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The Evolving Understanding of Recovery: What the Sociology of Mental Health has to Offer*

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Abstract

The meaning of recovery from serious mental illness (SMI) has evolved over time. Whereas it was not even considered to be a primary goal of treatment thirty years ago, it is the main focus of mental health policy today. These changes are partially the result of the work of sociologists who were studying mental health during the time of institutional treatment and the early stages of community-based care. Despite these early influences, the sociology of mental health has largely overlooked the explicit study of recovery. This is because sociologists began shifting their focus from the study of SMI to the study of less severe mental health problems beginning in 1970s. In this paper I (a) discuss the evolving history of mental health recovery; (b) how recovery is defined today in policy, practice, and research; and (c) present an argument for why sociological perspectives and methods can help shed light on the tensions between the definitions while assisting to develop better understandings of the recovery process. In this argument I place particular attention on qualitative social psychological perspectives and methods because they hold the most potential for addressing some of the central concerns in the area of recovery research.

Mental Health recovery has become an increasingly popular area of research over the past 30 years; however, sociologists who study mental health have given the topic little direct concern in their work. This lack of concern is problematic considering that a number of sociological methods are better suited than those employed by other disciplines for developing more person-centered understandings of recovery and for making connections between those understandings and the larger social structure. These understandings and connections are important for the development of more humane and effective policies and practices for facilitating recovery. In this paper I present an argument for the sociological study of recovery. I start with a general overview of the way the course of mental illness and its recovery have been conceptualized historically in the United States. I then discuss the two major theoretical perspectives of recovery along with the need for researchers to consider substance use and abuse in their studies of mental health recovery. Finally, I discuss the current lack of sociological research on mental health recovery and how qualitative social psychological investigations (particularly those set within a symbolic interactionist framework) can provide a better understanding of the recovery process.

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TRADITIONAL VIEWS REGARDING THE COURSE OF SERIOUS MENTAL ILLNESS

Serious mental illness (SMI) refers to a mental, behavioral, or emotional disorder that meets psychiatric diagnostic criteria and which results in impairments that substantially limit an individual's major life activities such as school, work, and/or parenting (see President's New Freedom Commission on Mental Health 2003). Examples of SMI include psychotic disorders such as schizophrenia, bi-polar disorder, and major depression. The wide majority of clinicians and researchers who study SMI today ascribe to the biomedical model of mental illness, which has its roots in research conducted by Emile Kraepelin ([1913] 1987) in the early 1900s. The subjects of Kraepelin's research displayed symptoms of what clinicians today would associate with schizophrenia. Kraepelin's observations of his patients led him to the conclusion that schizophrenia, which he called *dementia praecox* (i.e., premature dementia), was degenerative disease from which the sufferer had no hope of recovery. His work continues to hold relevance today as it is the foundation on which the modern neurobiological model of schizophrenia is based.

Kraepelin's ideas have extended beyond explanations of schizophrenia to inform treatment, social policy, and public attitudes regarding most forms of SMI for the past century (Corrigan and Ralph 2005). This is because schizophrenia is the illness the public most readily associates with SMI. Historically, misunderstandings of the course of schizophrenia and its confusion with other mental health disorders led to a view in both medicine and the larger society that individuals with SMI were dangerous. This view served to legitimize the institutionalization of people living with SMI in large state-run psychiatric hospitals (Davidson 2003; Szasz [1963] 1989). The confinement of mental health patients in these hospitals happened on such a large scale that around 77 percent of all treatment in 1955 occurred in these and similar institutions (U. S. President's Commission on Mental Health 1978, as cited in Frank and Glied 2006).

Moving away from the neurological perspective proposed by Kraeplin, Erving Goffman (1961) developed a sociological model for understanding the course of SMI in the late 1950s. In his essay *The Moral Career of the Mental Patient*, Goffman highlights the importance of the structure of mental health care in shaping the course of mental patients' lives. Goffman's work discusses three phases that the patients he studied transitioned through, the pre-patient, in-patient, and post-patient phases. His description of the first of these two phases outlines an increasing delegitimation of the mental patient as a "normal" human being that served to rationalize the control institutions had over their patients. He put no effort into describing the post-patient phase, which is most likely because the extreme control institutions had over patients resulted in relatively few of them ever transitioning back into the community. Since the time of Goffman's work, there have been sweeping changes to the way SMI is clinically treated. These changes have profound effects on the way SMI is understood by society and experienced by those living with it.

RETHINKING THE COURSE OF SERIOUS MENTAL ILLNESS

Neurological/biomedical understandings of mental illness and the overwhelming negative effects of institutional treatment resulted in a pessimistic view of the course of mental illness that largely failed to consider recovery a possibility. This is far different from views of mental illness today, which understand recovery to be both a possibility and the goal of mental health treatment. While there is currently no single consensus as to the meaning of recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA; 2005, 2012) has offered multiple working definitions of recovery over the past seven years that have had significant influence over the direction of mental health policy and treatment.

The most recent definition employed by SAMHSA states that recovery is "[a] process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (2012:par 5). The factors resulting in these changing views are many; however, most of them can be traced back to the move to community-based care and the individual and collected efforts of people living with serious mental illness.

Deinstitutionalization and the Move to Community-Based Care

Published accounts by formerly institutionalized patients were beginning to demonstrate that recovery was possible as early as the 1920s (see Frese and Davis 1997). Despite this, professional views regarding the course of mental illness remained pessimistic until significant transformations to the mental health system began during the 1950s. During this time advocates, including those patients who were writing about their own recovery, made the general public more aware of the dehumanizing conditions of the institutionalized mentally ill (see Davidson 2003; see Frank and Glied 2006). This resulted in the enactment of new laws that established quality-of-care standards, gave mental health patients greater control over their rights, and made it more difficult to commit them to long-term institutional treatment (Kaufmann 1999; McLean 2009). At the same time, advances in psychiatric medications were making the symptoms of SMI more manageable (Scheid and Greenberg 2007). These developments culminated in a period known as deinstitutionalization, which moved the locus of treatment into the community and resulted in the wide-scale dismantling of large psychiatric institutions. However, system fragmentation and lack of sufficient funding resulted in a number of large service gaps that never allowed a comprehensive community-based care system to become a reality (Frank and Glied 2006; Scheid and Greenberg 2007).

Despite its overall shortcomings, the move to community-based care did result in a number of studies that had positive implications for the concept of recovery. Research conducted in the community-setting by the World Health Organization (1973; 1979) demonstrated that the course and outcomes of schizophrenia were not as predictable outside psychiatric institutions. This research established that at least partial recovery from schizophrenia occurred in close to 50 percent of people with diagnosable symptoms who were living in community settings (Carpenter and Kirkpatrick 1988; Harding, Zubin, and Strauss 1987). Subsequent research that followed people living with schizophrenia over a 30-year time span demonstrated that one-third of the sample recovered on their own by using their existing skills and resources to assist them in meeting their life goals (Harding 1988). These changes in thinking about the course of schizophrenia, the most debilitating of all mental illnesses, ushered in a new way of understanding the course of all SMI among professionals (e.g., providers and researchers).

The Rise of the Mental Health Consumer-Survivor Movement

A number of social and political developments that have given people living with SMI more control over their lives and greater levels of inclusion in society are perhaps more important to the evolving understanding of recovery than the research findings previously discussed. The rise of the Mental Health Consumer-Survivor Movement (MHCSM) is arguably the most important of these developments. As Caroline Kaufmann (1999) notes, this movement is:

> an effort by people with mental illness to establish control over psychiatric treatment and the severe social stigma that attends a psychiatric diagnosis. Participants in this movement also try to acknowledge diversity among people with psychiatric diseases and to develop systems of care that reflect the diverse needs and wishes of mental health consumers. (P. 494)

The development of the movement can be traced to a small number of patients' rights groups that were working to improve conditions in hospitals and community treatment centers during the 1970s (Zinman, Howie the Harp, and Budd 1987), as well as accounts of consumers' personal recoveries and treatment system experiences (see: Frese and Davis 1997; Jacobson 2004; Tomes 2006). A group of these former patients adopted the label "psychiatric survivors", after it was demonstrated that the application of psychiatric labels had just as profound effects on patients as the symptoms associated with their diagnoses (Kaufmann 1999; McLean 2009; Pescosolido and Martin 2007). Indeed, research has continued to demonstrate how psychiatric labels can cause those with diagnosed mental illness to be rejected by others and/or to avoid social interaction because they expect social rejection to occur (Phelan 2005; Wright et al. 2007).

In the 1980s a growing number of individuals in mental health treatment began to refer to themselves as "consumers" (Kaufmann 1999; McLean 2009). The use of this term comes from the disability rights movement, and it is an attempt to shift the focus of mental health care from psychiatrically controlled treatment to services guided by consumer choice. Additionally, the influence of the Disability Rights Movement has resulted in an increasing emphasis on issues regarding human rights and citizenship as they relate to people living with mental illness (see Mulvany 2000). Highlighting this, William Anthony (1993), in one of the most frequently cited articles on the topic, discusses recovery as a consumer-driven process that is concerned with the person's *ability to manage the negative consequences* of their symptoms and the social processes involved.

It is important to note that while consumers and survivors are often lumped together under the banner of the MHCSM, opposing views regarding advocacy and the place of non-consumer/survivors highlight a significant difference between those who called themselves "consumers" and those who call themselves "survivors". As Tomes (2006) has noted, consumer groups tend to be focused on social advocacy and have aligned themselves with the mental health system, while survivor groups tend to be focused more on self-help and avoid involvement with mental health professionals.

The advocacy work of the MHCSM combined with new understandings regarding the course of mental illness resulted in less than 10 percent of people with SMI receiving care in inpatient settings by 1990 (Frank and Glied 2006). Since this time a number of important policy and legal developments have served to further increase the rights of consumers (see Power 2009). Of these developments, the legislation of the Americans with Disabilities Act (ADA) in 1990, which prohibited discrimination against those with mental disabilities in the public sphere, is arguably the most pivotal. These developments have all resulted in the move toward a recovery-focused health system that places consumers at the center of their treatment.

CURRENT PERSEPCTIVES ON RECOVERY

While recovery as policy is governed largely by a social model that is focused on consumers' attempts to negotiate the limitations of SMI and barriers to social inclusion, the biomedical model still holds significant sway over professional and popular opinions (see: Amering and Schmolke 2009; Borg and Davidson 2008; Davidson 2003; Jacobson 2004). Indeed, alliances that have formed between those who consider themselves *consumers* of mental health services and the psychiatric profession have assured that biomedical views are still alive within the debates regarding how to define recovery. This consumer mentality has also fed into the development of a relatively recent phenomenon known as *pharmaceuticalization*, a process whereby pharmaceutical intervention is increasingly understood to be a necessary part of medical intervention (Abraham 2010).

Pharmaceuticalization is such a powerful force within the field of mental health treatment that it continues to occur despite research findings that question the efficacy of some of the most popularly used psychotropic medications (Kirsch et al. 2008). Additionally, the bureaucratic nature of managed care encourages providers to engage in acute care aimed at managing the symptoms of SMI (i.e., provide medication), rather than providing more expensive comprehensive services aimed at recovery (e.g., therapy and case management services).

The dissonance that exists between biomedical and social models has resulted in two broad recovery perspectives within clinical practice and research (Liberman and Kopelowicz 2005), which I discuss in the following sections.

Mental Health Recovery as an Outcome: Provider-Directed Recovery

The outcome perspective of mental health recovery is rooted in the biomedical model. As an outcome, mental health recovery is conceptualized in a very similar way to that of recovery from a physical health problems (Davidson et al. 2006), and is generally measured in one of two ways. The first way it can be measured is the complete or almost complete remission of symptoms or return to a “normal” state of being (Liberman and Kopelowicz 2005; Resnick, Rosenheck, and Lehman 2004). The second way is when the consumer has reached goals that have been specifically defined by mental health professionals (Deegan and Drake 2006; Liberman and Kopelowicz 2005). These goals are usually related to a predetermined level of treatment adherence or functioning. Treatment adherence is generally measured as compliance with psychiatric orders (i.e., medication compliance), while level of functioning can either be the same it was before the onset of mental health symptoms or a level of functioning determined to be “ideal”/”reachable”/ “realistic” in important domains of life such as employment, housing, and relationships.

From the point of view of advocates and the recovery-focused social policies previously discussed, the outcome perspective of recovery is problematic in a number of ways. First, measuring recovery in terms of treatment goals ignores the more than thirty years of social and political struggle engaged in by consumers and their advocates by shifting the locus of control in the treatment relationship back to the psychiatric profession (Anthony 1993; Deegan and Drake 2006; Kaufmann 1999). This also ignores evidence that demonstrates recovery can and does happen outside of the structure of mental health treatment (Anthony 1993; Carpenter and Kirkpatrick 1988; Harding, Zubin, and Strauss 1987).

Second, while research has established that the symptoms of SMI can and do go into complete remission (see Amering and Schmolke 2009; see Andreasen et al. 2005), this is not always the case. Therefore, to require that an individual's symptoms be in remission for them to be considered “in-recovery” or “recovered” creates incredibly high expectations that might seem unrealistic for most consumers. These expectations have the potential to negatively impact consumers’ sense of hope and desire to engage with treatment.

Finally, the outcome perspective of recovery ignores the everyday experiences of those living with SMI. Previous research has demonstrated that recovery is a highly individualized and personal process (Borg and Davidson 2008; Davidson 2003; Mueser et al. 2002; White 2007). Additionally, previous research has demonstrated that consumers see quality of life to be a more important issue in their recovery than treatment adherence (Deegan and Drake 2006). It is therefore problematic to use medication compliance as a means for assessing whether a person is “in recovery” when the side-effects of psychiatric medications have been demonstrated to negatively impact quality of life for consumers (see Deegan and Drake 2006).

Mental Health Recovery as a Process: Consumer-Centered Recovery

The process view of mental health recovery addresses many of the problems outlined in the previous section. The process perspective treats mental health as a disability rather than an illness because it tends to focus more on quality of life, personhood, and empowerment than it does on complete remission or a return to normal functioning (Corrigan and Ralph 2005). For this reason, the process perspective is more popular among advocate groups that have developed out of the MHCSM.

When conceptualized as a process, the focus of recovery shifts from medical treatment to consumers' attempts to address the issues caused by their mental illness and to meet their life goals (Amering and Schmolke 2009; Anthony 1993; Davidson 2003). This shift in focus is reflected in three important ways. First, there is a larger concern with citizenship, i.e., consumers' access to fundamental rights and inclusion in society (Davidson et al. 2006; Ware et al. 2008). Second, it is recognized that the recovery process is a unique endeavor for each person and that any attempts at treatment should involve the full participation of the consumer as a shared-decision maker (Deegan and Drake 2006; Loveland, Weaver Randal, and Corrigan 2005). Third, the process perspective recognizes that the best setting for recovery is in the community, rather than a traditional treatment setting because it is within this setting that consumers can begin to reengage with "normal" aspects of their lives (Davidson and White 2007).

The process perspective of recovery is reflected in advancements in mental health policy discussed above. As a result of these advancements, a comprehensive panel including consumers, family members, and policy-makers convened by SAMHSA (2012) has proposed several guiding principles of recovery that included such key terms as: hope, person-driven, many pathways, and holistic. All of these terms have more in common with the process perspective of recovery than the outcome perspective in that they are focused on individuality, consumer control, and quality of life rather than symptom remission or treatment goals.

The Interaction of Serious Mental Illness and Addiction

Previous research has demonstrated that there is a significant association between SMI and substance use disorders, which highlights the need to consider the connections that exist between concepts of recovery from both types of problem. The National Epidemiologic Survey on Alcohol and Related Conditions reported that 19.7 percent of respondents displaying symptoms of a substance use disorder within the past 12 months also met diagnostic criteria for a mood disorder, while 14.5 percent met criteria for an anxiety disorder (Grant et al. 2004). Despite this overlap between SMI and substance use disorders, recovery focused research in both of these areas tends to concentrate on either mental health or substance abuse recovery, while largely ignoring interactions between the two. This has led to significant differences between the ways that recovery from SMI and substance abuse are conceptualized that are important to consider before moving forward.

Recovery has been a major concern of the addictions field for longer than mental health. In fact, most popular knowledge about recovery is informed by the 12-step model of addiction recovery developed by Alcoholics Anonymous in the 1930s and the disease concept of alcoholism developed in the 1960s (see Schneider 1978). From these perspectives, addiction (not just alcoholism) is viewed as a chronic disease from which the individual will never be cured. The only way for the addict to prevent complications of their disease on their overall health and life is to accept responsibility for their addiction (mental health consumers are never held responsible for their illness) and abstain from substance use. As such, recovery in addictions is almost always looked at as an outcome, namely abstinence (White et al., 2005).

The 12-step model has been heavily adopted by clinicians as the treatment model of choice for all addictions. Because of this, there is a dissonance between the way recovery is conceptualized in the mental health and addictions treatment and research. Mental health recovery goals such as treatment adherence and improvements in quality of life are usually formulated around the concept of "partial recovery" (i.e., recovery without complete remission of symptoms) even though full recovery has been demonstrated to happen, while addiction recovery is focused on the complete elimination of substance use behaviors (Davidson and White 2007). Because mental illness is treated as a *disability*, the symptoms of SMI are viewed as something consumers need to learn to live with, while the *disease* symptoms of addiction (i.e., substance use) are viewed as something from which consumers need to be "cured". This is why treatment for SMI is viewed as an ongoing process, while addictions treatment is viewed as an outcome.

Despite the fact that abstinence is the defining feature of recovery in the addictions field, research has demonstrated that consumers understand and experience substance abuse recovery in a similar way to mental health recovery and that substance abuse recovery is more personal and unique than the strict abstinence view asserts (Davidson and White 2007; Sowers 2007). For instance, in the first large-scale study seeking to understand addictions recovery as it is experienced by consumers, Alexandre Laudet (2007) demonstrated that consumers tended to experience and define recovery as more of a process than an outcome. She found that a number of people who were not abstinent still considered themselves to be in recovery, suggesting that abstinence and recovery are two different things. The findings also demonstrated that participants switched their definitions of recovery between phases of the study. Laudet's findings point to the need to develop a more nuanced understanding of the recovery process in the addictions field. For dually diagnosed individuals this means developing a better understanding of recovery from SMI and substance use disorder as a co-occurring process. This is one of many areas of recovery research where sociological methods can provide significant insight.

AN ARGUMENT FOR THE SOCIOLOGICAL STUDY OF MENTAL HEALTH RECOVERY

Despite the growing interest in recovery as a topic for policy and research, only a few sociologists have explicitly focused on mental health recovery in their work (Jacobson 2004; McCranie 2010; Markowitz 2005; Watson forthcoming; Yanos, Knight, and Roe 2007). Despite this, there are lines of sociological research that have investigated a number of factors demonstrated to be central to the recovery process. For instance, research on social stress has demonstrated the importance that resources such as coping, social support, and mastery have on mental health outcomes (Avison and Turner 1988; Mirowsky 1995; Wheaton 1999). Research on social integration has demonstrated the positive and negative influences social roles, community ties, and social support can have on mental health (Cornwell and Waite 2009; Yang 2006). Social stratification research has demonstrated the association between social inequalities and mental health disparities (see Williams and Collins 1995). Research in the area of stigma has demonstrated the significant power that negative cultural views regarding mental illness can have on diagnosed individuals (Phelan 2005; Wright et al. 2007).

All of these lines of research have implications for understanding recovery in that they have illuminated the social conditions that can harm or improve mental health. However, the majority of studies in these areas have focused on mental health and illness within the broader population or trying to understand how specific social phenomena apply to individuals who have already demonstrated a susceptibility or resilience to mental illness and have largely overlooked the consequences of mental illness that can affect recovery

(Markowitz 2005; Pescosolido et al. 2007). There have been relatively few studies investigating the effects of social factors on the mental health outcomes of individuals diagnosed with SMI who are attempting to manage their illness. In fact, sociologists have been criticized for moving away from studying people living with SMI in favor of studying the "worried well" (Mulvany 2000; Pescosolido et al. 2007), i.e., individuals in the broader society who display mental health symptoms but do not have diagnosable disorders. Those who study stigma and labeling are an exception, as a number of sociologists who conduct research in this area are concerned with consumers' attempts and ability to manage the negative effects of mental health diagnoses in their lives.

It is disconcerting that sociologists have paid little attention to mental health recovery considering the significant influence sociological work had in: helping to expose the problems associated with institutional treatment (Goffman 1961; Street 1965); demonstrating that SMI was more pervasive and not as degenerative as once thought (Carpenter and Kirkpatrick 1988; Harding, Zubin, et al. 1987); and encouraging the growth of the MHCSM (Scheff [1966] 1999; Szasz [1961] 1984). Sociologists have an opportunity to continue this tradition of influence through the study of recovery. As most work being carried out in other disciplines is concerned with recovery outcomes, sociologists can have the most impact by engaging in research that aims to understand the recovery process. This research should aim to address such issues as: (1) the way recovery is defined in political and professional discourse; (2) individuals' personal experiences of recovery and the meanings they associate with it; (3) and the social processes that occur within the context/ environment of recovery (which connect the political, professional, and personal realms).

Qualitative social psychological methods set within a symbolic interactionist framework are the best suited for this task because of their ability to focuses on the (1) meaning/ understandings of recovery and (2) social processes involved in the creation of those meaning/understandings (Blumer [1969] 1986), both of which have been recognized to be essential in moving the study of recovery forward (Amering and Schmolke 2009; Anthony 1993; Borg and Davidson 2007; Laudet 2007; Onken et al. 2007). While this tradition of research was strong in the sociology of mental health at the beginning of the sub discipline, it has been largely abandoned over the last twenty years in favor of more quantitative epidemiological and etiological approaches to studying mental health (Pescosolido et al. 2007; Schwartz 2002). While quantitative approaches can be useful for studying recovery, they are limited in their ability to understand the how and why of the recovery process through their focus on individual outcomes and an overreliance on psychologically predefined variables that ignore the meanings and experiences individuals associate with the recovery process (see Schnittker and McLeod 2005; see Schwartz 2002).

In the previous sections I have demonstrated how recovery has been socially constructed through research, advocacy, and policy. In the sections that follow I present an argument for a social psychological study of recovery that takes into consideration the meaning and experience of recovery at the individual level and the service context in which recovery happens.

The Meaning and Experience of Recovery

While the disability perspective of mental illness has found its way into the broader policy and treatment discourses, empirical research has been slow to catch up. The majority of scientists who study recovery continue to use biomedical approaches rooted in Kraepelin's theories of schizophrenia and the disease concept of addiction when investigating recovery from these disorders respectively. In order for the scientific domain to catch-up with social developments, there needs to be a greater appreciation of recovery as a social phenomenon and the process recovering persons go through as they attempt to manage their disorder(s)

(Davidson 2003). Additionally, the traditional discipline-based silo approach to investigating mental health and substance abuse ignores the complex relationship between these two disorders and the lived experience of individuals who have dual diagnoses.

Recognizing this, researchers have drawn attention to the fact that we need to make greater efforts to understand recovery as it is experienced in consumers' everyday lives because the majority of people living with SMI today are attempting to manage the symptoms of their mental health problems in combination with other areas of their lives in community settings (Borg and Davidson 2008; Davidson 2003; Davidson and White 2007). Additionally, the community context in which mental health recovery happens leaves the possibility of wider variation in the recovery experiences than there was in the era of institutionalization. This stresses the need to understand mental health recovery as a unique process that can vary between individuals and the personal meaning that those individuals attach to it (Davidson 2003; Mueser et al. 2002).

From this point of view, individual consumers' understandings are more important than mental health professionals when investigating the recovery process. Despite this, the majority of research conducted on mental health recovery today continues to investigate it as an outcome defined by medical professionals. This tide is starting to turn as a few studies conducted within the past decade have attempted to understand recovery from the consumer point of view (Borg and Davidson 2008; Davidson 2003; Liberman and Kopelowicz 2005; Topor 2001). Discussing the need for more research to be conducted in this area, David Loveland, Katie Weaver Randal, and Patrick Corrigan (2005) have pointed toward the need for new techniques aimed at developing this understanding. Symbolic interactionism's focus on meaning, interactional processes, and the "self" holds promise for filling this need.

Research set within a symbolic interactionist framework can help move the study of recovery forward by: contributing to attempts to create a recovery definition that takes consumers' individual situations into account; developing better understandings of the social consequences of mental illness through consumer understandings and experiences of recovery; and making visible the connections that exist between the structural factors that affect mental health and the recovery process as it is experienced by individuals. Nora Jacobson (2004) used a symbolic interactionist approach to investigate issues similar to these in one of the few sociological studies of recovery. Jacobson's work highlights the personal, professional, and political issues at stake in the development of recovery-oriented mental health policy in Wisconsin during the late 1990s. Sociologists engaging in work such as this can have a significant impact on recovery-based policies and practices by providing guidance to organizations such as SAMHSA (2005, 2012) that are currently struggling to develop stronger definitions of recovery for policy and practice purposes, such as SAMHSA.

The Measurement of Mental Illness and the Recovery Experience

A second argument for a sociological study of recovery is that the way in which sociologists conceptualize mental health and illness makes them more sensitive to consumers' actual experiences. Most researchers would agree that the severity of mental illness can vary within and between individuals; however, there is an overreliance on assessment methods that conceptualize mental health and illness as discrete categories. Though sociologists often use categorical assessment methods, the discipline as a whole recognizes the importance for distinguishing the subtle variations in mental health severity that exist within and between individuals (Wheaton 2001). This propensity within the discipline is rooted in an understanding that diagnostic mental health categories are the result of historical and political processes, as well as what sociologists recognize as a lack of objective evidence for the existence of "true" mental illness (Kessler, 2002). Because of this, sociologists are more

likely than researchers in other disciplines to conceptualize and measure mental health and illness as continuous variables.

Supporting the use of continuous assessment, sociologist Corey Keyes (2002) has demonstrated that mental health and illness are likely to exist along two separate continuums. Defining mental health as a "syndrome of symptoms of positive feelings and positive functioning in life" (p. 208), Keyes has demonstrated that symptoms of mental health are only modestly, negatively correlated with those of mental illness. His findings refute the view implied by categorical assessment methods that mental health and illness are simply opposites, which has important implications for recovery research.

Because researchers in other disciplines are more likely to view mental health and illness as discrete and opposing categories they are more likely to view recovery as an outcome that is equated with mental health. This is problematic considering that consumers' experiences demonstrate that mental illness and recovery can and often do co-exist (Amering and Schmolke 2009; Anthony 1993; Borg and Davidson 2008; Davidson 2003). Because of this, the continuum perspective of mental health and illness is more compatible with the process perspective of recovery discussed above. As such, sociologists are more likely to capture the variations in functioning that have important implications for the recovery process. Hilary Thomas (2004) has discussed how micro-sociological approaches such as those employed by symbolic interactionists can benefit the study of recovery by investigating the incremental processes related to it. Studies taking this focus can provide guidance for more quantitative sociological investigations by helping to develop continuous measurement scales that are (a) more reflective of consumers' actual understandings and experiences of recovery and (b) not completely based in psychological or medical concepts as a result.

Understanding the Context of Care

There is a long line of sociological research that has helped to illuminate connections between the social structure and mental health outcomes (see Schwartz 2002). Most of this research has focused on the way in which different structural arrangements expose different social groups to varying amounts of stress (McLeod and Lively 2007). This research has been invaluable for bringing attention to the connections between social factors such as poverty, homelessness, racism, low education, and lack of social support and higher rates of mental illness among disadvantaged groups. Additionally, large community studies have helped reconceptualize the course of mental illness by demonstrating that recovery can and does happen for individuals living with SMI (Carpenter and Kirkpatrick 1988; Harding, Strauss, et al. 1987). While research in these areas has been successful in demonstrating that a connection between individual mental health outcomes and the larger social arrangements exists, it has not addressed how these connections are facilitated in a way that is useful for understanding recovery as a process. One area where sociologists have the potential to provide a significant contribution in this regard is through organizational research.

Recovery from mental illness in the United States is generally guided by some form of institutionalized treatment modality or programming. Organizations that provide mental health services link consumers to the larger social structure through their policies (federal, state, local, and organizational) and practices, which are constructed through larger political and professional processes. Therefore, research on organizations that provide mental health services has the potential to uncover the processes through which the structure of society affects consumers' recovery.

Most of the research that has been carried out on mental health organizations has focused on the effects of external social forces on organizational processes without making the connection between these processes and consumer outcomes. In her study of CARE, a

public sector mental health facility, Teresa Scheid (2003) demonstrated how external pressures that moved the facility towards managed care created tensions for professionals that negatively affect the level of care provided to consumers. Studies such as these are valuable because they highlight how the larger social structure affects organizational processes; though, they do not highlight how these processes affect individual consumers. Research highlighting the connection between these processes and consumer outcomes will provide a more complete picture of mental illness, mental health, and recovery. A quote from Steven Onken et al. (2007) demonstrates why an investigation of these connections is necessary:

> The dynamic interaction among characteristics of the individual (such as hope), characteristics of the environment (such as opportunities), and characteristics of the exchange between the individual and the environment (such as choice), can promote or hinder recovery. (P. 10)

Therefore, sociological research can make a significant contribution to the study of recovery by paying greater attention to the consumer interactions that occur with and within social institutions and the effects this has on individual consumers (McLeod and Lively 2007; Schnittker and McLeod 2005; Watson forthcoming).

Qualitative methods can help uncover the social interactions and processes that shape the perceptions, meanings, and emotions that affect recovery. As an understanding of this processes develops, sociologists can make stronger connections between the beginnings and endpoints of the recovery process, provide greater theoretical and translational value that can shape future research and practice, and create bridges between the sociology of mental health and questions regarding recovery that are shaping the larger field of mental health studies (McLeod and Lively 2007; Onken et al. 2007).

CONCLUSION

Recovery is a socially constructed phenomenon that is the result of historical and political processes. While mental health policy today defines recovery as a consumer-centered process, clinical and scientific approaches largely continue to treat it as biomedically or clinically defined outcome. A pure outcome approach is problematic considering the connections that exist between the structure of mental health services and the course of mental illness that have been demonstrated in classic sociological mental health literature. Though these connections have been demonstrated, sociologists of mental health have not developed new models to account for changes in the structure of mental health services over the past fifty years that affect the course of mental illness. This has led to a lack of understanding of recovery as it is experienced by those who are living with SMI (and substance abuse disorders).

Sociologists are in a unique position to develop stronger understandings of mental health recovery. Qualitative social psychological investigations are well suited for this task because of their ability to develop stronger understandings of recovery as a consumer-centered process. They can best do this by illuminating the meanings and experiences individuals and groups associate recovery and by uncovering the connections that exist between the social structure and the recovery process as it occurs at the individual-level.

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Personal Reflexive Statement

My interest in mental health recovery stems from one year in which I worked as a case manager in an inpatient substance abuse rehabilitation program and three years I spent working in long-term care directing therapeutic services and mental health rehabilitation. During my time in these positions I became fascinated and frustrated with the contradictions that existed between the interests of health care facilities, managed care, professional and paraprofessional workers (e.g., case managers, therapists, counselors, psychiatrists), and consumers. I oftentimes witnessed how the incompatibility between the interests and goals of these groups regularly benefited facility owners and insurance companies, while often doing more harm than good to the patients who were at their mercy.