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Perspective Paper

THE FATE OF THE IDEA OF RECOVERY TODAY: A USER-CENTRED ANALYSIS

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This perspective piece examines one way, amongst many, in which power works to silence users and survivors of the 'psy' disciplines when they begin finding a voice. This is by re-claiming ideas that originated with survivor movements and making them part of mainstream discourses. In the process these ideas and practices are transformed. We can call this 'co-option'. I take as my example the 'Recovery Approach' and address three questions. First, is this approach a 'normalising' one? Second, is it claimed to be universal? And finally, what are the different perspectives of researchers, practitioners and service users on this way of dealing with distress? I identify some counter-narratives which bear the seeds of resistance, including from indigenous scholarship. The argument uses a lens of concepts and methods from survivor research.

Keywords: *User-led research, Recovery approach, Power, Co-option*

1. Background

The question to be interrogated here can be simply put: have the mad, silenced for centuries, now found a voice? To answer this question, I rely on concepts and methods discussed in a previous paper and will briefly summarise these here (Rose, 2021). First, I address the ways such silencing, a form of power, has operated historically and operates still. Asking the question of whether survivors can be knowledge makers, I used concepts of 'unreason' and 'epistemic injustice' to explicate the barriers to this, applying them critically (Foucault, 1967, 2013; Fricker, 2007). I also argued that *collectives*, as well as being the source of all knowledge, had a particular importance for those deemed mentally ill. This is because the act of pathologisation (a diagnosis) is simultaneously an act of *individuation*. The psy disciplines and associated practices tend to strip the distressed individual of all 'context'. This word is both over-used and underspecified. Ahonen and colleagues elaborate it like this:

> Context… is not, then, a 'variable' or 'background', but a complex of power relations, discursive practices and forms of knowledge that need to be analysed (Ahonen et al., 2014)

This includes the dimension of materiality and applies generally (Nazarea, 1999). The point here is that this 'context' is almost entirely absent in Western psy theory and practice and leads to people on the receiving end of such ministrations being ripped from their life worlds, symbolically and actually. So, in practice for example, if a client complains about their landlord, most professionals are not going to speak to the landlord. They are looking for signs and symptoms in how the complaint is framed: they are looking for pathology within the individual.

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This is, then, a question of power in which I again follow Foucault, conceiving power as mobile, multiple and generative (Hook, 2007; Miller & Rose, 2008; Still & Velody, 2012; Wandel, 2001). Yet, whilst Foucault argues that all power attracts resistance, he does not provide the kind of analysis that can address the issues that concern me (Foucault, 1977). Foucault is not alone, however, in that other writers also produce conceptualisations of resistance inadequate for present purposes (Putnam et al., 2005; Vinthagen & Johansson, 2013). This I will try to rectify using notions of counter-narrative, including indigenous scholarship.

Power, then, comes in various guises from domination in the involuntary elements intrinsic to mental health legislation in almost all jurisdictions, to the proposition that negative attitudes, or ‘stigma’, are the root of the disempowerment of survivors. But in the current paper I will address other forms that power may take, with a focus on one example: the ‘Recovery Approach’. This is an area where survivors can claim some authority and it is a topic of controversy as well as complexity. The form of power exercised here is *co-option*.

I will utilise the additional idea of ‘normalisation’. This concept was developed first by Wolfensberger in relation to people with learning difficulties (Wolfensberger, 1970). Such individuals were to be taught culturally-appropriate habits so that they did not stand out as ‘Other’ but fit with the population at large. This approach has been hotly contested, especially in the field of disability (Moser, 2000). Those who oppose it argue that there is a right to live as disabled people without being subject to exclusion. At the level of knowledge, this opens the way for an analysis of counter-narratives, that is to say, not just for ways of thinking that oppose dominant knowledges, but also for radically different ways of thinking about key issues which are not specific to the Industrialised West.

2. Aims of this paper

This paper begins an analysis that aims to look at specific settings, practices and knowledges where people with mental distress have claimed authority. The specific examples are: recovery, peer work and user involvement in research. These can be called practices of resistance but, more than mere opposition, they are also a positive move to reclaim power. These practices and their fates have some things in common, particularly a dissipation of what began as collective movements and consequent individualisation, operating at many levels (Parella, 1993). Co-option means they started as ideas generated by user movements or, occasionally, individuals but were subsequently taken up and changed, ‘co-opted,’ by mainstreams. Here I focus on ‘Recovery’ as a discourse and practice developed by survivors at the end of the last century which, in the last 15 years, has been taken up by the ‘psy’ disciplines and particularly psychologists. I aim to unsettle this discourse by asking three questions: is the approach a normalising one?; is it claimed to be universal?; are there different perspectives on the parts of researchers, practitioners and survivors?.

3. Method

As a ‘perspective’ or analytic piece evidence is vital. I amass writings relevant to my specific questions, working with pre-defined concepts as well as from a mental health services user standpoint. The method, then, cannot be ‘neutral’ although it is informed by the papers themselves. As these concepts are drawn from critical theorising, and the method is therefore partially deductive, then Critical Discourse Analysis of the interdisciplinary and sociological orientation seems the most appropriate approach (Fairclough et al., 2011). This applies a critical and questioning orientation to the papers, in the search for dominant discourses (Rose, 2021)These dominant discourses are surfaced through an analysis of the papers and some are hypothesised but some may be unexpected. This will be explicated to show the method in action.

4. Papers discussed

Although there is a large literature on the Recovery Approach, and it has grown exponentially, the majority is written by non-survivors; ironic given its beginnings. This is a problem for research in this area generally, because in claiming a voice for the mad we largely find accounts of mad knowledge as translated through mainstreams: allies or foes. We hear the survivor voice filtered by clinicians and researchers and much gets lost. So I 'oversampled' papers authored by survivors, in an attempt to correct this imbalance. Secondly, as we are concerned with people's understanding and views, all papers are qualitative. Finally, participants in the papers selected had long-term engagement with psychiatric services or other forms of support in the Global South.

5. Recovery

The idea of recovery arose in mainstream work in response to biomedical notions of 'cure', or its impossibility, claiming to bring hope for a meaningful life to the 'chronically mentally ill'. It is familiar to most in the mental health field as a counter- position to the focus on symptom control in biomedical psychiatry. It holds that people can lead fulfilling lives even in the presence of 'symptoms'. This approach is often acknowledged to have begun with survivors and almost coterminous with its take up at the hands of professionals, there has been controversy. For example, it has been argued that Recovery as a collective practice developed by users of psychiatric services ('consumers') in the last century in the USA (Deegan, 1988), was basically reinvented as a 'personal journey' by psychologists 15 years later (Slade, 2009).

What could possibly be wrong with this? Individuals want to recover, get back to a 'normal' life, away from the clutches of psychiatry or claustrophobic situations in hospital or outside. There were examples of these arguments in my own research: some wished to excise madness altogether whereas others viewed their psychosis as an asset to be incorporated productively (Lofthus et al., 2018)

But, for others, there is a problem in how this framing has developed. Recovery is seen as an imposition and normalization its unwanted underside. That is, and for various reasons, some survivors resist being 'normal', at least in some circumstances. Some want the possibility of living as mad people or see this as the only possibility under current conditions and conceptions of a 'normal life'. As one informant said, "you can't take the bipolar out of me". Others are more radical claiming pride in their madness: hence 'Mad Pride'.

In addition, recovery 'therapies' presume a level of privilege that is absent for those living on the margins of society, including in the Global South. One participant in a project interviewing user knowledge-makers recounted life in an area made up largely of half-way houses and dry-out centres. Money was virtually non-existent. This participant, a user researcher, witnessed some psychologists come to these residences and offer a 'radical psychological therapy'. The disconnect between this promise of psychological resolution, whilst literally not having money for food, was lost on the psychologists but not the residents.

This throws into sharp relief how recovery is generally framed: in terms of an individual secure in work, a family, with social networks but retaining autonomy, and resources to sustain this. Maybe an example will throw light on what looks like a straightforward wish. Because to 'recover' in this way, people with a mental health diagnosis need professional help. So has recovery has become a 'treatment'. This professional will ask you to set goals – your 'own' goals. They may even use an instrument called the 'Recovery Star' where the goals sit on the points of the star and at each session the professional and 'client' assess progress towards these (Dickens et al., 2012). This enterprise was recommended by the Department of Health in England for all services to use in 2010 and still holds. The same is true for New Zealand, although this had a special inflection to take account of Maori practices (O'Hagan et al., 2012). Latterly, the approach has become policy in multiple countries in the Industrialised West as well as in India, Brazil and Japan.

However, this apparently person-centred approach can be critiqued because in practice it can become extreme. Although you supposedly 'choose' your own goals, certain goals are not allowed. If you do not like people very much and prefer your own company, that is not an allowable goal as you are supposed to have 'social networks' and these must include non-mental patients, in the name of 'inclusion'. In fact, the goals allowed are quite narrow and, as has been pointed out repeatedly, incorporate a very particular idea of 'normality' (Gould, 2012; Harper & Speed, 2012; Rose, 2014). It is the normality of the stably employed, autonomous, choosing individual which characterizes many 'modern' societies. One organization in the UK has reworked the Recovery Star to demonstrate that 'recovery' under current social conditions is impossible for many – and so there is the 'Unrecovery Star' (RiTB, 2014). The 'points' on the Unrecovery Star are issues like poverty, racism, patriarchy and diagnosis. So, user knowledge sees the world differently. For proponents of Recovery, normalisation is a dominant discourse.

Mental health *policy* can also discourage collectives. In terms of settings for collective support, Finlay and colleagues argue for the importance of 'third places' (Finlay et al., 2019). This is broader than NGOs but includes them. Arguing that 'third places' are much more flexible than formal providers and often mixed in membership, the authors see them rapidly closing. This is mirrored in the UK, where 'user led organisations' (ULOs) are markedly declining in numbers (NSUN, 2020).

Consistent with this is the closure of Day Provisions in many regions in the West on grounds they promote 'dependency' and prevent friendships forming 'outside' (Bonavigo et al., 2016). Grim to an everyday person, Day Centres were a form of embryonic collective. People there gained mutual support at an elemental level, sometimes to save their lives. But that emphasis on collectivity has been banished, to be replaced by the autonomous individual 'in recovery'. The autonomous individual is another dominant discourse.

The 'recovery ideal' as just described is also a white form of knowledge and practice. Black participants talked about this differently, focusing on healing as a mutual experiential learning process. For some, the move to normalization together with a very hostile funding environment partakes of an almost *deliberate* strategy to undermine the survivor movement completely, and particularly the Black survivor movement. But more optimistically, participants pointed out, collectives as originally envisioned are still extant, have not been diluted or crushed. Although many organisations had been formalised, with governing boards and so forth, they were emphatic about never having left the grassroots – symbolically and on a daily basis. User and survivor views on the impact of 'the recovery movement' are not uniform and resistance persists.

The next section develops this thread, arguing that there is something systematic about the way survivor-led knowledge and practice has been differently mainstreamed by different groups.

5.1 Expanding the argument

There is now a huge literature on Recovery and I have narrowed the evidence according to the criteria described above. It is also clear that the *definition* of Recovery is not singular, it is multiple and contested. Each year, papers appear beginning with a statement that the definition is ambiguous (McWade, 2016; Neale et al., 2015; Price-Robertson et al., 2017; Ricci et al., 2021). In what follows, I will address two things. First, an elaboration on the debate about individualism, normalisation and universalism. Second, to try to compare professional with survivor views about Recovery today.

5.1.1 Does recovery entail normalisation?

This section expands on the above. Two of the leading authors in the field – Mike Slade and Larry Davidson – have tried to correct 'misconceptions' about recovery, including the premise that it is about becoming 'normal' (Davidson et al., 2006; Slade et al., 2014). Davidson and colleagues argue that recovery means having a meaningful life 'in the presence of disease', to make choices and be autonomous. The emblematic word 'autonomous' is emphasised. This approach at clarification reads to me as if the aim is to be a normalised individual whilst still a bit abnormal. Civil rights are invoked but obscured by the medical language that permeates the paper: it is almost gestural. Slade similarly argues that Recovery does not mean 'getting better' but living as an 'equal citizen' (despite illness). This evades the question because 'citizen' is standing in here for average persons. Again, civil and human rights are invoked and this time the UN Convention for the Rights of Persons with Disabilities (CRPD) as well. They quote Patricia Deegan, writing in 1988 (the CRPD was published in 2008), saying that a psychiatric disability is "simply a given" and the task is to "gain control over our lives and the resources that affect our lives". This extract is so bland, unlike most of Deegan's writing, which is poetic and full of metaphor; it is merely a statement of what many people want, many 'normal' people. Which is exactly the point – you are to want what normal people want.

5.1.2 Critiques

Note that these arguments by professional proponents of the recovery approach are *in response* to criticisms, they are not proactive. Critiques have consequently been forthcoming and alternatives proposed. Forrest advocates a full human rights approach to Recovery although he tends to focus on the Articles in the CRPD that are more to do with individual than social rights (Forrest, 2014). He mentions Article 5 – not to be deprived of liberty but not Article 12 – the right to legal capacity which has caused so much controversy (Freeman et al., 2015). Others have reversed the model and called for social recovery or relational recovery with Price-Robertson and colleagues mentioning structural inequalities (Price-Robertson et al., 2017; Topor et al., 2011). In other words, they are trying to move this terrain of knowledge in a more ‘social’ direction, but retaining the term ‘Recovery’ so tying themselves back into these dominant discourses.

Importantly, Recovery enthusiasts posit that their model is close to universal. However, this claim has been contested by writers from outside the Global North. This will be well known to readers of this journal (Myers, 2016; Kaiser, 2020). However, one should not underestimate the power and money of those who argue for ‘scaling up’ Western psychiatry globally (Eaton, 2011; Puschner, 2019). These efforts are funded by the WHO and the UN. But of course, challenges exists and I will now expand on two examples. Bayettti and colleagues argue that to implement the approach in India would be counterproductive because family and community are intrinsic to ways of living and factors such as poverty further compromise policy (Bayetti et al., 2016). In particular, the idea of individual autonomy makes little sense in many cultures, where actions and thoughts are understood to be shaped by structural, familial and social relations: they are not the activity of an individual Cartesian cogito. Understandably, these authors are concerned with the ‘export’ of Euro-Western psychiatry to the Indian sub-continent underpinned by universalism. Sumeet Jain argues that the appeal to localism sits well with the goals of people with psychosocial disabilities in the Global South (Jain, 2016).

Likewise, Ricci and Colleagues analysed individuals’ narratives about their experience in a CAPS (Psycho-Social Centre) in Brazil. They conclude that the narratives include elements of ‘clinical recovery’ and ‘personal recovery’. But for the latter, the actual quotations provided are less about personal recovery than about re-establishing life in the community and being part of society. To ‘interpret’ through a lens that does not chime with what people are saying is itself a form of power. Of course, I could be committing the same mistake and am aware of that. Yet, Mary O’Hagan and colleagues argue that Maori do not need an ‘intervention’ to heal, they have their own ways based in a different cosmology (O'Hagan et al., 2012).

I conclude, then, that most writings on Recovery that follow the models of Slade or Davidson do, indeed, seek to normalise the distressed individual. Normalisation and individuation are dominant discourses in the CDA sense. Universalism has been critiqued but still holds traction.

5.1.3 How do survivors think of Recovery?

I shall approach this question first by looking at a systematic review of papers on survivors’ views on recovery in Australia (Wood & Alsawy, 2018). It should be said that geography is significant here. Most Australian participants in my knowledge-makers research were committed to a recovery mode of thinking. Indeed, ‘lived experience’ was defined as having been in distress *and* recovered sufficiently to work or otherwise be active (Happell et al., 2019). But when I put this interpretation to some of these same people, they proceeded to tell me how bizarre they really were. Unrecovered persons cannot get published; it seems. Or otherwise be active. It is a form of power to expect people to sanitise their experience in the name of being ‘recovered’ and therefore acceptable.

The systematic review on survivor perspectives covered 21 papers and took a ‘thematic’ approach (Wood & Alsawy, 2018). The clients all had diagnoses of psychosis. There are some points about method in this article. First, the ‘extracts’ they use as data are *both* the original quotations from participants *and* the conclusions and comments of the authors. But second, some of the reviews are wholly or partly authored by service user researchers and no distinction is made in the analysis between these and studies by conventional researchers. So, as this paper is about service users' talk on recovery from psychosis, it is important to note that we actually have four types of data: quotations from people deemed psychotic selected by user researchers; quotations selected by non-user researchers; the conclusions and comments of user researchers and the conclusions and comments of non-user researchers. And fifthly all this is filtered through the orientation of the paper authors. This could have been very interesting had it been explored, but it was not.

In terms of the paper itself, it first identifies as themes: 'the person prior to psychosis' and 'the psychotic episode'. The authors then move on to the key elements of recovery. The first two are 'rebuilding self and life' and 'personal agency and hope'. Most of the quotations for the first mention establishing life in the community. The second – agency and hope - resonates with the language of the recovery literature but 'personal agency' is defined as claiming ownership of your experience. These do not see to me the same thing and claiming ownership of your experience also fits with those who saw the psychotic episode positively and as an opportunity to integrate the experience into a new self. The 'facilitators' and 'barriers' to recovery that were identified – optimistic staff v stigma and discrimination, for example, are not specific to 'recovery' but to life as a person in distress generally. Exactly the same themes arose in a study of domestic violence (Rose et al., 2011). In other words, and I shall make this point again, interesting things are said but they do not seem specific to 'recovery'. And therein lies the problem: recovery is an extremely elastic term.

5.1.4 How do staff practice Recovery?

I turn now to how staff see recovery *practice*, before moving to user writings so as to consolidate the comparison. Notably, Slade's major Randomised Control Trial on efficacy, REFOCUS, failed to find a benefit of recovery-oriented practice by mental health professionals over 'the provision of information' (Slade et al., 2015). The 'intervention' had been manualised and the reason given for the absence of effect was that staff did not follow the manual (although no process evaluation was carried out). So even here there seems a problem of 'implementation', that staff find it difficult, or uninteresting, to turn the Recovery model into practice.

The first paper to be discussed here is again a systematic review and narrative synthesis by Claire Le Boutillier and colleagues in the UK (Le Boutillier et al., 2015). Twenty-two qualitative studies were included. Much confusion was evident about Recovery as an 'approach' and even more about how to perform 'recovery-oriented practice'. Some participants again made the point that recovery, whatever it meant, was like an "unattainable goal" for those living in poverty. Conversely, other papers concluded that there was nothing new in Recovery principles, the staff were doing it all already.

The authors make a tripartite division: clinical recovery, personal recovery and service-defined recovery. Service-defined recovery is understood as driven by the institution's policy and administrative goals: throughput and cost-effectiveness, for example. The authors point to the inconsistencies and do say that the idea of service-led recovery aligns with the concerns of service users that the approach lends itself to service cuts. I would make two points. I am not sure why this is named as a form of *Recovery*, as it seems rather to be an obstacle. But more importantly, intrinsic to the recovery movement *has been service cuts*. The closure of Day Facilities throughout the Industrialised West is an example. Concerns about losing a worker are not unrealistic when ‘treatments’ are time-limited to six or eight sessions. These service changes are not getting in the way of recovery principles, the principles are bringing them about, particularly the focus on eliminating dependency.

Finally, in a stand-alone study, Laurence Osborn and Catherine Stein interviewed community mental health team members in the USA. They found an emphasis on client autonomy and personalisation which they argue is consistent with the idea of ‘personal recovery’ (Osborn & Stein, 2017). So this fits nicely with the discourses of normalisation and individualisation just discussed. However, staff also engaged in ‘directive practice’. They did this if they thought there was a risk the client might be unable to exercise autonomy. Risk thinking and recovery make for an uneasy couple. However, one member of staff at least was quite nuanced and articulates a dilemma with recovery practice:

> that’s a very difficult balance because you want to instil hope, and you hope that maybe one day they can have that (the American Dream), but even through recovery they may not have that. They may not have a significant other, they may not have a house with a white picket fence, they may not ever have a job…So I try not to get too far down the road, because it’s also daunting (p. 762).

These two, somewhat opposed, ways of acting lead the authors to two conclusions. The first is that recovery principles, as they understand them, are more likely to be put into practice with ‘high-functioning’ patients. They continue such patients are more likely to be compliant. My research and my own experience certainly do not confirm that point of view unless there is a tautology at work and compliance is the criterion for being designated ‘high functioning’. Second, Osborn and Stein conclude that these providers are working under “contradictory operating principles” and this impacts their possibility of working “appropriately”. This aligns with Le Boutillier et al (2015). It is clear that the settings in which recovery plays out are integral to practice. Service cuts in the name of dependency is part of this discourse, or discourses.

5.1.5 Survivors themselves

What do survivors themselves think of recovery approaches? I have touched on this throughout but here I mean first-hand accounts or research led by service users. This centres the survivor voice more strongly than Wood and Alsawy’s review. Firstly, Shifra Waks and colleagues describe their study as consumer-led (Waks et al., 2017). They conducted interviews with twenty people with ‘severe mental illness’ and set out to find what was important in their engagement in a Recovery programme in Australia. So, in contradistinction to the academic or the practice models, what mattered to *survivors* about the Recovery Approach? In this study, themes included feeling supported, feeling more positive and having a better social life. The authors say:

> To be recovery-oriented, the outcomes that define an effective service need to move beyond outcomes determined by service providers to examine the outcomes valued by consumers themselves (p. 5)

This is a positive statement and one I endorse. But it is not developed. The whole of the Discussion concerns itself with how to measure outcomes and different scales for doing so.

However, my main criticism of this paper is why they need to use the term ‘Recovery’ at all. What users want is a life. How they get it or do not get it is another question but although Waks and colleagues say that what users want aligns with the model of recovery, this is rather contradictory as the whole project was concerned with what users wanted *in contra distinction* to the academic and practice approaches. The paper shows that the particular service evaluated delivers some things that survivors like. No negatives are mentioned at all.

Some mainstream recovery researchers have moved onto looking at patients’ narratives of their journey out of psychosis. It is argued that by watching videoed recovery accounts, others just beginning this journey will benefit (Rennick-Egglestone et al., 2020). Much could be said methodologically here but I would like to highlight a survivor contribution. Lucy Costa and colleagues argue that we have reached the point that only certain stories are tellable – recovery stories (Costa et al., 2012). Some of this is so extreme and embellished that the authors call it ‘recovery porn’. If you cannot speak of your anger and rage, of your disappointments and oppressions, of a hostile environment, then the recovery narrative is actually suppressing an important part of the survivor experience. There is no co-option here – power takes the form of a discursive ban. Similar points are made by Myers, but more academically (Myers, op. cit.)

Danielle Landry discusses Recovery in the context of a discourse analytic investigation of user-led research (Landry, 2017). She notes that the value accorded the approach by survivor projects varies from very strong endorsement to complete deconstruction. There is no agreement. She interrogates in depth the methodologies used showing, for example, that modes of data collection put very strong constraints on what the ‘results’ can be. These are not new observations but as an example of user-led research it is compelling. She is supported by Jan Wallcraft who wonders whether recovery, in the sense originally meant by recipients of services, can “survive operationalisation” (Wallcraft, 2012). But Landry also argues that ‘recovery’, for some, has become a new and unquestioned taken for granted:

> this definition (of recovery) reproduces the common metaphor of recovery as a journey or path, which individualizes the experiences of madness (p.15).

This critique is consistent with the argument that the ‘Recovery’ approach is an individuating and normalising endeavour, that these are dominant discourses. Survivors are trying to contest this but alongside co-option of survivor thinking a further ‘obstacle’ is that recovery has become a moving object and can mean almost anything as long as it is ‘good’ (Hopper, 2007). If ambiguity can be a dominant discourse, Recovery writings certainly are.

In an editorial, Howelll and Voronka pick up on this confusion surrounding the term Recovery (Howell & Voronka, 2012). They argue that consequent on political and economic factors the idea of ‘recovery in’ has actually reverted to ‘recovery *from*’ mental illness. This is tied to administrative surveillance and the need to prove ‘good outcomes’, now perilously and ironically close to ‘cure’ and again redolent of Le Boutelier et al. (2015). They argue that most work now positions ‘recovery’ as complementary to mainstream psychiatric services and does not contest the central diagnostic categories nor forms of intervention that characterise that discipline. They propose that distress be taken out of the ‘health’ space altogether (Cf Joseph, 2019). Their counter-framing is a social justice one. So ‘social determinants’ of distress are to be seen in terms of equity and oppression and not as neutral epidemiological factors. For these authors, distress should be a matter of difference, not division and Othering.

These are all explicitly user-led arguments and empirical studies. Howell and Voronka's essay is an Introduction to a Special Issue of the *Journal of Social Justice* focussing on recovery and resilience. Many of the authors are service users and so it is a rich source from my perspective.

In a more personal article, Bassman gives an account of being diagnosed as schizophrenic and spending long periods of time institutionalised (Bassman, 2001). He then 'discovered' what he calls the 'c/s/x' movement ('consumer/survivor/(ex)user') which was an epiphany for him, as for many. He trained as a clinical psychologist, but his drive is to educate staff into seeing the strengths in people and eliminating hopelessness. He finds that a focus on relationships is the most effective way of doing this, contesting again the cognitive bias in the mainstream literature.

For Bassman, Recovery is a complex and time-consuming process. He asks rhetorically:

> Will the "mentally ill" continue to serve as the "not us" scapegoat that conveniently diverts people from confronting the always possible terror of life and death? (p.27)

So again we see the importance of relationships, even in an educational context, and a situatedness of the argument in a profound question. Autonomy and choice are side-stepped by such concerns I would argue and so we add to the counter-narratives described here.

Finally, Russo and Peters describe a respite house where roles are blurred and can be reversed and where crises are seen as interruptions in life and not medically (Russo & von Peter, 2021). It is, in a sense, a special form of peer support that goes to great lengths to ensure equity. The authors make it quite clear that this is a political matter and the crisis house space is driven by social justice. They do not use the word 'recovery'.

5.1.6 Academic perspectives on consumers?

Many clinical academics make a nod to the beginnings of Recovery in the survivor movement. However, the following shows that this is not enough, that science triumphs:

> Although recovery has emerged from the lived experience of people experiencing what professionals understand as mental illness, scientific research is catching up in its ability to validate the assertions of service users and their families (Slade et al., 2012, p. 2)

So, service users make 'assertions' and science 'validates' them – or not, as the case may be. This is an example of Fricker's 'epistemic injustice'. The mad are not credible knowers. This is a 'perspective' or 'analytic' piece and not a systematic review. I have selected what seem important and relatively recent qualitative papers and treated each in some depth. I have tried to counterpose professional thinking about recovery with that of service users.

Provisional conclusions include that there is no accepted definition of Recovery as model or practice but differences can be detected between researchers, practitioners and those on the receiving end of this. Ambiguity turns out to be a 'dominant discourse'. Further, I find no evidence that Recovery, as explicated by writers like Mike Slade and Larry Davidson and their followers has moved away from a very individuating model and practice that in addition is a normalising one and seen as universal by some powerful actors (Farmer et al., 2004). Although the picture is mixed, service users are focused more on social aspects of their lives than on an ‘individual journey’. Finally, material and organisational matters are important, a further relevant discourse. Poverty makes ‘recovery’ a luxury and health services are driven by factors that do not sit well with this approach. However, the approach itself has brought some of these service changes about but this is never said except by those who experience the effects.

6. A different way of knowing

Is there a different way of knowing about what we call recovery? We have already seen that some seem to be following a very different approach, one that prioritises the social and structural and that takes history and its legacies into account. Words like ‘healing’ and ‘reclamation’ characterise this. It was said primarily by Black participants in my work but all the survivor papers I have discussed are from the Global North. I could find no accounts by people with psychosocial disabilities in the Global South. Absence is significant.

However, a different example lies in the work of First Nation scholar, Joseph Gone. Some of his papers are very detailed about healing practices and he also provokes ‘community psychology’ to move away from individualistic, a-contextual and ahistorical thinking (Gone, 2011, 2013, 2016). He seeks to challenge Western ways of dealing with ‘mental health problems’ especially in the case of a community subject to ethnocide so that their people will reconnect with Aboriginal traditions and identity. He sees his work as political as well as socio psychological. He has a particular interest in historical trauma, the emblematic representation of this being the residential school. These schools set out to sever children from their languages and their native practices in very brutal ways.

Gone does not eschew notions of the therapeutic. But he is attuned to how ‘hybrid’ care may retain elements of Western therapy that are difficult to discern but which First Nation Canadians find alien. Laurence Kirmayer, a psychiatrist and anthropologist, has also written on historical trauma but is less inclined to emphasise the political (Farmer et al., 2004). Yet Gone and Kirmayer have co-authored an essay on this subject (Kirmayer et al., 2014). Tensions can be discerned but the paper also shows an alliance of points of view. Can survivor knowledge be part of this alliance or at least use some of the thinking?

Is this an example of something unique? That it is locally specific is clear but that is quite consistent with other arguments I have made and which have affinities with modern transcultural psychiatry (Rose, 2017; 2018). However, Gone insists that this is a ‘new way of knowing’, a new epistemology. Gone is not a psychiatric survivor but does involve the community in his work. It is not clear whether he involves persons with disabilities.

Finally, Adeponle and colleagues have addressed the question of Recovery directly (Adeponle et al., 2012). Beginning with debates around ‘personhood’ (and invoking Marcel Mauss), they argue that the dominant model of recovery is indeed ‘egocentric’ and normalising and would not be helpful in more ‘sociocentric’ settings, consistent with Bayetti et al (op. cit.) To this they add ‘ecocentric’ and ‘cosmocentric’ cultures; the one giving primacy to relations with the land and the second with the spirit world. The authors are at pains to stress that none of these four exist in a ‘pure form’. Calling Western approaches ‘Euro-centric’, they argue that a completely different way of thinking and acting will heal people in other forms of society.

Given the salience of sociocentric, ecocentric, or cosmocentric conceptions of personhood in many cultural groups, questions arise as to the suitability of current notions of Recovery for addressing the experience of other peoples and cultures (Adeponle et al, op cit). In other words, the supposed universalism of the approach is thrown into doubt as already said

This paper by Adeponle and colleagues is quite ambivalent about the 'consumer movement'. Rather than see a co-option of consumer history, they see a continuation, almost a straight line from William Anthony to Pat Deegan to Mike Slade / Larry Davidson. Although finding merit in what consumers argue, the authors characterise Deegan in particular as an 'individualist' (Deegan, 1996). Deegan's is certainly an individual story and she is committed to self-determination. But her early writing is nothing like the narratives of recovery that are on display in some contemporary projects (Ricci et al., 2021). Her story is told in terms of metaphor and holds a level of emotion that again makes one see how 'cognitive' contemporary accounts are. The emotional dimension of knowledge has been practically deleted by medicine but is not absent from survivor writings. Passion and justice figure as discourses here. Deegan also repeatedly talks about the importance of relationships including peer relations. It is true that she refers to all humans as unique but also clearly says:

> The goal of recovery is not to get mainstreamed. We don't want to be mainstreamed. We say let the mainstream become a wide stream that has room for all of us and leaves no one stranded on the fringes (Deegan, 1996)

It is an interesting dilemma and shows that different notions of 'personhood' can intermix.

The conclusion of Adeponle and colleagues is optimistic, however. They argue that providing careful attention is paid to local culture and context, underpinned by a focus on human rights, recovery can achieve its goals. Indeed, the term 'human rights' is making an appearance quite often in this literature, an unexpected discourse for me. But different aspects are stressed by different authors. Some would argue that the very idea of idea of 'human rights' is often an individualizing concept linked to 'Western' conceptions of autonomy. On the other hand, rights discourse is important to people with psychosocial disabilities in the Global South where social rights are stressed (Davar, 2013}.

7. Conclusion

If Western societies have cultures that claim to respect individuals, why do some survivors at least find these such uneasy places, even places of subjugation? Why do some resist recovery even though it looks so much softer and more person-centred than the medical model? Is it because they know from the inside what extreme individuation is like, that it leaves them on their own, literally sometimes? The discharge of thousands from specialist services in the name of ending dependency did not lead to an upsurge of individuals 'in recovery'; it led to an upsurge of isolation and loneliness. Inevitably this was put down to 'negative symptoms'; I would rather say it was iatrogenic. For example, in one study where I was involved, there was disagreement concerning how to interpret statements about "being alone". Psychiatric researchers saw 'negative symptoms'; survivors considered the statements a reflection of a lifetime of negative treatment, clinically and socially.

Again, the stress on 'choice' makes little sense to people with severe distress whose options are so limited. To be asked to be autonomous and make choices 'like other people' may just instil guilt that you cannot measure up. Because that is the language of 'psy' – not that settings and situations are the source of the limited 'choices'.

Such ‘interpretations’ are not prominent in the literature and yet they fit as well with the evidence I have amassed as does using that data to argue that users embrace the Recovery approach. My argument is that the voices of mad people, having had their original ideas turned into a ‘treatment’, are now subject to discursive power in the way their little acts of resistance are neutralised.

At the same time, the varying ‘mainstreams’ have not succeeded in providing a clear understanding of recovery; they have been shaken and become, frankly, muddled. Otherwise the defensive emphasis of much professional literature would be unnecessary (Davidson et al., 2006; Slade et al., 2014). One way to accelerate a shift to a more socio-centric understanding of supports for distress is to capitalize on the mobility of power by challenging the premises of the bulwarks of current regimes of truth: that everything ultimately centres on the individual; that questions can be decided by Randomized Controlled Trials; that problems can be solved in six sessions; that ambiguity is an enemy. In other words, approach the issues of harm and supports from the standpoint of survivors so that this time mainstream logics find themselves speechless.

Is the wish to transform the recovery approach just a dream? The research covered here has shown that people do not give up. Not all – many are crushed, people die, and any social justice work has a duty here. But there is an emergence of new forms of connectedness, within and between marginalized groups; new practices of community involvement even in Western countries; and new knowledges that can be vibrant and perhaps violate some of the principles, epistemologically and in terms of values and practice, that characterize(d) this episteme in the Global North. In such a situation, counter-narratives can flourish, new concepts and methods can emerge for understanding the experience of those deemed mad, from the standpoint of those who live under that description, and the foundations can be, and are being, laid for change.

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