural, social, or political discourses shaped their telling and structure of the narrative, and how they use language and metaphor to give a voice to their experiences and feelings.

A group of individuals who identify themselves as psychiatric survivors has been steadily growing in numbers, strength, and voice since the early 1970s. Most psychiatric survivors are vocally critical of the current mental health system and its symptom-focused, medical model approach. This critique applies both to the model's treatment practices and its way of conceptualizing mental distress and recovery. Beresford (1999) points out that "survivors are increasingly challenging the medicalisation of their distress and perceptions and rejecting psychiatry's preoccupation with causation and its denial of their feelings and legitimacy" (Beresford, 1999, p. 45). As a future clinical psychologist and ally of the survivor movement, I am interested in survivors' subjective experiences of emotional distress as well as how each individual defines and narrates the recovery process. Using Denzin's (2001) method of interpretive interactionism, I interviewed several psychiatric survivors about their experiences of recovery, analyzed and interpreted their narratives in relation to the dominant social discourse of the medical model of mental illness.

Narrative Psychology

Over the past twenty years, many psychologists have taken a narrative turn in their way of thinking about people in dialogical relation to others and their social world (e.g., Bruner, 1990; Frank, 1995; Hawkins, 1999; Josselson, 1995; Klienman, 1988; McLeod, 1997; Polkinghorne, 1988; Robinson & Hawpe, 1986; Sarbin, 1986; Schafer, 1992; Spence, 1982; White & Epston, 1990). For example, Sarbin (1986) has written extensively about how people think, dream, communicate, and construct their identities in narrative form. Because of people's tendency to story their existence in narrative form, Sarbin proposes the idea of narrative as a root metaphor for psychology, and describes his narratory principle "that human beings think, perceive, imagine and make moral choices according to narrative structures" (Sarbin, 1986, p. 8). In the current study, I work from this narrative perspective of psychology and contend that people consciously and unconsciously organize the chaos of existence in a world full of meanings, discourses, and symbols in narrative form.

The stories that people tell about their lives are situated in particular historical, cultural, political, and gendered contexts. In other words, people's life stories are created from a particular standpoint and worldview, and thus should also be interpreted in terms of the global context of their lives. Arthur Frank (2000) writes about the standpoint of a storyteller and points out that the way a story is recounted depends both upon the audience and the context in which the story is told. Frank defines "a standpoint as a political and ethical act of self-reflection: To take a standpoint means to privilege certain aspects of what your biography shares with others" (Frank, 2000, p. 356). We consciously construct the narratives that we tell to others about our lives and in doing so create a dialogical self identity. The self is not a static creation but is dynamic and relational to other people, our cultural, social, and political contexts. Persons who identify themselves as psychiatric survivors typically position themselves in opposition to the discourse of the medical model and align themselves with others who have had similar experiences in the mental health system. The psychiatric survivor takes a standpoint that "both reflects one's own unique experience and asserts membership in a community of those who understand shared experiences in mutually supportive ways" (Frank, 2000, p. 356).

Personal narratives not only are created within a certain social context but also in relation to cultural norms and ideals of the good life. Our self identities "[emerge] in line with specific social, historical, and discursive conditions regarding the importance of the individual as well as the importance of accounting for the life one has led in line with an overarching cultural system of ethical and moral values. The narrative integrity of the self emerges within this interplay" (Freeman & Brockmeier, 2001, p. 83). The extent to which people's life narratives are in congruence with prevailing notions of the good life can be understood in terms of what Freeman and Brockmeier (2001) call "narrative integrity." The authors define narrative integrity "as the conceptual space where autobiographical identity and the meaning of the good life meet" (Freeman & Brockmeier, 2001, p. 97). Narrative integrity can be evaluated in terms of both aesthetic cohesiveness or coherence and the extent to which it models the ethical or good life. Narrative integrity, like narrative truth (Spence, 1982), reflects the extent to which the pieces of the story fit together or reflect the good life to our satisfaction and has less to do with metaphysical or historical truth.

Freeman and Brockmeier (2001) argue that in times and cultures (e.g. ancient Greek culture) where there are strong agreed upon notions of the good life, there should also be a high degree of narrative integrity. In our post-modern times and Western culture, notions of the good life are highly individualistic; and universal ethics or values are harder (or impossible) to define. Therefore autobiographies, oral histories, or diaries "are useful vehicles for exploring not only the ethical dimension of identity construction but also the ethical fabric of the social worlds in which they emerge" (Freeman & Brockmeier, 2001, p. 77). In other words, through the study of personal narratives we come to recognize the values of the individual and the inherent notions of the good life in his or her culture.

Narrative psychologists tend to focus on people's strengths and strive to separate the person from his or her problem so that "rather than viewing people as something, such as a male or a depressive or an anorexic, narrative therapy views people as unique histories" (Polkinghorne, 2004, p. 53). Because of these foci, the narrative approach is

particularly well-suited for inquires into the psychiatric survivor movement, which typically takes a humanistic and non-judgmental position on a variety of human experiences. Narrative psychologists do not try to categorize experiences as pathological, as much as they attempt to understand the meaning and purpose of these experiences within the global context of a person's life. This person's life- or self-narrative is inextricably tied to social, economic, political and interpersonal influences; therefore, all of these factors must be taken into consideration when one analyzes life-narratives.

Mainstream, psychological inquiries often study people in experimental conditions that are designed to understand human behavior divorced from the context of the social world. Hoskins (2000) argues that "psychology has for too long studied a decontextualized self which often results in superficial understandings of the complexities of human experiencing" (p. 47). Qualitative methodologists have made great strides in trying to understand people in a naturalistic, experiential, relational, and holistic manner.

Cushman (1990) critiques psychology's narrow scope of the concept of self, which excludes political, cultural, and historical influences. The author points out that "many researchers have treated self-contained individualism as an unquestioned value and the current concept of self—the bounded, masterful self—as an unchangeable, transhistorical entity" (Cushman, 1990, p. 599). Because of his view that the self is a social construction and a product of the environment it is contained in, Cushman argues that psychologists cannot hope to understand people outside of their sociopolitical contexts. Cushman argues his point from a social constructionist perspective, which states that "humans do not have a basic, fundamental, pure human nature that is transhistorical and transcultural. Humans are incomplete and therefore unable to function adequately unless embedded in a specific cultural matrix" (p. 601). Modernist psychologists tend to emphasize the person's internal psychic mechanisms, while postmodernists focus on an external and relational self, which is co-constructed amongst other people, society, and culture. Social constructionists value local knowledges, pluralism, and reflexivity above master theories, positivism, unitary knowledges or Truths (McLeod, 1997).

Many psychiatric survivor narratives reflect the criticisms of McLeod, Cushman and other constructionists. The real-life consequences that stem from the medical model's narrow focus on symptoms and diagnosis are evident in survivor literature. For example, a person's long-term unemployment and poverty will most often be overlooked in favor of a simplistic diagnosis of depression. This stigmatizing psychiatric diagnosis makes the person's mental illness the real problem, while significant life stressors and the person's personal history go unaddressed. The newly diagnosed depressive becomes disempowered and even more despondent than before, because now he or she has been told that he or she has an incurable illness and his or her only hope of living a normal life is life-long dependency on psychopharmacologic drugs. Psychiatric survivor and pioneer of the ex-patient movement Judi Chamberlin (1978) recalls from her own experience:

...this label, depression, for years thwarted my chances to get my life moving in a positive direction. A depression is something to get rid of and the goal of psychiatry is to "cure" people of depression. That my depression might be telling

me something about my own life was a possibility no one considered, including me. (p. 23)

In addition, social constructionists contextualize people in relation to their environment, culture, and the dominant or master narratives of that society. People's understanding and tellings of their subjective experiences are dynamically positioned in relation to time, place, and cultural master narratives. Narrative positioning "refers to the social and emotional stances that individuals take vis-à-vis real or imagined others" (Thorne & McLean, 2003, p. 171). The gatekeepers of society or those in positions of power and authority typically define and perpetuate the master narratives and cultural norms of a society. Thorne & McLean (2003) explain that "master narratives are not simply regarded as appropriate ways to experience the world; they are enforced in large and small ways...master narratives thus function as cultural standards against which community members feel compelled to position their personal experience" (Thorne & McLean, 2003, p. 171).

The discourse of empirical science has power and authority in Western medicine and psychology. Currently, the medical model of mental illness is the master narrative dominating psychological literature, research, and clinical practice. Empirically supported treatments that demonstrate marked symptom reduction on measures such as the Beck Depression Inventory have come to define the meaning of recovery from mental distress. However, alternative narratives of recovery, or subjugated knowledges, exist that emphasize a holistic approach to emotional healing and personal growth and depart from the master narrative's recovery script of symptom reduction.

For many people, the medical model's reductionistic discourse defines their experience of mental distress and recovery in terms of illnesses, chemical imbalances, and broken brains. However, Western society's dominant medical model narrative does not represent every individual's lived experience, and furthermore "explaining human unhappiness in medical terms is still nothing but a hypothesis, one which minimizes the possibility that people can change, grow, and develop" (Chamberlin, 1978, p. 110). In contrast to the medical paradigm, narrative and constructionist psychologists deconstruct socially oppressive discourses and strive to understand how people make meaning from lived experience and perform those meanings in a construction of self. In this sense, recovery could mean freeing oneself from the restrictive and reductionistic discourse of such socially dominant narratives as the medical model. Recovery may also mean no longer striving for the goal of normality as advocated by mainstream cultural scripts, instead accepting a wide variety of experiences as a part of being human rather than pathologizing them. This recovery process may involve rejecting a previous self-narrative such as defining oneself as a schizophrenic or clinically depressed and creating a new narrative identity of a psychiatric survivor or human rights advocate.

The current study focuses specifically on psychiatric survivors' narratives of recovery. I am especially interested in this group of individuals because most of them have rejected the dominant medical discourse of mental illness and therefore have authored alternative tellings of their experiences of emotional distress, healing, and recovery. According to social constructionist theory, "individuals can be seen as continually striving to position themselves within the larger community in an effort to make satisfactory sense of their expectations" (Thorne & McLean, 2003, p. 183). After

interviewing several psychiatric survivors, I explore how they position themselves in relation to the medical model master narrative of recovery from mental illness.

Based on my conceptual framework of the life narrative, the concept of recovery may take on an assortment of meanings. For example, recovery may mean restoring a sense of narrative integrity to a life story that was interrupted by a personal crisis or period of emotional distress. Recovery may be introducing an alternative telling of the life story to make this narrative richer and multi-dimensional. Or recovery may be a re-framing of (medical) discourses that once defined a life narrative in such a way that the person attains the power to define his or her own experiences and not let others' narratives define them. Narrative deconstruction and reconstruction is one part of the process of recovery, and another important piece is coming to realize how one defines his or her good life narrative. The good life narrative of the survivor movement goes beyond a counter-narrative to the medical model's narrative of recovery and operates within an entirely different discourse than the master narrative's dichotomies of illness and health. Before I further examine the significance of the good life narrative in terms of the current body of recovery literature, I will present a short history of the psychiatric survivor movement in order to contextualize the positioning of the alternative narrative in relation to the master narrative.

History of the Psychiatric Survivor Movement

Psychiatric survivor and psychologist Ronald Bassman traces the historical beginnings of the psychiatric survivor movement in the "early 1970s [when] groups of diverse self-identified mental patients...began to meet and develop strategies to change their status from powerless victims to agents of change" (Bassman, 1997, p. 238). These individuals had experienced inhumane, coercive, and abusive treatments at the hands of their doctors and psychiatrists, and they joined together with others with similar experiences to share their stories and unite against the deplorable actions committed in the name of psychiatry. The psychiatric survivor movement developed along with other human rights activist movements such as the civil rights, women's, gay and lesbian's, and physical disabilities movements. Over the past 30 years, the consumer/survivor/ex-patient movement has grown in numbers internationally and includes hundreds of grass-roots organizations of human rights advocates and peer-to-peer support networks.

Mental health consumers, psychiatric survivors, and ex-patients are often grouped together into one human rights movement (often referred to as c/s/x); but each group of individuals has unique identities and goals for change in the mental health system. The term "mental health consumer" was created by the system itself to encourage a respect for users as active, informed citizens as opposed to passive recipients or patients. Unlike consumers, a "psychiatric survivor" is a designation created by ex-mental patients and "is intended to convey strength in the face of adversity, a sense of optimism and independence, and above all, power" (Everett, 2000, p. 145). Jennifer Chambers, one of the survivors interviewed for Everett's (2000) study explains: "consumers tend to be people who believe in mental illness while survivors look more at the social causes of people's distress" (Everett, 2000, p. 146). Another survivor, Walter Osoka offers a comprehensive definition:

Being a survivor means surviving mental health services, surviving the help we were supposed to get, surviving the stigma, the side effects of the medications, the loneliness, hunger, homelessness, abuse, the illness itself and surviving losing your rights as a citizen. (Everett, 2000, p. 149)

The current study focused specifically on people who identify themselves as psychiatric survivors, which means that these individuals have experienced human rights violations in the mental health system. Examples of such human rights abuses include forced treatments such as electroshock, psychiatric drugging, as well as the use of physical restraints, coercion, and involuntary commitment (i.e. incarceration).

The right to define one's own problems in living and narrate one's life story has been denied to countless psychiatric survivors, and it continues to be denied to many people who seek help from the mental health system. Bassman points out, "as people whose feelings, thoughts, and experiences have been described, judged, and interpreted by others, survivors insist on speaking for themselves and defining their own experience" (Bassman, 1997, p. 239). A vast and rich literature of first-person accounts written by ex-patients, consumers, and psychiatric survivors exists today, but this literature has been largely ignored by mainstream psychologists in their practice and research (Adame & Hornstein, 2006; Hornstein, 2002; Hornstein, 2005). Mental health professionals, who hold fast to their own psychological theories as authoritative and disregard the accounts of psychiatric survivors, perpetuate an oppressive power relationship between themselves and those whom they claim to have expertise in understanding.

Everett (2000) has studied the relationship between the consumer/survivor movement and the Canadian mental health system. She demonstrates how the movement connects individuals' personal experiences to matters of political engagement in a shared social discourse of protest, resistance, and empowerment. The author explains that "these new movements [i.e. consumer/survivor] don't separate individual change from collective action. Instead, members see their own individual transformation as integral to wider societal change. In other words, they make the personal political" (Everett, 2000, p. 56). Everett points out two ways that survivors transform their personal experiences into social action and political causes. One is by sharing with other survivors their past experiences and new perspectives on life and the mental health system. The second way is when these individuals listen to their peers' stories and "through these vicarious means, come to embrace a politicized identity" (Everett, 2000, p. 106). A collective sense of strength, solidarity, and feelings of anger directed towards the psychiatric system are generated amongst survivors in such exchanges of personal experience; and these dialogues become the catalyst for protest, advocacy, social action and change.

Ronald Bassman (2001) has written about his emotionally painful and traumatic experiences of being hospitalized and treated for a diagnosis of schizophrenia. He was told by his doctor that his was an incurable disease which had to be treated with medication and insulin shock and that he was not to spend time with any of his friends. He seemed doomed to a life of dependency on the psychiatric system; but instead of being a compliant patient, he took control of his own future and fully recovered from both the mental health system and his own emotional turmoil. Bassman challenged the dominant cultural and medical narrative of schizophrenia as an incurable brain disease that only psychotropic drugs can provide a more normal life for those diagnosed as

schizophrenic. The dominant medical narrative must not only be challenged, but also deconstructed and subverted in order for alternatives to become apparent. The author explains that “each [psychiatric survivor] defies set formulas...without risk, without choice, the whole process is perverted into stabilization and maintenance at best and incarceration at worst but never growth and development” (Bassman, 2001, p. 40). Bassman was successful in creating an alternate narrative of recovery; one of hope for a better life and a transformation of the self.

Bassman does not regard recovery in the traditional sense of a cure from an illness, but instead argues for conceptualizing it as a process of self transformation, growth, and positive change that affects many lives, not just the life of the former patient. He speaks openly about his past experiences and explains that “like other psychiatric survivors, I feel duty-bound to share what helped and hurt me so that we may eliminate the ineffective treatments and abuses of the mental health system, and help make our communities more supportive and inclusive” (Bassman, 2001, p. 38). The counter-narrative of recovery that the author describes is a collaborative endeavor that requires dedication, resiliency, a strong support system, and the freedom to explore one’s feelings and experiences without the fear of being labeled with a mental illness. Bassman explains: “It isn’t one person or incident or clinical intervention that is critical for change to occur. Instead, it’s a complex process. One essential factor is keeping the spirit alive. Connecting with others helps: Receiving respect and warmth breaks through the isolation and helps you feel worthy and alive” (Bassman, 2001, p. 39).

Schiff (2004) discusses recovery from severe mental distress in relation to both the consumer/survivor movement and her own life. Although she is a mental health professional, Schiff recognizes that “the recovery movement belongs to consumer-survivors, not to practitioners” (Schiff, 2004, p. 212). The author reveals her own identity as a consumer/survivor and explores what recovery means in terms of this social and political movement. Schiff situates the themes of self-agency, empowerment, taking an active role on one’s own recovery, and the sharing of one’s healing story with others in the recovery paradigm of the consumer-survivor movement.

The survivor movement embraces humanistic ideologies of the therapeutic relationship that eliminate the oppressive and disempowering doctor-patient power structure, and replace it with an I-Thou relationship based upon the philosophy of theologian Martin Buber (1958). The collaborative relationship between a person and the therapist is based on respect, honesty, and shared goals for growth and change. Most importantly, the therapist acknowledges that “consumers hold the key to their own recovery, and the role of professionals is one of facilitating this recovery” (Schiff, 2004, p. 214). Peer-to-peer support networks also play a large role (if not replacing psychotherapy altogether) in the recovery process of many consumer/survivors. Recovery, like emotional distress, is understood holistically and the person’s life is contextualized in terms of his or her culture and interpersonal relationships. The emphasis on peer-support from other survivors helps to move the concept of recovery beyond a personal endeavor to a relational and political matter.

As was pointed out by Everett (2000), psychiatric survivors united to form a “politicized identity” where personal experiences are shared and transformed into collective social action. Beresford (1999) explains:

...survivors have particular reasons to connect the personal and the political. Their experience is of psychiatry and broader social structures which devalue, reject, and control their experience, emotions, perceptions, and interior world. The medicalisation of their madness and distress, and the chemical and mechanical “treatments” they receive, are frequently both physically and psychically destructive and sometimes lead to death. (p. 44)

The accounts of Bassman and Schiff demonstrate how the personal is made political when Western psychology’s ideal of radically individualistic recovery is replaced with a community model of recovery based in peer-support and social activism. One of the goals of this study was to explore the ways that survivors’ recovery narratives differ from individualistic, archetypal forms such as the hero or quest narrative. Real alternatives from traditional narratives of recovery must be created by and sustained by those in the psychiatric survivor movement. In other words, in order for true alternatives to exist, they must remain completely separate from the discourse and influence of the mental health system.

Survivors like Judi Chamberlin argue that real change and alternatives to the conceptualizations of and healing from mental distress must not be tainted in any way by mental health professionals. She explains that “mental health professionals tend to be skeptical of true alternatives because they cannot see patients as competent people...true alternatives are threatening because they do away with the need for professionals” (Chamberlin, 1978, p. 98). Once psychologists are brought into the dialogue with their academic knowledge and empiricist understandings of emotional distress, the unequal power relationship is re-introduced and the counter-narrative is co-opted.

Chamberlin makes the distinction between real, survivor run alternatives to the mental health system, and those co-opted by the language and hierarchical power structure of the mental health profession. The partnership model is where professionals and nonprofessionals work together but “the distinction between those who give help and those who receive it remains clearly defined” (Chamberlin, 1978, p. 87). Chamberlin does not believe this is a true alternative because professionals “interfere with consciousness raising and because they usually have mentalist attitudes” (Chamberlin, 1978, p. 87). An example of a partnership model is Fountain House located in New York City, which originally began as an organization called WANA (We Are Not Alone) run by ex-patients of Rockland State Hospital. Eventually mental health professionals worked their way into the organization, and quickly the ex-patients lost control of administration and decision making abilities. After the re-introduction of mental health professionals Chamberlin (1978) observes:

Although the hierarchy is not rigidly structured, it exists, and the role performed by the director is quite different from that performed by members. Administration and direction of the program are clearly and unequivocally in the hands of the staff. (p. 89)

A similar situation exists at a partnership model organization based out of Boston called Center Club, which “strongly upholds mental health ideology and terminology. Ex-

patients are viewed as handicapped people needing services with a mental health orientation” (Chamberlin, 1978, p. 91).

The driving message of Chamberlin’s book, *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, is that the movement must belong to ex-patients and survivors and not mental health professionals. In order to realize alternative conceptualizations of mental distress and recovery, a new language, power structure, goals, and ethical values must also develop. Chamberlin emphasizes the point that true alternatives for survivors cannot involve mental health professionals in any capacity because to do so reestablishes power structures and reintroduces psychotherapy’s language of recovery and ideals of the good life. By no longer participating or speaking in the language of the mental health system, survivors are free to dialogue in their own voices, on their own terms, and most importantly define their own version of the good life narrative. In essence, they are creating alternative narratives of mental distress and recovery with an emphasis on the social construction and political implications of such concepts. If a viable alternative to the dominant medical narrative is to be sustained then a community of voices is needed to continue the discourse. Alone, an individual can reposition him or herself in relation to the medical model, but a survivor community creates and speaks a new language describing the subjective experience of emotional distress and recovery from a dysfunctional mental health system.

Dialogue among survivors creates a space for counter-cultural communities that have their own moral vision and version of the good life that is distinct from traditional narratives of mental health. Some of the moral standpoints of the survivor movement include a respect for a person’s right to refuse psychiatric treatment (involuntary hospitalization, medication, ECT), the freedom to define experience of extreme emotional distress not in terms of dysfunction, and the acknowledgement of such experiences as a part of the human condition and not an indicator of a chemical imbalance. For psychiatric survivors the mental health system itself is the cause of abuse, coercion, and mental distress, which begs the question, how can the system facilitate the recovery process if people must first recover from the system?

Narratives of Recovery

Within a narrative framework of understanding, many researchers have conceptualized recovery in terms of integrating or assimilating problematic experiences into a coherent life-narrative (Botella, Herrero, Pacheca, & Corbella, 2004; Greenberg & Angus, 2004; Osatuke et. al., 2004; Polkinghorne, 2004). Botella et al. (2004) hypothesize that a commonality in most types of psychopathology “is the subjective experience of *unintelligibility* and *loss of personal agency*” (p. 122, emphasis in original) in terms of people’s life narratives. According to this view, recovery is understood as a re-authoring of one’s life narrative into a logical, complete, and coherent plot line. However, these researchers overlook the possibility that narrative coherence and continuity may not be the only way to conceive of recovery from mental distress. Some people may narrate their experiences of recovery in a less organized and non-linear fashion and also not define a good life narrative in terms of coherence and stability.

Hydén (1995) interviewed a group of women about their experiences in psychotherapy and analyzed the discourse and various constructions of their narratives of

recovery. The women's stories were focused on their changing conceptions of self, new directions of the life narrative, and not on such themes as pathology or symptom reduction. Many of the women described recovery as a transformation or re-narration of a new self that represented their version of a good or idealized self. A common theme in many of the stories was the sense of "*moral development*, imbued with the need to enhance one's influence over one's own life in order to become able to live a 'better' and 'truer' life" (Hydén, 1995, p. 88, emphasis in original). Because this analysis focused on the women's individual stories, there is little discussion of the social contexts that shaped the women's concepts of a moral and good life. However, Hydén does discuss the dialogical nature of the women's narratives and explains that "the rhetorical expression of recovery and cure takes place in the communicative exchange between patient and another person—a doctor, a member of the family or a researcher" (Hydén, 1995, p. 75). The researcher points out that the women were constructing their personal recovery narratives from larger cultural narratives of recovery from emotional distress. However, Hydén does not discuss how these women's re-narrations of self may have been constrained by the few accepted cultural narratives of recovery.

Hoskins (2000) analyzed one woman's recovery process and how her identity changed from one of a person struggling with anorexia to a self-narrative of health and well-being. Hoskins sought to understand how the woman constructed a narrative of recovery and how she was influenced by cultural discourses of both recovery and those that may have contributed to her difficulties in the first place. What began as a qualitative study investigating the themes of recovery from anorexia "developed into a study of how identities are constituted in relation to certain dominant and marginalized discourses" (Hoskins, 2000, p. 49). Hoskins points out that it is not only important to analyze the ways that people make meanings and construct narratives of change and recovery, but also "*how* one interacts with dominant and marginalized discourses [that] becomes a valuable site for exploring processes of changing identities" (Hoskins, 2000, p. 63, emphasis in original). In other words, in order to interpret the process of change and recovery one must also understand how the person positions his or her narrative in relation to society's master narratives of mental health and recovery.

However, Hoskins's example of one woman's dialogical re-positioning rests entirely upon language and there is no discussion about the potential roles of counter-cultural communities and political activism to serve as catalysts for narrative re-positioning. Other recovery research, such as McLeod's (2001), has examined the relationship between the personal narrative of recovery and the concept of living a good life, which in part entails engaging with the world as a politically active citizen.

McLeod's (2001) notion of a recovery oriented therapeutic relationship "contains within it the potential to assist the person to be fully human in the sense of getting closer to the values and relationships that reflect their idea of the good life, and to participate meaningfully as a citizen" (McLeod, 2001, p. 18). I consider McLeod's concept of the good life narrative in terms of what I would call a recovery narrative. Each person's recovery narrative is unique, and there is no one-size-fits-all therapeutic intervention or theoretical orientation that works for everyone. However, McLeod's notion of a good life is not limited to what is simply good for the individual, but rather how the individual can live a good life in the context of his or her socio-political environment as an active political citizen.

There are many versions of a good life narrative depending on one's life circumstances, goals, values, and cultural background. However, the Western medical model's definition of the good life that guides many theoretical stances of psychotherapy does not typically acknowledge alternative narratives of the good life. McLeod (2001) explains that psychotherapy today:

...reflect[s] the values and world-view that have driven the expansion of modern industrial society: rationality, the primacy of scientific knowing, individualism, globalism, progress, militarism, avoidance of risk, heterosexism, mastery. It is becoming increasingly apparent to many people that this constellation of beliefs and constructs omits many central aspects of humanity: emotionality, faith, spirituality, community, tradition, mystery, respect for the natural environment, diverse sexualities. (p. 18)

McLeod makes the point that there are counter-narratives of the good life and various ways of how people define recovery which may not coincide with master narratives of mental health. By ignoring the existence of the diverse array of counter-narratives of recovery, psychologists are silencing the voices of those who know what is best for them in terms of achieving the good life. The current study recognizes the existence of alternative narratives of recovery as told by psychiatric survivors, a group typically marginalized from mainstream psychological research, but one that offers valuable critiques of the mental health system that ought to be acknowledged.

McLeod and Lynch (2000) explore the good life narrative from the perspectives of both the client and the therapist, and through an example of a case study, demonstrate how to identify and reconstruct the good life narrative. The case study presented documents a woman's telling of her problematic story and the researchers analyze it looking for the strong evaluative clauses that define this woman's good life narrative. Also taken into consideration is the therapist's concept of a good life narrative based on her humanistic theoretical stance. First, the problematic story is articulated and consolidated with meaning by the client, and then this story is placed within the larger context of her life narrative. Then, the client and therapist explore new ways of articulating the problematic story, which give the client different perspectives on her life and world.

Healing or recovery is seen in terms of repairing a fractured good life narrative, and the therapist facilitates this process by encouraging the client to "perform emotions which seem more constructive to her than those expressed within the central problematic story" (McLeod & Lynch, 2000, p. 402). This process was originally described by White and Epston (1990) as "the emergence of *subjugated knowledges*" that "makes possible the formulation of a new story which helps the client to live in ways that they find more satisfying" (McLeod & Lynch, 2000, p. 402, emphasis in original). Narrative discontinuity is replaced with continuity and coherence, which the researchers imply facilitates the process of recovery. However unlike McLeod & Lynch, I do not assume that every experience of recovery takes the form of a coherent or unfragmented narrative. Furthermore, I do not assume to know that narrative continuity or assimilation of problematic experiences necessarily causes or facilitates recovery in every case.

Although not dealt with directly in their article, McLeod & Lynch do draw attention to the psychosocial nature of re-evaluating the good life narrative: “Attention to the stories of the ‘good life’ hovering around the therapy room takes the focus away from the inner, individual self, and back out into the relationship between the person and the culture in which they have being” (McLeod & Lynch, 2000, p. 404). The authors need to press this issue further and explain exactly the role society’s meta-narratives play in the creation of a good life story. In the current study, I looked at what a good life meant for each individual interviewed and also how our culture’s concept of a good life was integrated into (or left out of) the psychiatric survivors’ narratives. Previous research on first-person accounts of recovery from emotional distress has shown that people experience recovery in a variety of ways. There is a small but growing section of the literature that focuses on alternative conceptualizations of recovery and some of those studies do look specifically at psychiatric survivors’ experiences. However, relatively few of these studies analyze the dialogical positioning of the discourse of the survivor movement in relation to cultural master narratives of mental illness and recovery.

Survivors’ Perspectives on Recovery

Within the movement, various definitions of recovery exist including the assertion that one can fully recover from mental distress, while others define recovery as accepting and integrating problems into one’s life. In either case, recovery involves a re-authoring of the life narrative in some way related to either the acceptance or rejection of the problems associated with severe emotional distress. Survivors have also created their own alternatives of peer-to-peer support networks in which there is no outside interference from the power model of the mental health system.

Dan Fisher and Laurie Ahern, psychiatric survivors and members of the National Empowerment Center, have written about the difference between a rehabilitation view and an empowerment view of recovery from mental distress. The rehabilitation view is akin to the medical model’s narrative that “mental illness is seen as a primary, permanent impairment” and recovery means that “people can regain some social functioning, despite having symptoms, limitations, medication, and remaining mentally ill” (National Empowerment Center URL). This narrative is contrasted with the empowerment vision in which “one is capable of recovering from mental illness itself, not merely regaining functioning while remaining mentally ill” (National Empowerment Center URL). The empowerment model acknowledges both the positive and negative influences of social systems in the labeling and treatment of experiences of severe emotional distress. Recovery is achieved “through a combination of supports needed to (re)establish a major social role and the self-management skills needed to take control of the major decisions affecting one” (National Empowerment Center URL). Consequently “self-help and peer support are fundamental elements in this journey of recovery” (National Empowerment Center URL) as these elements also play a vital role in the larger survivor movement.

Another element of the empowerment model is the role of employment that the person finds meaningful, as well as participation in other activities that are rewarding and challenging. Opportunities for employment help persons to regain a valued and respected role in society and create an identity not primarily defined by being a consumer or mentally ill. Fisher points out that the empowerment model of recovery differentiates

between recovery from mental distress (such as depression or schizophrenia) and the life-long process of recovery from emotional distress from traumatic experiences. It is possible that some experiences of recovery fit neither into the rehabilitation nor into the empowerment models. For example, I interviewed some individuals who never considered themselves to be mentally ill in the first place and therefore have recovered from psychiatric abuse and iatrogenic mental distress. Psychiatric survivor and director of MindFreedom International David Oaks explains:

Many of us do not think of ourselves as ever having been mentally ill, even though we have been diagnosed as such. However, we do think of ourselves as having experienced emotional or spiritual crises or intense growth periods, as well as much mistreatment as patients in the mental health system. Additionally, most SCI [Support Coalition International] members have been physically damaged by psychiatric drugs and/or electroshock. All of these experiences require recovery processes. (Support Coalition International URL)

Unlike narratives of, for example, cancer survivors, in which people recover from a disease with the help of their doctors and medical interventions, psychiatric survivors are typically at odds with their doctors and feel that they have been harmed physically and psychologically by their medical interventions. The medical model's narrative fails to capture the experience of the psychiatric survivor who has not recovered from an illness but rather from abuses of the mental health system.

One study that looks specifically at survivors' experiences of recovery is Cohen's (2005) work that documents the results of an oral history project he completed while an intern at the psychiatric survivor organization Support Coalition International. Cohen inquired into both the survivors' experiences of recovery from severe emotional distress and also how they overcame the abusive conditions they encountered in the mental health system. Most of the participants described recovery as an ongoing process in which many different methods of support were helpful including: friends and family, involvement in social activism, exercise, individual/group therapy, and psychiatric drugs. Cohen points out that the survivors tended to emphasize the importance of peer-support and empowerment in their recoveries; qualities that can be facilitated by involvement in the survivor movement and alternatives to the psychiatric system such as Mosher's (1999) Soteria House model.

Davidson (2003) also examines psychiatric survivors' experiences in his qualitative study on recovery from schizophrenia. His findings were very similar to Cohen's (2005) in that the people he interviewed described recovery as an ongoing process rather than an end product or fixed state that one may achieve. He explains that "many people view the process of recovery as something that almost defies definition. It is often described as more of an attitude, a way of life, a feeling, a vision, or an experience than a return to normalcy or health" (Davidson, 2003, p. 44). In accord with previous studies on recovery from severe mental illness (Anthony, 1993; Deegan, 1996), Davidson notes that people do not so much recover from emotional distress as they recover from the stigmatizing consequences of being labeled a "mental patient" or "schizophrenic." He explains:

What recovery seems to entail is that people overcome the effects of being a mental patient—including the rejection from society, poverty, substandard housing, social isolation, unemployment, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to retain, or resume, some degree of control over their own lives. (p. 38)

For many ex-patients and people who are psychiatrically labeled, the isolation, loss of a sense of self and purpose in their lives is perhaps the most devastating aspects of their experience and the most difficult to recover. Nor are these existential dilemmas addressed by psychiatric interventions that narrowly focus on symptom reduction rather than the meaning and significance of psychopathology in a person's life. Conversely, the survivor movement often addresses such issues and provides dialogical spaces for such explorations in the form of peer-to-peer support groups. The survivor movement's emphasis on the importance of human connection and meaningful relationships is in line with Davidson's conclusions that "the underlying issue of the important role of social inclusion versus social isolation as providing the basis for efforts toward recovery" (Davidson, 2003, p. 181).

Thornhill, Clare, & May (2004) studied the narratives of individuals who were either recovered or recovering from psychosis, defined as "experiences such as hearing voices other people do not hear, seeing or sensing things other people do not see or sense, holding unusual beliefs (delusions) or beliefs about the malevolent intention of other which seem unwarranted (paranoia)" (p. 181). The researchers asked participants to define recovery and what they feel that they have recovered from. In addition, they inquired about what was helpful or not helpful in the recovery process and if there were any significant turning points throughout.

Based on their narrative analysis, Thornhill et. al. found that the participants' stories could be categorized into three groups: "narratives of escape, enlightenment, and endurance" (p. 187). "Narratives of escape" described a literal escape from psychiatric institutionalization or involuntary treatment. This type of narrative also described an escape "from the imposition of a certain kind of belief system [medical model of mental illness] and from the identity of a chronic psychiatric patient" (Thornhill et. al., 2004, p. 188). "Narratives of enlightenment" described the person's experience of psychosis in an existential framework of spiritual growth, self-insight, or greater understanding of others and the world. For narrators of the "enlightenment" type, recovery often involves life-long process of making meaning from their experiences of psychosis, and using their insights help others in a similar position. The researchers note "the recovery journey often involves taking on the role of activist to attempt to address or repair, for others if not for the self, some aspects of what was experienced as unjust or damaging" (Thornhill et. al., 2004, p. 194).

Finally, in the "narratives of endurance" type, "the experience of psychosis is often regarded as akin to a disability or a chronic health condition such as diabetes" (Thornhill et. al., 2004, p. 191), and the stories typically centered on the acceptance of one's psychiatric diagnosis. Although this type of narrative most closely resembles the medical model's narrative in that diagnoses of mental illness should be regarded like any other physical illness, this message was "accompanied by a strong strand of angry protest" (Thornhill et. al., 2004, p. 191). Narrators of the "endurance" type advocate

passionately for the rights of the so-called “mentally ill” and fight against the stigma and discrimination experienced both in society and in the mental health system. Thornhill et. al. demonstrate with their study that recovery from psychosis is not only possible, but there are many different paths to healing that do not necessarily adhere to the master narrative.

Ridgeway (2001) examines alternative conceptualizations of recovery from the medical model across a selection of first-person accounts not exclusive to the survivor movement. Ridgeway acknowledges the importance of using first-person accounts “that can help us refocus our thinking beyond the myopic and outdated deficit perspective [of the medical model]” (Ridgeway, 2001, p. 336). Based in grounded theory, her analysis uncovered several main themes of the four accounts as well as a core narrative structure. A few of the themes of recovery that the researcher found include, “the reawakening of hope after despair,” “breaking through denial and achieving understanding and acceptance,” “active coping rather than passive adjustment,” and “moving from alienation to a sense of meaning and purpose” (Ridgeway, 2001). The study highlights each person’s individual journey of recovery while uncovering the common themes found in each narrative. Ridgeway emphasizes that each person’s concept of recovery as well as the process itself is unique and encourages mental health professionals to respect their clients’ subjective experiences, values, and goals.

Having a respect for what works best for each person also means that therapists have to acknowledge the fact that they do not have all the answers or tools for recovery and that “[they] must support the great adaptive strengths people have, and honor the healing power of active coping, symptom self-management, and peer self-help” (Ridgeway, 2001, p. 342). Through the study of first-person recovery accounts, an empowerment narrative of recovery is revealed—one that emphasizes people’s strengths, resiliency, and capacity to grow as a result of difficult life problems. However, Ridgeway’s analysis highlights the culturally dominant narrative of Western individualism and overlooking other community-based or peer supports modes of recovery. As previously discussed, social constructionists have reacted against the idea of the autonomous, masterful self and self-narratives of radical individualism. This study is one such attempt to show how narratives of recovery can go beyond heroic tales of individual healing and further incorporate social and political action as essential components of the recovery process.

In her research on recovery narratives, Jacobson (2001) works from the theoretical perspective of symbolic interactionism, which “explores how individual and collective understandings of the world—and the ‘social objects,’ or phenomena of interest, that composes it—are formed through the process of social interaction” (Jacobson, 2001, p. 249). Jacobson performed a dimensional analysis in order to evaluate 30 recovery narratives. She found four dimensions that are central to the concept of recovery in these accounts: “self,” “others,” “the system,” and “the problem.” In addition, she also found “component processes that correspond to these dimensions: recognizing the problem, transforming the self, reconciling with the system, and reaching out to others” (Jacobson, 2001, p. 248). Jacobson does not consider recovery to be a static goal to be obtained and found that “recovery is understood to be a process, rather than an outcome, that is unique for each individual” (Jacobson, 2001, p. 248).

Narrators in Jacobson's study had a wide array of explanatory models for their life problems and emotional crises, including biological, abuse or trauma, spiritual or philosophical, or political. Depending on the various ways, or combinations of ways, that the narrator explained his or her life problems, the processes of recovery (self, others, the system, the problem) varied accordingly. For example, those who narrated a spiritual or philosophical explanatory model described a self that was destroyed and reborn in an enlightened state. Others label the experience as "mental illness" or a "breakdown," but the person reports experiencing an emotionally intense yet ultimately positive and life-changing event. Interventions from the mental health system such as forced medication, a diagnosis of schizophrenia, or institutionalization interfere with the person's spiritual or philosophical journey of enlightenment. For these individuals, recovery is defined in terms of spiritual rebirth or philosophical enlightenment which they in turn share with others and provide support for those experiencing similar existential crises.

Jacobson illustrates both the many ways in which people story and give meaning to their emotional crises and the equally diverse ways people construct the concept of recovery. These conclusions encourage therapists to strive to understand their clients' subjective constructions of their problems and respect each person's unique processes of recovery. Jacobson outlines not just the individual psychological processes involved in recovery, but also highlights the social, political, and spiritual dimensions that are often overlooked in the psychotherapeutic dyad. For example, many psychiatric survivors see recovery as a process of politicization in which "the individual is able to transform his or her anger against the system—anger that in the past has been destructive to self—into constructive rage, learning to question, to resist...in a demonstration of both personal and collective empowerment, the individual joins with other survivors to effect social change" (Jacobson, 2001, p. 253). The socially collective action of psychiatric survivors is essential for the construction of counter-cultural narratives of recovery. Instead of psychology's typically Western notions of radical individualism, survivor's counter-narratives tend to highlight the importance of peer-support and a community in which to share their stories and experiences.

Weaver Randall and Salem (2005) looked specifically at peer-support groups and the interweaving of personal and community-based narratives of recovery in their qualitative study of a schizophrenics anonymous organization. Peer-support communities such as schizophrenics anonymous base their approaches to recovery upon the experiential base of knowledge provided by its members. Thus, the community affords greater variability in the ways that people talk about their experiences and define the recovery process in contrast to the medical model which "tend[s] to focus on pathology and disease and to define recovery as a set of predetermined outcomes that emphasizes symptom elimination and a return to premorbid functioning" (Weaver Randall & Salem, 2005, p. 175-6). The researchers highlight the importance of the community narrative of recovery that is created "through the telling and retelling of personal stories of mental illness and recovery" (Weaver Randall & Salem, 2005, p. 180). Essentially, the community narrative clears a dialogical space for people to re-conceptualize what it means to recover from schizophrenia and live a meaningful life.

Although schizophrenics anonymous does not endorse a specific religious focus their "members are encouraged to recognize their spirituality as it pertains to finding meaning or a higher purpose in their lives" (Weaver Randall & Salem, 2005, p. 184).

The encouragement of spirituality and a search for meaning in one's life goes beyond the interpersonal community component of healing. In other words, the recovery process is not restricted to a personal or group endeavor but may also include a spiritual component that reconnects the individual to a meaning or purpose greater than oneself. Unlike the survivor literature that tends to define recovery as a holistic and politically engaged process, the master narrative of the medical model conceptualizes recovery as an individual's heroic journey of better living through biochemistry.

Medical Model as Master Narrative

The medical model of mental illness conceptualizes human experiences such as depression, hearing voices, and other instances of human suffering as the result of a neurobiological deficit or dysfunction. Mender (1994) explains that "the standard Western medical approach to illness today assumes that the body functions as a machine, illness results from mechanical breakage, and the doctor acts as a repairman...symptoms are merely categorized in a disease taxonomy, and their relation to the entire life history of the patient is fragmented and obscured" (Mender, 1994, p. 93). The discourse of the medical model reduces persons to bundles of neurotransmitters, and one can easily overlook a holistic appreciation of the persons' life experiences and cultural contexts.

Fancher (2003) writes about the various cultures of healing that exist in our society, and gives a historical overview of the social and political contexts of the development of mental health care in this country. Fancher criticizes the field of psychology for distancing itself from the disciplines of sociology, history, and philosophy and modeling itself upon the biological science. He argues that this shift in focus has in turn produced therapeutic approaches that tend to focus exclusively on the individual (whether in terms of ego, learned responses, cognitive schemas, or chemical imbalances) at the expense of socio-political and philosophical contexts. He critiques the medical model and those cultures of healing such as biological psychiatry and cognitive-behavioral therapy for promoting normality as a goal of one's individual recovery at the expense of ignoring problems that plague our society.

One of the cultures of healing that Fancher addresses specifically is cognitive-behavioral therapy. He discusses the ways in which cognitive-behavioral approaches limit the possibilities for imagination, creativity, and challenging the status quo of the person's life circumstances. Cognitive therapy rests on the premise that "psychopathology results from fundamentally erroneous ways of comprehending life and the situations that constitute it" (Fancher, 2003, p. 198). The counter-narrative of the survivor movement takes the opposite stance, holding that fundamentally we live in a troubled world that manifests itself through the people who dwell within it. Thus, it is not sufficient for psychologists to heal only the individual person, but ideally the profession would also concern itself with matters of activism, advocacy, and consciousness-raising. Cognitive therapy is a good example of an approach that ignores the importance of political activism and instead takes the perspective of radical individualism.

In terms of the discourse of the medical model, recovery is construed in terms of symptom reduction and long-term maintenance of normality, understood only as an absence of symptoms. The historical origins of the term "recovery" in the context of

mental health is “ascribed to hospital superintendents who were reporting treatment outcomes of people admitted and discharged from their asylums...their definition of recovery usually consisted of elimination of observed symptoms, at least during the hospital stay” (Loveland, Weaver Randall, & Corrigan, 2005, p. 25). The potential for positive life change, a deepening of one’s spirituality, or personal growth are rarely if ever considered in the medical model’s definition of recovery. The focus remains upon persons’ internal dysfunctions, deficiencies, disorders, chemical imbalances, and broken brains to the exclusion of culture, environmental stressors, interpersonal relationships, and existential crises.

Within the discourse of the master narrative, individuals who are diagnosed as schizophrenic or bipolar can fall into a dangerous cycle of defining their thoughts, actions and behaviors in the medicalized discourse of psychopathology. Experiences such as hearing voices are re-construed as delusional or a hallucination and are considered to be symptomatic of schizophrenia. Johnstone (2000) argues that “what any medical approach crucially fails to address is the *meaning* of so-called ‘schizophrenic’ experiences. Personal meaning is the first biggest casualty of the biomedical model” (Johnstone, 2000, p. 81, emphasis in original). Psychiatrists tend to focus exclusively on what symptoms such as hearing voices indicate in terms of diagnosis, but they fail to ask seemingly basic but important questions such as, “What do the voices mean to you?” Instead of disregarding the phenomena as insignificant by-products of mental illness, efforts need to be made to understand the person’s experience of hearing voices, what this experience means to him or her, and how is it affecting his or her life.

Rogers, May & Oliver (2001) explore how the different discourses of doctors and their patients result in a discrepancy between the patient’s needs for recovery and the medical profession’s way of defining those needs for them. The qualitative study done by Rogers et al. examines the contrasting discourses of people who sought treatment for depression and that of their primary care physicians. People’s subjective experiences of depression must be negotiated when they encounter the objectivist, medical discourse of their doctors. This study, done in the United Kingdom, focuses on primary care physicians (GPs) and not psychiatrists because the former have become the main resource for people seeking treatment for depression. From the semi-structured interviews of 27 patients and 10 GPs, the researchers identified main themes to compare and contrast the two groups’ experiences of mental health care.

For some of the participants, the diagnosis of depression marked a major turning point in their lives. For others, the label simply confirmed what they suspected all along. Most of the people experiencing depression reported feeling overwhelmed and having a very fragile sense of self. Therefore, when the participants received a formal diagnosis of depression, for many it “constituted a point of passage in which the person became...a patient and began to reshape their self-identity in relation to this” (Rogers et. al, 2001, p. 325). However, in the doctors’ accounts of how their patients experience depression, “this reshaping of the subjective experience of self is missing” (Rogers et al., 2001, p. 325); and overall there were major differences between the doctors’ narratives and their patients’ accounts of depression.

The doctors’ central task was to identify and diagnose the type of mental distress that their patients presented with. By and large, the GPs recognized external social and situational influences on the feelings of depression the person was having; however, they

framed these problems in a medical discourse emphasizing that the “true” underlying problem was mental illness. One doctor described a patient’s marital problems as “a relationship breakdown” and diagnosed her with “reactive depression.” Interpersonal conflicts, environmental stressors, and social oppression are all seen as triggers that set off the underlying pathology of the person. Both the patients and the doctors were pessimistic about the extent to which they believed that primary care interventions could be of help. Patients seemed aware of the fact that taking a pill would not solve their life problems; doctors recognized that they could not help their patients with their problems in living and were limited to prescribing anti-depressant medication as their main form of therapeutic intervention. Despite the fact that both patients and doctors acknowledged the shortcomings of primary care in dealing with depression, both preferred medical interventions over seeking out assistance from a mental health professional. Patients choose not to seek help from a psychiatrist or counselor, fearing the stigma of being labeled “mentally ill”; their doctors also preferred prescribing anti-depressants instead of referring their patients to an already overwhelmed secondary care service.

Based on the analysis of the patients’ and doctors’ accounts, the researchers found that both parties were not completely satisfied with the extent that either primary care or mental health counseling was useful in helping individuals deal with various types of problems in living. Alternative resources such as “advocacy, advice and mediation in dealing with adverse personal and social circumstances” (Rogers et al., 2001, p. 332) were identified in patients’ interviews as being more useful to individuals experiencing depression. While at times helpful, doctors’ and mental health professionals’ interventions were not as useful in participants’ recovery processes as their taking a role in self-advocacy and becoming an informed mental health consumer.

Recovery, moreover, typically is defined in the medical model in terms of a static or fixed goal, rather than an ongoing process of change and growth. Hydén (1995), in contrast, contends that recovery or mental health should not be thought of in terms of a goal to be reached or an objectively measurable attainment but as a re-narration of one’s cultural, social, and psychological elements of self. The experiences of mental distress and recovery in Hydén’s view are inextricably tied to the overall life narrative; thus, the social, cultural, political, and spiritual contexts of one’s self must be taken into account in the study of recovery narratives. Hydén explains that “by being linked to a life narrative, the patient’s recovery acquires meaning within the context of his or her aspirations and self-image, and becomes a part of the individual’s evaluation of his or her life” (Hydén, 1995, p. 76). Similar to McLeod’s & Lynch’s (2000) work, Hydén writes about recovery in terms of how a person conceives of his or her good life narrative.

According to the medical model, severe mental illnesses like schizophrenia or bipolar disorder are permanent conditions that may be treated or stabilized with medications and psychotherapy; but can never be completely cured. From this perspective, full recovery is not possible and thus persons typically remain dependent upon the mental health system and psychiatric medications in order to achieve a normal and productive life. Ironically, recovery may sometimes be an unappealing goal within the medical model, because for the person, it means losing the social services that one has become dependent on both financially and emotionally. The current system inhibits recovery and personal growth, instead of facilitating recovery by encouraging people to seek out help and support outside of the narrow frame of traditional psychiatric treatment

plans. Counter-narratives, like that of the psychiatric survivor movement, reject the medical model's good life narrative. These counter-narratives hold that full recovery is possible without the use of medications or other traditional psychiatric interventions that address only the brain and not the whole person.

Bonnie Burstow, a psychotherapist and activist in the psychiatric survivor movement, calls upon other progressive psychotherapists to support and connect with the survivor movement in their private practices, advocacy work, and writing (Burstow, 2004). Psychologists have much to learn from the testimonials of psychiatric survivors and, through the acknowledgment of these accounts in our practice and research, their experiences finally are given the attention and respect they deserve. In the current study, I conducted four semi-structured interviews with self-identified psychiatric survivors and examined their stories of recovery in relation to the master narrative of mental illness. I have chosen a qualitative approach because of its emphasis on rich descriptions and a holistic understanding of the ways that people create meaning in their lives through the use of language and stories. Bassman (1997) notes that "consumer/survivors are finding validation in narrative approaches that seek to understand life experiences as constructed stories" (p. 240). I then contextualized my interpretations in terms of the dominant cultural discourses that have influenced and shaped the survivors' narratives. From my qualitative approach, I strove to achieve a nuanced understanding of the construction and form of the recovery narratives as well as an interpretation grounded in the dominant social discourses from which these narratives emerged.

As I have outlined, previous studies (Cohen, 2005; Davidson, 2003; Jacobson, 2001; Ridgeway, 2001; Thornhill et. al., 2004; Weaver Randall & Salem, 2005), have shown that, contrary to the master medical model narrative, many people define the origins of their emotional distress in terms of social, political, spiritual, and economic factors. These fundamental differences between the medical model's narrative and the survivor narrative about the origins of emotional distress led me to the question: what does recovery mean for those who do not subscribe to the medical model?

With this question in mind, I had two purposes for this study. First was to qualitatively explore the concept of recovery from the perspective of a group of people who are typically marginalized within the field of mainstream psychology. My second purpose was to recognize the voices of those who feel abused by and are critical of mainstream psychology and bring greater public and professional awareness to alternate conceptualizations of recovery. First-person accounts reclaim the authority of defining experience from dominant social discourses and give the individual the power of language and the ability to define the meanings of one's own experience. The best way clinicians can learn and grow in their capacity to help people in times of extreme emotional distress is to listen to people's subjective experiences and regard these accounts as the master narratives rather than the impersonal and often dehumanizing narrative of the medical model.

Researcher's Positioning in Relation to Current Study

The hermeneutic or interpretive approach to research takes into account the researcher's positioning in relation to the phenomena of investigation. In terms of Kelly's (1955) personal construct theory, we approach the world through the lens of our

personal constructs and thus no one has an unbiased perspective or God's-eye-view. Thus it is often the practice of qualitative researchers to articulate and critically examine their fore-structure or prior knowledge and experiences that are relevant to the current project. The results of this study represent a co-creation of meaning between the participants and me. What follows is a narrative that I have written in order to contextualize those interpretations in light of my experiential knowledge base and also documents my own development as a researcher and ally of the survivor movement.

My interest in this area of research began in college when I took a seminar on first-person madness narratives. I was amazed to learn that the vast majority of psychologists were not familiar with this important area of literature and would let their own theories take precedence over the life stories of people about whom they claimed to have expert knowledge. It simply seemed illogical to ignore the voices of people who could help inform the practice and culture of mental health care.

One of the professors of the seminar (and my future senior thesis advisor) had become involved in local advocacy groups for patients' rights in the mental health system and informed the class about the existence and mission of such organizations. At the time, I had never heard of the psychiatric survivor movement, let alone had much exposure to social activism in general. However, once I learned more about the history, purpose, and presence of the movement in Western Massachusetts, I wanted to find ways to get involved and share what I had learned with other psychology majors. I volunteered on an oral history project that documented the experiences of psychiatric survivors and made contacts with members of a local advocacy and peer support group. I also started to plan out my senior thesis project which was an extension of my growing interest in the marginalized voices of people labeled "mentally ill" by both mental health professionals and society in general. I carried out a narrative analysis of ten first-person madness narratives, by examining the authors' experiences.

In many ways, my junior and senior years of college were filled with personal epiphanies and transitions (not all of them smooth) as I embarked upon my research. The survivor movement introduced me to the anti-psychiatry literature of Szasz, Breggin, and Laing among others. Both the survivor and anti-psychiatry movements made a powerful impression upon me and challenged me to question many of my previously held assumptions about the nature of psychopathology as well as the political underpinnings of the mental health system. As I carried out my senior thesis project, I was also in the process of applying to clinical psychology PhD programs; I often felt conflicted about joining the very system that the survivor movement so strongly criticized. I felt that I was able to synthesize my two passions in a meaningful way with my senior thesis. I realized that I could pursue my interests in psychology while still honoring the voices of individuals who have been abused, mistreated, and marginalized by mainstream society. In short, I came to the realization that I would never be a mainstream psychologist but was comfortable with this positioning.

When I entered graduate school and began planning the current study, I again wanted to integrate my two interests in clinical psychology and the survivor movement. This time I decided to focus on the phenomenon of recovery from the psychiatric survivor's point of view. In this study, I felt I would be able to honor my participants' voices, and look at the positioning of the counter-narrative of the survivor movement in relation to the master narrative of the medical model of mental illness.

As I think about my own positioning and researcher voice in the current project, I recognize that I am in the margins of both the survivor movement and clinical psychology. In general I feel that I am at the margins of my own professional field (and this is where I am most comfortable) because of my interests in groups like the psychiatric survivors and non-traditional views about the nature of psychopathology. However, I am also at the margins of the survivor movement (a position where I feel less secure) because of my affiliations with the field of psychology and the mental health system. In some ways, my marginal positioning was advantageous in the context of the current project because I was able to traverse fairly easily between both discourses and cultures. In other ways, I was at a disadvantage because I was quite unsure at many times about which of my identities was interpreting, writing, and representing the stories of the participants.

In these moments of self-doubt I was (and still am) very grateful to my participants for their words of encouragement and support of the project. They helped to remind me of the importance of getting this kind of work out to the public, a goal that ultimately took priority over my own personal struggles about identity, voice, and power. I am sure that I will continue these dialogues with myself throughout my career, and I welcome the opportunity for further self-reflection in both my research and clinical work. As the current project comes to an end, I am pleased with the final representation of the survivors' stories, which I hope serve as an accurate portrayal of their experiences. I am honored that I was trusted with presenting these individual's narratives of recovery, and am grateful that I had the opportunity to hear and share these stories of survival with others.

Method

Interview and Recruitment Procedure

I conducted four semi-structured interviews with individuals who identified themselves as psychiatric survivors; the list of questions that were used for these interviews can be found in Appendix A. Because of the semi-structured nature of these interviews, the order in which I asked the questions varied for each participant; depending on the direction of the conversation, I omitted or added additional questions to accommodate each interview. I spoke with people from both Western Massachusetts and Eastern Ohio. Prior to this study, I had been acquainted with several members of a psychiatric survivor community in Western Massachusetts and three of my participants came from my previous connections with that group. One of these participants put me in contact with the fourth interviewee from Eastern Ohio. I interviewed three of the participants in one sitting, and the fourth over the course of two interviews. On average, each interview lasted approximately two to three hours. Prior to each interview, I sent each participant the list of interview questions in order to give them the opportunity to review and raise any questions or concerns before participating in the study. Each participant was given an informed consent form (see Appendix B) to read and sign before being interviewed and also was given a debriefing form afterwards (see Appendix C). After I analyzed the narratives and wrote up my interpretations of our conversations, I sent each participant a copy of the results section and asked for his or her feedback and

reactions to the work in progress. I wanted to involve the participants in the research process so that their stories were portrayed accurately and not taken out of context or misinterpreted.

Analysis of Narratives

Qualitative researchers seek to understand human phenomena by looking at how people construct their lives in relation to others, their environment, and the larger social, historical and political discourses which have shaped their lives. Put simply, “the primary aim of qualitative research is to develop an understanding of how the world is constructed” (McLeod, 2001, p. 2). My project adopted a hermeneutic inquiry into the phenomenon of recovery and my goal is to obtain a nuanced understanding of the collected narrative accounts. McLeod (2001) defines hermeneutics “as ‘interpretive’ social science, which takes as its goal the achievement of ‘understanding,’ without specifying any further what is implied by the act of interpreting, or the experience of understanding” (p. 22). The approaches of hermeneutics and social constructionism tie in with Cushman’s argument that we cannot understand people in a social and historical vacuum. McLeod (2001) explains that “social constructionist research widens the interpretive horizon to include the cultural and historical context within which the study is located. Social constructionism seeks to understand the ways in which the world is co-constructed by persons living within a cultural tradition” (p. 29).

I used interpretive interactionism (Denzin, 2001) as the methodological foundation of my study and the approach helped to guide the interpretive process. The method of interpretive interactionism follows a hermeneutic pattern of analysis, acknowledging the power and voice of the researcher in the interpretive process. The goal of the method is to create thick descriptions of the phenomena of interest. Denzin (1998) explains that “a thin description simply reports facts, independent of intentions or circumstances. A thick description, in contrast, gives the context of an experience, states the intentions and meanings that organized the experience, and reveals the experience as a process” (p. 324). I structured the results section of my study in a dialogical format between myself and the participants’ narratives in an attempt to represent my own positioning in relation to their stories. Throughout the results section, I attempted to contextualize the survivors’ narratives in relation to the master narrative of mental illness; in the discussion section, I have tried to provide insight into the ways that I have chosen to structure and present the narratives.

The method of interpretive interactionism seemed most appropriate for analyzing the counter-narrative of the survivor movement in relation to the mental health system’s master narrative of recovery. Interpretive interactionism is typically used to explore the relation between personal problems and the public institutions that have been created to address those problems. Denzin (2001) points out that in many cases “the understandings that these programs are based upon bear little relationship to the meanings, interpretations, and experiences of the persons they are intended to serve. As a consequence, there are gaps or failures in understanding” (p. 3). The survivor movement faults the psychiatric system for these sorts of gaps in understanding created in large part from the system’s disinterest in understanding the lived experience of its patients’ diagnosis and medicalization of people’s distress.

Interpretive interactionism addresses epiphanies or “those life experiences that radically alter and shape the meanings persons give to themselves and their life projects” (Denzin, 2001, p. 34). During the interviews and subsequent transcript analysis, I listened carefully for the epiphanies in the stories of recovery. These were moments that revealed the person’s character, values, morals, and the turning points that changed the directions of the life narrative. Moments of epiphany also occurred when personal crises become public or interactional and, as a result of these experiences, the person’s perspective is shifted, previously held beliefs are challenged, and the process of consciousness-raising has begun. I frequently heard these stories of epiphany, when the personal crisis becomes public, when the survivors’ talked about their first (and often traumatic) encounters with the psychiatric system.

Denzin’s process of interpretation requires seven steps, which I will outline in relation to the specific method of the current study. It begins with framing the research questions. The three research questions of the study were: (1) how do psychiatric survivors define recovery, (2) what meanings does recovery hold within the context of their lives, (3) and what is the positioning of the counter-narrative of the psychiatric survivor movement in relation to the master narratives of mental illness and recovery? I referred to Denzin’s second step, connecting personal troubles to public issues, in the discussion of moments of epiphany as well as in the introduction to the thesis. The third step is to deconstruct the phenomena of interest. I began this deconstruction in the introduction section in my review of the recovery literature. I will more thoroughly address this deconstruction in the results and discussion sections in light of the survivors’ narratives.

I accomplished the fourth step (capturing the phenomenon) by conducting several interviews with psychiatric survivors about their experiences of recovery and identifying the moments of crisis and epiphany in those stories. After that, the collected interviews were transcribed, analyzed, and systematically compared to one another in order to uncover the themes, narrative structures, and plotlines that constituted the narratives of recovery. Denzin refers to this stage of interpretation as “bracketing the phenomenon,” which is in reference to Husserl’s (1913/1962) use of the term “bracketing” in which the researcher attempts to set aside his or her preconceived notions of the phenomenon and tries to understand it on its own terms. In the next step, constructing the phenomenon, I took the information I identified in the bracketing stage and re-organized the themes and patterns I identified into a coherent whole that is the results section.

Finally, I contextualized the phenomenon of recovery by examining my interpretations of the counter-narratives in relation to the master narratives of the medical model and the American good life. Throughout both the results and discussion sections, I tried to contextualize the lived experiences of the participants both in terms of the mental health system and my own positioning in the interpretive process. The final step of the interpretive process is especially important for future political action because, without re-contextualizing the alternative narratives of recovery back into the world of lived experience, the results of this study are limited to the confines of the written report.

Results

Dialogical Positioning of the Researcher's Voice

Throughout the process of writing up the results of this study, I had many concerns and spent a great deal of time considering how to present the survivors' stories. No matter how personally connected to the movement I feel, I recognize that in many ways I am still writing from the perspective of professional psychology. Am I co-opting these survivors' stories because *I* am the one telling them and deciding how to present them? This dilemma cuts to the very core of my project—who gets to be the author of the narrative of recovery? Does the mental health system (through me) still have the final say because I am the one writing up the results of the study? Or is this an opportunity to challenge the traditional notions of recovery and wellness by bringing these stories to light and educating other clinicians about the survivor movement. It is hard to say if I am perpetuating the problem of professionals speaking for the marginalized or if I am looking for a way to help the participants speak for themselves in their own words, and with them challenge traditional ideas about mental illness and recovery.

I considered these issues of voice and power throughout every stage of the project and have tried to honestly present my own background and positioning that I bring to the study, as well as collaborate with the participants about the final presentation of the results. I sent each participant a working copy of the results section so that they had the opportunity to correct, question, revise, and give me feedback on my portrayal of their lives. The interviews and my written impressions and interpretations are a co-creation of meaning between myself and each participant. In the interviews, my relationships and rapport with each of the participants shaped the ways that they responded to my questions, and their answers shaped the sorts of questions I asked. Therefore, each of the survivor's narratives is not objectively "true" in the sense that there is only one accurate way of telling or presenting them, but rather that these stories are "true" within the context of the interaction they are being told in.

As I set to the task of writing up the results of this study I felt as if I were traversing between two different realms; one the field of clinical psychology and the other, the psychiatric survivor movement. I am addressing simultaneously two different discourses, agendas, and audiences. However, this does not mean that I must combine them into one coherent whole. Like the Trickster archetype, one of my goals with this study is to stir up the conventional notions of recovery and mental health, and, through the presentation of the survivors' stories, invite the reader to engage in these dialogues as well. This project may be described as a dialogic research study in the sense that I am in the "process of continually accommodating opposites under the sign of a complex and perhaps contradictory heterogeneous whole" (Kamberelis, 2003, p. 686). In contrast to the dialogic is the dialectic—"the master Western trope of synthesizing opposites through the abolition of difference" (Kamberelis, 2003, p. 686). I do not wish to concretize the definition of recovery, nor do I think it is possible to do so. Recovery is a unique, cyclical journey that is ongoing and, like a person's life, is indefinable until one's death. Even in retrospect, though, the phenomenon of recovery eludes a single, coherent definition or theory that encompasses all the complexities of the journey.

Presentation of Results

A research project cannot be written up in any way the author sees fit; the presentation of one's findings ought to be related to the nature and agenda of the study. My agenda is to challenge the traditional notions of recovery by exploring the phenomenon through the stories of a marginalized group of people. In doing so, I not only introduce new perspectives on recovery but also a new way of dialoguing about the process through the counter-cultural discourse of the survivor movement.

I contextualized the presentation of the survivors' narratives in terms of the organization of the results section and the project's methodological foundation in interpretive interactionism, which focuses on both the participants' and researcher's personal epiphanies. For example, I decided to convey the dramatic characteristics of Ruta's and Will's stories and highlight their significance in terms of the structure of the overall results by recounting them in the form of a performance text. Denzin (2001) defines performance texts as "storied retellings that seek the truth of life's fictions via evocation rather than explanation or analysis" (p. 16). Instead of only describing the survivors' lived experiences in from an analytical perspective, the performance text "asks readers as viewers (or coperformers) to relive the experience through the writer's or performer's eyes" (Denzin, 2001, p. 16). I have also made use of the stanza text presentation format throughout much of the results section for similar reasons. One is that the poetic form helps to animate an interview transcript by capturing the felt sense of the words, intonation, emphases, breaths, and pauses that convey the participants' lived experience.

In the same vein of lived experience, I tried to use the stanza text when presenting a quote that was not simply a description or explanation but highlighted a particular event, encounter, or epiphany in the person's life. By presenting these events in such a way, I hoped to convey the drama, emotion, and aesthetic sense of these short narratives. The visual interplay between the stanza text and my own words also help to present the results in the form of a dialogue between the participants and myself. This layered text format is an attempt to capture the conversational quality of our interviews and convey that relationship to the reader. My aim was to present the quotes as responses to or commentaries on my interpretations; and in turn, I responded to those commentaries in an ongoing dialogue.

The presentational format of people's life stories seeks to influence the audiences' lives, unsettle their previous conceptions, and motivate the readers to take action and become an agent of social change. Thus, this research project could be called enriching because instead of building upon or creating abstract theories, the goal is to convey the results to the reader at an experiential level in order to encourage further interest and involvement in the psychiatric survivor movement. My goals were to present the results in such a way so that the survivors' stories resonated at an emotional level with the reader and also to challenge the reader's notions of the meaning of recovery.

I have chosen not to present the results of this study as a recovery model or even a general typology of psychiatric survivors' narratives of recovery. Instead, I have presented a series of themes that emerged from my conversations with the participants, which do not serve to define and generalize but serve as markers of how the survivors' narratives vary in their positioning to the master narrative throughout the recovery

process. The organization of the results section by theme also does not imply a linear temporal sequence of the recovery process. Again, the aim of the project, reflected in the organization of the results, is to demonstrate how a political movement has created an alternative narrative of the good life that is clearly distinct from the medical model's narrative of recovery.

Recovery as a Process

"I define recovery in a lot of different ways. But recovery is a process. It's important to recognize that it's a process." (Oryx)

The survivors I interviewed would agree to varying degrees with Oryx's opening quote that recovery is a process that does not necessarily have defined beginning and endpoints. Part of the healing process is learning how to not live in fear of the inevitable setbacks and not automatically construing these experiences as failures but simply as part of life. There will always be unexpected tragedies and other instances of great distress throughout a life, yet the survivors said that part of recovery is realizing that it is possible to get through them without being hospitalized or medicated.

It was often difficult for the survivors I spoke with to pinpoint a specific beginning of the recovery process; but there were several clear turning points, such as unexpected acts of human compassion and connection that they did highlight. Even though it was hard to define the beginnings of the recovery process, as I listened to the survivors' stories, there was a clear sense of when a person was in recovery that was noted both by the participants and me. I asked Ruta to define what recovery means to her, and she struggled to put into words the sense of being in recovery:

Normally I'd just say I think it's just a process cause that I think it is, but I don't know where you—I don't know how you'd define it. Because I think that everybody should be growing. Hopefully becoming happier, wiser, and more giving people or something. I think in many ways, just with the most horrible suffering that I was living with, the fact that that's not present in my life. Especially on a daily basis. That to me is like an endpoint too. Not being afraid I'll ever end up back in a system like that. Not being afraid I'll ever need to live in so much pain again no matter what happens. Life had continued with its little, normal tragedies, or things like that. People die, you lose people you love. Things get scary, things like that. But to have normal life problems and go, "Ok, I can cope. As a matter of fact, I think I can cope real well." (Ruta)

In this passage, Ruta identified two key turning points in the recovery process that also were noted by the other survivors. First, she escaped from being victimized by physical, sexual, or psychological abuse, and made the decision that her family's cycle of violence ended with her. The second clear turning point was her escape from the mental health system both in the sense of leaving the hospital setting and also abandoning its ideologies and conceptualizations of human suffering. Both of these escapes mark a major transition in the person's life from being victimized and oppressed to becoming an empowered survivor.

Unlike standardized markers of recovery used by mental health professionals such as a score on the Beck Depression Inventory or the suppression of voice hearing with psychotropic drugs, the survivors identified alternative markers of recovery such as involvement in their local communities and engaging in political activism. I asked Oryx if he thought a person could be in recovery while still experiencing what the DSM would classify as symptoms such as depression, mania, or hearing voices and he acknowledged that:

You may have good days, and you may have bad days. And you may have days when you can't sleep. And you may have days when you're, or weeks when you're down, really down. Or you may be flying high, you know, for some time or whatever. So yeah, I think you can have recovery with having quote "symptoms." (Oryx)

Without the mental health system's traditional indicators of recovery and mental health, the recovery process described by the survivors had no clear endpoint or sense of finality because this would mean no longer dynamically experiencing life. Thus, another important distinction to make between the survivor movement's approach to recovery in comparison with psychiatry's is the lack of change and movement in the latter case. The survivors talked about the importance of political activism, challenging society's status quo, and embracing people's eccentricities as part of the overall recovery process. In contrast, the psychiatric enterprise chooses a politically "neutral" front of neuroscience, seeks to help people adapt to societal ills, assimilates them back into the mainstream of our consumerist-driven culture, and chemically suppresses people's eccentricities with the goal of returning them to a state of normality.

*And I read Rachel Redman's book, and
she talked about medically having,
she had gone through a surgery
where they had opened up her abdomen
so wide that the only way
it could heal
was to give it time to fill in.*

*And I think I write about it in this last issue of the newsletter
because that's how my life has felt in my soul.
You know, it was this big, gaping
open wound.
And no medication,
no cognitive-behavioral group is gonna—
and those may be band-aids.
I know some people find them useful.
They're band-aids.
But this wound has to fill in
over time, little by little.
And it does fill.*

*Even when you think it's just too big,
and too deep to survive.
That's why I think I wanted to talk about,
a bit about the severity of the history
because that can heal.
I think...we must have an innate...desire to heal. (Ruta)*

Another notable characteristic of the recovery process is that it is a time-consuming endeavor that no quick-fix intervention, pill, or cognitive restructuring therapy can replace. Time does not heal all wounds; but many of the survivors said that the passage of time, patience, and a trusted companion on the journey of healing was greatly helpful. In an analogous sense, recovery is a great deal like the mourning process and healing begins with taking the time needed to mourn the losses and tragedies of one's life. However, in a culture that demands to be "better than well" (Elliot, 2003) and encourages people to seek quick, easy, and external solutions to life's problems, the concepts of mourning and grief-work are not readily tolerated. Most therapies (both psychological and psychiatric) mainly focus on getting people through their depression and despair as efficiently as possible in order to return them to a state of productivity and consumerism. The notion of giving people the time and space to grieve their losses and to explore the meaning and significance of their lives seems a foreign concept in a society run by the ethos of productivity, progress, and efficiency.

When discussing recovery in terms of a process, it is important distinguish the survivor's use of the word "process" from traditional notions of progress, growth, and self-actualization that imply a forward-moving or linear trajectory. The recovery processes described by the survivors were far more complex, cyclical, and seemed to elude a single definition or model of recovery. Each individual's healing process was both idiosyncratic and connected to the survivor community's political missions. Each survivor described an individual recovery process that, at the same time, was also a story of a family's recovery, a society's recovery, a world in recovery. In other words, it is a recovery process that cannot be mapped out, described linearly in terms of getting from point A to point B. Like life itself, recovery is a process that defies definition and simply is.

Recovery from the Mental Health System

"And started slowly figuring out that I don't think what happened to me should have happened. It was so brutal. And I felt so much more broken than when I went in." (Ruta)

Each of the survivors interviewed identified the mental health system and the various psychiatric interventions (i.e. ECT, drugs, solitary confinement) they endured as some of, if not the, largest obstacles in their recovery processes. In most cases, the hospital stay had nothing to do with the healing process and actually compounded the problems that people were dealing with prior to admission. When asked to describe her experience of psychiatric hospitalization, Cheryl replied:

I've recovered from the mental health system. The mental health system had been one of the largest obstacles of my own recovery, and my own internal saboteur. ECT knocked out whatever little sense I had that I could have used at the time to start managing some of my problems. But I was rendered incapacitated. (Cheryl)

The survivors often described the psychiatric hospital environment as soulless and devoid of any sincere human compassion or relationships. Most of the people interviewed described the majority of the doctors and other professionals working in the mental health system as being terrified of any non-ordinary state of consciousness or expressions of distress. In order to separate themselves from the patients, the psychiatrists pathologized and medicalized human expressions of suffering ranging from hearing voices, to self-injury, to crying. Cheryl questioned the system's ability to facilitate recovery when psychiatrists seemed more concerned with behavior management and diagnosis than trying to understand her distress within the context of her life:

Going to the mental health system where I'm not even asked what might be the underlying cause of my distress. But boy, is my distress codified, numbered, catalogued. And nuances of words; who ever heard of "depersonalization" and some of this jargon? So the whole focus is taken off etiologies, so how can you ever effect a deep healing? You can affect symptom stabilization and maybe even amelioration. But transformation and becoming stronger in the broken places, it only happens when you name the demon. Not the mask of the demon, which I think is what labeling and diagnosis does. It isn't like other aspects of medicine. Obviously nobody gets together and votes on whether pneumonia will be a disease this year. But that's what happens with the DSM. (Cheryl)

Ironically, the same diagnostic labels that create distance between doctor and patient also keep people dependent upon the system. When a person receives labels like schizophrenia, bipolar disorder, or borderline personality disorder, it often leads to feelings of helplessness, hopelessness, and dependency upon the mental health system in order to maintain any semblance of a "normal" life.

Alex: So it sounds like there a lot of fear that's driving the mental health system, preventing connections. Even between sympathetic staff members possibly.

Cheryl: Right. It's almost an impediment to the natural human connections that maybe we used to know before we inherited this asylum mentality of putting people away who are different. And now we forget how to be with people with differences, and isn't that playing out in the world arena with Muslims, and Iraqis and the whole xenophobia....It's that part of me that I've forgotten, and rather than connect with you and become more whole myself because I'll reintegrate that part of me that for whatever reason I've chosen to discard or it's not been comfortable in my life to keep. Yeah, I just project that. So we have a lot of well people who get to be well at the expense of this other minority population.

Other participants also spoke extensively about the fear of extreme expressions of pain and suffering that drives many professionals in the mental health system. It is easier

for psychiatrists to distance themselves from unpleasant and frightening situations than to risk opening themselves up to connect with another human being in crisis. Many participants expressed their concern that experiential and existential therapies are currently considered to be outside of the mainstream, and those that are more commonplace (i.e. cognitive-behavioral therapy) are approaches that emphasize technique over human connection. The lack of empathy and connection stemming from the doctors' own fear and insecurities creates a paternalistic atmosphere that reenacts the paternalism of other institutions like family, school, religion, and thus has great potential to re-traumatize the person compounding an already overwhelming situation.

*And that was my first experience,
was just being taken into a hospital,
and taken to the most secure unit
and strapped and put in a room
all by myself.
And being told that was
in my best interest,
and people
knew better than I did
what I needed,
and that kind of thing.*

*Because those experiences were horrible
and they so reenacted my childhood of,
you know, "this is good for you."
And you can't speak out against it
because you've got a label
and you're psych labeled.
And I got a ton of different labels.
None of them I felt
were anything that meant anything.*

*I think my childhood caused me a
great deal of struggle;
the psychiatric system
kind of topped it off.
And for years after that
I struggled to work
and I ended up being
nearly homeless and ended up on disability.
And over time, even though I was on disability,
I got the chance to piece myself together,
and get back to where I can work part time.
But it was only when I left that place
that I said,
I'd rather die*

*than go back to any kind of
formal mental health services. (Ruta)*

For the survivors interviewed, the paternalistic nature of the psychiatric system discouraged patient autonomy and choices regarding treatment decisions, which lead to many instances of coercive or forced interventions. Without the freedom to discuss and choose treatment options with one's mental health care provider, the patient becomes dependent upon the system and disempowered in his or her recovery process. Even when patients comply with their doctor's orders, there is no guarantee of either increased autonomy or emotional healing.

*And the drugs knock you out so much
you can hardly get up.
But if you don't go then like, you know,
they take points away.
So I quickly learned that
you had to act good to get out.
So I did what I was told.*

*You had to act like nothing was wrong.
Everything was fine,
and yes I need the drugs,
and answer the questions right
in order to get out.
So I started playing the game more.
And also it helped to have family
that wanted me to get out too.
So I think I got out quicker
because I had the support.
Some people are just alone. (Oryx)*

Another issue regarding lack of choice in the mental health system was involuntary commitment procedures that, again, many feel are paternalistic, coercive, and potentially re-traumatizing. Most of the people I interviewed described their experiences of involuntary commitment as some of the most violent, manipulative, and traumatic incidents that they encountered while in the mental health system. One of the survivors I interviewed, Will, shared with me his terrifying story of being involuntarily committed after initially seeking help voluntarily from a mental health clinic. Will explained to me that at the time of his hospital admission he was not aware that he could be committed for simply talking about suicide or his previous attempts. After waiting for over four hours in a clinic to speak with a doctor, he was told that he was going to have to be hospitalized, despite his protests:

I told them this was really, really upsetting to me because I had to work the next day. I didn't want to lose my job. That I was really, really upset about the shame

that that was going to cause, and that was a really horrifying terrible, terrible thing to me. And it was really, really traumatizing in and of itself. (Will)

Against his consent, Will was forcibly restrained and taken to a state psychiatric hospital; thus began one of the first in a long-line of traumatic experiences he experienced while within the mental health system.

*So I was restrained in this wheelchair
and it was locked
in the back of this dark van
with no lights at all. Driving—
I didn't have a chance to call anybody
I didn't know where I was going.*

*And I ended up in the General Hospital's
psychiatric emergency room.
Which was just really—
cause it was just like a jail.
It was like a jail.
Like being in a drunk tank of a jail.
And all kinds of people
screaming all night.
And really scary people
in an overwhelming situation.*

*And trying to talk to a nurse there,
talk to a staff there,
and they were really not—
the interactions I would have with them
would just make me more upset,
and more threatened,
and more confused
about what was going on.*

*And so that was a really
shattering experience
and the trauma of that was just like,
it was just enormous.*

*And the combination of having this
incredibly shameful thing
happen to me;
of losing my jobs,
and everybody knowing
that I had been hospitalized.
And being in restraints,*

*and going into this locked unit,
which was just
really, really, really
traumatic.*

*Afterwards, I had nightmares
that I was being raped.
And I was just basically in a daze from that.
I was really, really disoriented
and really in shock,
and really disassociated from it. (Will)*

Surviving Trauma

“But also most people have been abused as kids. You know pretty severely; physically and sexually. And that’s just something that’s not talked about. It’s said that the person is mentally ill, they’re sick.” (Oryx)

Several of the psychiatric survivors I spoke with disclosed that they were also survivors of sexual and physical abuse prior to their first encounters with the mental health system. The prevalence and severity of childhood abuse in this country is a factor that is often overlooked in the relentless pursuit of a biological or genetic etiology of mental illness. When abuse is acknowledged in the etiology of mental illness, it is typically cited as an environmental trigger that sets off the underlying medical condition (i.e. the diathesis-stress model; see Plomin, 1989; Pam, 1995). However, the survivor movement has worked to raise awareness about the harmful impact of trauma in and of itself. Many survivors would contend that if people are recovering from anything it is not “mental illness” so much as from abuse and trauma.

*You know, I was a trauma survivor
from before I was in the psych system.
And the psych system itself
is very traumatizing.
And since then I
learned to deal with trauma directly.
Has been a huge part of what I’ve been through.*

*I think it’s kind of the essence of,
one of the big problems
that’s with the mental health system
is that it’s not a trauma recovery system.
It needs to be, you know.
It’s a medical model rehabilitation,
custodial kind of system
not dealing with trauma. (Will)*

Trauma may be construed broadly not just in terms of childhood sexual or physical abuse, but also emotional abuse, traumas from the mental health system, trauma of poverty, social injustice, bigotry, political oppression; in short, life is traumatic. But the current focus of the mental health system is not so much on people's lives as it is on their neurotransmitters, chemical imbalances, and bad genes (Frattaroli, 2001; Johnstone, 2000). One of the messages of the survivor movement (borrowed from the women's movement) is that the personal is political, and until this connection is recognized, we are trapped by reductionistic reasoning that blames the person and their broken brain rather than contextualizing the individual in the world at large.

If the exclusive focus of trauma recovery is taken off of the individual and turned back onto the society and culture in which the person dwells, then psychotherapy and healing take on new meanings and practices. Ideally, therapy would not simply be in service of the ego, but instead, would pair personal healing with social activism and working to change the conditions that foster such abusive acts in the first place. However, oftentimes before such political action can take place, some degree of personal healing has to take place in the person's life so that there is a foundation of safety and stability on which to stand. The psychiatric survivors who also had been abuse survivors before entering the mental health system spoke about this process of first gaining a general sense of stability in one's life by fulfilling basic needs like physical safety, housing, and food. The next task involves attending to one's own emotional, spiritual, and physical wounds through relationships, therapy, or simply the passage of time. There is not one correct approach or therapeutic technique for addressing these wounds; but as several of the survivors explained to me, the key was having a safe (both physically and psychologically) environment for the healing process to take place in.

An Epiphany of Human Compassion

A survivor of both severe childhood abuse and the traumas of the psychiatric hospital, Ruta found that it was extremely difficult to trust and connect with other people. After being betrayed by the very people who were supposed to love, protect, and care for her, the thought of engaging in the world again seemed like an overwhelming and terrifying undertaking. A vision of healing characterized by political activism may seem years away, if not impossible, when the prospect of interacting with other people distresses you so much that only cutting your own body can temporarily numb the fear.

This brief yet profound encounter described below redeemed Ruta in a sterile hospital environment void of kindness, patience, and compassion. The housekeeper did what the psychiatrists and nurses could not—she was able to sit with Ruta's sadness without fear, judgment, or pity. Like a guardian angel, the housekeeper enters softly and swiftly into Ruta's world; and the effect she has on her life lasts a lifetime. The anonymous angel teaches Ruta a lesson about the healing power of empathy, listening, and honoring another person's despair. She did not try to fix, change, or rescue Ruta; sitting and bearing witness to her suffering was enough, and more than any psychiatric intervention could have offered. Today, Ruta shares the wisdom she gained in experiences such as these with other survivors as well as with mental health professionals. Ruta has found meaning in her past sufferings and purpose in her current

activities by sharing her gift of insight with those who share a vision of a humane way of healing.

*The biggest difference was the housekeeping lady;
I remember her.*

*It was such a touching thing because it was the slightest act.
I was in my room
in this hospital
by myself
and I was just so sad.*

*And I usually couldn't cry much at all,
but I was finally crying,
and the housekeeping woman was coming to, I don't know,
do something with the room.
And she didn't act like the rest of the people that go,
"Oh God, you're a borderline
or you're so depressed
and I don't want to hear your story."*

*She just came by and she didn't say a word,
and she sat down next to me on the bed.
And she just sat with me for a couple of minutes
and then she said,
"I'm so sorry,
that you're so sad.
I hope you feel better honey."*

*And it was just the most soothing,
human kindness
in an environment that was just looking at you
at how you're behaving,
and we can ask you what you're feeling
but if you demonstrate a feeling
they start getting scared.
Like if you start crying in a psych unit
it's not seen as,
"Great, you're learning how to cry."
It's like, "Oh you must be really upset,
what are you going to do to yourself" kind of stuff.*

*And I instinctively knew
what I needed to do
was learn how to cry,
and learn how to be angry and things like that...*

*I was really good at being afraid.
But not those other feelings.*

*And I guess that one woman's comforting
was the thing that taught me,
that's what helped.
It was a simple,
human,
not trying to control what you're doing,
how you're feeling
or anything else.*

*It was just simple empathy
that didn't have to be a big deal,
and it just touched my heart.*

*And she could have easily walked out of the room.
It wasn't anywhere in her job description to say, you know,
I have anything to do with any of these patients.
As a matter of fact
she's probably not supposed to.
She's probably just supposed to empty the garbage or something.*

*I love her.
It's like sometimes I just say,
"Thank you" to the air.
I don't know her name, nothing.
But she had the greatest impact on me
in a positive way there. (Ruta)*

Recovered Voices, Recovered Lives

*"And I learned to speak the language of psychiatry instead of my language of what
happened to me." (Cheryl)*

A common topic of conversation throughout each of my interviews was the ways in which the survivors rejected or reframed the medical model's conceptualizations of mental illness and health, found their own voices, and narrated their own stories of recovery. The survivors I spoke with rejected the notion of recovery as simply symptom management or returning to a state of normality because these conceptualizations suggest that symptoms such as feeling depressed, cutting, or hearing voices are manifestations of a literal underlying illness. One of the most difficult yet essential qualities of the survivors' recovery stories was their escape from the medical model's web of meaning that traps people into believing that they are literally dysfunctional if they have been given a psychiatric label.

*I don't believe it cause I think this
Decade of the Brain
has inspired it to be perceived as a
biological only problem,
and I don't believe that.
To me, when somebody else talks about it,
somebody's really struggling with something.*

*But I don't use that language.
I don't apply it to myself,
even though I'm quote
"psychiatrically disabled."
I do believe I have a disability,
but it's not an illness or a disease.
It's the remnants of my own history
that have left me
with these gaps in terms of
I can't necessarily do things
many other people can do
like work a forty hour week.*

*So I think it's the medicalization of it
that upsets me most.
I mean that's the illness part,
whether it's...
you know to me, it's soul ache.
That's what I'd call it, soul-angst.
But you don't get paid for people to come to
help you with soul-angst. (Ruta)*

The widespread use of the discourse of the medical model in our culture creates an especially difficult situation for psychiatric survivors who attempt to re-define their struggles and imagine a version of the good life that is not necessarily in accord with mainstream, Western values. Sadly, even speaking about one's struggles in terms of "soul-angst," an existential crisis, or political oppression rather than passively accepting a psychiatric diagnosis often is interpreted by mental health professionals as resistance, lack of insight, or symptomatic of the person's psychopathology.

The recovery of voice and agency ties directly back to the survivors' struggles to recover from the mental health system. The people I spoke with felt oppressed, misunderstood, and generally ignored by their doctors who all too readily assigned them labels such as schizophrenic, borderline, and bipolar without listening to each individual's story in his or her own voice. Even when an occasional doctor or nurse did stop to listen, the meaning was often lost or misinterpreted in light of a psychiatric discourse that is completely devoid of moral, spiritual, and social discourses that often lie at the heart of people's suffering. Cheryl described this struggle between two competing systems of meaning:

*There's an insertion
of somebody else's meaning
into my meaning system,
which is another fancy way
of saying my spirituality.*

*The crisis in meaning,
ontological insecurity.
I'm having trouble understanding my world,
and my world is having trouble, in turn, understanding me.*

*Somebody gives me their world view,
which is really inserted.
It's kind of like a rape.
It's not really like, "Oh there's this way,
there's this way. Let's talk about how maybe
some of your elements, and some of my elements...
No. We don't talk your story.
We're going to talk my story—
the master narrative." (Cheryl)*

Cheryl eloquently highlighted the difficulty of separating oneself from the master narratives of mental illness and recovery. One effective form of resistance to a master narrative is the creation of a counter-narrative that rejects the medicalization of people's suffering and does not locate the problems solely in the person's brain or genes. The survivor movement itself clears a dialogical space where people may begin to construct or participate in counter narratives. In such a space, they gain the freedom to define exactly what it is that they feel like they are recovering from, whether it is child abuse, poverty, political oppression, or the mental health system. Will explained to me the importance of finding one's own voice within the safety and freedom of the survivor movement:

*The idea that recovery should be self-defined,
which I think is great.
Because our survivor group
is all about self-determination.*

*And we're all about people defining it for themselves.
We say that people are free to define their own recovery,
or healing, or wellness, or whatever they want to call it.*

*Because other people are going to have different kinds of reactions to those terms.
A lot people don't feel like there's anything wrong with their mental health.
They have nothing to recover from.
That the problem is that they're*

*being hounded by the mental health system,
or they're being oppressed by political forces.*

*So again, I think it's a question of self-definition.
Like I said, I'm really sympathetic
to the idea of self-definition
and you know, people being able to say,
"I take meds. I work part time.
I'm in recovery because I feel like I'm in recovery.
Because I'm better than I was,
and I'm achieving the goals that I want to achieve and I'm recovering."*

*But also really important to understand at the same time,
that we allow people to define recovery for themselves
we have to also look at the way in which
the mental health policies are biased
in certain kinds of directions based on bad science. (Will)*

Once a person is able to find the words to describe their experiences outside of the master narrative's discourse, then an initial component of the recovery is often a reframing of past and present struggles as strengths, resiliency, and survival in light of new possibilities for the future. This means that the goal of recovery is not to simply eliminate these ways of coping outright without first attempting to understand their significance and meaning within the context of the person's life. Lived experiences, though painful and terrifying, are something to be lived through and learned from rather than suppressed with drugs and cast aside as meaningless symptoms of a neurological glitch. One may never completely heal from the wounds of severe trauma, but some are able to reframe their reactions to those experiences not in the language of pathology but in the language of survival.

*And we don't help people
find their internal resources.
And, when the therapist said,
"You know, I won't stop you from cutting.
I wouldn't. You need it."
And she literally said,
"You'll stop when it's time."
And she did that with everything I was doing
whether it was being
in an abusive relationship,
or smoking, anything.
You'll stop when it's time.
You'll stop when you don't need it anymore. (Ruta)*

Under the yoke of managed care and its demands for empirically validated treatments, the current mental health system seeks to employ well-defined models of the

recovery process. However the kind of therapy that Ruta describes above avoided the confines of treatment plans, didactic or cognitive interventions. Instead it put the healing process in the hands of the patient rather than the therapist. It was for Ruta to explore the meaning and significance of cutting for herself instead of her therapist mapping out the course of Ruta's recovery process for her. In other words, Ruta rejected the medical model's conceptualization of her experiences and reclaimed authorship of her own life story. Through the process of finding her own voice, Ruta also encountered the psychiatric survivor movement, whose goals and focus on human rights advocacy resonated strongly with her own values and conception of living a good life.

Cheryl raised some important questions around the topics of survival, empowerment, and finding one's own voice amidst a cultural mindset that has little tolerance for suffering, existential crises, or even facing our own shadows that create conditions of oppression and social inequality:

So how do you help people author their own lives and be their own authority when the system itself is so disempowered? When people are afraid to do these creative things, or truth-telling and name the violence for what it is. There are so many political forces that are at odds with healing. Between the pharmaceutical companies, and some special interest groups, and really just a culture and a society in itself that hasn't—individually we haven't embraced our own inner demons so collectively there's no way we want to really grapple with the darker sides of individuals. (Cheryl)

The larger issue that remains to be addressed is whether we are a culture and mental health system that is truly promoting healing or we are just returning people to a state of normality, which may be defined by the values of being productive, well-behaved, and high-functioning? Another way of talking about this mainstream version of recovery is in terms of the consumerist mindset that drives our capitalistic societal structure. In this sense, psychiatry may be used as a means to numb people to their own suffering and the plight of their fellow human beings so that they can quickly return to work and continue the cycle of production and consumption. For many of the survivors I spoke with, part of the process of defining recovery in their own terms was to ignore society's expectations that they should work 40-50 hours a week and stay on their psychiatric drugs for the rest of their lives. The counter-narrative of the survivor movement helps to illuminate some of the more troubling characteristics of the master-narrative of recovery such as chemically numbing away distress and striving for conformity rather than embracing people's eccentricities. These goals and values trouble the entire notion of recovery, and beg the question, which is in greater need of healing: those labeled with mental illnesses or the system and the society that has created such distinctions of illness and health?

The Myth of Incurability

“And recovery is weird; it's not mutually, it's not like, oh these people were sick and they have to learn how to recover, and these people are just well. No. It's the same concept applied to these people and these people. Everybody.” (Oryx)

Many of the participants in this study emphasized that a message of the survivor movement is that recovery is a possibility for all people, regardless of psychiatric label or severity of trauma. It was clear from the participants themselves, and other survivors they spoke of, that people can be incredibly resilient. Not only can people carry on, but also offer their help to others in need. According to this conceptualization of recovery, it is possible to break through limitations that people imposed upon themselves or others imposed upon them, and realize the full potential of one's life.

*So I learned not to believe in the limits
that other people tell you you have.
Like in the hospital, you know,
"You'll be lucky if you ever get out
and live in a group home."*

*It's like well, no thanks;
I prefer my cabin in the woods
with my family, friends, and this job I have instead.*

*I think sometimes if the mental health system
doesn't believe in healing
they just believe in controlling your quote "disease,"
you don't instill hope in people.
That they can get further
than you envision they can.*

*And I think a lot of them considered that I should
just end up on the back wards
and stay there,
at best maybe,
maybe get out with supervision.*

*And you know now I go to meetings
and tell them off for that kind of mentality.
I don't think people who were anywhere near—
people in the mental health looked at my biggest struggles,
which they called symptoms,
and instead of helping me find my strengths.
And I think that's what the one therapist
and the friends I started making would find for me. (Ruta)*

Far too often in clinical literature, and in the media at large, people labeled with so called mental illnesses like schizophrenia, bipolar disorder, or depression are told that these are permanent and in some cases degenerative conditions from which complete recovery is not possible. Of course in this case, complete recovery would be returning to a state of normality—a questionable label and goal in and of itself. However, the survivors interviewed emphasized that we as a society should not create false

dichotomies between “mentally ill” and “normal” people because everyone has or is recovering from something in their lives. The word recovery, with its medical model connotations, actually forces clinicians into making these divisions between illness and health. Thus the master narrative creates a mindset where doctors declare that complete recovery is not a possibility for some extreme states (i.e. schizophrenia).

*But they're [psychiatric labels] horribly hurtful.
And I've met a lot of people who I think
are stuck in the system
cause they believed them.
There's a lot of hopelessness
associated with them.
And it was like
a spiral going down
once you received the bad labels.*

*So I think people
(that breaks my heart)
that I think are stuck
because they start believing what the system believes.
And then they lose their hope,
and they don't want to leave the hospitals
cause they're scared that they can't survive.
That's the thing that hurts. (Ruta)*

Ruta and the other participants raised the possibility that it is not the so-called mental illness that prevents people from leaving the mental health system, but the structure of the system itself that keeps people dependent and disempowered. In this way, the psychiatric institution perpetuates a vicious cycle of involuntary commitment, diagnosis of a medical condition from which there is supposedly no chance of recovery, and an atmosphere of isolation and fear; all of which hinders people from imagining another fate. Some of the central themes of the survivor movement are empowerment and freedom of choice, and the people I interviewed stressed that offering people the possibility of recovery (even with its medical model connotations) was of utmost importance if we hope to break the cycle of disempowerment and dependency upon the mental health system.

*And in that sense
I think it's very positive.
But I'm talking about you know,
like back-groups, back ward, massively,
totally un-commutative, cannot be themselves,
on massive drugs, who were exposed to violence,
and not just normal people,
but the most extreme people
can have turnarounds.*

I think everyone has to be treated with that potential of recovery. And that's where the message of recovery is a really positive thing. And the National Empowerment Center, and Dan Fischer, and Laurie Ahern's work, and Judi Chamberlin, they've really zeroed in on that message—yes, you can recover from the most severe mental illness. And it's been a very positive contribution to changes in the mental health system. (Will)

Deconstructing Recovery

In order to give due respect to the counter-narrative of the survivor movement, the term “recovery” (with its medical associations) is not appropriate for describing the change that occurs in people’s lives. Perhaps I have been missing the point all along because of my use of the word recovery from the perspective of the mental health system. The survivors I interviewed were not recovering a former state of health because most would agree that they were not ill in the first place.

The survivor movement presents a different vision of recovery in comparison to the medical model notions of symptom-elimination and a return to mainstream society. Survivors encourage one another to break through the limitations imposed on them by society, embrace their eccentricity, and use their talents and abilities to pursue their dreams. This vision of recovery harks back to the idea of living a good life, which everyone strives for regardless of pathology, experience of trauma, or abuse. But is everyone in recovery? Again, perhaps the word recovery with its medical connotations is the wrong term to describe the kind of healing and way of living that the survivors spoke about. Ruta struggled to find the words to describe what it means to be recovered or living a good life:

It's hard to find language for it. Just like it is to find language for the super struggle inside, when everything is really hurting, that drives you into the system. It's hard to find words for how different it is. It's just wanting to wake up in the morning looking forward to the day and being grateful for everything that you've got. And for not being locked up. For not being homeless. For having many, many things you value. And knowing that you don't need to fear losing them, or that you can't survive something happening. (Ruta)

Oryx explained that a holistic sense of “wellness” is a better descriptor than recovery for what we are all striving for in life:

But then there's the thing of wellness, and actually everybody's going to get there at some point. But there's a thing of wellness where it's for everybody.

Everybody. It's not like the quote unquote "normal" people don't have these quote "symptoms." Cause everybody's human. Everybody's going to have their good days and their bad days. And so to me it's more about you know, wellness. (Oryx)

Ironically, the focus of this entire project is a product of the medical model's discourse; and I often found myself wondering if my interest in these survivors' stories was less about recovery and more about wellness or living a purposeful life. Will discussed how the term "recovery" is complicated and problematized by its roots in the medical model and associations with twelve step groups:

I think that there's a way in which the word gets kind of twisted around, and the way in which a lot of the sort of traditional kind of framework, like long-term medication usage for example, or a long-term custodial relationship with psychiatrists kind of seeps back in to the whole idea of recovery. I also think that recovery is a stigmatizing word in its own way. Because I mean like the twelve step movement is stigmatizing. And you know, it can be empowering and helpful and useful to people, but there's a way in which for example, the president of the United States is not going to be, or any politician, or any head CEO, or police chief for example is going to be able to openly say, "I'm in recovery." Cause it discredits them, it's perceived as a kind of weakness, and a vulnerability, and a lack of capacity and makes them questionable. So there's a part of me that just doesn't want to buy the whole thing at all. So I think it's a complicated, I guess my answer is that it's a complicated term, you know. It's a political term. It's a term that's being used by the mainstream system. (Will)

As a result of dialogues like these I began to question what it is that survivors are recovering. What are they recovering to? And finally, if not recovery in the medical and psychological sense, what *did* happen to bring about such a drastic change in their lives? Psychologists remain focused on the mental illness of the individual, whether the focus is on prevention or integration back into the fabric of society (which ironically drove them to madness in the first place). Also important to note, the mental health system is concerned with the recovery of the *individual*, not with the well-being of our environment, culture, the impoverished, oppressed, and tortured.

In contrast, the aim of the survivor community is not on individual recovery as much as addressing social injustice across many domains through political activism, advocacy work, and consciousness-raising. It also serves as a safe place for people who reject many of the master narratives of Western society (i.e., medical model of health and illness, consumerism) to engage in these sorts of counter-cultural discourses. However, the key distinction between mental health community and survivor community is that the latter's aim is consciousness-raising; not recovery of normality or living a symptom free life. Consciousness-raising may begin with an individual epiphany that the personal and the political cannot be separated, and thus it is futile to attempt to cure the person through medical means when the trouble more accurately exists in the body-politic.

Meaning of recovery—

*Well at first I thought
it was personal,
which was about
me getting better
so I can get on with my life.*

*Now I realize
that my life is all about
helping others in the same boat.
And if the system is interested in having a clue,
of cluing them in.*

*And now it's even wider than that.
It's really as you say,
about organizing and activism,
and some other of those initial discrepancies
that put me into distress to begin with.*

*Like how come most of the world
doesn't have access to
hot running water everyday like I do?
I cry when I'm in the shower
about the fact that
I still have hot, running, clean water
anytime I want. (Cheryl)*

The conception of recovery solely in terms of growth and self-transformation is also problematic because this perspective still locates the problems and solutions inside the autonomous, bounded individual. Especially troubling in this definition of recovery is when self-transformation and growth is emphasized in exclusion to the social, institutional, political, and environmental dis-order that exists in the midst of the person's journey of recovery. Understanding recovery solely in terms of personal growth and development perpetuates a false dichotomy between the personal and the political, and thus recovery is not holistic or complete because it separates the individual from the soul of the world.

Recovery and the Good Life

"This is a good life. This is very happy, very alive, very connected to my purpose. I'm here. I'm part of, I believe, a small group of people who are working to drastically reshape the paradigm of mental illness in this dimension at this time. You know, that's nice to be connected to something so lofty." (Cheryl)

After reflecting upon my conversations with the psychiatric survivors interviewed for this study, I came to the realization that their stories were less about recovery in a medical or psychological sense, and more about living a good life. The survivors defined

a good life in a variety of ways; but some of the common themes revolved around participating in meaningful relationships, having a purpose in life, and a large part of that purpose being of service to greater causes. This pull or calling to help others (including people, animals, environment, and society) often leads people to start or join survivor communities in order to share their story and pass along the knowledge and wisdom from their varied experiences.

*People who've gone through something,
and they're singing about it.
And they're putting it to music
and they can sing about
really sorrowful things
but you end feeling
happy for having heard it.
There's something to—for me,
to be said for that. (Ruta)*

The participants described their journey out of the mental health system and beginning the process of recovering the meaning and purpose of one's life from the sterile and depersonalized language of the medical model devoid of moral, political, and spiritual discourse. In contrast, the discourse of the good life reconnects the individual the environment, society, other people, and most importantly a greater purpose in life, or destiny.

*I think in terms of just
realizing that we're part of a bigger picture.
A bigger universe
that makes sense,
and we have a place in it.
That things are interconnected
and we are interconnected.*

*It's helpful.
It's something bigger than yourself.
Because we're in a society
that places so much stress
on the individual.
And to realize that
I am important, yes.
But I'm also part of this bigger thing.*

*Yeah, service to the greater good of the whole universe.
You're small but you're important.
You don't have to sweat the small stuff
because ultimately there's a
much bigger picture out there.*

*The little stuff doesn't matter.
Helps keep things in perspective. (Oryx)*

Living a good life was described as an active and politically charged endeavor, and this re-connection of the personal and the political was an essential component in the survivors' stories of healing. When the medical narrative of the autonomous, bounded individual is rejected in favor of the survivor alternative narrative, then a new vision of healing and living a good life emerges that has less to do with personal growth and transformation and more with social activism and advocacy work. The horizon of personal struggles (i.e. emotional distress, poverty, discrimination) is expanded so that the individual serves as a representation or manifestation of political and social unrest. Thus, therapy and healing can no longer be limited to the confines of serving the ego, but instead, must be expanded to address the state of society as whole. In turn, a new conceptualization of holistic healing emerges from this alternative narrative that shifts away from the airy discourses of transformation and transcendence and pulls the person back down into the soul of the world (Hillman, 1979; Sardello, 1992). When asked to describe what living a good life meant for her, one survivor replied:

*Simplest way is
getting to have a life of my own.
How it feels.
Not feeling jailed by
fear, or shame, or guilt, or all those things.
Being out in the world.
Having connections with life.
Whatever ways they show themselves to me.
It's just, wanting to live now, and enjoying it. (Ruta)*

The process of re-engaging with the anima mundi often begins with joining counter-cultural communities, like the survivor movement, which call into question social injustice, institutional oppression, and other abuses of power and authority. For example, two of the participants in this study began a grassroots support and advocacy group for survivors, ex-patients, those labeled as mentally ill, and people who experience extreme states (a third participant is an active member in this group as well). This once small group has grown rapidly over the past four years in membership as well as in advocacy initiatives and has also gained respect in the wider community.

*I mean there was a study done on political activists
and it showed that they scored much better
on mental health than other people.
And that's one of the reasons that our group
has an activist component,
has a mutual aid component
is because helping other people,
and changing the world
really gives meaning to people's lives.*

*And there's so many people in the mental health system that—
what are they doing with their lives?
They're taking meds,
and watching TV,
and going to their appointments.*

*No, you cannot—
I mean unless you
medicate someone and control them—
that's unsustainable.
The human organism rebels against meaninglessness.*

*And the fact that counselors,
and case managers, and therapists
are forcing this on people—
it's just complete madness.
You know what I mean?
There has to be some real purpose
that people have in their lives. (Will)*

Another participant, Ruta, became involved in advocacy work and the survivor movement by starting a non-profit newsletter for self-injurers, which over the past fifteen years has created an international community of ex-patients and survivors from all walks of life.

*When I started trying to do these,
just connections with other people
out of a couple of those workshops,
people decided that they
wanted to stay connected to each other.
And we were from different parts of the country,
so I started this little newsletter
to stay connected.*

*Actually trying feel like
I was of service,
of use to somebody else
with the newsletter.
Because it literally took everything I had
to come out with the quarterly issue;
of a couple page editorial and some reviews,
and whatever poetry or writing or artwork
that people would send in.
That took me to my limit of struggle
cause it's so emotional.*

*But then when people send in a letter saying,
"I thought I was alone."
It's like, yeah I thought so too.
Boy, I'm glad I did something about it,
which just seemed to take off. (Ruta)*

All three of these participants spoke about how their advocacy work sustains them and emphasized the importance of being involved in projects that serve the greater good. In other words, the political activism these survivors are engaged in is not simply for their own personal healing but more broadly conceived as healing through attempts to change the world for the better. Living a good life of political activism also implies joining with a counter-cultural community of voices that together has the strength to openly question and challenge the status quo.

*I think that's probably,
the definition of healing is:
Oh, it's not about me.
And it's not about how
I think things should be.
It's just like, what piece can I do?
And then just leave it.
If it's going to have an impact, it will.*

*And there's a couple times in my life
that I was selectively mute.
I just stopped talking.
And now it's like
I go in front of a microphone,
and I'm actually happy to have the privilege.*

*I think to me,
my work now is a privilege.
There's so many people who went through
things similar to what I did,
who would like to have
their voices heard in Washington.*

*And then I get behind the microphone
and get to say what I think.
And that keeps me going.
Because I don't wash down what I'm saying
because I think of the people
that are still in the institutions.
And the faces of the friends I've made
for whom this is a passion.*

*So it's been really fun because it's—
the fear is gone.*

*For the person who's lived
her whole life fear-based, it's like
oh, give me the microphone.
I've got something I want to say.
I represent a group of people
that I honor deeply,
and it's been a real privilege.*

*Not that you don't end up
in the bathroom crying sometimes
cause you're so upset.
But that's ok. You know? (Ruta)*

Counter-cultural communities like the survivor movement can be empowering because people are no longer forced into master narratives of mental illness and recovery. The question that then arises is whether there are some counter-narratives that are better than others? Does each person get to define what a good life means for him or her? If so, are there some good lives that are better than others? Are they all good? Obviously, conversations about what constitutes a good life have the potential to degenerate into relativism, but only if we continue to conceptualize the good life subjectively, as a personal choice. Following Hillman's (1996) acorn theory, each person is born with a unique purpose, gift, or destiny in life; and living a good life means serving that greater purpose, which is in service of the soul of the world. From this perspective, living a good life is not a subjective choice or personal expression. Destiny is not to be confused with fatalism; people still have to make choices as what they want to do with their lives, but some choices bring us closer to fulfilling our life's purpose.

It's Not All About Me: Destiny and the Good Life

The survivor movement supports and encourages people to express their personal freedom and ability to make choices about their lives and right to refuse psychiatric interventions. Within counter-cultural communities, dialogical clearings are created for survivors to redefine their symptoms, mental illnesses, and recovery in any way they see fit. This dialogical space also allows for open questioning of the mental health system and many of Western society's values and cultural norms that many survivors find corrupt and flawed. The survivors I interviewed readily acknowledged the importance of having the freedom to give voice to their own experiences and choose their healing paths. At the same time, our conversations about what it means to live a good life went beyond self-expression and personal choice, centered instead on living a life in service to others in need.

Will, a life-long activist committed to such causes as environmentalism, anti-militarism, and social justice, is one such individual who has dedicated much of his life and energies towards advocating for those who are still oppressed, abused, and mistreated by the psychiatric system. When I asked him to describe what living a good life meant

for him, Will discussed with me his unique perspective of the good life and the tension that exists between a self-definition and recognition of the larger forces at work directing our lives.

*I think that I have a personal view that's not,
that wouldn't be necessarily be a view
that the survivor movement as a whole would take.
Which is that the good life isn't a personal expression.*

*It's not, how do I find the good life?
How do I have a good lifestyle?
That that's already seeing it as a commodity
that you can just kind of achieve.
And it's seeing it as part of the mainstream ideal
that if you play a certain kind of game
and you're successful in that
you're going to have the good life.*

*That you make enough money,
that you're smart enough,
or if you work hard enough,
if you try hard enough,
that you're disciplined enough,
or you're beautiful enough,
or you're intelligent enough
you're going to get these things.*

*It puts the focus on the individual's virtue.
And I think that the real question is,
what kind of values our society has?
And what kind of life is our society promoting?*

*Look at the amount of poverty
that our economy tolerates.
The kind of serious social problems
that aren't being addressed.
Like domestic violence,
and violence against women,
and environmental problems.*

*I mean these are all, to me,
bound up in the idea of what is a good life.
So it's not like an individual thing.
It's that it's a group thing.
It's a social thing.*

*So, for me in a sense,
I don't think the good life is possible for me
because I'm tied up with this society and this planet,
which is already way out of bounds
and very much unhealthy.
So my own health and my own good life
is really connected to the larger.*

*So that's one of the reasons that
I'm really involved with social activism and social projects.
And I think that communities of people
and movements of people
can create more positive, healthy oases inside of this
larger, unhealthy, problem-riddled society.*

*But I think that that's limited.
I mean, I don't know have any illusion that
I'm going to be ever one-hundred percent healthy
because I don't think the planet is going to be
one-hundred percent healthy. (Will)*

Consciousness-Raising and Participation in Counter-Cultural Communities

*"And I think people heal in community. And if you provide them with access to do that.
And it's information, connection, opportunity, and basic respect." (Ruta)*

An essential element of the recovery process that each of the survivors emphasized was the importance of their involvement with the psychiatric survivor movement. The counter-cultural survivor movement provides the opportunity to escape from Western master-narratives of mental illness and recovery and to dialogue with others who share an alternative perspective on the meaning and significance of psychopathology and wellness. Within these counter-cultural dialogues people realize, sometimes for the first time, that they are not alone in their particular struggles and have the opportunity to connect with others who have survived the system's abuses. The people interviewed cited the mental health system as an impediment in creating connections with other survivors. They pointed out that during their hospitalizations even the doctors discouraged a sense of community among the patients.

*I think isolation,
like actually making connections
with other people who
didn't buy into the system.
And the system didn't provide,
didn't make a survivor support group.
The system never even connected me
with other people who shared my point of view.*

It should.

*The system should be working to
help people form communities, you know?*

*It should be working to
help people with similar interests
and points of view get together,
and communicate with each other,
and help each other.*

But it doesn't do that.

*It makes everyone depend on a
relationship with the service provider,
and fragmented from each other.*

And I think isolation is the main problem.

The lack of visibility for the survivor movement.

*And if the survivor movement was
more visible, and more effective,
people could find each other more easily.*

*And then people who don't want to
buy into the mainstream view
can have alternative groups and alternative individuals
that they can connect with.*

So yeah, isolation is the biggest obstacle. (Will)

The act of joining with others who have had similar experiences of oppression and maltreatment leads to the consciousness-raising component of the survivor communities. The survivors interviewed said that a clear turning point in their healing process was deciding to permanently leave the cycle of custodial care in the psychiatric hospital system. After years of being on the receiving end of psychiatric treatment the survivors came away with a new and disturbing perspective on the inner workings of the mental health system. Through this new level of conscious awareness, they could see through the benevolent façade of the system and recognized more clearly the financial alliance of pharmaceutical industry and the American Psychiatric Association. Armed with this knowledge and insight, psychiatric survivors joined together to form communities based on the premises of peer-support, political activism and advocacy work, and consciousness-raising efforts directed at both the mental health system and the general public.

*And I think there's a lot of people
that leave the system.*

Who was it?

*Rae Unzicker once wrote,
most people don't come out
to join the ex-patient movement.*

They just go away from the system

*and never come back.
And go on to lead lives
that they kept that part of their life secret.*

*Because it's so hard
not to feel ashamed.
Even though I've been publicly
doing work in this stuff,
to sit here
and try to talk to you about it
from personal places,
like I'm bumming smokes off my neighbor.*

*Cause it does, it's a profound judgment, I think,
we as a society have about that label
and we don't want to talk about it.
You don't want to admit it.
So I think it's tough stuff. (Ruta)*

Oftentimes, the first and most difficult step survivors make in the healing process is finding the courage to come out about their experiences of psychiatric abuse and ally with other survivors in a counter-cultural community. More than simply moving through the personal shame and stigma of psychiatric labeling, finding the survivor movement connects like-minded people who refuse to adjust to the status quo and empowers individuals to resist the limits and expectations of society, doctors, and family.

*I don't think without the movement I could have made it.
A full recovery.*

*Because I could see other people that had done it,
and that weren't on any medications at all.
And were doing great.
So just having those role-models to look up to.*

*I don't think I could have done it without the movement.
Yeah, I mean there's other things that helped.
I mean my family being supportive.*

*But without the movement,
I don't know if I could have convinced my family that—
I was able to convince my family
that the system was messed up.
Cause they're pretty smart people,
but without having anybody to back me up,
it's hard to do that. (Oryx)*

The survivor community also provides a dialogical space for people who do not conceptualize or narrate their struggles and distress in the language of the medical model. The survivors interviewed rejected the notion that the problems in their lives and various experiences of altered consciousness were the result of a biochemical imbalance or any other somatic process. Instead, they connected personal problems with political, societal, and existential ones such as oppression, discrimination, unemployment, poverty, and life's lack of meaning and purpose. This blending of the personal and political also served as a catalyst for involvement in political activism, resistance, and working to change the status quo that created the conditions for dis-order to express itself through the individual in the first place.

It also is important to note the distinction between a survivor community and the field of community psychology or other community initiatives designed and maintained by the mental health system. People are often forced to define mental health by the program's standards, which usually involve complying with orders to take psychiatric drugs, and obtaining steady employment regardless if the person ready to resume work. The emphasis in most community mental health initiatives is assimilating the ex-patient back into the flow of mainstream society, although there are community psychologists who argue that their profession "must be concerned with social justice and raising critical consciousness" (Rappaport, 2005, p. 236). As the survivors pointed out, it is the values and pressures of mainstream society that they believe contributed to their difficulties in the first place.

*Ultimately, I think that we are
living in a society that
drives people crazy.*

*And we need to start
moving towards a society
that promotes health
on all levels.*

*And I think the mental health
psych survivor movement
has to make a common cause
with low-income rights,
and non-militarism,
and environmental movement
so we can really start thinking
about what it is we want
to replace our present profit driven,
growth oriented,
privatized,
fragmented,
society with. (Will)*

Survivors do not need nor want the mental health system to play any part in co-opting their communities and defining successful outcomes in terms of having fewer symptoms, compliance with psychiatric prescriptions, or willingness to blend into the fabric of Western consumerist and capitalistic culture. The survivor community is unique because it is built on a model of peer support that does not demand that people demonstrate measurable improvement but simply allows the person to *be*, and be in the presence of others who refuse to assimilate back into the mainstream.

*And I wish I could teach
mental health professionals that.
Cause I know when I was working as a counselor
I felt like I had to
change everything for somebody.
And you want so much for somebody.
You want them to be
free of the suffering so badly.*

*And it's like I think sometimes
the more damaged you are
the less it takes.*

*Cause it took so little
by some people sometimes for me
to be completely changed.
And the whole, new, you know,
deep open wound
that was there
just started healing. (Ruta)*

Although the participants in this study could speak to the healing component of survivor communities and political activism, it is important to note that participation in a survivor or any other counter-cultural community does not guarantee healing or wellness. There is no magic formula that says that joining a counter-cultural community plus political activism equals recovery. If this were the case, the mental health system would most likely be tempted to test the empirical validity of such a recovery paradigm; co-opt the movement's goals into the master narratives of mental illness, growth, and transformation; and oversee watered-down community service programs in outpatient mental health centers. All of these things miss the point of the survivor movement: to challenge the premise of the mental health system's discourses of mental illness and health, as well as the consumerist, Western values that the system is a product of. Many survivors who take part in the movement talk about the benefits of community and political activism but without the explicit goal or expectation of recovery as a result of such involvement.

*Well, you don't know it's going to get better.
But if you're hooking up with somebody*

*who knows at least it's going to change.
It's not going to be this hell.
It might be a different hell.
But maybe that particular other hell might
afford an opportunity to do something.
You look for somebody that has hopes.
They can be like being in a choir;
they can carry the note
when you take a breath. (Cheryl)*

Unlike communities created by the mental health system that continue to focus solely on the individual, survivor communities actively address the larger social, political, and cultural dis-orders that manifest themselves through us and are subsequently labeled as mental illnesses. When we reject the false dichotomy of the personal and the political, it becomes clear that the “illness” does not reside within the brain at all; the dis-ease is more properly located in the world at large, or beyond this material world, in the *anima mundi*.

*So we started the survivor group
and we realized that we wanted to have
support and activism at the same time.
Which there was no model for.
And the only real model for
was the women's movement,
the consciousness- raising groups.
Where women would get together and talk about
their experiences and their lives with sexism with men.
And then how that would be connected with
political issues like legislation, funding battles, and political analysis.
And looking at the larger structural issues
behind their personal experiences. (Will)*

Thus, the major distinction between traditional notions of recovery in community and survivor communities is that survivors embrace counter-cultural communities that actively challenge and subvert master narratives of normalcy, adjustment, and assimilation into the fabric of mainstream America. Archetypal psychologist, Hillman (1996) stresses that the goal of psychotherapy should not be recovering normalcy but enhancing eccentricity and recapturing the beauty and mystery of each unique life's purpose and contributions to this world. The mental health system has no role by definition in the production or maintenance of these counter-cultural communities; because once the discourses of growth, transformation, and recovery (in the medical sense) are inserted into the vernacular of these communities, they cease to resist the master narratives of illness and health.

Discussion

In the following discussion, I outline the ways in which I organized the themes of the results section to reflect the movement from traditional constructions of recovery to the counter-narrative to the alternative narrative of the good life. The findings of this study that replicate some of the major themes of the existing recovery literature are the focus of the first part of my discussion. Next, I examined the ways in which psychiatric survivors rejected the master narrative and created a counter-narrative that exists in opposition to medical constructions of recovery. In the last group of themes, I discuss an alternative narrative of the good life that moves well beyond the existing recovery literature. The alternative narrative of the good life takes up ideas that are less often discussed in the literature or not at all. In this sense, this project not only broadens and deepens the previous literature but serves to substantially reconstruct the very notion of recovery.

Traditional Constructions of Recovery: Recovery as Process, Recovery from the Mental Health System, and Surviving Trauma

The first three themes that I discussed in the results section included “recovery as a process,” “recovery from the mental health system,” and “surviving trauma.” They do not deviate greatly from the themes that exist in the recovery literature (e.g., Cohen, 2005; Davidson, 2003; Jacobson, 2001; Ridgeway, 2001; Schiff, 2004), although this is not to say that each person interviewed did not contribute a unique perspective on these topics. In fact, some of the survivors’ accounts trouble and challenge the traditionally held notions of recovery, as can be seen for example, when they talked about recovery as a process. Instead of a temporally linear, forward-moving developmental process or stage model of recovery, the process that the survivors spoke about was defined less clearly by particular components and usually defied temporal description. The one exception was Cheryl’s narrative in which she constructed her experiences in terms of a stage model of recovery. However, this stage model was not necessarily confined to a linear progression and was largely cyclical in nature. Cheryl also differed from the other people I spoke with because of her affiliations with self-help groups like Alcoholics Anonymous and Mary Ellen Copeland’s (1997) Wellness Recovery Action Plan. These organizations may have influenced the construction of her recovery narrative.

An important aspect of the survivors’ recovery processes was escaping the mental health system, which typically entailed physically leaving the hospital setting, getting off of psychiatric drugs, rejecting traditional psychotherapy for peer-support groups or a non-traditional therapist, or some combination of the above. The recovery process is not limited to the individual’s psychic processes or state of mental health, but includes healing at many systemic levels including hospital, family, and work environment. This common element of the survivors’ recovery processes leads into the next theme discussed in the results—“recovery from the mental health system.”

Countless first-person madness narratives, as well as writings of critical psychologists, have documented the organization and conditions of psychiatric institutions throughout the history of psychiatry in America (e.g., Beers, 1908; Boisen, 1960; Olofsson & Jacobsson, 2001; Ward, 1946). These writings often describe horrific

experiences of the patients (or, as many in the survivor movement call them, “inmates”) of these institutions where they have experienced physical and emotional abuse, neglect, discrimination, and forced treatment. Those involved with the anti-psychiatry movement, (e.g. Thomas Szasz) have argued strongly against the use of involuntary commitment, coercion, solitary confinement, and physical force in institutional psychiatric treatment (Szasz, 1963, 1986, 2003).

The survivors interviewed for the current study consistently reported that their experiences of being involuntarily committed were some of the most traumatic instances of the treatment they received while in custodial care. All four participants felt that recovering from the mental health system was one of the, if not the single largest challenge in their entire healing process. This difficulty may have stemmed in large part from the fact that many felt that they were alone in trying to escape the system as their protests fell on deaf ears. When the survivors initially left the mental health system, most still felt trapped in the language of psychiatry; their friends, family, and employers often spoke in terms of mental illness and health as well. Thus, one reason that recovery from the mental health system is so challenging is the isolation, loss of community, and voice that many ex-patients experience upon discharge from the hospital. In this light, it is easier to understand why many people feel dependent upon the mental health system throughout their lives in that they feel that they have no alternative community to turn to in times of need.

It is important to note that the theme of escaping from the mental health system is not limited to the literal escape from the buildings of an institution, a set of so-called treatment procedures (solitary confinement, behavior management), or a group of professional helpers. The system *is* the master narrative that informs all of the above mentioned places or people to recover from. This master narrative precludes easy access to alternative communities, because, in effect, entry into such communities requires a “foreign” language of mental illness and health. Without access or exposure to such alternative narratives, people remain trapped in the in mental health system that is the master narrative.

The final theme included in the group of traditional constructions of recovery is “surviving trauma”—traumas experienced prior to and as a result of the person’s time in a psychiatric institution. All of the survivors emphasized that a trauma focus is lacking from psychiatrists’ training and interventions. Several noted that, although so-called mental illnesses made logical sense in the context of a person’s abuse history the psychiatrists focused on symptomatology to the exclusion of the individual’s life story. Thus, the psychopathology appears to emerge spontaneously from within the person’s brain.

While there is a large and growing body of mainstream clinical literature on the subject of trauma related to such topics as rape, incest, domestic violence, and childhood sexual abuse, the participants pointed out that this body of research is not applied effectively in psychiatric institutional settings. Even psychotherapists who work from a trauma-informed approach may keep the focus exclusively on the trauma survivor and neglect to address the social milieu that allowed the abuse to occur. In other words, a great deal of trauma therapy compliments the master narrative of mental health by focusing on the personal to the exclusion of the political. An alternative approach is to consider the experience of the trauma survivor not as an isolated instance of abuse but as

an expression of a violent, stressful, and non-relational social context in which the person may dwell.

As I listened to the psychiatric survivors' narratives about recovery from trauma, I got the sense that, at points, some had not yet made the dialogical shift from survivor of abuse in the literal sense to survivor of abuse in the political sense. As Will explained to me, one of the primary concerns for a survivor of trauma is establishing safety and security:

And I knew that I didn't have that. I hadn't had that for like ten years. I mean I hadn't had basic kinds of safety in terms of like a stable place to live, a stable routine, stable social interactions, stable food, stable money...I got a job that I could, a part-time job so I had enough money to live. And I found some stable places to live. And I just focused on that. And eventually I was able to start getting a handle on what was, what I needed...And that's really what started turning things around. (Will)

For practical reasons, trauma survivors may not even consider (or desire) political activism at this point in the healing process because of the intensity of their own suffering and the energy it takes to find a home, food, and financial support. However, it also is possible that some may thrive while engaging in political activism and supporting other trauma survivors at this point in the healing process. For example, Cheryl explained how being a survivor connected her to others in healing relationships of peer-support:

So what I later realized was this transformation piece really does affirm and herald the knowing who I am and why I'm here piece. Cause just like with alcoholics who may be here to help another recovering alcoholic, *we* have to be change agents. Not only in our own lives, but helping out the next guy who may not have that awareness but really change agents in the system and society at large. So we don't cordon off this small, subset of people who are sick so we get to feel healthy and well. (Cheryl)

As I previously discussed in the results section, the theme of surviving trauma has been widely researched and can be found throughout the existing recovery literature. However, the current study differed from past research in that the narratives of trauma survival transcend the distinction between personal healing and political activism directed towards the society in which the abuse occurred in the first place.

Turning Point: An Epiphany of Human Compassion

As I read all of the interviews transcripts, there was one story of healing in particular that stood out to me. This was Ruta's moving encounter with a housekeeper when she was being held at a psychiatric hospital. I called this section of the results "an epiphany of human compassion." The story marked a turning point in Ruta's own recovery narrative as well as a shift away from the master narratives of recovery and mental health. This story offers a new vision of healing that cannot be planned for, put into a treatment model, or empirically validated. Ruta's narrative reminds us that healing is not confined exclusively to the roles of doctor and patient but can be a spontaneous

moment of connection, an epiphany that can forever re-define a person's life. The other survivors I interviewed also experienced epiphanies of healing similar to Ruta's in that these turning points were spontaneous, unexpected moments of human compassion.

Ruta's epiphany of human compassion also marks a turning point in the results section as the discussion turns away from the traditional notions of recovery and moves towards a critical deconstruction and revisioning of such ideas. In other words, this section marks the beginning of a shift from a personal recovery narrative to a politically conscious and engaged recovery narrative. The first themes that I have discussed above are concerned primarily with the personal processes of healing. It was not clear to the survivors at those points in their narratives as to how their personal struggles could be revisioned as part of a political movement. As a first step towards political action, the master narrative is deconstructed, analyzed, and challenged before the creation of a counter-narrative can begin. The next three sections, "recovered voices, recovered lives," "the myth of incurability," and "deconstructing recovery," document the move away from the traditional notions of recovery and mental health by means of questioning and deconstructing the origins of these ideas.

Revisioning Recovery: Recovered Voices, Recovered Lives, and The Myth of Incurability

In the "recovered voices, recovered lives" section, I attempted to show that in order to question and challenge the mental health system, the survivors first had to break away from the discourse of the medical model and start to reconstruct their experiences in their own words. In order to stop communicating in the language of psychiatry, an alternative discourse or counter-narrative is needed to more aptly capture the psychiatric survivor's experience. However it is no small (or individual) feat to escape the medical model's web of meaning and to create a counter-narrative. The latter requires imagination, innovation, and persistence.

Before the creation of a counter-narrative can occur, there needs to be a clearing of dialogical space to make the shift away from the master narrative. Involvement in grassroots political activism or a peer-support group may provide such a dialogical space. These types of groups can connect people with similar experiences who work together towards shared goals of change, usually within their local communities. The psychiatric survivor movement began (and still flourishes) at the level of local activism. At the same time, it has also grown so large that it has an international presence as can be seen with groups such as Support Coalition International. The survivor movement's counter-narrative of mental health rejects the discourse of chemical imbalances and broken brains and resituates people's problems in living within their socio-cultural environments.

As Cheryl discussed in this section of the results, even with the movement's counter-narrative, it is challenging in our society to espouse such views on mental health and openly question psychiatry's obsession with returning people to a state of normality. It is important to point out this difficulty though, because, in a sense, the tension between the master and counter narratives is essential for the maintenance and sustainability of the alternative narrative. Without such opposition to the medical model, the counter-narrative runs the risk of being re-assimilated into the confines of the master narrative. For example, stories of recovery from schizophrenia without the use of medications could be normalized by saying that the people were misdiagnosed or that they were really in a

state of remission. This observation also underscores the necessity of political activism if the movement is to sustain the distinctive characteristics of its counter-narrative of recovery.

One of the central characteristics of the counter-narrative is that it challenges the idea that people labeled as schizophrenic, bipolar, or psychotic are not amenable to psychotherapy and therefore are resigned to a life-long regimen of psychiatric drugs and custodial care. In this way, the current system promotes disability and coping rather than recovery and living a meaningful life. In this section of the results, I use the survivor's accounts to deconstruct the myth of incurability and, in doing so, break down the dichotomies between the psychologically ill and healthy. The survivor movement tends to situate people's struggles beyond the internal confines of brain chemistry, irrational cognitions, and psychodynamics and locates the source of such distress within the contexts of societal unrest and injustice. Again, we see that the shift from the personal to the political may help people to break the cycle of dependency upon the psychiatric system and reject the medical model's reductionistic construction of psychopathology. The medical model's myth of incurability obscures one's vision or imagination of constructive alternatives for living. On the other hand, political activism and advocacy work requires creativity, ingenuity, and the ability to think beyond the limitations of the status quo.

An important point that arises from the deconstruction of the myth of incurability is that it is oppressive and defeating for mental health professionals to deny people labeled with severe mental illnesses the right to pursue a good life that may be free of psychiatric interventions if they so choose. Some of the participants recalled fellow patients who resigned themselves to the psychiatric labels they had been given and came to believe in the limitations and deficiencies that psychiatric narrative conveyed to them. Another point that becomes clear from the deconstruction of the myth of incurability is that it is mistaken to believe that people who are working through their own struggles cannot help and support others in a similar position. In fact, this practice is commonly used in peer-to-peer support groups within the survivor movement and serves as a popular alternative to psychiatric treatment. After critically examining the notion that recovery is not a possibility for people with severe mental illness, I began to seriously question the concept of recovery altogether, and in the following section I deconstruct the subject of this study.

Turning Point: Deconstructing Recovery

The section of the results called "deconstructing recovery" marks a significant turning point in my own understanding of the concept of recovery. The original aim of this project was to understand the phenomenon of recovery from the perspective of the survivor movement. However, framing this question in the language of the medical model had the potential to distort my interpretations of the survivors' narratives. I experienced this epiphany about the power of language over my perceptions when I was traveling around the country doing the interviews; as a result, the project began to take on a slightly new trajectory. I began to focus less on recovery and more on what it means to live a good life. When I posed this question to the participants, nearly all of them responded that they believed they were living a good life, one that was connected to a

purpose greater than themselves and allowed them the freedom to pursue their passions in life. The one exception was Will, whose answer I included in the section “It’s not all about me: Destiny and the good life.” In that section of the results he explains that living a good life is relative to the environment in which we dwell; thus, given the dis-eased state of the world today, he is not sure that a good life is possible as he envisions it.

The move that I made in this section of the results is one way to resolve the tension regarding the necessity of the master narrative as something to position counter-narratives of *recovery* against. The solution to this problem is to make a conceptual shift from writing about what recovery means to what living a good life means. Thus, in the section called “deconstructing recovery,” I challenged the use of the word recovery as a descriptor for the experiences of the survivors I interviewed. With its origin in the medical model, recovery brings with it a host of connotations and assumptions that do not aptly capture the meanings of the stories I heard and analyzed. Although this disconnect should not be surprising because the medical model does not conceptualize people’s experiences of psychological distress within the contexts of their life narratives. Instead, the medical model eschews the matter of subjective experience altogether in favor of an explanation of people’s experience in terms of mechanistic and biological processes. Will and Oryx problematized the concept of recovery further by pointing out the historical and political implications (and limitations) of using such a word to describe survivors’ experiences. As I analyzed the answers to the question, “How would you define recovery?” I found that the survivors had difficulty in fitting their own experiences into such a concept, or trouble finding the words to define recovery at all.

The most fundamental misconception that comes with the word recovery is that the person was sick in the first place and is thus recovering from an actual illness. The experiences that survivors described could be called psychopathologies in the original sense of the word—suffering of the soul. However, even if we label those painful experiences as such, the survivors acknowledged that these pathologies were important parts of their lives and identities and not something to recover from per se. Most felt that if they had anything to recover from it was the mental health system. They described a healing process that involved such themes as getting off of psychiatric drugs, living a life independent of mental health services, finding meaningful work, becoming involved in political activism, and forming relationships with other people.

The section on “deconstructing recovery” also marks a transition to the last few themes of the interviews which center on the reconstruction and revisioning of recovery in terms of the good life. The survivors described a good life that is based largely upon political activism, community-building, and consciousness-raising. Thus, in the following sections of the results we also see a major shift in the counter-narrative’s positioning to the master narrative. There is a marked transition from the personal (healing the ego) to the political (addressing social injustice) that is possible when the concept of recovery has been deconstructed and is re-visioned in terms of living a good life.

Re-Constructing Recovery: Destiny and the Good Life

In the last three themes of the results section, I take the lessons learned from the deconstruction of the myth of incurability and recovery in the medical model sense and

apply them to the narrative reconstruction of recovery in terms of the good life and political activism. In the section “recovery and the good life,” psychopathology is reconceived in the original sense of the word, suffering of the soul. I also use the term psychopathology in this manner in my own clinical work. My views on the subject of psychopathology have been influenced by the archetypal perspective and the writings of James Hillman, particularly *Re-Visioning Psychology* (1975). The archetypal conceptualization of soul however differs from the Judeo-Christian construction of an individual soul. Instead, the archetypal psyche refers to a collective soul of the world, or anima mundi, that manifests itself *through* (rather than being contained *within*) every person and thing in this world. Therefore, the symptoms of psychopathology that we call “mental” illness actually have little to do with mind and mostly to do with experiencing the collective suffering of the world.

It is vital to make this distinction between the individual and the collective when discussing what it means to live a good life in the context of the survivor movement. The master narrative of recovery seeks to quell individual dis-ease without honoring the larger context and meaning of such suffering. The goal of recovery is relieving a person’s discomfort, while the alternative narrative focuses on living a meaningful or purposeful life which most likely will include some periods of distress. In other words, the alternative narrative eliminates the dichotomy of either health or illness and replaces it with simply living. The survivors then connected the idea of living a good life to a life in the service of some higher purpose that is greater than the individual and gives back for the benefit of the general good. However, this notion of the good life also opens up the question, are there some narratives of the good life that are better than others? Who is to say what is good and what is not?

In order to answer these questions I again turned to my background in archetypal psychology and particularly Hillman’s (1996) acorn theory that he writes about in *Soul’s Code*. The premise of Hillman’s acorn theory centers upon the meaning of a good life in terms of living one’s life in service of one’s destiny. Matters of political engagement, the good life, and especially destiny are typically not the sorts of topics that mainstream clinical psychology grapples with; I found my own positioning on the fringes of the field quite helpful in trying to understand the counter-cultural discourses of the survivor movement. I most clearly heard an explanation of a good life from a non-egocentric perspective in Will’s response to my question about the meaning of living a good life.

The next section, “It’s not all about me: Destiny and the good life,” which I wrote as a performance text, stood out to me as I was analyzing the interview transcripts. Will’s response to my question about what it means to live a good life was strikingly different from how the other three participants answered the question. Ruta, Oryx, and Cheryl all said that they currently are living a good life; but in the passage that I presented, Will talked about the meaning of the good life in terms of an individual’s life being inextricably connected to a larger collective. Thus, it was impossible for Will to say what a good life means for him alone because his life is embedded within the social, economic, environmental, and political contexts that shape the meaning of the good life. Will prefaced his response to my question about the good life by saying that his is a perspective that may not be embraced by the movement as a whole. Yet, in terms of this study that does not aim to come up with a single, boiled-down definition of the survivor movement and its vision of recovery, his answer was not problematic. Will adds a

crucial new dimension to the argument that the survivors' narratives were less of a personal recovery narrative and more of an alternative narrative about living a good life.

Will's response to my question about the good life is a critique of the American, capitalistic and consumerist version of the good life that implicitly underlies the culture of mental health care, and therefore grounds the master narrative of mental illness and recovery. He suggests that adhering to this vision of success not only distracts us from the collective suffering that surrounds us but also leaves us with a good life that is shallow and disconnected from meaning or a sense of higher purpose. In other words, the pursuit of the American dream has the potential to create an "empty self" (Cushman, 1990) that seeks fulfillment through comparably meaningless possessions and activities. Speaking from the position of a first generation American of Eastern European decent, Ruta also had a critical point of view of the American dream. Like Will, she was cognizant of her counter-positioning to American cultural scripts of the good life. She also discussed her juxtaposition between two very different cultures. Ruta initially pursued a traditional path of self-reliance in an attempt to achieve a successful, happy life. In retrospect, she realized that the ideals promoted by the American script of the good life were a destructive illusion. Both Ruta and Will currently live lives based on the values of simplicity, a sense of community, meaningful relationships, and service to social, political, and environmental causes.

Will's narrative about the good life also introduced the idea of destiny or calling, which helped in avoiding the potential to fall into relativism when talking about what it means to live a good life. He demonstrated why living a good life is more than just doing what you want to do or a personal expression. Living a good life means living in service of what your life (or calling) asks of you. Different cultures of therapy such as cognitive-behavioral and biological psychiatry each offer their own versions of what it means to live a good life; but these approaches place the focus on the individual's psyche (or neurotransmitters) rather than the state of person's environment. The survivor movement takes an approach to living a good life that is similar to archetypal psychology's which is that a good life is one lived in service to others as an engaged political citizen.

The final section of the results ties together the psychiatric survivor movement's alternative narrative of the good life with political activism, consciousness-raising, and participation in counter-cultural communities. Our society's general lack of communities and clearings for political dialogue may be one reason there is so much blame placed upon the individual in many modes of psychotherapy. Alone and without the support of like-minded companions, it is a daunting task to challenge the practices of psychiatry and the entire medical conception of mental illness. But within a supportive community of other survivors a person may find his or her voice to openly question these issues. Within the survivor community one may also address the larger societal problems typically ignored by the narrow scope of psychiatric treatment. Sometimes personal healing cannot begin until one finds peer-to-peer support or other ways of making a therapeutic connection with another human being. This narrative of healing in terms of mutual support and understanding is a great departure from unidirectional interventions in which the professional fixes the patient.

The participants also talked about how getting involved in counter-cultural communities and the survivor movement opened up a world of literature, resources, and alternative viewpoints on mental health care that they were not previously aware of. All

of the survivors I spoke with said that reading first-person madness narratives, the survivor literature of Judi Chamberlin (1978) and Rae Unzicker (1989), as well as other narratives of recovery and healing were helpful in trying to understand their own lives. Many also were introduced to the work of writers such as Peter Breggin (1991), Robert Whitaker (2002), and Thomas Szasz (1970) that helped them to become informed and critical consumers of psychological practice and research. The participants also credited the survivor movement with introducing them to or providing access to alternative healing resources such as yoga, meditation, writing groups, acupuncture, and holistic/homeopathic healers.

The alternative narrative of the survivor movement is not represented by a single voice or point of view but instead embraces a pluralistic appreciation for diversity of all kinds. While many survivors vehemently oppose the use of psychiatric drugs in any circumstance, others support their use under the condition that the person has made a fully informed and voluntary decision to do so. Some survivors find psychotherapy to be helpful, while others prefer to utilize peer-to-peer support in lieu of further participation with the mental health system. Although there always will be diverging opinions on what is in the best interest of the individual, the underlying theme of the alternative narrative is that people should be free to make those choices without the fear of involuntary commitment, forced treatment, or discrimination.

Although the survivor movement's narrative clearly is separate from the master narrative of mental health care in America, it does have implications for the possible directions that the field may take in the future. Community psychology takes a systemic approach of understanding people's struggles within the many overlapping contexts of their lives. Going back to an earlier point, most archetypal or feminist approaches take a more politically conscious and active stance towards mental health care. From these points of view, psychopathology is not simply addressed as solely the individual's problem; and therapists often take a hermeneutic approach to understanding their patients' lives, which takes into account the clinician's own biases and preconceptions about the good life that they bring to the therapeutic relationship.

The "Empty Self," American Psychology, and the Good Life

After reflecting upon the results of the current study, I began to think about the ways the project has shifted many of my own views on recovery and has influenced the ways I approach my clinical work. The final section outlines the theoretical and conceptual shifts I experienced as well as personal beliefs that have been challenged as a result of this project. In addition, the final section attempts to tie together many of the themes of study that have implications for the practice of clinical psychology, as well as highlight the uniqueness of the survivor movement's alternative narrative.

Cushman (1990) has written about American psychology's notion of the "bounded, masterful self" that refers to a decontextualized, ahistorical, and radically individualistic construct of the self. The "bounded, masterful self" is also an "empty self"; one that craves wholeness, coherence, and substance yet seems insatiable in its pursuit of fulfillment. Cushman defines the empty self as one that "experiences a significant absence of community, tradition, and shared meaning—a self that experiences these social absences and their consequences 'interiorly' as a lack of personal conviction

and worth; a self that embodies the absences, loneliness, and disappointments of life as a chronic, undifferentiated emotional hunger” (Cushman, 1995, p. 79). This “bounded, masterful self” has no connection to the *anima mundi* or a sense of calling to heal the suffering of the world at large. The medical model’s narrative of mental illness and health is a direct product of the idea of a bounded, masterful self, which locates the source and cure of pathology within the biological and psychologically subjective interior of each individual. Thus, the suffering comes from within the person; a view that neglects the political, sociological, interpersonal, environmental, existential, and spiritual spheres of influence.

As a result of interiorizing pathology, psychiatrists seek internal (biological) origins and treatments for such problems. Again though, the narrow focus of the medical model misses the nature of the problem, which has less to do with hearing voices, cutting, or feeling depressed, and more to do with what these phenomena are trying to communicate to us about our lives and our world. By turning to treatments that only address our biochemical and psychic interiors we also are turning our backs to the crime, injustice, and inequality that plague our society. Instead of finding meaning and purpose by advocating for others’ rights and addressing social problems, we choose the easy way out—filling the empty self. Consumerism and catering to the ego’s needs serve to numb, blind, and satisfy (if only temporarily) people as they move through life void of a purpose or calling. Americans thrive on consumerism and attempt to fill a moral and spiritual void by purchasing happiness and status. We buy extravagant homes, expensive cars, huge quantities of food, and compulsively shop—all in an effort to satisfy the gnawing hunger of the empty self. People feel secure, safe, and protected with their purchases; but this literal mindset separates the personal from the political and keeps us out of touch with the *anima mundi*.

The medical model’s solution to people’s distress is another example of the consumerist mentality. So are the typical kinds of therapy supported by managed care (e.g., cognitive-behavioral), that promote a temporary life-style solution to people’s problems in living rather than addressing the larger cultural and political contexts from which these problems have emerged. In these cases, the good life is conceived of in terms of self-satisfaction, self-fulfillment, and minimal personal discomfort. It has little or nothing to do with morals, self-sacrifice, or service to others. The master narrative of mental illness and recovery has no room for inquiring into the meanings of people’s pathologies. Are we depressed because of our dissatisfaction with our self-serving existence? Do we feel guilt and shame because we have so much and others have so little? The mainstream mental health system, entrenched in the language of the medical model, does not see why it should concern itself with politics and activism if the real problem lies within each individual. However, the survivor movement’s alternative narratives of pathology and healing transcend the individual and address these larger issues.

The etiology and maintenance of psychopathology, I believe, are tied to the notion of not living a “good life;” a complicated idea that is connected to ideals of living a life of meaning and purpose, service to others, humility, and selflessness. Briefly described, each of our lives has a unique purpose and place in the greater soul of the world. We never can be certain of exactly what our purpose or destiny is, nor if we are on the right course towards fulfilling it. However, we get clues through dreams, exploring the

imaginal realm of the world, and exploring the significance and meanings of psychopathology.

The primary role of the psychotherapist is to bear witness to the client's psychopathology and join with him or her in an exploration of its many layers of meaning and implications for what it means to the person to live a good life. The process or journey of therapy and healing is the focus rather than a fixed goal or final outcome because, as our lives continue to change, so will our goals and aspirations. Recovery or mental health does not guarantee a happy ending, a life free of worry, pain, and unexpected tragedies. All of these things will inevitably continue, but what changes is how the person experiences or makes meaning from them. Having a good life means experiencing *more*; a life lived more deeply. This is not the same as living happier, better, or healthier. Experiencing more means living with the joys as well as the sorrows and recognizing that it is all part of the journey.

When one experiences more, the person may be able to embody and express anger for the first time since the occurrence of a trauma. In the case of ex-patients and survivors, an important part of recovery means construing and using that anger in a new way—turning it outward in order to address the social systems and institutions that led them to believe that they were sick, insane, and defective. The anger and fear are no longer directed towards oneself for being a dysfunctional, broken person. It is re-construed as a vehicle for social protest against the doctors and the system at large that crushed their spirit for so long.

When I write about living the good life, I hope to move beyond these individualistic desires and proclamations of freedom that further contribute to the narcissism of the ego. This is why I think that to live a good life necessitates qualities such as humility and compassion, a self-less desire to improve the lives of others, and a sense of purpose or commitment to some higher cause greater than ourselves. Such a self-less commitment to others suggests a transcendence of the ego. Of course, one must be careful not to take this transcendence to the opposite extreme, which would be completely losing one's unique voice and special gifts to the world by becoming completely absorbed by the community. Like so many things in life, the good life requires a delicate balance between recognizing the individual's uniqueness and abilities, and using those same talents to give back to others instead of focusing exclusively on self-growth and self-transformation. Living at either extreme of the continuum freezes the movement of our psychic energies, limits our ability connect with the world soul, and leads us further astray from the path of the good life.

Different visions of the good life have the potential of collapsing into relativism. Maybe the distinction between relativism and a firm philosophical basis upon which to stand is the capacity and willingness to help others live out their good lives. Medicalization of people's problems in living may discourage them from recognizing their strengths and derail them from the path of the good life. They remain trapped in a holding pattern of normality or functioning in a world that is harmful to maintain and adapt to. Adaptation to a society of greed, corruption, violence, sexism, racism, and homophobia is hardly a good outcome; many unknowingly maintain these standards by playing into the ideals of radical individuality, and progress and efficiency at any cost. An alternative narrative connects the individual voice to political movements and activism groups that challenge and critique the status quo.

In contrast to individualistic goals of the vast majority of therapies in service of the ego, survivors' stories of healing and recovery are less about self-growth and more about reaching out to others in a collective journey of peer-support and political activism. The people interviewed in this study not only joined and formed survivor communities, but also other social justice and political causes such as environmentalism, domestic violence prevention, and anti-war movements. In this sense, recovery meant recovering a connection to one's life purpose—helping and serving others by passing on your story, experiences, and wisdom to them. From its inception, the survivor movement has been committed to fighting for the rights and freedom of those who cannot speak for themselves—locked in seclusion rooms, electrically shocked, bound by chemical straightjackets, and tied down in four-point restraints. Some of those who manage to survive the human rights abuses of the psychiatric system do not stay silent about what they went through. They continue to fight for those on the back wards who were not so fortunate to escape. The individual survivor's voice is no longer just his or her own, but speaks as a representative of the entire community of survivors. And this collective voice demands freedom from an oppressive and paternalistic psychiatric system. The survivor movement's collective voice calls for a respect of basic human rights, especially the right to refuse psychiatric treatment if one so chooses. The collective voice rejects the reductionistic views of the medical model, and envisions a more humane, peer-support model based on the ideals of empathy and human connection rather than fear and coercion.

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Appendix A Interview Questions

Encounters with the Mental Health System

- How did you first encounter/enter the mental health system?
- Have you been diagnosed with a label of mental illness?
- Could you describe how it felt to be diagnosed with a label of mental illness?
- What did that label mean to you?
- Did this label change your conceptualization of self-identity?
- When you hear the term “mental illness” what does it mean to you?

Survivor Movement

- How did you come to identify yourself as a psychiatric survivor?
- How did you come to be involved with the psychiatric survivor movement?
- Has the survivor movement influenced or changed any of your views about what mental distress is?
- What has been the role of the psychiatric survivor movement in your recovery?
- Are you currently involved in a local survivor community or advocacy groups such as Mindfreedom (Support Coalition International), NARPA, etc.? Consumer groups?

Recovery

- How do you define recovery?
- Do you think recovery is a goal that can be attained, an ongoing process, or something else?
- What would a good life be for you/How do you define living a good life?
- Could you describe for me the story of your own recovery?
- Could you describe the turning point(s) in your recovery process?
- How would you describe the obstacle(s) that you have recovered from?
- What have been some of the largest obstacles of your recovery?
- What has been the role, if any, of the mental health/psychiatric system in your recovery?
- Have psychiatric medications or treatments (ECT) played any part in your recovery?
- Has psychotherapy of any kind been a part of your recovery process?
- Has there been certain people in your life that you feel have been instrumental in your recovery?
- Have your roles in your social communities changed throughout your recovery process?
- What role, if any, have peer-to-peer support groups played in your recovery process?
- Have you found literary resources such as other people’s first-person accounts of emotional distress, self-help books, etc. useful?
- Has spirituality played a role in your recovery process?
- Have you used any “alternative” or holistic healing methods like meditation, yoga, acupuncture, nutrition, etc. as part of your healing process?
- Has the meaning of recovery changed for you over your life?
- How would you describe an ideal mental health system?

-What reforms would you suggest for the current system?

Current Activities/Background Information

-Could you describe your current activities, for example are you currently working?
Hobbies? Activism or advocacy work?

-Could you describe for me your cultural, family or ethnic background and how these communities have helped to shape your self-identity?

Appendix B

Informed Consent for Participation

STUDY TITLE: Recovered Voices, Recovered Lives: A Narrative Analysis of Psychiatric Survivors' Experiences of Recovery

PRINCIPAL INVESTIGATOR: Alexandra Adame

The purpose of this study is to explore the experience and meanings of recovery from the perspective of individuals who self-identify as psychiatric survivors.

By consenting to participate in this study, the participants agree to share with the researcher their experiences with the psychiatric and/or mental health system as well as their recovery process. At no time is anyone required to disclose information they do not wish to reveal. Participants are free to end the interview at any time for any reason and participation is strictly voluntary.

The interview is expected to take between 1 to 2 hours total per participant and all interviews will be audio-taped. If at any time during the interview the participant would like the interviewer to turn off the recording device they are free to do so. The interviews will be audio-taped and later transcribed so that the information shared can be used by the principal investigator. The participant's name will not be associated with this information at any point in the research process and any identifying information that the participant mentions will be removed. The names of participants will be kept in a separate, locked file from the locked file containing the interview materials. The only other persons who will have access to the transcripts are the principle investigator's faculty advisor, and members of the principle investigator's research team.

If the participant has questions about the study at any time, the participant is invited to contact either **Alexandra Adame** by phone at (513) 664-6863 or by email at adameal@muohio.edu or **Roger Knudson** by phone at (513) 529-2404 or by email at knudsorm@muohio.edu. If a participant has a question regarding rights of research participants, the participant may contact the Miami University Office for Advancement of Research and Scholarship at (513) 529-3734.

_____ I have read and understand the above information and I agree to participate.

_____ I give my permission for the researcher to quote from my interview responses I contribute, verbatim, in part or in whole in any reports of this research (including papers presented at professional conferences, articles in professional journals, or book chapters). I am free to withdraw this consent at any time for any reason. There is no penalty associated with withdrawing this consent.

Signature of Participant

Date

Appendix C
Debriefing Form

STUDY TITLE: Recovered Voices, Recovered Lives: A Narrative Analysis of Psychiatric Survivors' Experiences of Recovery

PRINCIPAL INVESTIGATOR: Alexandra Adame

Thank you for your participation in the current study on the experiences of recovery. If you have any questions in the future please contact Alexandra Adame at 513-664-6863 or at adameal@muohio.edu.

For further readings and resources on the topics of recovery and the psychiatric survivor movement, please see the following:

<http://www.mindfreedom.org>

<http://www.narpa.org>

<http://www.freedom-center.org>

<http://www.power2u.org/>

Bassman, R. (2001). Overcoming the impossible. *Psychology Today*, 34(1), 34-40.

Chamberlin, J. (1978). *On our own: Patient-controlled alternatives to the mental health system*. New York: Hawthorne Books, Inc.

Everett, B. (2000). *A fragile revolution: Consumers and psychiatric survivors confront the power of the mental health system*. Waterloo, Ontario: Wilfrid University Press.

Jacobson, N. (2001). Experiencing recovery: A dimensional analysis of recovery narratives. *Psychiatric Rehabilitation Journal*, 24(3), 248-257.

Ridgeway, P. (2001). Restorying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal*, 24(4), 335-344.

