Title: Concept Analysis of Recovery in Mental Illness in Young Adulthood

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Abstract

Introduction:

Recovery, as a concept, emerged as a core philosophy of the service user movement that began in the late 1960s and 1970s. Previous reviews on recovery in mental health have presented definitions or a conceptual framework; however, over time it has been open to disparate interpretations.

Aim:

To conduct the first concept analysis of mental health recovery in young adulthood within various multidisciplinary contexts.

Method:

Rodgers's (2000) six-stepped evolutionary method enabled the analysis of recovery's conceptual characteristics, the identification of an exemplar and the proposition of a hypothesis with implications for practice.

Results:

The derivation of the term recovery does not convey its' identified conceptual characteristics. Identified attributes include the reawakening of hope, reclaiming a positive self and meaning through personal growth. Antecedents include the disruption of illness, stigmatisation, internal inventory and contemplative recovery. Identified consequences include the return to normality, reconstruction of self and active social connection.

Conclusion/ Implications for Practice:

The new conceptual definition is *the reawakening of hope and rediscovery of a positive sense of self, through finding meaning and purpose within personal growth and connection using creative self-care coping strategies*. This paper reveals an apparent disparity between professional and personal interpretations of recovery. Therefore, the implication for mental health nursing is the congruence of recovery-orientated practice with the process of recovery experienced by young adult service users.

Key Words

Concept analysis, mental health, mental illness, psychiatry, recovery, young adults

Accessible Summary

What is known about the subject?

- Previous work on recovery in mental health has generated definitions and conceptual frameworks that provide an empirical basis for recovery research.

- Because there is no agreed definition of the term mental health recovery, it has been open to disparate interpretations within various contexts.

What this paper adds to existing knowledge?

- The analysis of the concept of mental health recovery in young adulthood uses Rodger's (2000) evolutionary method.

- This concept analysis suggests that in some contexts the word "recovery" does not reflect the conceptual components identified in this paper.

- The concept analysis has revealed a disparity between the professional and personal interpretations of mental health recovery.

What are the implications for practice?

- A new conceptual definition of mental health recovery in young adulthood

- Conceptual clarity will facilitate the congruence of mental health recovery and nursing practice with the process of recovery experienced by young adult service users.

Introduction

Recovery remains one of the most widely discussed aspects of mental health globally, featuring as an integral element of the World Health Organisation's comprehensive mental health action plan 2013-2020 (WHO 2013). As a concept, it emerged as a core philosophy of the service user movement arising from the Civil Rights Movement in the 1960's (Roberts and Wolfson 2004), alongside the activism of black power, women's liberation, gay, lesbian and physical disability equality movements (Adame and Knudson (2007). The formation of the Mental Patients' Union 1971 saw the development of user lead organisations where patients' wanted a communicative space where their voices were be heard.

The terms "service user or survivor movement" describe the collective action of individuals who have experienced mental health difficulties, yet advocate for equality, self-determination and inclusion within the context of societal stigma and discrimination (Wallcraft and Bryant 2003). Now widely referenced in mental health literature and government policy, the concept of recovery has evolved from a movement advocating equality for all "*psychiatric survivors*" (Adame and Knudson 2007, p.157). External influences have influenced the development of the concept (Marrow and Weisser 2012) and thus, over time, mental health has been open to disparate interpretations.

The demarcation of "*recovery from*" and "*recovery in*" has been used to gain greater conceptual clarity (Davidson and Roe 2007) and more recently through the use of terms like '*clinical recovery*' and '*personal recovery*' (Slade 2010). Such discussions have enabled a crucial delineation in terminology indicative of the perspective that underpins each term. Leamy et al (2011) conducted a systematic review and narrative synthesis on personal recovery producing a robust conceptual framework. Three significant findings emerged from

this work: characteristics of the recovery journey; recovery process; and recovery stages. However, the 'recovery process' was viewed as the most important to research and was summarised with the acronym CHIME (connectedness, hope, optimism about the future, identity, meaning in life and empowerment). While this provides a good foundation to understanding the concept, Rodgers's (2000) proposed that a concept is developed within the social context in which individuals interact, and as social factors vary over time, so too will the evolution of the concept mental health recovery.

Brennaman and Lobo (2011) conducted a concept analysis of serious mental illness using Wilson's (1963) methodology. While some authors argued that Wilson's (1963) method be conducted sequentially to achieve an advanced analysis, findings confirmed the established view that recovery should be understood as a *"process"* (Brennaman and Lobo 2011, p.661). However, Rodgers (1989; 2000) asserted that the evolutionary and dynamic view of concept development *"does not proceed in a linear fashion"* (Rodgers 1989, p.333). Therefore, this may present a more compatible perspective for the exploration concept of recovery described as as non-linear and dynamic (Deegan 1988).

Tofthagen and Fagerstrom (2010, p.22) argued that Wilsonian methods aim to produce an operational definition of a concept, understood as *"cognitive constructions"* which change with time. This differs significantly from Rodgers (2000) proposition that the way a concept is understood is directly related to how it interacts with the social, cultural and personal context of an individual. Tofthagen and Fagerstrom went on to suggest that the importance of Rodger's (2000) method of concept analysis within nursing science was to understand how a concept evolved within the various healthcare contexts it was relevant to. Campbell-Yeo et al (2008) used Rodger's (2000) evolutionary method was in a concept analysis of empathy. While 25 papers was a smaller sample than Rodgers recommends, Campbell-Yeo et al (2008) proposed that nurses had unintentional self-imposed conceptual barriers within nursing care

leading to significant implications for practice. This, and similar research, lead to the selection of Rodgers (2000) evolutionary method to gain a greater understanding of mental health recovery. This will enable an exploration of the *"mental cluster that lies behind the word" (*Rodgers and Knafl 2000, p.79) and to chart how the concept of mental health recovery has evolved over time.

Mental health and young adulthood.

Kessler et al (2005) conducted a National Comorbidity Survey in the United States to estimate the lifetime prevalence and age of onset of DSM-IV disorders. Findings indicated that three quarters of all lifelong cases of disorders had presented at twenty-four years. The researchers noted that the highest prevalence of anxiety was between the ages of 18-29 and 30-44 years with rates of 30.2 % and 35.1 respectively (Kessler et al 2005). Additionally, the highest rates of mood disorders were among those who were 30-44 years, with a rate of 24.6%, with the rates of all disorders decreasing with increasing age. Bunting et al (2012) presented similar findings in their epidemiological estimate of lifetime prevalence of mental health disorders in Northern Ireland. Their results identified that young adults, defined as 18-34 years old, had the highest risk in all disorder classifications and as the age group requiring further research. Therefore, this analysis will define young adulthood as the period between 18-35 years to accommodate the variation between child/adolescent and adult service provision (NMHDU 2011).

Patel et al (2007) also suggested that mental health difficulties most commonly present in young adulthood. This is often the stage in life where an individual embarks on a career, independent living and the establishment of romantic relationships and social connections. The disruption of these vital processes disrupts the life trajectory of an individual, potentially causing significant personal social and economic implications for the individual and wider

society (Patel et al 2007). The WHO (2014) has identified suicide as the second leading cause of death among young people aged between 15- 29 years globally. Therefore, Patel et al (2007) saw mental ill health in young adulthood as a significant public health challenge with lifelong implications. Reviews on mental health recovery have previously focused on an adult population (Brennaman and Lobo 2011), with limited exploration of the young adult demographic. While it is probable that the experience of mental health recovery shares similar characteristics across age groups, a "*life course approach*" is required to explore the concept's development within the clinical and cultural contexts, as experienced by young adults (WHO 2013, p. 12). This provides the justification for the age range of this analysis. Conceptual clarity would inform the provision of recovery-orientated care focused on, and relevant to, young adult service users.

Methods

This concept analysis used Rodger's (2000) evolutionary method. The rationale was based on the view that socialisation and cultural interaction contribute to a concept's association with specific defining attributes (Rodgers 1989, p.332). Rodgers's (2000, p. 85) evolutionary method of concept analysis involves six primary activities:

• identifying the concept of interest and associated expressions;

• identifying and selecting an appropriate realm for data collection;

• collecting data to identify: (a) the attributes of the concept; and (b) the contextual basis of the concept, including interdisciplinary, sociocultural and temporal variations;

• analysing data regarding the above characteristics of the concept;

• identifying an exemplar of the concept, if appropriate;

• identifying hypotheses and implications for further development of the concept.

Identify the Concept of Interest

Rodgers (2002) rejected the view that concepts were static entities facilitating an understanding of historical use and contemporary application (McCabe 2009), rather they are temporal and contextual (Tofthagen and Fagerstrom 2010). The Oxford English Dictionary traces the origins of the word recovery to late Middle English denoting a means of restoration; it is from Anglo-Norman French *recoverie,* from *recovrer* meaning to "get back" (Oxford University Press 2013). The Encarta English Dictionary (1999) defined the term recovery within the traditional medical model context as a reference to disease or injury, "*return to health of somebody who has been ill or injured*", "*return to a normal or improved state after a setback of loss"* or *"the regaining of something lost or taken away*".

While there remains no globally agreed definition of mental health recovery, Anthony (1993, p.527) offered a description from a psychiatric rehabilitation perspective:

"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and /or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by illness".

Within the addiction field, The Substance Abuse and Mental Health Services Administration (2012, p.1) provided a working definition of recovery from mental disorders and/or substance abuse as,
"a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential".

Psychiatry has increasingly referenced recovery as a personal process not reliant on the remission of symptoms. It has been defined as "*social recovery; building a life beyond illness without necessarily achieving the elimination of symptoms of illness*" (NHSFT 2010, p.11). However, Barber (2012) argued that recovery could be understood as the new medical model within psychiatry; after all the approach is not unlike that used in physical conditions in which rehabilitation and patient management would be encouraged.

Such terminology has not facilitated a clearer understanding of mental health recovery as it has remained closely aligned to the traditional medical model. Collins English Dictionary (2014, p.1285) best illustrates this:

"*The act or process of recovering, esp. from sickness, a shock, or a setback; recuperation*", "*restoration to a former or better condition*", "*the regaining of something lost*".

Additionally, the term recovery is used in varying contexts and disciplines including archaeology, conflict politics, economics, arts and culture, sport and even recovery transport vehicles. This adds to the confusion surrounding the concept.

As alluded to above mental health recovery may be best understood and differentiated by the individual who is exposed to it. However, this could present difficulties for service users as they encounter the concept within a clinical setting where its use may resonate or create dissonance between them and practitioners.

Identify and select an appropriate realm (settings and sample) for data collection

A review was undertaken of academic papers from a number of disciplines including nursing, psychiatry, behavioural sciences and humanities. A computerised search was also conducted of electronic databases MEDLINE, PsycINFO, CINAHL, Applied Social Sciences Index and Abstracts (ASSIA) and the British Humanities Index (BHI). For the purposes of this analysis, the period chosen was 1986-2013. This was chosen to explore any conceptual change in the years preceding the publication of service user narratives advocating for the concept (Deegan 1988; 1995). As the concept analysis was conducted in 2013, the time frame did not extend beyond this. Therefore, the exploration spanned the concept's development over a period of 27 years.

A database search used identical search terms; however, on occasions, the search was adapted for the various databases configurations. '*Recovery* 'was searched as a keyword in databases to ensure references to it were identified. Search terms included *"mental health" or "mental illness", mental disease, or mental disorders* as used by Leamy et al. (2011). The search strategy was further limited to English language papers only with a young adult sample.

Analysis

Initial reviews of the results lead to the removal of duplicates and papers not related to the concept; these included addiction, dual diagnosis, professional training, and measurement of recovery and brain injury/trauma or other comorbid health conditions. This reduced the search results from CINAHL to 16, Ovid MEDLINE to 24, PsycInfo to 18, ASSIA to 9 and BHI to 4 thus producing an initial sample of 71 papers.

As outlined by Rodgers (2000), this sample was then categorised by the discipline to which it belonged. The academic focus of the paper determined the discipline, where this was potentially multidisciplinary; Rodgers (2000) suggested that discipline was determined by the first author's academic credential. The sample was again reviewed to ensure relevance and reduced to Psychiatry (6), Behavioural Sciences (7) Mental Health Nursing (5) Occupational Health (4) and Other (6). The other section included the categories of Social Work, Public Health, and Theology. Two pieces of literature from recovery pioneer Deegan (1988; 1995) where included to ensure the full exploration of the original attributes and to enable an evolutionary approach to the analysis. The final sample was 30 papers. Rodgers (2000) stated that each discipline should have 30 papers per discipline or 20% of the total sample, which would equate to a sample of 6 papers per discipline.

This data analysis process involved an intensive literature review, exploring pertinent meanings of the concept until the stage of "diminishing returns" was reached (McKenna, 1997). Reading each paper several times enabled the identification the major characteristics of the concept. Following this, those sections of text that most clearly articulated the specific characteristic were extracted, e.g. the attributes or the antecedent of the concept. The data extracted were then collated and organised into each category. This was to enable the analysis of each significant characteristic and a separate analysis for each discipline to facilitate comparison (Rodgers 2000).

Rodgers's (2000) proposed data collection method facilitated the data analysis. This entailed the use of separate documents to record data relevant to each major category: attributes; antecedents; consequences; references; surrogate terms and related concepts. Following Rodgers's (2000, p.93) methodology *"each coding sheet is identified as to both category of data and discipline from which the data were generated".* The researchers selected quotations to reflect accurately how the major characteristics of the concept were depicted

within each discipline. Each category of data was then collated to produce new documents relating specifically to each characteristic of the concept. To facilitate conceptual clarity, further analysis was conducted on each category using thematic analysis to identify significant themes (Rodgers 2000).

Results

Identify Surrogate Terms

Deegan's (1988) seminal writings on recovery defined it as "*the birth of hope*" (p.56) and the "*resurrection*" (p.57). This evocative, almost spiritual, description had become firmly rooted in the view that recovery should be conceptualised as "*a journey of the human heart*" (Deegan 1995, p.92). It was Deegan's (1995) view that recovery related, not only to the effects of mental illness, but also to the trauma individuals endured within the mental health system. Therefore, it is not surprising that across various mental health disciplines, recovery is defined and understood differently.

The psychiatry literature reviewed described recovery as "*sustained symptomatic remission*" (Resnick et al. 2004, p.666). Therefore, '*remission*' of psychiatric symptoms predominates as the definition of an individual's recovery (Resnick et al. 2004; Resnick et al. 2005; Doroshow 2007), otherwise termed as '*cure*' (Makin and Gask 2012, p. 66). The goal of psychiatry within its '*rehabilitation model/approach*' (Zanarini et al. 2010) or '*recovery orientation*' (Resnick et al. 2004) was to '*perform a cure*' (Doroshow 2007, p.235) and ensure a '*returning to normality*' (Doroshow 2007, p.73).

Occupational therapy literature used the term recovery interchangeably with the term "*psychiatric rehabilitation*" (Merryman and Riegel 2007, p. 52). It involved the "*restoration of mental health*" (Kelly et al. 2010, p. 131) and the return to "*normality*" (Lloyd and

Waghorn 2007a, p. 207). Not surprisingly from occupational therapy, this conceptualisation of recovery was functional in orientation and thus defined recovery as "*personal self-discovery and self-generated strategies*" (Lloyd et al. 2007b, p.213).

The term "*psychiatric rehabilitation*" (Braehler and Schwannauer 2012, p. 3) was again used to define recovery throughout the reviewed behavioural science literature. Young and Ensing (1999) described it as "*psychosocial rehabilitation*" (p.4); this conceptualisation of recovery defined it as a personal process within a social context. Within the mental health nursing literature, Aston and Coffey (2012) perceived recovery to be a return to "*a former state of health*" (p. 259); however, they later defined it as a "*rediscovering the self*" and "*achieving a new orientation*" (p. 482).

It was evident from exploring the term recovery in social work, public health and theology that the medical definition had influenced its conceptualisation and focus, describing it as "*psychiatric rehabilitation*" (Bussema and Bussema 2007, p. 302). However, within humanities the influence seemed less apparent and was more reminiscent of Deegan's (1988) more activised conceptualisation, describing it as the "*revolution from within*" (McInnes 2001, p. 160) and "*fighting back*"(Ellenger 1986, p.19). This terminology has evolved over time, from "*resurrection*" (Deegan 1988, p. 57) to "*revolution*" (McInnes 2001, p.160). Yet mental health sciences literature has not taken such an approach, rather describing it as "*rehabilitation*" (Young and Ensing 1999, p.4; Braehler and Schwannauer 2012, p. 3).

Related Concepts

Recovery and the term rehabilitation are used interchangeably throughout the psychiatric, mental health nursing and behavioural sciences literature. This may have contributed to its

lack of conceptual clarity; after all rehabilitation is most often used in reference to "*functional impairment*" (Braehler and Schwannauer 2012, p. 49) or "*social functioning*" (Makin and Gask 2012, p. 66). Nonetheless, this functional focus may detract from the personal process that recovery involves.

In the review of behavioural science literature, the concept of *'adaptation'* emerged. This was discussed as a process which involved the development of an *"adaptive way of living"*, building a positive self-image (Young and Ensing1999, p. 17) through "*stages of adaption*" (Braehler and Schwnnauer2012, p.49). This would suggest a relationship between the concept of adaptation and that of recovery. It is possible that this could be one reason why Roy's adaptation theory is attractive to some mental health nurses (Freeman and Roy, 2005).

The concept of "*personal growth*" (Van Gestel Timmermans et al. 2012, p. 522; Kogstad et al. 2011, p. 480) is also an associated concept. The ability of an individual to discover a new sense of self and meaning in their experiences was evident in the literature reviewed (Pettie and Triolo 1999). This process of personal discovery indicated a trajectory rather than a return to pre-illness state (Aston and Coffey 2012), requiring the person to undergo emotional growth.

Attributes

Deegan's (1988, p.57) assertion that "*recovery is a process, a way of life, an attitude and a way of approaching the day's challenges*" became the working ethos of the concept's inception. Deegan (1988, p. 58) proposed that recovery was a "*journey*", a unique "*continuum*" of "*on-going adjustment*" (Merryman and Riegel 2007, p.67) but crucially not an "*endpoint*" (Resnick et al. 2004). Key attributes included *"the birth of hope"* (Deegan

1988, p.54) *"empowerment, hope, optimism, and life satisfaction"* (Resnick et al. 2005, p.119). This '*evolving process*' (Bradshaw et al. 2007) has been recently characterised as '*self-responsibility*' (Merryman and Riegel 2007, p.54), '*redefinition of the self*' (Lloyd and Waghorn, 2007a, p.55), '*re-authoring element of recovery*' (Onken et al. 2007, p.13) and '*personal growth and autonomy*' (Van Gestel-Timmermans et al. 2012).

As this concept has evolved over time, a dual meaning has emerged. As recovery and "*psychiatric rehabilitation*" have been used interchangeably, some attributes defined through this analysis make specific reference to "*the remission of symptoms*" and *"vocational functioning"* (Zanarini et al. 2010, p.663), *"overcoming symptoms and psychiatric disability"* (Lloyd and Waghorn 2007a, p. 55) *"returning to normality"* (Makin and Gask 2012, p. 70). Aston and Coffey (2012) highlighted that the word recovery can imply a medical model reference, thus the attributes include *"getting better", "returning back to the frame of mind you were prior to being ill", "a former state of health"* (Aston and Coffey 2012, p. 259).

Interestingly, Aston and Coffey (2012) found that service users feel forever changed by the experiences they have lived through. The identified attributes of this personal interpretation provide an alternative conceptual basis for the concept "*as the reawakening of hope and reclaiming of a positive self*" (Bussema and Bussema 2000, p 304),*" through the discovery of meaning and purpose within personal growth"* (Jones 2008) and "*using creative self-care coping strategies*" (Borg and Davidson 2008)*. * As the literature has presented the defining attributes of the conceptual perspective, the term 'recovery' may no longer be useful or applicable.

Antecedents

Recovery was discussed as being proceeded by the traumatic and catastrophic shattering of the world of the individual following the onset of symptoms (Deegan 1988; Stein and Mann

2007) often leading to the derailment of their lives (Merryman and Riegel 2007). Overwhelmed and struggling (Spaniol et al. 2002) the individual perceives themselves as significantly altered and destroyed (Braehler and Schwannauer 2012). These disruptive effects exacerbated by the developmental stage of early adulthood. This is due to "*partly individuated self-structures*" (Braehler and Schwannauer2007, p.63) and the transitional challenges of separating from family and developing autonomy (Lloyd and Waghorn 2007; Braehler and Schwannauer 2012). The shattering of the pre-illness self leaves the daunting task of reconstructing a new self and resolving how it will exist in its external environment (Young and Ensing1999).

This is an evolutionary process with the external world increasingly becoming a reference point for self-perception (Pettie and Triolo 1999). An internalised response to societal or professional stigma was evident in the literature reviewed (Lloyd and Waghorn 2007a). When labelled by their illness, individuals can experience disempowerment and feel they must subordinate themselves in order to receive treatment (Pernice-Duca and Onaga 2009) and rely solely on mental health professionals (Merryman and Riegel 2007). Such reliance can significantly affect their social role, leading to discrimination and poverty and providing substantial barriers to social inclusion (Merryman and Riegel 2007). Social exclusion can lead to feelings of shame, loss of control and reduced social connection (Braehler and Schwannauer 2007; Merryman and Riegel 2007).

The continued loss of emotional integrity, motivation, hope and autonomy can lead to a disconnection from social life (Braehler and Schwannauer 2012). Those who found solace in religious faith often experienced estrangement. However, the feelings of being unworthy or unredeemable presented a direct challenged to the hope and faith that spiritual belief required (Bussema and Bussema 2000). Deegan (1995, p.93) argued that at this stage feelings of

abandonment and directionless despair lead the individual to cease caring. Such indifference can lead to a *"hard heart"*, also described as being *"psychiatrized"* (McInnes, 2001).

However, such feelings may be essential in the preceding stage of recovery. Deegan (1995) and Bradshaw et al. (2007) would assert that within this hardened state awareness takes place of the fragmentation between previous self and current experience. This recognition leads to a new perspective on illness (Jones 2008), a desire for normalcy and contemplating independence (Bradshaw et al. 2007). A crucial antecedent of recovery is where an individual conducts an "*internal inventory to determine what parts remains intact"* (Young and Ensing 1999) and which has evolved to the performance of the vital phase of "*pacing recovery"* (Bradshaw et al. 2007 p, 30).

Consequences

As the consequences of recovery have evolved, three key themes have emerged the return to normality; the reconstruction of self; and active social connection. The return to normalcy was evident in the foregoing discussion of concept attributes (Aston and Coffey 2012) and as an antecedent of recovery (Bradshaw et al. 2007). Makin and Gaskin (2012, p 69, 70) described individuals *"getting back to what they used to be like"* and *"feeling normal"*, which appears to be related to the outcome orientated perspective on recovery. However, Das (2012) maintained that the "*medicalization of recovery*" could infer shame on those who are slowly progressing through this process.

On closer analysis, the return to normalcy was not a sole reference to state of health. Lloyd et al. 2007b (p, 212) argued, "*they believed they were normal in their own right"*. Borg and Davidson (2008) stated that a return to normality was "*being occupied with the independent pursuit of ordinary activities"* (p.132). Therefore, *"being normal"* enabled individuals to step away from the "*problematic arenas of their lives (e.g. psychiatric settings) in order to be an*

ordinary person carrying out ordinary activities" (Borg and Davidson 2008 p. 133), allowing distance from the mental health system (Bradshaw et al. 2007).

The reconstruction of the self was a key developmental consequence of recovery that was evident across disciplines. This involved four further sub-themes; first *"the acceptance of the reality of the illness"* (Merryman and Riegel 2007, p54), which enabled a new perspective on the *"relationship between self and illness"* (Young and Ensing 1999). This acceptance encouraged the assimilation of illness as in integral aspect (Braehler and Schwannauer 2012) of a more *"complex, multidimensional self"* (Young and Ensing1999, p. 16).

The second sub-theme is the process of self-discovery; Pettie and Triolo (1999, p. 256) suggested that throughout the recovery process "*a person's awareness of oneself changes over time"*; this can lead to the discovery of new aspects of self with new potentials for growth (Young and Ensing 1999). Finding meaning from the illness experience (Young and Ensing 1999) has significantly evolved from *"new meaning; new interpretation and new understanding"* to "*new insight", "turning points*" and a "*gradual change process"* (Kogstad et al. 2011, p. 480).

"*Perceptual transformation*" was the third sub-theme highlighted by Pettie and Triolo (1999, p. 260) providing an increased sense of meaning in illness. This enabled individuals to turn negative life experiences into positive learning opportunities (Kogstad et al. 2011). As the concept has evolved this appears particularly evident in young adults in which the acceptance of illness and the search for meaning had a developmental element involving *"increased maturity and self-awareness"* (Braehler and Schwannauer 2012, p. 55).

This transformation in personal perception leads on to the final sub-theme of narrating self. Lysaker and Buck (2006) proposed that this re-organised self-perception facilitated the development of a richer narrative incorporating past, present and future self. The formation of

this integrated narrative enabled the "*consideration and reformulation of realistic future hopes*", and was a crucial element as, *"recovery begins with people seeing themselves as somebody somewhere about whom a story might be told*" (Lysaker and Buck 2006, p. 32). Through externalisation, the illness experience occupies a less defining role in a personal story (Bradshaw et al. 2007).

A return to a sense of normality external to the mental health system may provide the space required to reconstruct the third theme, active social connection. As individuals progress through this process, they desire a "*more active role in their recovery and the community at large*" (Merryman and Riegel 2007, p. 64). This process involves *"actively broadening social support to include others"* (Merryman and Riegel 2007, p.59), enabling individuals to have their "*basic needs for affection and affiliation*" met (Lloyd and Waghorn 2007a, p.56). This challenges established societal stigma where individuals were on *"the receiving end of their relationships with others"* (Borg and Davidson 2008, p.137). This transforms an individual's self-perception, *"from a recipient of support to that of an equal contributor"* (Pernice-Duca and Onaga 2009, p.5)

References

Within the psychiatry literature Resnick et al. (2004) considered recovery as a "*complex concept*" involving three factors, a reduction in symptoms, medication side effects and participation in "*psych education*" (p, 546). This work had evolved with considerable specificity to a greater outcome orientation defined by Zanarini et al. (2010) as, *"2 –year symptomatic remission and attainment of good and vocational functioning"* (p.663).

While recovery appears a relatively new area within the occupational therapy literature, its remains defined, *" as an occupational journey involving responsibility, active choice, empowerment, hope and a search for personal meaning*" (Kelly et al. 2010, p. 133). The

"recovery from" versus *"recovery in"* conceptual conflict was evident in mental health nursing literature, with recovery being a dual process of individual experience and professional support, "*the acceptance of several dimensions in the recovery concept implies that different life paths are honoured*" (Lysaker and Buck 2006, p.484).

Identify an exemplar of the concept.

Patricia Deegan is a leading advocate for the mental health recovery movement, a psychologist and a researcher. The model case was identified in Deegan's (1995, p.93) description of her own process of recovery as a young adult suffering mental ill health.

If I turn my gaze back I can see myself at seventeen years old, diagnosed with chronic schizophrenia, drugged on Haldol and sitting in a chair. I can see her shuffled, stiff, drugged walk. For me, giving up was not a problem, it was a solution. It was a solution because it protected me from wanting anything. If I didn't want anything, then it couldn't be taken away. If I didn't try, then I wouldn't have to undergo another failure. If I didn't care, then nothing could hurt me again. **My heart became hardened.**

I cannot remember a specific moment **when I turned that corner from surviving to becoming an active participant in my own recovery process**. *One thing I can recall is that the people around me did not give up on me. It was through small steps like these that I slowly began to discover that* **I could take a stand toward what was distressing to me**. *I was so outraged at the things that had been done to me against my will in the hospital as well as the things I saw happen to other people, that I decided that I wanted to get a powerful degree*

*and have enough credentials to run a healing place myself. In effect, **I had a survivor***

***mission** that I felt passionately about.*

*My journey of recovery is **still on-going**. **I still struggle with symptoms, grieve the losses that***

***I have sustained**. However, now I do not just take medication or go to the hospital. I have*

*learned to use medications and to use the hospital. This is the **active stance that is the***

hallmark of the recovery process**. Sometimes **recovering from mental illness is the easy

part. Recovering from these deep wounds to the human heart takes much longer**. **Recovery

does not mean cure**. Rather **recovery is an attitude, a stance, and a way of approaching the

day's challenges.

The choice of Deegan's (1995) account as the exemplar for the concept critically illuminates

the internal dimensions of the process of mental health recovery. Deegan (1995) presented a

challenge to the conceptualisation of recovery as symptom reduction and functionality by

acknowledging that "*I still struggle with symptoms, grieve the losses I have sustained*".

While Deegan's (1995) description of hospitalisation at a young age is emotive, she located

the damage of her ill health and treatment to "*my heart became hardened*". In this example,

Deegan (1995) described her experiential view in young adulthood that recovery did not

mean cure as "*recovering from mental illness was the easy part*". However, the process of

recovering from *"the deep wounds of the human heart"* was a longer and "*on-going*"

endeavour.

Therefore, from this example the process of recovery must involve an internal movement

where an individual "*turned that corner from surviving to becoming an active participant in*

my own recovery". To "*take a stand", "a survivor mission"* all require what Deegan (1995)

defined as the *"active stance that is the hallmark of the recovery process"*. From this perspective, Deegan (1995) articulated a view of recovery as an attitudinal stance to life and its challenges. This provides an insight that recovery may involve a strategy for personal healing and future growth rather than the established definition of a '*return to a former state of health'* (OUP 2013).

Discussion

The usage of the word recovery in varying contexts and its surrogate terms inferred the *"returning to or retrieving of something lost"* (Encarta 1999). The idea of "*returning to a former state of health*" (Aston and Coffey 2012, p.259), implied recovery had a rehabilitative outcome orientation, evident in the concept's attributes and antecedents. The return to normalcy has been refined through analysis, meaning to live an ordinary life despite the presence of symptoms, "*feeling normal*" (Makin and Gaskin 2012, p.70) rather than "*being normal*" (Borg and Davidson 2008, p.133).

The definition of recovery has remained unchanged from, "*returning to a former state of health"* (1999) to "*restoration of a former or better condition*" (OUP 2014). The literature described recovery as on going and non-linear, and frequently referenced it as a journey influenced by the "*returning to"* designation (Encarta 1999). Based on Rodger's (2000) analysis methodology, which proposed that concepts are not static entities, recovery does not return an individual back to their former self, or indeed provide a designated route. Rather, it is the on-going movement and process within the individual to reengage with themselves and with life.

The definition of "*retrieving of something lost"* (OUP 2013) has influenced an alternative understanding of recovery. Analysis of the attributes and the antecedent of the concept reveal

an "*internal inventory*" takes place of old and new parts of self (Young and Ensing 1999, p.16). As the reconstruction of the self is an identified consequence, this reflects merely an initial stage and not the entire "*journey of the heart*" (Deegan 1995, p. 93). Brennanman and Lobo (2011) acknowledged the ambiguity of language across health care settings and they proposed that recovery was a process. However, from this analysis recovery in mental health in young adulthood may apply to a stage in the process rather than the process itself.

The consequences of the concept identified through this analysis would suggest that a reconstruction of the self and a return to normality may create the space for active social connection. This would concur with Leamy et al's (2011) systematic review of personal narratives highlighting connectedness and empowerment as key components of a developed conceptual framework. This differs significantly from the definition of recovery as meaning "*to get back*" (Oxford 2013) a former life or social position. Rather this process involves the active engagement with society as "*an equal contributor*" (Pernice-Duca and Onaga 2009, p.5). Therefore, conceptual clarity for the young adult service user population is essential as within their emerging adult role they will be embarking on employment, forming intimate relationships and living independently. This requires an understanding of their connectedness to others and self-determination (Patel et al 2007).

This concept analysis has generated new knowledge in the conceptualisation of recovery through Rodger's (2000) evolutionary methodology. There are differences in interpretation between various health care disciplines and individuals who have experienced recovery. This was all too evident in how psychiatric literature described recovery as "*sustained symptomatic remission*" (Resnick et al. 2004, p.666). Mental health nursing papers, described it as "*rediscovering the self*" and "*achieving a new orientation*" (Aston and Coffey 2012 p. 482,). Behavioural science and occupational health literature tended to use term recovery

interchangeably with the term "*psychiatric rehabilitation*" (Merryman and Riegel 2007, p. 52).

In contrast, service user narratives presented a more fundamental process described as "*revolution from within*" (McInnes 2001) and a *"resurrection"* (Deegan 1988, p.57) not simply *"rehabilitation"* (Young and Ensing 1994, p.4; Braehler and Schwannauer 2012, p.3). Findings suggest that recovery involves an internal process that creates movement from *"my heart became hardened"* (Deegan 1995, p.93) to the *"the birth of hope"* (Deegan 1988, p54).

Furthermore, the findings from this concept analysis of mental health recovery in young adulthood suggest that the word "recovery" is not applicable to the conceptual components identified. The new knowledge generated from this analysis has enabled the identification of a new definition of the concept: ***the reawakening of hope and rediscovery of a positive sense of self, through finding meaning and purpose within personal growth and connection using creative self-care coping strategies.***

Limitations

While highlighting recovery's lack of conceptual clarity, this analysis has some limitations. The small number of papers reviewed may limit the depth of analysis. The exclusive search of electronic databases, while influenced by Rodgers (2000), could have limited the sample selection through the exclusion of grey literature. In addition, the age group demarcation was not comparable throughout each database with MEDLINE and CINAHL classifying young adulthood as ranging from 19-44 years.

The use of English language papers only as selection criteria may also be a limiting factor. Further, as the concept analysis was conducted in 2013, the time frame of sample selection from 1986-2013 may be a limiting factor in the selection of more recent papers. Rodger's

(2000) use of a model case derived from literature provides a real life example, but one case may not cover the vast range of emotions this concept encapsulates.

Conclusion

The term mental health recovery is not reflective of the identified conceptual characteristics and the development of new terminology is required. Therefore, we proposed a new definition aligned to its identified conceptual characteristics. The implications of the new knowledge generated from this analysis are particularly significant for the mental health nursing profession. The conceptualisation of recovery differs across those health professions with whom an individual might engage as they embark on the process of mental health recovery. Such differences in interpretation have profound implications for the sensitivity and appropriateness of therapeutic communication and have the potential to be detrimental to patient care. There are also implications for the delivery of services that have been orientated towards a differing vision of recovery than that which the individual experiences. Such misunderstandings could render the term evocative, irrelevant and divorced from its conceptual roots.

The disparity between how professionals and service users interpret recovery, revealed by this analysis, could have significant implications for the delivery of recovery orientated mental health nursing care. This is especially the case if service users do not "*own the definition*" of recovery (Weinstein 2010, p.31). Marrow and Weisser (2012) call for the concept that emerged from a service user movement should be returned to service users for reformulation. Cowles (2000) proposed that a concept analysis can offer the basic components, but to ensure its relevance, conceptual refinement and validation, empirical data must be sought from those who have experienced the concept. Therefore, a second stage of

analysis to compare the identified conceptual components of service user interview based data to examine if conceptual modification is required (Cowles 1996).

Funding Declaration

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