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Relational recovery: beyond individualism in the recovery approach

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\textbf{ABSTRACT}

\textbf{Objective:} While the recovery approach in mental health currently enjoys immense support, it is not without its critics. The most persistent criticisms focus on the individualism underpinning many conceptualisations of recovery. In this paper, we outline the shortcomings of individualistic approaches to recovery, and explore the alternative notion of \textit{relational recovery}.

\textbf{Method:} We begin this article by reviewing recent research and theory that critiques individualistic approaches to recovery. We then draw together disparate bodies of research that view recovery as an inherently social process.

\textbf{Results:} Our reading of the literature suggests that although many models of recovery recognise relationships or connectedness as a component of the recovery process, an overemphasis on the ‘inner’, subjective experiences of people with a lived experience of mental ill-health largely obscures the interpersonal contexts of recovery. Interpersonal relationships can more accurately be seen as suffusing all aspects of recovery, including experiences such as hope, identity and empowerment.

\textbf{Discussion:} We conclude by arguing that the way forward for mental health systems lies in developing, promoting and implementing approaches that properly acknowledge the irreducibly relational nature of recovery.

\textbf{ARTICLE HISTORY}

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\textbf{KEYWORDS} Recovery; family recovery; individualism; connectedness; relational; mental illness

\textbf{Introduction}

Recovery is said to be ‘personal’; it is ‘deeply individual’. Why would anyone object to that? Because we are not isolated individuals, to put it bluntly. (Rose, 2014, p. 217)

In recent years, the recovery approach has increasingly influenced mental health policy and practice throughout the English-speaking world (Slade et al., 2014). As Hunt and Resnick (2015) observed, recovery is ‘the rallying cry of 21st century mental health care reform’ (p. 1235). With its genesis in the liberatory psychiatric survivor movement of the 1960s and 1970s, recovery has since ‘gone mainstream’, and is enthusiastically embraced by mental health professionals, academics and policymakers alike (Braslow, 2013; Rose, 2014). Like the biopsychosocial approach in psychiatry, which provided the grounds for the adoption of holistic and integrated approaches in mainstream mental health services...
(Falloon & Fadden, 1993), the recovery movement offered a powerful language with which to critique and move beyond the narrowness of the biomedical approach to mental health. While the biomedical approach emphasises clinical recovery, as indicated by the remission of mental health symptoms, the recovery approach centres on personal recovery, which aims not necessarily at symptom-free normality, but rather ‘living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems’ (Mental Health Commission of Canada, 2012, p. 12). In this way, as Duff (2016) noted recovery ‘connotes neither the full restoration of health nor the symptomologies of chronicity, introducing the need for new ways of conceiving of health in illness’ (p. 2, emphasis added). Recovery is seen as an ongoing journey rather than a final destination, with consumers described as ‘being in’ recovery rather than ‘recovering from’ mental ill-health (Davidson, O’Connel, Tondora, Styron, & Kangas, 2006).

The recovery approach is an important alternative to coercive, deficit-based mental health practices, and as such currently enjoys enormous support. Yet recovery is not without its critics. Some commentators have noted its conceptual fuzziness, highlighting the bewildering array of ways in which the notion of recovery is put to work, ‘variously used to mean an approach, a model, a philosophy, a paradigm, a movement, a vision and, sceptically, a myth’ (Roberts & Wolfson, 2004, p. 38). Others have argued that the radical intent of the original concept has been subverted by governments and mental health professionals, who have deemphasised notions of social justice and promoted a ‘normalising’ view of recovery that ultimately aligns with biomedical discourse (Harper & Speed, 2013; Hunt & Resnick, 2015; Rose, 2014). Perhaps the most persistent criticisms, however, have focused on the individualistic worldview underpinning most conceptualisations of recovery. As Adeponle, Whitley, and Kirmayer (2012) observed, the ‘consumer-oriented recovery approach builds on Anglo-American individualism and on an egocentric concept of the person as a self-sufficient, self-determining, independent entity’ (p. 116).

In this article, we outline and expand upon the existing critiques of the individualistic nature of the recovery approach. We argue that while interpersonal relationships are currently recognised as a component of the recovery process, they can more accurately be seen as suffusing all aspects of recovery, including experiences like hope, identity and empowerment, which are often seen as purely intra-psychic processes or achievements. Drawing together recent bodies of research that view recovery as an inherently social process, we explore the notion of relational recovery, which is a way of conceiving recovery based on the idea that human beings are interdependent creatures; that people’s lives and experiences cannot be separated from the social contexts in which they are embedded. This paper is largely focused on the theories underpinning different conceptualisations of recovery, and is not intended as a guide to practice. Although it is beyond the scope of this paper to develop a full-fledged model of relational recovery, we attempt to provide some examples of what such a view of recovery may look like, and to convince the reader of the importance of working towards more relationally oriented conceptualisations of mental ill-health and recovery.

**Individualistic recovery**

It would be useful to begin this section by distinguishing between two closely related expressions of individualism: individualism as cultural ideal and individualism as
philosophical understanding of the nature of personhood (Orange, 2010). As a cultural ideal in Western countries such as Australia, the US and the UK, individualism can be seen as the dominant, everyday way of understanding of what it means to be a person. Individualistic cultures generally emphasise the values of independence and personal achievement, conceive healthy development as a natural movement from the dependence of childhood to the self-sufficiency of adulthood, and celebrate the ‘self-made’ man or woman who through effort and determination transcends the adverse contexts of their past (Adeponle et al., 2012; Orange, 2010). The more formal or philosophical doctrine of individualism is also a product of the Western world, arguably taking its clearest form in Descartes’s famous distinction between the immaterial mind and the material body. Although most philosophers consider Cartesian dualism to be a discredited view, its influence is still deeply embedded in contemporary psychological disciplines, which implicitly promote the concept of an ‘individual, inner, subject, self-enclosed “mind” or “self” distinguished from an outside, objective, extended universe’ (Orange, 2010, pp. 43–44). The recovery model can be seen as founded on individualism, both in its cultural and philosophical expressions.

In what has become the classic definition, Anthony (1993) described recovery as:

… a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness. (p. 17)

In this definition, recovery is construed as an intra-psychic process that occurs when people with a lived experience are successful in modifying or outgrowing their limiting thoughts, feelings and beliefs. The only word in this definition designed to signify social relationship is ‘roles’, and even this is ambiguously relational as it often refers to an internalised identity. There is no mention of the social determinants of mental health, even though they have been consistently identified as among the strongest predictors of mental health outcomes (Allen, Balfour, Bell, & Marmot, 2014; Furlong, 2015). As in many conceptualisations of recovery, the onus of recovery is placed on the individual, while the familial, social, material, educational, economic and political contexts of mental ill-health and recovery are largely obscured (Adeponle et al., 2012; Harper & Speed, 2013; Rose, 2014). It is noteworthy that Anthony’s highly influential view of recovery was developed in the early 1990s. As Braslow (2013) observed in his detailed history of the emergence of the recovery model in the US, recovery rose to popularity in the wake of the Reagan administration’s deinstitutionalising of mental health services, dismantling of entitlement programmes and cuts to the welfare system, all of which provided the conditions for the emergence of the individualised, self-managing mental health consumer that continues to animate most recovery literature. Promotion of a self-help approach by the consumer and carers rights movements further legitimised efforts to individualise mental health care (Tomes, 2006). Numerous commentators have agreed that the emergence of recovery as an increasingly influential discourse in mental health service delivery neatly dovetailed with neoliberal efforts to shift the care of severe mental ill-health from a collective responsibility to a private, individualised responsibility (Adeponle et al., 2012; Harper & Speed, 2013; Howell & Voronka, 2013).
Of course, recovery has come a long way since the 1990s. There now exist more comprehensive frameworks that attempt to capture the various elements that comprise personal recovery (e.g. Davidson, O’Connell, Tondora, Lawless, & Evans, 2005; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). One of the most rigorous and popular attempts at synthesising the many existing conceptualisations of recovery is the CHIME framework (Leamy et al., 2011); ‘CHIME’ being the acronym for the five recovery processes in the model (i.e. connectedness, hope, identity, meaningfulness and empowerment). While this framework is less obviously individualistic than Anthony’s (1993) definition – the ‘C’ does stand for connectedness, after all – it still shares many of the characteristics of earlier views of recovery. Again recovery is characterised as an ‘individual and unique process’ (Leamy et al., 2011, p. 448), and again the structural determinants of mental health warrant limited mention. With the exception of connectedness, all of the CHIME recovery processes are construed intra-personally. Although some of the processes (e.g. identity and empowerment) could potentially denote collective phenomena, it is clear that this is not the intention of the framework. For instance, the sub-categories of the empowerment process are ‘personal responsibility’, ‘control over life’ and ‘focusing upon strengths’, indicating that the political empowerment of consumers as a group is not what is being referred to. Thus, while the authors of the CHIME model go some way in capturing the importance of relationships to mental health, they ultimately present an individualised framework in which social life and relationships play a secondary role. The onus of recovery still rests squarely on the shoulders of self-governing consumers, who are implicitly encouraged to modify their personal thoughts, feelings and beliefs. The recovery journey is still one of personal transformation, ‘at its heart … a subjective experience’ (Slade et al., 2014, p. 12).

To their credit, the authors of the CHIME model are aware that their framework is ‘monocultural’ and have suggested that future work should ensure that recovery is applicable to consumers in ‘collectivist cultures’ where ‘emphasis is placed on interdependence among family members and relatives over and above the independence that is often promoted in Western cultures’ (Slade et al., 2014, p. 17). Indeed, a number of researchers have recently explored the friction generated as individualistic recovery frameworks are adopted and reinterpreted by countries (e.g. Hong Kong) and cultural groups (e.g. Aboriginal and Torres Strait Islanders) with strong collectivist cultural orientations (Brijnath, 2015; O’Hagan, 2004; Schön & Rosenberg, 2013; Tse & Ng, 2014). This is important work that will be discussed further in the following section. However, there are problems with viewing individualism solely from a cultural perspective, where individualism is diametrically opposed to collectivism. The recovery approach has encouraged people with a lived experience to assert their autonomy and challenge the many ways in which they may have been coerced or restrained by others, or subjected to abuse and oppression. This focus on autonomy is surely an important gain, and to argue for a return to collectivism – where power moves from the consumer to the collective or the state, and where people with a lived experience may be discouraged from expressing their individuality and defining their experiences in a personally meaningful ways – would rightly be opposed by many. Many of the critiques of the recovery approach’s individualism falter because they remain at the level of culture, and thus their proposed solutions necessarily revolve around some form of collectivism. It is our view that in order to more adequately
understand the problems with the individualistic nature of the recovery approach, it is necessary to also conceive of individualism as a philosophical view of personhood.

In the majority of recovery frameworks, as in many approaches associated with the psychological disciplines, the mental health consumer is positioned as an ‘isolated mind’ (Stolorow, 2013, p. 384) or a ‘biologically enclosed island’ (Furlong, 2015, p. 20) on a deeply personal journey who is encouraged to interact with others but always as a separate entity in relationship with other separate entities. For example, the very structure of the CHIME framework, where connectedness sits aside the four intra-personal recovery processes (hope, identity, etc.), reinforces the view that that which goes on inside people’s minds is of a fundamentally different order from that which goes on in their social interactions. This view is predicated on the anachronistic Cartesian dualism that draws an artificial line between the ‘inner’ world of subjective experience and the ‘outer’ world of other people and things (Orange, Atwood, & Stolorow, 1997; Stolorow, 2013). In this dualistic view, the labour of recovery is almost always seen as occurring on the ‘inner’ side of the equation, meaning that individuals’ effort or will to recover is foregrounded while the ‘varied resources, relationships, spaces and objects involved in this work’ recede to the background (Duff, 2016, p. 2). This emphasis on personal experience ensures that recovery frameworks such as CHIME fail to rigorously account for the complex ways in which experiences like hope are actually developed and sustained in the daily lives of people with a lived experience; lives that are never hermetically sealed from the ‘outer’ contexts of which they are a part. In other words, individualistic philosophies focus on only a portion – perhaps a small portion – of the complex clusters of causes and conditions that give rise to the emotional and cognitive states that are seen as comprising recovery (Topor, Borg, Di Girolamo, & Davidson, 2011). This is how the individualism of the recovery model should be regarded: not simply a matter of cultural difference, but also a basic philosophical bias vis-a-vis the nature of human subjectivity and its place in the world.

On the other hand, post-Cartesian psychological theories – in their systems, ecological, intersubjective and relational forms – posit that we are not beings in relationship, but rather relational beings from the outset (Gergen, 2009; Jacobs, 2009; Stolorow, 2013). Experiences such as hope, identity, meaningfulness and empowerment emerge at the intersections between people, their relationships and environments; they are best seen as interactional processes rather than states possessed by any one individual. From a post-Cartesian perspective, the language used by many advocates of recovery betrays a fundamental dualism. This can be true even of those who stress the importance of social relationships. For example, in a literature review of social factors in recovery, Tew et al. (2012) argued that ‘relationships are vital to recovery: they shape identity and contribute to or hinder wellbeing’ (p. 451). Relationships are seen as vital, yes, but vital only in regards to their capacity to ‘shape’ or ‘contribute to’ (or, elsewhere, to ‘promote’, ‘enable’, ‘influence’ and ‘inspire’). Such terms tend to imply a fundamental separation between that which is being shaped (e.g. identity and well-being) and that which is doing the shaping (e.g. relationships). From a post-Cartesian perspective, it is insufficient to assert that social factors contribute to recovery, as long as recovery is still conceived as something that sits apart from these factors. Experiences such as hope and empowerment are not shaped by material, social and economic contexts, but are more accurately seen as inconceivable outside of these contexts. Importantly, many post-Cartesian theorists would
agree that ‘holding a relational perspective is not the equivalent of a return to collectivism’ (Fairfield & O’Shea, 2008, p. 29). From a relational perspective, the opposite of individualism is not collectivism, but rather something closer to interdependence; the kind of interdependence that underpins systems and ecological thinking, which see people as fundamentally inseparable from their environments. A relational perspective ultimately seeks to transcend the polarising duality between individualism and collectivism with a view of interdependence that takes seriously the needs of the individual and the needs of the collective (or community) in ways that understand and hold that they are inseparably linked.

Towards relational recovery

In the last section we discussed two closely related ways in which the recovery model, as it is most often conceived, can be considered individualistic. First, it resonates with the cultural individualism of countries such as Australia and the US by strongly emphasising self-sufficiency, responsibility and autonomy, while simultaneously downplaying collective experience, the structural determinants of health and the relational contexts of consumers’ lives. Second, even when the importance of social connectedness is acknowledged, it is done in a way that maintains a factitious boundary between the ‘inner’ world of emotional and cognitive experience, and the ‘outer’ world of interpersonal contexts. In this section, we explore some recent attempts at establishing relationally oriented conceptualisations of recovery. Although these may not all qualify as consistently post-Cartesian, as we described it above, they all at least convey a sense of the forms that thoroughly relational views of recovery may take. Our focus in this article is on research or frameworks that emphasise the interpersonal aspects of recovery, meaning that we do not explore efforts at challenging the recovery model’s individualism that concentrate on social justice (e.g. Hunt & Resnick, 2015) or the collective political identity of mental health consumers (e.g. Harper & Speed, 2013), as important as these efforts are.

The first body of work that can inform relationally oriented views of recovery has explored the cross-cultural applicability of the recovery approach, focusing particularly on the clash between individualistic and collectivistic value systems, as well as the particular needs of consumers from marginalised cultural-linguistic communities (e.g. Jacobson & Farah, 2012; Schön & Rosenberg, 2013; Tse & Ng, 2014). An illustrative example of this literature comes from Toronto, which has a very high degree of cultural and linguistic diversity. In the 2000s, community mental health organisations throughout Canada increasingly aligned their policies and practices with the recovery approach. However, service providers in Toronto indicated that the strategies associated with the recovery approach tended to be culturally insensitive, failing to address issues such as migration stress, social marginalisation and racism. In response to this situation, the Toronto Recovery and Cultural Diversity Community of Practice oversaw the development of the Culturally Responsive Model of Recovery (Jacobson & Farah, 2012; Jacobson, Farah, & the Toronto Recovery and Cultural Diversity Community of Practice, 2010).

This culturally-sensitive model ‘recognizes that individuals exist in a fluid web of relations constituted by the family, community, and larger socio-political units’ and therefore ‘places culture, systems of oppression and privilege, the social determinants of health, and history in the foreground, positing that these factors are central to recovery’ (Jacobson
Farah, 2012, p. 334, emphasis added). In this model, many of the recovery processes that are seen as individual experiences in the CHIME framework take on a collective hue:

Recovery thus refers not just to the processes of hope, healing, empowerment, and connection occurring at the individual level, but also to the need for these processes to work at other levels. Hope encompasses not only an individual’s belief that a better life is possible for himself, but a broader sense of opportunity for an entire cultural-linguistic community. Healing means not just that an individual’s distress is lessened, but that his extended family is able to move toward better health and functioning. Empowerment speaks to parents’ wish to be able to act so as to create a better life for their children, and also to the need for communities to be active participants in making decisions about the government systems with which they interact. (Jacobson & Farah, 2012, p. 335)

Thus this model not only foregrounds the structural components of recovery, but also approaches a post-Cartesian understanding of recovery processes, where consumers’ personal experiences of hope, healing and empowerment are seen as inseparable from the social and cultural milieus from which they emerge.

The next relevant body of literature is the growing research on the social nature of recovery (e.g. Marino, 2015; Mezzina et al., 2006; Topor et al., 2011). Although the authors working in this area have approached the topic from different angles, all have in one way or another viewed recovery as an ‘inherently social process’ (Marino, 2015, p. 68). Of particular note, a group of colleagues in Europe conducted a series of qualitative studies exploring the pivotal roles played by family members, friends, professionals and the broader community in the recovery process (Mezzina et al., 2006; Schön, Denhov, & Topor, 2009; Topor et al., 2006). For example, in a grounded theory study involving 58 Swedish participants who had recovered from severe mental ill-health, Schön et al. (2009) attempted to determine the main factors that respondents themselves identified as being conducive to their recovery. The core category that emerged from this analysis was ‘recovering through a social process, which emphasized social relationships as decisive in recovery from severe mental illness’ (p. 339, emphasis in original). As the authors described:

An individual’s recovery takes place within a social context and the respondents in this study attached central importance to the relationships in their lives. … It is through social relationships that the individual is able to redefine themselves as a person (as opposed to a patient) – a person with problems but also with abilities. (p. 345)

In this study, achievements that are normally seen as deeply personal, such as positive changes in self-perception and identity, were described as interpersonal processes. Social relationships did not ‘shape’ or ‘contribute to’ changes in identity; rather, the social was seen as where recovery ‘takes place’, and it was ‘through social relationships’ that participants were able to redefine their experience (p. 345, emphasis added). In other words, the social world was the very medium through which personal transformation became possible.

Perhaps the literature that comes closest to the relational view of recovery that we are advocating for in this article focuses on the notion of ‘family recovery’ (e.g. Glynn, Cohen, Dixon, & Niv, 2006; Maybery et al., 2015; Nicholson, 2014; Solantaus & Toikka, 2006; Wyder & Bland, 2014). The authors working in this area point out that the family is the most salient interpersonal context for many consumers: estimates have indicated
that over 50% of Australians living with severe mental ill-health have daily contact with family member/s (Morgan et al., 2012) and roughly 20% live with dependent children (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009). For many, it is impossible to separate their own recovery from the functioning of their family or their responsibilities as parents. Nicholson (2014) developed a model of family recovery that demonstrates the systemic and ecological thinking evident throughout this literature by laying out ‘the relationships between parent and child characteristics, the family and the environment, and the interactions and transactions among them to suggest targets and pathways for recovery’ (p. 7). In outlining this model, which was developed for mothers with severe mental ill-health, Nicholson argued:

Clearly, women who are mothers are not living in a vacuum. The context of their lives is often defined by family parameters. Families are commonly understood as systems in which members are engaged in reciprocal relationships (i.e. family members affect each other) and events are multiply determined by forces operating within and external to the family. For mothers living with mental illnesses, recovery is a dynamic process that contributes to and is influenced by family life, family experiences, and the well-being and functioning of other family members. (pp. 6–7)

Here an emphasis on intra-psychic experiences is replaced by a complex, situated and processual understanding of the ways in which mental ill-health and recovery manifest in mothers’ lives. The importance of accounting for mothers’ individual needs is still stressed, but these needs are seen as always situated in, and emerging from, a relational matrix.

While Nicholson’s (2014) model focuses of families of procreation or choice, other authors have explored the potential of a recovery orientation in interventions designed for families of origin (e.g. the parents and siblings of adult consumers) (e.g. Glynn et al., 2006; Obradovic & O’Hanlon, 2015) For example, Glynn et al. (2006) outlined the ways in which the large number of evidence-based psychoeducational family interventions for schizophrenia, developed over the last 35 years, are generally consistent with the principles of the recovery approach. Most of these interventions are premised on the findings that family members’ emotions, behaviours and attitudes towards mental ill-health are among the strongest predictors of both relapse and recovery for people with a lived experience. In practice, many of these psychoeducation family interventions share a number of common features with recovery-based interventions, such as assuming a non-pathologising stance, utilising a collaborative approach, teaching problem-solving and communication skills, and the inclusion of mutual self-help and peer support. Glynn et al. (2006) argued that by making some modifications to the language, content and outcomes of concern of the interventions, they could be made consistent with an approach to recovery that has family life at its heart; that is ‘primarily community-focused and deal[s] with “the real world”’ – the consumer and his/her loved ones’ (p. 451).

Finally, Wyder and Bland (2014) recently took the family recovery literature in a promising new direction by reworking the CHIME framework to distinguish between consumers’ recovery journeys and their families’ own experiences of recovery. This was prompted by the growing body of evidence demonstrating that family members often suffer prolonged and serious distress, especially if they are in a caring role for the family member affected by mental ill-health. In this modified CHIME framework, each of the recovery processes (i.e. connectedness, hope, identity, meaningfulness and
empowerment) is conceptualised as taking a different form depending on whether it is considered from the perspective of the consumer, the caregiving relationship or the family. For example, empowerment for the consumer involves taking responsibility for their own behaviour and recovery, learning to better manage their own distress, and so on. From the perspective of the caregiving relationship, empowerment introduces a new set of requirements, such as the need for family members in the caring role to balance their attempts to maintain control with efforts to hand back control and allow people with a lived experience to take risks and potentially fail. Finally, for family members themselves, empowerment may entail developing a life that moves beyond the caring role, learning to better manage their own distress or reactions, and feeling motivated to improve their families’ situation. This tripartite division promotes a perspective of the recovery processes as distributed throughout an interpersonal network, rather than residing entirely within one individual.

**Conclusion**

In this paper, we have explored some of the shortcomings of individualistic recovery approaches and started the process of articulating a view of recovery based on the understanding that people are inherently relational beings. The three bodies of literature outlined in the previous section are simply examples of the forms that relational recovery may take. Each points to a way of conceptualising recovery that avoids treating people with a lived experience as ‘isolated minds’ on deeply individual journeys for which they alone are responsible. Each sees psychological phenomena such as hope and empowerment as emerging from the contact between individuals and the social and cultural milieus in which they are embedded. Such a view in no way invalidates the experiences of people with mental ill-health, but simply suggests that the genesis of these experiences is more complex and relationally situated than individualistic interpretations of recovery allow. Likewise, this view does not suggest that the path of recovery will always involve an increase in collective or social experience. For some, recovery may necessitate disconnecting from certain relationships and establishing firmer boundaries. From the perspective of relational recovery, however, even these assertions of autonomy and boundary-setting are seen as interpersonal acts; acts that only have meaning within the context of relationships that undermine the autonomy or transgress the interpersonal boundaries people with a lived experience wish to establish.

The practice implications of our call for a revised approach to recovery require more expansion than is possible in this introductory theoretical paper. In light of this, an associated practice resource (Price-Robertson, Olsen, Francis, Obradovic, & Morgan, 2016) aims to offer practitioners and services six key strategies for promoting relational recovery as it relates to those affected by parental mental illness, including direct examples and resources. For now we would note that in practice, relational recovery leads to a way of working that increases the number of potential interventions open to service providers. To persist with the example of boundary-setting: individualistic models of recovery would tend to see this as an issue to be dealt with intra-personally, perhaps through psychoeducation or counselling that assists people with a lived experience to assert their independence and establish healthy boundaries in their life. This is likely to be effective to some extent, but may also leave untouched many of the factors that are holding the unhealthy
boundaries in place. Perhaps one consumer feels unable to assert his autonomy while he is still financially dependent on his parents. Maybe another’s husband threatens her and her children with violence every time she tries to establish clearer boundaries in the home. In these cases, the issue of unhealthy boundaries is at least in part related to the social and material configurations of consumers’ lives. To insist, like Anthony (1993, p. 17) in his famous definition of recovery, that the development of appropriate boundaries is ‘a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles’ is to place all responsibility for change on the individual, obfuscating the environmental conditions that support their current situation and which could potentially be modified in order to catalyse change. From the perspective of relational recovery, service providers would want to ask questions such as: Are there any interpersonal factors that support this consumer’s unhealthy boundaries? Would there be costs or risks involved if they established firmer boundaries? If so, how can these costs or risks be minimised? Are there ways in which their life situation could be modified in order to facilitate the work of healthy boundary-setting? In this way, the issues of psychological boundaries and personal responsibility are acknowledged, but they are held in a broader frame, one that appreciates the complexity of people’s lives, and that may open up novel avenues of intervention for service providers.

In his history of the rise of the recovery approach, Braslow (2013) observed that

Cycles of hope and despair have characterized mental health policy making over the past 200 years. Heroic efforts to redesign an entire system of care are followed by resigned defeat as policies fail to address the complex realities of chronic mental illness. (p. 782)

Our concern is that if the recovery approach does not grow beyond its individualistic roots it will remain unable to address the complex realities of many consumers’ lives, and so become yet another movement in the gradual cycle of hope and despair. We need mental health frameworks that resist the stereotype of consumers as single, childless people for whom meaningful recovery revolves mostly around independent living and vocational engagement. We also need frameworks capable of acknowledging consumers’ multiple relational roles and identities, ones from which they may have been disenfranchised. People with lived experience normally adopt, or at least aspire to adopt, numerous different relational identities – spouses, lovers, friends, children, parents, siblings, aunts and uncles, grandparents, carers of loved ones themselves – all of which entail complex networks of interdependence. These frameworks must be capable of acknowledging the experiences of all individuals, families and communities in contemporary society, many of who face immense challenges. Take the example of Aboriginal and Torres Strait Islander communities in Australia, whose strength and resilience is compromised by historical and ongoing dispossession, marginalisation and racism, all of which contribute to high levels of poverty, unemployment, violence and substance abuse. Do we really want our mental health models to implicitly tell the people of these communities that the solution to their suffering lies in the space between their ears? That the best advice we have is that they attempt to modify their own thoughts and emotions? Individualistic recovery approaches are simply not up to the task of dealing with the full range of experiences, identities and challenges faced by many people living with mental ill-health. We believe that
the way forward for mental health systems lies in developing, promoting and implement-
ing approaches that properly acknowledge the irreducibly relational nature of recovery.

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backgrounds (e.g. Aboriginal, culturally and linguistically diverse, rural and regional, same sex and
single parent) and include parents with mental ill-health, partners, young people, siblings, adult
children, and extended family such as grandparents. Members identify as having multiple individ-
ual and shared lived experiences that do not necessarily fit with commonly accepted service system
descriptions, such as ‘consumer’ or ‘carer’.

Disclosure statement

No potential conflict of interest was reported by the authors.

Notes

1. Within this article individuals experiencing the symptoms of mental ill-health will be referred
to as “people with a lived experience” or, where ease of readability requires, as “consumers”.
The term “consumer” equates to the international term “service user”, which is less common
within the Australian context. Co-design is an important value position of the Emerging
Rights and COPMI National Initiative and hence these definitions and terms are intention-
ally used to honour the principle of rejecting singular cohort membership for people with a
lived experience.

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