# What recovery means for mental health services users in Catalonia

*Qué significa la recuperación para las personas usuarias de servicios de salud mental en Cataluña*

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## Abstract

In this study we explored the meaning of the recovery concept from the perspective of users of mental health services in Catalonia. We conducted five focus groups to collect the data, and we used grounded theory for the analysis. We identify eleven themes or topics around which participants organized their arguments. How people understand recovery are linked to the conceptual framework from which their ideas are derived: the biomedical model or the recovery paradigm. Some of these issues coincided with the CHIME model of the international framework of recovery-oriented public policies. The topics or themes which correspond to assumptions of the biomedical model generated conflicting perspectives and counterarguments. Participating in spaces for mutual support and mental health activism seems to promote the incorporation of the conceptual framework of the recovery paradigm.

Keywords: **Qualitative Research; Biomedical Model; Mental Health; Recovery Meaning**

## *Resumen*

*En este estudio exploramos el significado del concepto de recuperación desde la perspectiva de las personas usuarias de servicios de salud mental en Cataluña. Realizamos cinco grupos focales para recopilar los datos, y utilizamos la teoría fundamentada para el análisis. Identificamos once temas o tópicos en torno a los cuales los participantes organizaron sus argumentos. La manera como las personas entienden la recuperación está vinculada al marco conceptual del que derivan sus ideas: el modelo biomédico o el paradigma de la recuperación. Algunos de estos temas coinciden con el modelo CHIME, propio del marco internacional de las políticas públicas orientadas a la recuperación. Los tópicos o temas que se corresponden con supuestos del modelo biomédico generaron perspectivas en conflicto y contraargumentaciones. Participar en espacios de apoyo mutuo y activismo de salud mental parece favorecer la incorporación del marco conceptual del paradigma de la recuperación.*

*Palabras clave: **Investigación Cualitativa; Modelo Biomédico; Salud Mental; Significado de Recuperación***

## INTRODUCTION

Due to its limitations and counterproductive effects (Deacon, 2013; Faulkner, 2017; Lebowitz & Ahn, 2014), the biomedical model, the prevailing paradigm in public policy on mental health for decades, has begun to be replaced for a recovery-oriented approach. From this new perspective, the objective of the treatment is to promote that people have a satisfying life, with hope and contributions to society, developing a meaning and propose in one's life, whether it is with the presence or the absence of symptoms (Anthony, 1993; Copeland, 2004; Shepherd et al., 2008).

In this paradigm, personal recovery has been defined as a five-dimensional process (CHIME, for the English acronym) (Leamy et al., 2011) in which the following is acquired or strengthened: connection with others and with the community; hope and optimism about the future; construction of a positive sense of one's own identity; a meaning and purpose in life; and empowerment to have control over one's own life.

Currently, we refer to recovery-oriented approaches, and not to a model (as opposed to the biomedical), since it is a practical orientation in relation to the objectives, the type of care that mental health services should provide and the roles and rights of the users, rather than an articulated theory about what health and illness are (Thornton, 2012; Thornton & Lucas, 2010). These recovery-oriented practices are characterized by complying with four basic aspects (Le Boutillier et al., 2011):

> (a) Promoting citizenship (respect for rights, social inclusion, and meaningful occupation);

> (b) Organitzational commitment (giving primacy to the needs of people rather than to those of services);

> (c) Supporting personally defined recovery (informed choice, holistic approach, strengths focus);

> (d) Therapeutic relationship that fosters collaboration and promotes hope (peer support, shared decisions, etc.).

Many countries are already implementing strategic plans and public policies aimed at recovery, following the guidelines of the World Health Organization (World Health Organization, 2013; 2021; World Health Organization – Regional Office for Europe, 2013) and the Convention on the Rights of Persons with Disabilities (United Nations, 2006). This change has been taking place in most Anglophone countries (Leamy et al., 2011) and, more recently, in Northern Europe (Slade et al., 2008), Italy (Governo Italiano, 2021), and some Autonomous

Communities of Spain (Carmona Calvo et al., 2016; Generalitat de Catalunya, 2017; Consejería de Sanidad de Castilla - La Mancha, 2018).

The Government of Catalonia is currently implementing a number of initiatives in order to promote this change in public mental health policies. One such initiative is the program *Activa't per la Salut Mental* (Rojo-Rodes et al., 2019), developed in collaboration with relatives' entities and with users and psychiatric survivors' movements. This program promotes the creation of mutual aid groups, empowerment workshops, and information and guidance services, among other objectives[1].

In the context of these changes, a four-stage participative process of mixed methodology was undertaken during the years 2016-2017, in order to create a guide for developing personalized plans for recovery, such as those proposed by the WHO in its QualityRights materials and guides (WHO, 2019). The result was the creation of the Manual for Recovery and Self-Management of Well-being (Sampietro & Gavaldà-Castet, 2018), a similar tool to the Wellness Recovery Action Plan (Copeland, 1997), or the Personal Assistance in Community Existence: A recovery Guide (Ahern & Fisher, 1999), but adapted to the context and local resources of Catalonia.

In the second stage of this participative process, a qualitative study with focus groups was conducted with double aim: to understand what recovery means for mental health service users, and to identify what kind of resources, both professional and informal, these people use to recover. In this paper, we present the findings of the first part of this qualitative study, answering the research question: How do mental health service users of Catalonia define recovery?

To understand what people do to recover, it is also necessary to know what they understand by recovery, since the concept has very different meanings depending on the paradigm from which it is used (Pilgrim, 2008). It means remission of symptoms in the biomedical model; it implies functional adaptation of the person to society in the rehabilitation paradigm; and it refers to finding meaning in one's own life in recovery-oriented practices. Precisely, a distinctive feature and added value to this study is that it has been carried out in a cultural context in which policies aimed at recovery are incipient and various paradigms still coexist.

And although a process of change has begun, both in therapeutic dynamics and in the role given to users, the biomedical hospitalocentric model is still active in professional practice (Martínez-Flores et al., 2021). It is in this context that

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[1] More information in http://activatperlasalutmental.org/

it becomes necessary to know what people are talking about when they talk about recovery. Previous literature highlights the importance of understanding the meaning attributed to the concept to promote recovery-oriented care (Aston & Coffey, 2012; Mead & Copeland, 2000).

In relation to the concept of meaning, this study follows the proposals of the philosophical tradition that derives from the second Ludwig Wittgenstein (1953/2017). That is, the meaning should not be understood as representing something that is beyond the use or function given to words in a community of speakers. From this conception, meaning is an intransitive verb (Quine, 1981/1982), while meanings as predetermined realities and prior to any act of language do not exist. Therefore, no meaning will be considered as correct or incorrect, but the use made of a concept (recovery) will be taken into account depending on what it is used for (what is meant by using it).

## METHODOLOGY

### Design

The study was framed as exploratory. A qualitative approach was chosen as it is particularly suitable for the research objectives. Focus Groups (FG) were used as a data collection technique. Open questions were used to explore the meanings that the participants attributed (in their own words) to certain concepts, identifying in the process recurrent themes among the definitions and arguments that they used to explain their ideas (Morgan, 1996).

Based on a review of the literature, the research team developed a standardized protocol for FGs, which was subsequently approved by the board of directors of the *Activa't per la Salut Mental* project. The protocol included information about the purpose of the study, the rights of the participants, and the benefits associated with participation.

### Participants and recruitment

The participants were people of legal age, not legally incapacitated (to sign their consent), users or ex-users of mental health services, and residents in Catalonia. In the recruitment, no distinction was made from the type of services. These could be both hospital and community settings, including: Psychiatric Hospitalization Units, Outpatient Mental Health Services, Community Rehabilitation Services, Residences, Social Clubs, etc.

For recruitment, 7 mental health services, collaborators of the *Activa't* project, were contacted, as well as the people associated with the entities Federació Veus, Salut Mental Catalunya and ActivaMent Catalunya Associació. About 300

people were invited to participate in the FGs, 50 of whom responded. Finally, 36 of them attended the sessions that were recorded.

The participation in the study was voluntary. Those who were invited received a document explaining the objectives of the research, the data collection method and what would be required from them if they agreed to participate. Informed consent was obtained from all participants. A coding system was used to identify individuals and maintain anonymity.

The participants were selected using an intentional sampling strategy that took into account three demographic variables —age, gender and territory—, and the activism variable. The demographic variables were used for trying to have a certain equality of profiles among the people participating in all the FGs, but they have not been considered as categories of analysis in the configuration of the groups, nor in the elaboration of the protocol script.

Taking into account that this research was part of a larger study, the demographic variables of gender and age were considered in the sampling due to their relevance in relation to various aspects that affect mental health and recovery, for example: self-stigma and willingness to seek help (Eisenberg et al., 2009; Mackenzie et al., 2006); linkage to mental health services (Temkin-Greenyr & Clark, 1988); attitudes towards treatment (González et al., 2005); etc. The territory variable was considered because the differences between Barcelona and other Catalan towns in terms of mental health services may be relevant, which affects the resources that people use. Finally, the activism variable was considered due to its importance for empowerment and recovery processes (Adame & Knudson, 2007; Mancini, 2007). In this research, an activist has been considered as any person who defines himself/herself in this way and participates in the activities of an entity, social movement or collective that carries out activism in the first person in the field of mental health (Cazorla Palomo, 2018; Sampietro, 2016).

When creating the FGs, an equitable distribution in terms of gender, age and geographic location was sought, but the participants were divided based on the activism variable. Thus, FG1, FG2 and FG3 were made up of activists, while FG4 and FG5 were convened by service users without such experience. However, in practice, FG4 was finally considered a mixed group because two of its participants began attending the activities of a mental health user association in the period between recruitment and the day of the FG.

Likewise, in practice, parity of gender was not achieved in terms of the people who attended the FGs, resulting in twice as many men as women in the sam-

ple. In the FGs of activists, this difference was not as remarkable (10 women and 14 men), but only 2 women attended the non-activist FGs (see Table 1).

| Age % (n) | Gender % (n) | Territory % (n) | Activism % (n) |
|---|---|---|---|
| 18-45 50.0 % (18) | Women 33.3 % (12) | Barcelona 41.7 % (15) | Activist 66.6 % (24) |
| +46 50.0 % (18) | Men 66.7 % (24) | Otras ciudades 58.3 % (21) | Non-activist 33.4 % (12) |

**Table 1.** Profile of the people participating in the focus groups

### Data collection

The data was collected from February to April 2017. The FGs were carried out in Barcelona and Vilanova i la Geltrú. The sessions lasted approximately 90 minutes, they were audiotaped and transcribed verbatim.

### Data analysis

Transcribed data were analysed using ATLAS.ti 6.2 (Muhr, 1991). Data-driven coding was followed to answer the research question (Gibbs, 2009). The identification of the meanings attributed to recovery was based on the principles of Grounded Theory (Glaser & Strauss, 1967/2006). The open and flexible character of the Grounded Theory method allowed us "to create theoretical categories from the data and then analyse relationships between key categories" (Charmaz, 1990, p. 1162). Grounded theory is useful when research begins without a priori hypotheses, as it helps to minimize presuppositions and to build empirical knowledge grounded in the meanings of research participants. We specifically use Anselm Strauss and Juliet Corbin's model of grounded theory (Corbin & Strauss, 1990; Strauss & Corbin, 1998), which acknowledges that empirical observation can never be totally free from theoretical influence. We drew upon constructivist grounded theory, which assumes that data and theories are constructed by the researcher as a result of his or her interactions with the field and its participants (Bryant, 2003; Charmaz, 2000, 2008).

Data analysis was performed in three stages. First, the transcription of each FG was read by two different researchers in order to identify extracts in which participants referred to recovery and what helped or hindered it. A third researcher was then involved in selecting the final pool of quotations. Her task was to choose the most intelligible option between two quotations expressing a similar view or idea, as well as to decide whether a quotation identified by just one of the first two researchers merited inclusion or not. In the second stage,

we created a series of categories that reflected the themes that the participants used in their arguments to account for their experience. The two principal researchers compared their proposed categories in order to arrive at a consensus. The criterion for deciding the utility of each category was the theoretical saturation of codes, which was evaluated independently by each researcher (Charmaz, 2006; Glaser, & Strauss, 1967). This process led to the identification of eleven categories or emergent themes. Finally, researchers looked for relationships among quotations within each category.

## RESULTS

Eleven themes or topics were identified in the meanings that people ascribed to the concept of recovery. In six of them, there was no dissent or counterargument among the participants of the FGs when presenting them. These six topics were:

### Recovery involves empowerment

Although the word "empowerment" only appeared in the activist FGs, the dimensions of the personal level of empowerment (World Health Organization - Regional Office for Europe, 2010) are factors that were highlighted as basic in all the FGs. Autonomy, self-management skills, the ability to make decisions, and overcoming self-stigma emerged as key variables in the recovery process and as prerequisites for well-being.

> Recovery is being able to take control of my life, deciding what I want to do, being able to choose at all times. […] It is being empowered. (Participant 2, Focus Group, February 16, 2017)

People defined their autonomy and self-determination in relation to possible external limitations, both from within the family environment and from mental health services:

> I think of recovery as the moment when I begin to have some autonomy with regard to health services, when I don't need to be followed up so intensively. (Participant 8, Focus Group, February 14, 2017)

Likewise, self-determination and autonomy are also linked to the mental health problem itself. For some people, it means being able to function in daily life without the constraints and limitations derived from the symptoms.

> Recovery means that it is possible to exercise free will in a way that is not constrained by a pathology. (Participant 2, Focus Group, February 11, 2017)

**Recovery requires a project of life**

The participants highlighted that without the sense of one's own existence nor a motivation to live, there is no possible recovery nor subjective quality of life.

> [Recovery] is being able to develop your own life project, whatever it is. (Participant 6, Focus Group, February 16, 2017)

A personal life project, however, does not need to reflect the social expectations. Some participants highlighted that recovery is not necessarily linked to productivity nor insertion in the labour market:

> I would not focus recovery so much on social functionality in the capitalist framework. I would focus it more on personal fulfilment. (Participant 2, Focus Group, February 11, 2017)

Accordingly, a lack of meaning in life would have a negative impact on a person's mental health. The absence of such meaning is a barrier to recovery, and it could lead to a crisis or be experienced as a relapse.

> For me, a relapse is a breakdown in your life project. (Participant 8, Focus Group, February 14, 2017)

**Recovery requires satisfying social relationships**

In all the FGs, the participants highlighted the social-relational dimension of mental health. In these cases, people give a definition of recovery that is based on the human being's need for interaction and connection with others.

> If I have someone to share my time with, and to feel accepted and loved, then I have a large part of my mental health covered. [...] Having satisfactory social relationships. For me, that is my well-being in mental health. (Participant 2, Focus Group, February 16, 2017)

From this perspective, any impairment on the ability to establish or maintain healthy social bonds is experienced as a relapse or a mental health problem.

> The moment I stop having that ability to interact with society in a constructive way, I say that I am entering the process of relapse. (Participant 1, Focus Group, February 11, 2017)

For many people, what defines recovery is reversing the process that leads to isolation, regaining the ability to interact and bond.

> The fact of recovering your social life, your sentimental life, it's like that is giving you well-being. For me recovery is this. (Participant 5, Focus Group, February 11, 2017)

## Recovery involves self-knowledge

Participants defined recovery as a process of self-knowledge. Some people highlighted the need to learn from experience and acknowledge one's own limits as a condition of possibility for personal well-being, as well as a requirement to achieve and maintain a positive sense of one's own life.

> Recovering is also about knowing yourself and knowing where your limits are. For example, I've always liked cars, but I can't drive because the medication I'm on makes me drowsy. But I'm prepared to accept that rather than risk killing someone. (Participant 3, Focus Group, February 16, 2017)

Participants also saw their crises as a learning experience, as an experience that is useful for their process of recovery, in the sense that this would allow them to be aware of what affects their well-being and quality of life. It is the idea of crises as a source of insights.

> What we call relapse often can be a means of healing. When we have a relapse, it is the subconscious that guides us. And we do things that we wouldn't do consciously, and this can help us heal. (Participant 4, Focus Group, April 12, 2017)

## Recovery involves an identity recognition

Some people define recovery as having a positive self-concept. Having wellness would basically mean feeling good about who I am and with what I do in life. Without a positive appraisal of oneself, there would be no emotional well-being.

> On a personal level, recovery is being well with oneself. (Participant 7, Focus Group, February 14, 2017)

Complementarily, other people described mental health crises as a loss of identity. For them, relapse feels like they cease to be themselves and they struggle to recognize themselves in their actions, thoughts, and emotions.

> It's like you get cut off from who you are, you get carried off somewhere else and you don't know how you're going to get out or find your way back. (Participant 4, Focus Group, February 16, 2017)

For these participants, recovery would be being themselves again, recognizing themselves in their own behaviours, thoughts, and feelings. Therefore the recovery process would suppose a reconstruction of the self.

> Recovery is when you become yourself again, little by little, one step at a time. (Participant 1, Focus Group, February 11, 2017)

## Recovery is built on hope

For many people, recovery relies on the hope of having a better quality of life, with an optimistic view of the future. For these participants, recovery is not defined as a state but as a horizon to walk towards.

> I could define what recovery is in one word: having dreams. A person who has dreams of future, that's a good definition of recovery. (Participant 1, Focus Group, February 11, 2017)

For some people, thinking of recovery as possible is a basic motivational element and a key facilitator to face their own process.

> You need that confidence, that hope, knowing that one can feel better with oneself, right? [...], because if not the road ends. (Participant 8, Focus Group, February 14, 2017)

For these people, hope is a personal quality that can be cultivated. Their own life experiences can serve as reference and model to face the current situation.

> Something very important is to look at the past and say: "I have had super bad experiences and I have overcome them, therefore, I can do it". (Participant 4, Focus Group, February 11, 2017)

Likewise, hope can also be cultivated from other recovery experiences, by knowing the life stories of those who have gone through a similar experience and who currently enjoy a full life.

> The main thing to recover is to see that there are people who have recovered. (Participant 7, Focus Group, February 14, 2017)

In contrast to the previous topics, the remaining five themes that were identified in the analysis generated conflicting ideas, and discussion among the participants.

## Symptoms are/are not a parameter of recovery

The issue of symptoms as an indicator to assess the recovery process itself is a topic that generated conflicting ideas. Some people saw the presence or absence of symptoms as the benchmark in this respect. For them, recovery means the absence of illness, whereas relapse is equated with being symptomatic.

> If you return to have the symptoms that you have when you are ill, you realize you are relapsing. (Participant 7, Focus Group, April 12, 2017)

When people think about mental health in absolute terms, that is to say, as the absence of symptoms, the fact that symptoms can reappear leads them to conclude that they can never recover.

> What they've told me is that the illness goes in phases, that there'll be really bad times and other times when things aren't so bad, but for me there's no such thing as a full recovery. (Participant 6, Focus Group, April 6, 2017)

Thus, some people who live with persistent symptoms think recovery as impossible and they see themselves as chronic patients.

> It doesn't come a time when you say: "Now I'm resurrected, the illness is over". [...] The illness will surely be with you till you die." (Participant 2, Focus Group, April 12, 2017)

It could be highlighted that the argument of recovery as impossible, with the "illness" defined as irreversible even though there are asymptomatic periods, only appeared in FG4 and FG5, the groups with participants without experience in contexts of mutual support and activism in mental health.

On the contrary, other people think on health as a *continuum* in which there can be more or less quantity, and not in absolute terms. When this idea is applied to the notion of recovery, participants argue that recovery is not a one-time action or an end state, but rather a permanent "journey", a gradual process.

> I see it like climbing a mountain. One is always on the way, going up or down, but never reaches the top. [...] In other words, it is not a stable entelechy. Recovery is not the mountain; it is the mountaineer climbing. (Participant 6, Focus Group, February 11, 2017)

For these people, the key is not the presence of symptoms, but the extent of how these symptoms affect their quality of life and their ability to exercise autonomy and self-determination.

> I don't think recovery has much to do with symptoms, it's more about how well you function as a person. (Participant 6, Focus Group, February 16, 2017)

From this perspective, the appearance of symptoms or a relapse does not have the same dramatic meaning, as it is not seen as a failure nor the loss of everything that has been achieved.

> I see recovery as a path along which there may sometimes be relapses, but that doesn't mean you're knocked completely off course. [...] Experience allows me, in periods of relapse, to feel that I'm still in my process of recovery. (Participant 2, Focus Group, February 14, 2017)

By the same token, those who think about health as a process understand that, on the road to recovery, there may be stages or partial objectives that allow us to think of different levels or stages.

> Like the mountaineers, one goes on setting his/her (own) flag in this base camp: "this is my recovery from now on". But one can keep going up and reach another base goal: "this is my new level of recovery". (Participant 6, Focus Group, February 11, 2017)

These stages would depend on the point or moment of the process in which the person is, a moment defined more from discomfort and suffering or more from well-being and quality of life.

> I think there are two levels. The first level is basically not suffering. The second level is having well-being, it is enjoying life. (Participant 6, Focus Group, February 14, 2017)

**Normality is/is not a mental health criterion**

The idea of normality generated a lot of conflicting opinions among the participants, and these can be grouped according to two definitions of what is normal. The first definition is normative and refers to what most people do. Recovering would mean being normal (being like most people in the own environment):

> You're recovering because you're doing more or less the same things that everybody does. (Participant 5, Focus Group, Abril 6, 2017)

Accordingly, a relapse would mean going beyond the boundaries of what is considered normal in society, engaging in a behaviour that is not expected within a given social context.

> What you have to do is try to analyse yourself and observe whether you're doing something that might be considered, for want of a better word, odd, and if so then you can be sure that you've relapsed. (Participant 2, Focus Group, April 12, 2017)

The second definition of normality is built around what is usual or habitual for a particular individual. A relapse would be an interruption in that person's ability to carry out daily activities.

> [Relapse...] It's like a break from the things you do normally. (Participant 1, Focus Group, February 16, 2017)

From this conception, recovery means regaining the capacity to go on with their own daily life, regardless of whether they continue to have symptoms.

> Recovery would be doing everyday things: shopping, taking a shower, going for a walk, meeting someone and talking with them. (Participant 6, Focus Group, April 6, 2017)

Finally, some people problematized the very idea of normality. In this case, there is no doubt that the behaviour itself is outside the norms or conventions,

but it is questioned if these conventions are valid as a health criterion when evaluating behaviour.

> What is normal for some people is not normal for others. But "normal" in quotation marks. [...] There you already have to consider some philosophical things: what is normality? (Participant 5, Focus Group, April 12, 2017)

## Recovery is/is not a subjective matter

How and who can measure recovery was another issue that generated conflicting opinions. Some people saw recovery as a subjective matter. For them, mental health is personal, and it would depend on the meaning that each person ascribes to it. Thus, each person must find out what recovery means for herself/himself, because there is not a single definition that fits everyone.

> Recovery is relative and highly subjective. [...] I think it has to do with how the person sees and feels it. (Participant 5, Focus Group, February 16, 2017)

In these cases, recovery is synonymous with well-being. Some participants stated that only themselves can define when they feel good enough to consider themselves recovered or bad enough to realize they have relapsed. For these people, the experience of psychological well-being is the measure of recovery.

> A sign that tells you 'You're well' is when you start to enjoy life, when you have positive feelings, you feel optimistic. (Participant 6, Focus Group, April 12, 2017)

This argument has two sides. On the one hand, people may consider that their quality of life is good enough to see themselves as recovered and as having sufficient well-being, regardless of what other people think. Conversely, someone who still experiences high levels of suffering may refuse to accept that he or she has recovered, despite professional opinion of the contrary. The same occurs with the experience of relapse. Some participants considered that there are no external benchmarks of psychological suffering and only their own subjective experience can tell them when they have relapsed.

> I think that everybody judges their own relapse. What I mean is, maybe the psychiatrist sees it as a clinical relapse, whereas you don't feel as bad as you did before... even if you have the same symptoms. I mean, I think it is highly subjective. (Participant 4, Focus Group, February 16, 2017)

In contrast to the above, some participants used the notions of "lack of illness awareness" and "dangerousness" to argue against the possibility that people could adequately assess their own situation and take responsibility for their own recovery process. From this perspective, recovery should not be seen as a

purely subjective matter, and the judgment of professionals should always be included in any assessment of a person's mental health.

> In order to have a more complete or exhaustive view of relapse we need to include the perspective of the mental health professional [...]. Otherwise, we're talking about relapse only in terms of well-being. If a person is out of touch with reality, he might have an exaggerated sense of his well-being, and then one day he decides to fly, he jumps off a cliff and dies. That person is not recovered. (Participant 2, Focus Group, February 11, 2017)

**Objective reality is/is not a measure of mental health**

This topic is an intersection between the idea of normality, the value that people give to symptoms as a yardstick, and the debate on recovery understood as an idiosyncratic issue. Participants used the metaphor of reality as a place (where someone can be inside or outside) to explain their unusual perceptions and thoughts.

> [being recovered] means that you are inside reality. (Participant 2, Focus Group, April 12, 2017)

Accordingly, relapse is defined as a perception that goes beyond the margins of what is intersubjectively valid, a definition that is linked to a normative notion of reality.

> Relapse is when what I consider reality is actually a distortion. What I mean is, I have thoughts that are not objectively verifiable. (Participant 7, Focus Group, February 14, 2017)

Sensations and perceptions that do not fit within the framework of social normality would be located outside of reality. Recovery would be equated with the cessation of these experiences and the return to socially shared cognitive frameworks.

In contrast, there are people who question the very notion of reality and, especially, the value of this parameter as a criterion of health and illness.

> I already doubt that the perceptions we have are unreal, because for me they are my reality [...] And this, as a differentiation between mentally ill and non-mentally ill, I don't seem to understand it. (Participant 2, Focus Group, February 14, 2017)

**Recovery does/does not involve a return to the past**

Some participants saw recovery as a return journey to a time before their mental health crises. The idea here is that something lost (life, job, friends, etc.)

can be regained. This is usually felt, specially, when the present is character-ized by suffering or distress.

> Recovery means regaining certain aspects of life or things you have lost. (Participant 5, Focus Group, February 11, 2017)

For people who think in this way, recovery and wellness might seem like impos-sible goals because they can never regain what has been lost.

> There are some things you can never get back, relationships you can't pick up again. And of course, I'll never be 100% well. (Participant 3, Focus Group, February 14, 2017)

Conversely, if the present is experienced as a time of wellness and people feel recovered, then the return to a previous time has the opposite meaning: it is a return to a time of crisis or suffering. This is experienced as a relapse and a backward step.

> There is a return to the past, to certain symptoms, to certain situations that make me feel like I did back to those times when it was really hard for me to live a normal life. To me that is relapse. (Participant 5, Focus Group, February 11, 2017)

Finally, some participants were critical to the idea that you can turn the clock back. For them, time is irreversible, and believing otherwise only produces suf-fering and is a barrier to recovery.

> What I don't believe is that recovery is about going back to how things were before the first episode. First, because thinking like that only ham-pered my recovery [...] and second, because I came to understand that re-covery is a path towards the future. I see recovery as a new stage in my life. (Participant 7, Focus Group, February 14, 2017)

From this perspective, recovery is a process of personal growth. Overcoming a mental health problem means having more tools and resources than before, and thus being better prepared for dealing with distress or suffering.

> I don't want to go back to how I was before, because now I'm much better than I was back then, I'm much more aware as a person. [...] I haven't re-covered, I've grown as person. (Participant 2, Focus Group, February 14, 2017)

## DISCUSSION

When talking about recovery, the participants of the study expressed a series of arguments that can be organized around eleven main themes or topics. One way to understand the variety of meanings that people ascribe to recovery in mental health is to consider the conceptual framework from which these ideas

derive. The hegemonic biomedical model and recovery-oriented public policies currently coexist as paradigms for explaining and addressing mental health problems. Each of these paradigms has its own assumptions, its goals, and therefore, its corresponding definitions of what it means to have recovered or to be in the process of recovery.

Five of the topics around which there was no disagreement or counterargument roughly correspond to the categories in the study by Mary Leamy et al. (2011), which consisted of a systematic review and narrative synthesis of 97 other previous studies dedicated to defining the concept of recovery, carried out in the English-speaking world, Scandinavia and other European countries. In other words, when users of mental health services in Catalonia speak about recovery, in general, they use the ideas of the conceptual framework of the recovery-oriented public policies, as it is the case in the countries that have been implementing them for more years. In this sense, the CHIME model (Connection-Community, Hope, Identity, Meaningful Life and Empowerment) by Leamy et al. (2011) also seems to be valid for understanding the meaning attributed to the concept by people who have undergone or are undergoing a recovery process in our cultural context.

Regarding the importance of self-knowledge for recovery, the last topic on which there was consensus, it is a topic that has also been pointed out in previous literature in this area. For example, in the multinational study led by Larry Davison (Davidson et al., 2005), participants highlighted self-knowledge (being able to identify one's own needs, know where one's limits are, and learn from experience) as a crucial factor to have agency over one's own life. Likewise, Sylvie Noiseux and Nicole Ricard (2008) identified the development of the capacity for insight, introspection that leads to self-awareness, as a basic step in the recovery process. In short, self-knowledge is recognized as a condition of possibility for empowerment, which, in turn, would favour personal recovery.

On the contrary, the issues that generated disagreements among the participants correspond to ideas of the prevailing biomedical model, which conflict with the recovery paradigm. For example, some participants argued that recovery implies absence of symptoms, return to normality (normal biological functioning), and being in touch with (an objective) reality. Questions all of them interwoven argumentatively and that would require an external assessment by the authorized knowledge of a professional. These are precisely some of the premises of the biomedical model, which regards health as the absence of disease (Lundström, 2008; Wade & Halligan, 2004;) and where the symptoms of a disorder constitute an objective reality. From this perspective, deviations from normality would be independent of historical and cultural contexts (Oña-

Esteve, 2018). In addition, in this model medication is the treatment modality, being a priority in relation to psychosocial interventions for mental health problems (Deacon, 2013; Deacon & McKay, 2015). Accordingly, psychiatric knowledge is ascribed with a privileged role in the understanding and treatment of these problems. Under this assumption, some participants rejected the idea that affected people themselves are best placed to assess their own well-being and suffering. Under this view, responsibility for assessing and managing a person's recovery process should fall ultimately to a professional with biomedical training.

It is noteworthy that when people do not define health in negative terms —such as the absence of symptoms—, but in positive terms (Herrero-Jaén & Madariaga-Casquero, 2018) —as the presence of well-being, with a life project, agency over own life, etc.—, the concepts of recovery and mental health are often used as synonyms. In other words, for these people what would be recovered are these psychosocial factors that define the meaning of mental health, in accordance with the current proposals of the WHO (World Health Organization – Regional Office for Europe, 2013).

The last topic that generated disagreement, namely the meaning of the past in the context of a recovery process, can be understood partly as independent of the paradigm in which the participants frame their arguments. In this case, what did appear to influence the meaning attributed to the past was people's appraisal of their current mental health. Likewise, this issue may have also generated conflicting arguments due to differences in the basic assumptions of both paradigms, since the biomedical model has as its purpose a type of return to the past: the main objective of its interventions is to restore a lost (neurochemical) balance (Cohen & Hughes, 2011).

Another way to understand the plurality of definitions is attending to the background of experiences of the participants. In this sense, the activism variable, the only one that was used differentially to shape the FGs, allows us to make some conjectures about its influence on people's conceptual frameworks when they think about recovery.

First of all, it should be noted that ideas from the biomedical model appear in all the FGs, showing that both paradigms coexist in these groups. An example is the criticism of the definition of recovery as an idiosyncratic process linked to emotional well-being. The idea that the biomedical knowledge of a mental health professional is always necessary to assess a recovery process appeared in both, activist FGs and non-activist FGs. However, this premise was questioned only among people with a background in spaces of mutual support and activism.

Perhaps the idea that most clearly marks the difference between both types of groups is the notion of irretrievability: the fact of thinking of themselves as people who, although they have asymptomatic periods, have a chronic and ir-reversible problem. The main argument that leads these people to define themselves in this way is that they continue to have symptoms or are likely to have them. In this study, the idea that symptoms are crucial to any definition of recovery only appeared in FGs involving non-activists (FG4, FG5). On the contrary, this idea was explicitly rejected by the participants of the FGs composed only of activists (GF1, GF2, GF3), for whom the recovery process was in-dependent of the symptomatology. In this case, the argumentative strategy that people used is to define recovery as a process, rather than as a recovered-not-recovered dichotomy, where the ups and downs (symptoms, relapses, cri-ses) can be understood as part of the same process and not as a failure or an impossibility to recover. This observation is consistent with previous findings. Thus, in a study on social identity processes in people with chronic mental health conditions, the authors found that people who perceive themselves as "in recovery" obtain better results in their own process (Cruwys et al., 2020).

In accordance with the idea of recovery as a process involving different stages (Andresen et al., 2003; Spaniol et al., 2002), some participants also referred to a shift from an initial level of recovery, defined as not suffering and being symptom free, to another more advanced level, where they felt satisfied with who they were and what they were doing with their lives. It should be noted that this latter idea only appeared in activist FGs. This suggests that among the participants of the study only those who defined themselves as activists saw themselves as having reached this final stage of the recovery process.

In summary, we found that activists were more likely to have assimilated key insights from the recovery paradigm, while non-activists' narratives were framed more in terms of the biomedical model. This finding is consistent with previous studies showing that activism is a positive factor when it comes to empowerment and recovery (Rogers et al., 1997). It also suggests that partici-pation in spaces of mutual support and/or in movements of users and survivors offers an alternative narrative to the biomedical model of mental illness, and that this allows people to begin reconstructing their experiences and identity in their own words (Adame & Knudson, 2007).

## Strengths and limitations

Although previous studies have explored the meaning of the concept of recov-ery from the perspective of mental health service users (Kidd et al., 2015; Mancini et al., 2005; Noiseux & Ricard, 2008; Piat et al., 2009), the present

study is, to our knowledge, the first to examine this issue in a Spanish-speaking cultural context. A context in which recovery-oriented public policies are beginning to be implemented and coexist with care practices from a biomedical perspective. The study was also a key step in developing a new guide for implementing personalized plans for recovery and self-management of well-being, aimed at users of mental health services in Catalonia (Sampietro & Gavaldà-Castet, 2018).

On the contrary, although we intended to have a relative equity in the FGs demographic profiles, twice as many men as women attended. A difference that does not correspond to the use of mental health services in Catalonia, in which, although 56% of psychiatric admissions are men, in adult outpatient mental health services 6 out of 10 people served are women (Agència de Qualitat i Avaluació Sanitària de Catalunya, 2017). This is a limitation of the sample that could have influenced the collected meanings. Therefore, larger comparative studies of mental health service users are needed to examine the possible influence of demographic variables on how they understand and define recovery.

## CONCLUSIONS

Recovery is a polysemic concept. The plurality of meanings that people attribute to it depends on the conceptual framework from which they think about their own process. Our analysis suggests that the arguments that users of mental health services use when talking about this topic vary depending on whether their experiences are understood from the conceptual framework of the biomedical model or the recovery paradigm.

On the one hand, we found that some of the main topics used by the participants to define the concept correspond to the categories of the international (Anglo-Saxon) conceptual framework of the recovery paradigm. In this sense, the CHIME model (Leamy et al., 2011) is also applicable in our cultural environment.

However, in our social context, the biomedical discourse continues being hegemonic. Its main premises appeared in all the focus groups as counterarguments and resistance to the new paradigm. A clear example is the debate regarding the agency on the recovery process itself. For some participants, the evaluation of the situation and the ultimate responsibility for the process should always fall to a professional with biomedical training. Another common counterargument that works in the same direction is the link between recovery

and the absence of symptoms. An idea that leads many people to define themselves as unrecoverable and to think of recovery as impossible.

Participation in spaces of mutual support and mental health' activism seems to be a factor that affects the conceptual framework from which recovery is thought. In this study, we observed that it is more usual for people with previous experience in activism to have assimilated key ideas of the recovery paradigm. In contrast, the narratives of non-activists were framed more in terms of the biomedical model. In this sense, the narratives and learning shared by people expert by experience seem to favour the development of a critical look at biomedical assumptions and a change of perspective. If mental health policy administrations wish to promote a paradigm shift, it is recommended that they promote participation in spaces of mutual support and activism, and/or that they begin to include people experts by experience at all levels of professional care.

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