Chapter 8

Cultural contexts and constructions of recovery

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Introduction

Across cultures there are wide variations in the ways in which mental disorders are understood, diagnosed, and treated (Kleinman et al, 1978; Kirmayer, 1989). These variations include different notions of what constitutes desirable outcomes of recovery, health, and well-being. In biomedicine, as in many other health systems, there are close links between explanatory models of disease, definitions of positive outcome, and models and expectations of recovery. Much of current psychiatric practice emphasizes symptom-based diagnosis and treatment of mental disorders (McNally, 2011). One consequence of this emphasis is that notions of recovery are often framed in terms of clinical outcomes (Bellack, 2006). This understanding of recovery, often operationalized as sustained remission of symptoms, has been termed *clinical recovery* (Slade et al, 2008). One appeal of clinical recovery definitions is that they claim to offer a measure of outcome that is invariant across individuals and presumably across a diversity of geographical settings. However, notions of efficacy, health, and well-being vary significantly in different healing systems (Kirmayer, 2004).

Recently, a new view of recovery has emerged and is being adopted—in some jurisdictions and agencies more than in others—as a leading approach to the organization and delivery of mental health services in the USA, New Zealand, Australia, the UK, and Canada (Roberts and Wolfson, 2004; Davidson et al, 2005b; Slade et al, 2008). This new approach to recovery is inspired by the perspectives of mental healthcare users and individuals who have experienced mental illness, and hence is often called *personal recovery* (Deegan, 1997; Saks, 1999, 2000; Davidson and Roe, 2007; Slade et al, 2008). The approach to personal recovery sets aside the notion of cure or even the notion of remission as central to recovery, and emphasizes instead "the rights of the individual diagnosed with a serious mental illness to … a personally meaningful and gratifying life in the community despite his or her psychiatric condition" (Davidson et al, 2009, p. 11). Consistently, consumers identify as key to recovery dimensions of hope, purpose, self-identity, connection, spirituality, empowerment, and overcoming stigma, in addition to symptom management (Onken et al, 2007; Schrank and Slade, 2007). Along with this reorientation, recovery is increasingly conceived of as a process, as much as an outcome, with individuals described as "being in recovery" rather than

as "recovering from" an affliction (Davidson et al, 2009). Yet insufficient attention has been given to the cultural and social contexts of recovery as a process that involves people with mental illness as well as their families and communities.

In this chapter we examine the concept of recovery through the lens of culture. We consider the social and cultural roots of current notions of recovery, and the ongoing struggle between competing visions, values, and knowledge systems. We consider the ways in which recovery may be rooted in specific concepts of the person that vary across cultures. This leads to some reflections on the relevance of current notions of recovery for diverse ethnocultural groups and social contexts. Finally, we outline some of the implications of a cultural perspective on recovery for psychiatric ethics, research, clinical services, and public health. Our approach draws from cultural constructivist and critical medical anthropological perspectives that examine how discursive practices and institutions create the objects of medical systems (Kirmayer, 2006; Gone and Kirmayer, 2010). We view psychiatric diagnostic categories as well as notions of wellness and recovery as culturally constructed ways of construing the complex realities of psychopathology, illness, and healing. As Ian Hacking (1999, 2002, 2007) has argued, clinical discourse provides modes of self-construal that become part of everyday life and that can loop back to reinforce the sense of the naturalness and inevitability of the dominant concepts and constructs of mental health. Similarly, ideas that arise in other social arenas can be taken up in clinical settings and become part of the assumptions of mental health professionals and institutions. Philosophical analysis, with the aid of comparative ethnographic observations across cultures, can allow us a measure of distance from received categories and open the way toward constructive critique.

Cultural constructions of recovery

The term recovery has been used to refer to "an approach, a model, a philosophy, a paradigm, a movement, a vision and, skeptically, a myth" (Roberts and Wolfson, 2004, p. 38). Indeed, an analysis of the recovery literature noted a lack of consensus regarding the definition of recovery and the very abstract nature of the concept (Onken et al, 2007). However, there is agreement that recovery involves multiple dimensions, and complex processes that permeate the whole life context of the individual with some elements that are linked primarily to the individual and others that are more deeply embedded in the structure of the community that provides resources and opportunities for the individual's "journey" of recovery (Onken et al, 2007, p. 10).

Early definitions of recovery in the USA tended to frame it in characteristically individualistic terms. William A. Anthony, one of the early inspirations for the contemporary recovery movement, in his seminal paper "Recovery from mental illness: the guiding vision of the mental health service system in the 1990s" (Anthony, 1993, p. 17), defined recovery as:

> *a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*

Interestingly, Anthony saw recovery as entirely compatible with the biomedical perspective: "for service providers, recovery from mental illness is a vision commensurate with researchers' vision of curing and preventing mental illness" (Anthony, 1993, p. 17).

In its original formulation, then, the notion of recovery was seen as intertwined with earlier, clinical notions of recovery as cure or remission of symptoms.

In an autobiographical account, Patricia Deegan, a mental health services consumer and survivor, and a renowned recovery advocate in the USA, described recovery as "the lived or real-life experience of people as they accept and overcome the challenge of the (mental) disability" (Deegan, 1988, p. 11). For Deegan, recovery is "a way of life, an attitude, and a way of approaching the day's challenges", built on the cornerstones of hope, desire for a full life, and responsible action. This emphasis on individuals' lived experience shifts authority away from biomedical practitioners and institutions and toward the afflicted individual's own self-understanding and agency.

Recovery was officially designated the overarching aim of mental health services in the USA in the 1999 Surgeon General Report on Mental Health (Department of Health and Human Services, 1999). In 2002, the US government set up the President's New Freedom Commission on Mental Health to make recommendations on reform in the mental healthcare system. In its final report, the Commission defined recovery as:

> *the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.*
>
> (The President's New Freedom Commission on Mental Health, 2003, p. 7)

The report recommended a fundamental transformation of the approach to mental healthcare, to ensure that "mental health services and supports actively facilitate recovery and build resilience to face life's challenges" (The President's New Freedom Commission on Mental Health, 2003, p. 1). Resilience was defined as "the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses—and to go on with life with a sense of mastery, competence, and hope". The report went on to state that "We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members" (The President's New Freedom Commission on Mental Health, 2003, p. 7).

In short, the New Freedom Commission definition restated a view of recovery as largely an individual process, but added a developmental dimension to recovery and recognized the role of community and social supports in recovery. Michael F. Hogan, chair of the New Freedom Commission, in a report on the Commission and its work described recovery as:

> *a process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment. … This view of recovery aligns with a definition developed by Anthony (1993), who wrote that recovery "is a way of living a satisfying, hopeful, and contributing life even with 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."*
>
> (Hogan, 2003, p. 12)

This view was also adopted in the definition of recovery proposed by the US Substance Abuse and Mental Health Services Administration (SAMHSA) after lengthy consultation with key stakeholders, including consumers, clinicians, family members, and others. It has become one of the most frequently cited definitions of recovery: "mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential" (Substance Abuse and Mental Health Services Administration, 2004). In addition, the SAMHSA definition specifies 10 components that are central to the implementation of recovery-oriented models in mental health services—self-direction, individualized and person-centered, empowerment, holism, non-linear path, strengths-based, peer support, respect from service providers, personal responsibility, and hope.

Other models have been proposed by psychiatric researchers and clinicians, based on their experience working with people with severe mental illness. Jacobson and Greenley (2001) described a two-dimensional model related to recovery that distinguishes between *internal conditions* (hope, healing, empowerment, and connection) and *external conditions* (human rights, a positive culture of healing, and recovery-oriented services). A broader typology of recovery dimensions has been provided by Whitley and Drake (2010), who have built on existing work to propose a model of recovery that incorporates five superordinate dimensions—*clinical recovery* (experiencing improvements in symptoms), *existential recovery* (having a sense of hope, empowerment, agency, and spiritual well-being), *functional recovery* (obtaining and maintaining valued societal roles and responsibilities, including employment, education, and stable housing), *physical recovery* (pursuing better physical health and a healthy lifestyle), and *social recovery* (experiencing enhanced and meaningful relationships and integration with family, friends, and the wider community).

In summary, although recovery is understood in terms of multiple domains and viewpoints, it privileges the voice and experience of the service user or consumer in defining outcomes. This language of "the consumer" is not neutral, but points toward specific types of agency, activity, and consumption. In most published accounts from the USA, recovery is described in ways that emphasize the individual's self-determination and engagement with life pursuits, including education, employment, sexuality, friendship, spirituality, and participation in groups and communities in ways that reflect particular systems of value and economic activity. Moreover, as we shall see, this focus on individual experience and autonomy takes for granted certain culturally based notions of the nature of self, identity, and personhood.

Recovery in cultural context

The dominance of Euro-American definitions of recovery in the literature has raised questions about the cross-cultural applicability of the construct. For example, Mary O'Hagan, Commissioner of the New Zealand Mental Health Commission and a

mental health service user herself, who was intensively involved in developing the recovery vision adopted by the New Zealand Mental Health Commission in its *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, 1998), noted that the New Zealand vision of recovery was very much driven by dissatisfaction with conceptions of recovery that were emerging in the US literature at the time (O'Hagan, 2004). In particular, the New Zealand Commission was troubled by the emphasis on recovery as an individual process and the relative discounting of social processes (community, economic, and political) that enable and/or impede recovery. They noted that recovery in the USA grew out of psychiatric rehabilitation, was still circumscribed by the medical model, and was driven more by the needs of professionals than by those of service users. The approach in the USA was monocultural, with an emphasis on individual processes and personal responsibility in ways that reflect the dominant ethos of libertarian, rugged individualism (Bellah et al, 1985). For O'Hagan and her colleagues, given the legacy of European colonialism and New Zealand's commitment to righting the wrongs committed against its indigenous Maori population, it was important "to acknowledge cultural diversity and a connection to one's own culture as a key to recovery" (O'Hagan, 2004, p. 2). The commissioners argued that adopting American definitions wholesale would be wrong for New Zealand, because egalitarianism and collective responsibility are more salient values in New Zealand society.

Even within North America, investigators have argued that current notions of recovery unduly privilege Euro-American values, and that the emphasis on individual responsibility and empowerment may be less central for other ethnocultural groups (Carpenter-Song et al, 2010; Mental Health Commission of Canada, 2009a,b; Shahsiah and Yee, 2006; Whitley, 2012). For example, Lavallee and Poole (2010, p. 272) cite findings from a participatory research project in Toronto which indicated that "most advocates of mental health recovery are white, with little attention given to culture and racism".

Although cultural differences in the values central to concepts of recovery have been recognized by critics, it remains unclear how much cultural differences actually influence processes of recovery, due to lack of research on this topic. In a multinational study of recovery of people with psychosis, Davidson et al (2005c) found that cultural differences between study participants in the USA, Italy, Norway, and Sweden existed mainly in relation to specific facilitators of and barriers to recovery, whereas the recovery process itself was similar for study participants across all of the study sites.

Understanding the cultural dimensions of recovery of people with mental illness requires attention to two interacting levels—first, the discursive level at which social and political interests and actors shape the theory and practice related to recovery, and secondly, the level of lived experience in which the values and ways of life of ethnocultural communities or local worlds influence the actual course of illness and social reintegration.

Neoliberalism and the origins of the recovery movement

Current notions of recovery are usually traced to three key developments:

1. recognition of inadequacies in the implementation of the deinstitutionalization policy in the 1950s and 1960s in the USA, and the consequent expansion of community-based mental health services from the 1980s onward

2. findings from national and international longitudinal studies, from the 1970s onward, indicating heterogeneity in the course and outcomes of severe mental illness such as schizophrenia, contrary to accepted Kraepelinian wisdom of a uniformly deteriorating course (Hopper and Wanderling, 2000)
3. the emergence, in the 1990s, of a "recovery movement" comprised of ex-patients, consumers, and survivors who, based on insights from their personal experiences of mental illness and recovery, pushed for reform of mental health services (Anthony, 2003; Ralph and Corrigan, 2005; Davidson et al, 2009).

Deinstitutionalization witnessed the discharge of patients in large numbers from mental hospitals and institutions, with the goal of appropriately supporting them in the community. Two drivers of deinstitutionalization were the social psychiatry revolution that began in Western Europe after World War Two, and the introduction of antipsychotic medications. Social psychiatry promoted a new therapeutic optimism in psychiatric care geared toward early patient discharge, and rehabilitation and treatment in the community (Warner, 2004, p. 91). The use of the medication chlorpromazine enabled the effective management of psychotic symptoms and of disruptive behaviors, making life in the community an increasingly viable option for many severely mentally ill patients. However, in an analysis of the political economy of deinstitutionalization, Warner (2004, pp. 98–102) argues that the key political motives behind deinstitutionalization were cost-saving efforts on the part of US federal and state governments, the rise of the welfare state, and the post-war demand for labor, especially in Northern Europe.

The initial implementation of the deinstitutionalization program in the USA fell far short of its intended goal of supporting discharged individuals in the community. Within weeks of discharge, many individuals were back in hospital, establishing a "revolving-door" pattern of repeated admission and discharge (Hopper et al, 1997; Luhrmann, 2007). Others ended up on the streets, or in overcrowded nursing and care facilities, and some ended up in jail. However, by the 1970s and 1980s more effective community care and service provision began to take root, as service providers began to have a clearer picture of the challenges of living with a severe mental illness (SMI) in the community. The work of journalists and ethnographers showed the ways in which people with SMI struggled to maintain their lives in the community (Baxter and Hopper, 1982; Estroff, 1985; Sheehan, 1982). Changes in the organization and delivery of services helped to fashion innovative, evidence-based programs tailored to meet the range of needs (residential, vocational, educational, social, and other) of people with SMI in a diversity of non-hospital settings. Innovative models of community care that emerged included the community support system (Anthony, 1993), the psychosocial clubhouse model of rehabilitation (which had older roots in the USA as manifested in the establishment of Fountain House in New York City in the mid-twentieth century) (Rosenfield and Neese-Todd, 1993), assertive community treatment (ACT) (Teague et al, 1998), supported employment (Bond et al, 1997), and peer support (Davidson et al, 1999). The emergence of these approaches laid the foundation for the recovery movement of the 1990s (Anthony, 1993).

A second impetus for the recovery movement came from longitudinal studies that investigated the course of psychiatric illnesses and disabilities in the community (Loveland et al, 2005). The World Health Organization (WHO) International Pilot

Study of Schizophrenia (World Health Organization, 1973) provided evidence of a better outcome in schizophrenia in some developing countries. Since then numerous longitudinal studies have been conducted, both national (Harding et al, 1987; Mojtabai et al, 2001) and international (Jablensky et al, 1992; Davidson et al, 2005a). These studies have established that the majority (around 75%) of individuals who develop SMI achieve some form of recovery (Davidson et al, 2009). Although these studies have been subject to methodological critiques (Cohen et al, 2008) and have produced some contradictory findings, they also demonstrate significant heterogeneity in the course and outcome of schizophrenia, suggesting the importance of social and cultural context in recovery (Hopper, 2004).

The current use of the term "recovery" reflects the emergence of the user/survivor recovery movement which can be traced back to influences from the civil rights and independent living and disabilities movements of the 1960s and 1970s, and the self-help community in addictions recovery (Davidson et al, 2009). The 1960s civil rights movement in the USA was concerned with establishing rights of full citizenship for marginalized peoples, particularly for racial minorities and women. This movement was instrumental in the emergence of disability rights advocacy and the subsequent birth of the disability rights movement dedicated to ensuring equal rights and opportunities for people with disabilities. This culminated in the Americans with Disabilities Act (1990), which conferred numerous new rights for people with disabilities. The independent living movement emerged out of the disability rights movement, and has as its tenets the principles that individuals with disabilities are the foremost experts on their own needs, and that people with disabilities individually and collectively must take the lead in service planning and delivery, with minimal or no input from health professionals (Fleischer, 2001).

The term "recovery" has been used by Alcoholics Anonymous (AA) and the "12-step programs" since the mid-twentieth century (Galanter, 2007). These programs view individuals with alcohol or other addictions as having a disease and a lifelong vulnerability to relapse. As a result, cure is not considered possible. Recovery is a process in which individuals learn to exercise vigilance and reclaim control over their lives. AA is a spiritual recovery movement that engages participants in a social system that promotes a new identity and provides a source of "transcendent meaning in their lives" (Galanter, 2007). This emphasis on spirituality finds resonance with the recovery experiences of many individuals, especially those from ethno-racial minorities, who have an SMI (Whitley, 2012).

Although it is not discussed much in the recovery literature, it is important to recognize the political and economic context of the emergence of the recovery movement. Indeed, many commentators (Rose, 1996; Tousijn, 2006; Ilcan, 2009; Teghtsoonian, 2009) have argued that the public policies and practices that inform current healthcare delivery are rooted in an ethos of neoliberalism (Harvey, 2005; Urciuoli, 2010). Interest in recovery in the mental health field has developed in parallel with fundamental changes in the organization of the health system in the USA, with the advent of health maintenance organizations (HMOs) and third-party payer systems as major players in the shaping of national and state health agendas. These changes in healthcare have been part of broader changes in US politics and

governance since the 1980s, with debasement of cooperative values, skepticism about the value of social reform, the ascendance of a libertarian, neoliberal ethos, and the growing influence of corporations (including pharmaceutical companies) and economic globalization (Mechanic, 1993; Pescosolido et al, 2000; Rubin, 1996; Conrad, 2005). Larger changes in healthcare include government investment in medical effectiveness research, a decline in physician cultural authority since the 1980s, the rise of consumer power, and the reassertion of non-physician providers (Pescosolido et al, 2000). Thus, apart from the rise of free-market thinking and the reign of private enterprise, the neoliberal turn in US healthcare delivery brought with it profound changes in value systems that have influenced the patient/service user–clinician/provider relationship, institutional practices (e.g. changes in the definitions of roles and duties expected of health professionals), and the culture of healthcare delivery as a whole.

Although framed as an economic philosophy, neoliberalism can also be understood as a cultural belief system (Bourdieu, 1998; Rossiter, 2003; Urciuoli, 2010), or "a social and political imaginary which draws upon a more or less coherent set of philosophical presuppositions … including negative liberty, methodological individualism, suspicion of the powers of the state and support for free-market capitalism" (Frow, 1999, p. 424). Neoliberalism's capacity to command belief and to leave its mark on the imagination, as well as the resonance between its core tenets and traditional American beliefs that privilege the individual, rationality, choice, and private enterprise, can account for its wide acceptance, at least in North America. The neoliberal frame of mind is "characterized by an ethic of entrepreneurial self management … the desire to subject all sociocultural practices to the laws of the market … [and] turn any form of knowledge into product" (Urciuoli, 2010, pp. 162–164). In effect, "each person becomes his or her own product … [and] becomes responsible for parsing himself or herself into elements whose primary function is *productivity*—making profit for oneself and/or one's organization" (Urciuoli, 2010, p. 163).

This emphasis on self-management, rationality, and choice as hallmarks of the ideal individual is reflected in most definitions of recovery, including that of the New Freedom Commission with its emphasis on recovery as self-resilience, self-mastery, and self-competence, as well as the SAMHSA definition, which identifies key dimensions of recovery as including self-direction, personal responsibility, and strengths-based and person-centered care.

Thus the origins of current notions of recovery can be traced to shifts in politics and culture in the USA (and to varying degrees also globally), marked by government disinvestment in healthcare and its transformation into a marketplace, the rise of consumer power and an ethic of self-help, as well as the increasing influence that corporations—including pharmaceutical companies—exert in setting health agendas.

Recovery and the cultural concept of the person

In a seminal essay, the sociologist Marcel Mauss (1985) argued that "personhood" is a social construction, a moral and juridical concept that can vary across cultures. Cultural concepts of the person encode ethnopsychological concepts of mental health and illness, as well as social norms for gender roles and developmental tasks. These models influence individuals' attributions and interpretations of their own thoughts,

feelings, and actions in health and illness. Each version of personhood is associated with specific moral and religious systems that contribute to the process of recovery and to the way that narratives of recovery are organized and told.

The Western or Euro-American view of the person has been termed *individualistic* or *egocentric* (Bellah et al, 1985; Johnson, 1985). This view of the person emphasizes the values of independence, autonomy, and self-direction, as well as individual accomplishments. The normal developmental trajectory is seen as moving from the child's inevitable dependence on caretakers toward the adult as a free-standing, self-sustaining individual. As a result, dependence on others tends to be viewed as evidence of immaturity or maladaptation. (In a reflection of this cultural bias, official psychiatric nosology recognizes excessive dependence as a cardinal symptom of dependent personality disorder (American Psychiatric Association, 2000). There is no corresponding "independent personality disorder", although difficulty in forming and maintaining normal bonds of trust and attachment and stable relationships is considered to be a symptom of some disorders.) This model is also gendered, in that the image of the self-made man or rugged individual is often contrasted with women's greater dependence on (and identification with) relationships. In the value system of individualism, to be a strong and healthy person is to be a unique individual, autonomous and able to enjoy the free pursuit of one's own private goals (Bellah et al, 1985). Care for others can be part of one's personal project, but the constraints of community must be minimized so that freedom can be maximized. Although American individualism has undergone historical changes— from the Puritan Biblical ideal, which emphasized the person's unique standing before God based on their strength of character and moral rectitude, to more utilitarian and neoliberal forms, in which individuality is expressed in terms of mobility and material consumption—the core values that place the individual over and above the group persist. Thus, from the perspective of individualism, recovery is expressed through the person's capacity to identify and pursue their own goals. Individuals are responsible for achieving and maintaining their own well-being. Functioning as an autonomous individual is the central value, and dependence on others is to be minimized except insofar as it is consistent with conventional norms. The values of individualism extend to the ways in which stories of recovery are constructed to emphasize the individual's efforts to achieve their own well-being. Autobiographical accounts of recovery in SMI, such as those by Deegan (1988) and West (2011), provide illustrative examples of such individualized narratives. The illustrative extract below is taken from a first-person account authored by Corinna West (2011, p. 445), a mental health peer worker in Kansas, and published in *Schizophrenia Bulletin*:

> *My recovery involved finding a way to maximize my strengths and move beyond my weaknesses, and active transportation, including walking, running, and bicycling, is an important element in my daily routine. Patricia Deegan, PhD, a psychologist who has also recovered from schizophrenia, has come up with a term called "personal medicine," which is what we do for ourselves. Pill medicine is what we take, and personal medicine is what we do, both how we stay well and the reasons we find for wanting to stay well. I have incorporated my art, my work, and my life, in a way where many of the things I do will enhance my recovery. I ride a bicycle everywhere I go and advocate for the 8.3% of Missouri households that have no access to an automobile. I use exercise as a positive coping tool for stress, I am out and involved in the community, and I have made a great group of friends and supporters who enjoy my per-*

sonality with or without mental illness. My plan, my power, and my way is to do what I can to be a positive, inspirational person who has immense potential to make the world a better place.

Despite expressions of community advocacy, the emphasis on "my art, my work, my life, my plan, my power, and my way" in this narrative is characteristic of individualism. In contrast to the individualistic concept of the person, many societies configure personhood in ways that have been termed collectivist, communitarian, or sociocentric. The sociocentric person construes the self largely in terms of relationship to others. The good person is then characterized by values of relatedness, and connectedness to family, lineage, clan, or community.

The notion of a self that is defined in relational terms is well articulated in many cultural concepts of the person throughout Africa, Asia, and indeed most parts of the world (Appiah, 2004; Bharati, 1985; Kitayama and Park, 2007). For example, traditional Chinese Confucian culture was sociocentric, including relationships with others in the definition of the person (Tu, 1985). The Chinese word for character or personality, *ren*, aptly captures this—a person with *ren* is fundamentally a social being who expresses self and personhood through a mature commitment to family or some larger social group. These metaphors situate the value of the self in its social embeddedness and connection to others, rather than in its detachment and inviolability as emphasized in the West. In sociocentric cultures, systems of healing typically involve rituals that engage the whole family, clan, or community. The healing intervention thus affirms the person's connectedness and aims to repair or reorder relationships with others. Recovery according to this view will be expressed primarily through the restitution and maintenance of social ties and the ability to contribute to the collective well-being of family and community. Narratives of recovery will then emphasize the role of family and others in enabling the afflicted person to realize his or her social personhood.

The contrast between individualist and collectivist orientations has been a key analytical framework in cross-cultural psychology. However, it paints culture with a broad brush and tends to overgeneralize differences between ethnocultural groups and ignore individual variation within each group. Moreover, there are other concepts of personhood that may influence illness experience, healing, and recovery. These include notions of the *ecocentric* self (oriented toward connections to the land and the environment) and what might be termed the *cosmocentric* self (connected to a larger world of departed ancestors and spirits) (Kirmayer, 2007). Each concept of personhood has its own modes of construing the self and other, specific values that characterize the ideal self, as well as ways of narrating stories of suffering, healing, and recovery.

The ecocentric self, which has been an aspect of personhood for many indigenous peoples, relates the individual to the environment as a physical place and active partner in human life (Kirmayer et al, 2008). According to this conceptual framework, people understand themselves to be in constant transaction and exchange with the environment. The notion of personhood then encompasses non-human persons, including animals and the elements, which have their own perspectives, motives, and agency (Gone and Kirmayer, 2010; Williamson and Kirmayer, 2010). For hunters, the salient actors in the environment include animals and other living creatures as well

as the forces of the natural world (Stairs, 1992; Stairs and Wenzel, 1992). In shamanism, a type of healing practice associated with hunting cultures, healers derive their powers from animal helpers, who allow the healer to restore the necessary balance and reciprocity between the afflicted person or the community and the natural world. Similarly, for agrarian peoples, the cycle of plant life is central to their sense of identity, and plants may provide medicines for healing. In both systems of healing, the natural world also provides models and metaphors for recovery, which may then be viewed not so much as a personal achievement but rather as a gift from these other-than-human beings. Thus, compared with the individualist or collectivist accounts of recovery, agency is displaced to a non-human order, with which humans must maintain good relations. The maintenance of reciprocity and respect is paramount.

Many cultural traditions view the person as embedded in a larger cosmic order, which may include ancestors, spirits or gods, and the forces of nature. For example, in Yoruba philosophy, the person is formed by the union of the *ara* (body), *emi* (mind/soul), and *ori* ("inner head"), each of which is brought into being by specific gods (Adeofe, 2004). Although the emi corresponds roughly to the Western notion of mind and soul, it has no personal characteristics. The individual's distinctive qualities and destiny come from the *ori*, which is viewed as a deity. Ongoing relationships with these deities give rise to individual personality, as well as both afflictions and healing. Similar notions of a cosmic agency contributing to personhood are found among many African peoples and groups, including the Tallensi, the Kallabari, the Lugbara, and the Taita, who all hold beliefs that ancestors play an active part in individual life, acting as moral guardians and enforcers of the social order (Paris, 1995; Kpanake, in press). The belief is that ancestors understand fully what is happening to the person and share his or her projects and preoccupations. The function of the ancestors as keepers and enforcers of the collective in African culture lends support to the conceptualization of the person as extending beyond the individual's boundaries and lifetime (Kpanake, in press). Healing practices associated with cosmocentric concepts of the person may employ methods of divination to determine what has gone wrong in the relationship with the gods on the part of the individual, family, clan, or community, and through this to identify the appropriate actions to propitiate (appease) the gods and restore the cosmic order. Recovery in such traditions is understood as restoring and living in harmony with a cosmic order. Human agency then centers on correcting the moral errors and infractions that have disturbed this order and resulted in the illness. This moral correction may in fact be carried out by people other than the afflicted person. Stories of recovery will then highlight their corrective actions and the subsequent positive response of the spirits.

These brief outlines of different forms of personhood represent ideal types that are never found in pure form (Hollan, 2010). In any real instance, different forms coexist and are used to guide action and make sense of experience in ways that depend on the social context. Each individual's experience involves an ongoing process of psychological and social negotiation between modes of autonomy and relatedness. Egocentric and sociocentric views may coexist in a variety of hybrid forms of "ensembled individualism" (Sampson, 1988). The embedding of the person in larger webs of relatedness with the environment and with the spirit world, characteristic of ecocen-

tric and cosmocentric views, respectively, frequently coexists in indigenous concepts of the person. Within every society, people may make use of different concepts of the person to interpret and respond to specific types of situations. Thus what is distinctive about any particular culture are the contexts in which specific concepts of the person are deployed. In the case of mental illness, this depends crucially on how the initial signs and symptoms of affliction are interpreted (Kirmayer et al, 2004; Saravanan et al, 2007a,b).

Concepts of mental illness and trajectories of recovery

In this section we provide two short vignettes to illustrate how different socio-cultural interpretations of mental illness influence the trajectory of recovery in people with SMI. The case examples are drawn from our research studies in Nigeria (Yoruba) and the USA (African-American). Details have been changed to protect the individuals' anonymity. Clinical Vignette 8.1 describes a patient who presented to the psychiatric department of the University of Ilorin Teaching Hospital, Ilorin, Nigeria, where Ademola Adeponle completed his psychiatric residency. Details have been changed to protect patient confidentiality. Clinical Vignette 8.2 describes a participant in Robert Whitley's ongoing "creating communities" project, an examination of recovery among a sample of predominantly African-American women in Washington, DC (Whitley, 2012).

Clinical Vignette 8.1

Olayemi

Olayemi is a 28-year-old single woman, Pentecostal Christian, who is a high school teacher in a city in south-western Nigeria. She was engaged to be married, and the wedding date had already been set, when her fiancé unexpectedly called off the engagement a few months prior to the wedding. Two months later, she presented to the psychiatric hospital with a psychotic episode characterized by auditory hallucinations, ideas of reference, delusions of being possessed by evil spirits, and excessive religiosity. Additional history revealed that she had been engaged twice previously, and both relationships had ended abruptly with the partner calling off the engagement. She was the only child of parents who had separated when she was 2 years old, and she had been raised by her mother, who was a teacher and school principal. Her mother had remarried one year after separating from Olayemi's father. Olayemi had not had any contact with her father or his family since the separation when she was 2 years of age, although he lived in a town around 200 km away.

At the time of onset of illness Olayemi was taken to Pentecostal Christian prayer houses in the belief that the problem was demonic possession. When her condition did not improve she was brought to the psychiatric hospital. She was admitted and started on antipsychotic medication, and by the third week of hospitalization she had stabilized.

At time of the onset of her illness, her relatives also consulted an *Ifa* priest of the Yoruba religion to help to ascertain the cause of the schism in cosmic harmony of the *ara* (body), *emi* (mind/soul), and *ori* ("inner head"), and be informed of the rites or propitiations that needed to be made to departed ancestors and to personal and family deities who help to restore harmony. As part of the prescription given by the *Ifa* priest, the patient had to perform some rites in her

paternal ancestral home as propitiation to the spirit of her paternal grandmother, who apparently had died a heartbroken woman because she had been denied a part in the upbringing of Olayemi, her first grandchild. The grandmother died a few months after the parental separation, saddened at the failure of her son's marriage and at losing her grandchild. According to *Ifa*, Olayemi's troubles were traceable to the patient's *ori* being prevented from reaching its true destiny by the spirit of the departed grandmother, and by paternal ancestral deities who were unhappy that her age-group initiation rites had yet to be performed. Her relationship failures and eventual mental breakdown were attributed to these cosmic events. Recovery ("cure" in this case) involved addressing the cosmic by performing rites and propitiations to "wash" (reset) her *ori*. The rites to the grandmother involved both the patient and her parents, while the age-group initiation ceremonies involved the patient, her mother, and womenfolk in her paternal extended family. These rites and ceremonies were performed over the period of 6 months to 1 year following her discharge from hospital. During this period Olayemi established a relationship with her father and her paternal relatives, attending family and social events in which they were involved. At the last clinic visit, around 18 months after discharge from hospital, she intimated to the doctor that there was a new man in her life, that she had met his family and he had met her parents, and she was happy.

Although psychiatric hospitalization and treatment with medication played a role in the reduction of her symptoms, the involvement of traditional healing was central to Olayemi's recovery. The diviner located Olayemi's affliction in a web of relationships and prescribed ritual actions that led to changes in her relationships with her estranged father and extended family as well as with her deceased grandmother. Crucial dimensions of recovery occurred on both the horizontal plane of family and communal relationships and the vertical plane of relationships with ancestors. Recovery means being able to live in a proper relationship with one's ancestors as well as with family, the larger clan, and community. This in turn makes possible a fulfilling life lived in ongoing connection with others.

Clinical Vignette 8.2

Latoya

Latoya is an African-American woman in her thirties. She was raised in Virginia by her highly religious mother, but moved to Washington DC in her late teens, where she has lived ever since. She states that she "got involved with the wrong guy and the wrong crowd" in her early twenties. She became a victim of sexual and physical abuse, and began taking crack-cocaine and drinking heavily. She did not have a home of her own, and would sleep wherever she was welcome, including at hostels, with friends, and at her boyfriend's house. Due to financial problems, she also became involved in prostitution in her twenties. She states that she had a "mental breakdown" as a consequence of this lifestyle and was hospitalized. On discharge, she returned to the familiar life of homelessness, prostitution, substance abuse, and dysfunctional romantic relationships, cycling in and out of mental hospital, prison, and homeless shelters. She had by now borne two children, who she rarely saw and who were in the custody of relatives. During this time she received minimal care from community mental health services and was constantly living "on the edge".

Latoya eventually started to receive intensive concurrent treatment (for addictions and mental health problems) from a community mental health agency, which also offered her counseling, vocational rehabilitation services, and the possibility of secure housing. She also received social, emotional, and instrumental support from members of a local church, which she started to attend. Being involved in these two organizations gave Latoya a renewed sense of hope and

belonging. With their help she eventually gave up drink and drugs, and availed herself of the vocational rehabilitation service, which led to a part-time job in retail sales. She also accepted an offer of secure independent housing, and settled in a one-bedroom apartment. In talking about her recovery, Latoya notes the difference between the chaotic world of drink, drugs, and untreated psychiatric illness, and the ordered world of abstinence, secure housing, and regular social support. When asked what recovery means to her she states:

> *Well, now I can deal with day-to-day issues. Like your job, your family, your kids, and your bills. Anything that comes with living like normal people live. I just kind of got to get back in the swing of living like that, because for so many years I didn't pay no bills, I didn't deal with my kids, I didn't deal with my family. So all these issues … now there is no fighting, no confusion, it's quiet. … I am doing the next right thing, going to meetings and connecting with people, being honest and compassionate. I just feel free from all the chaos. And I feel like a human being getting back into society again. Because you know, when you're in that lifestyle, you're just kind of in your own world. Nothing matters but you. So that's what it means to me. I try to give peace and I try to receive peace.*

In her recovery narrative, Latoya asserts traditional notions of recovery. She mentions work and "living like normal people live". However, she also mentions factors which are often absent from common definitions of recovery. These include connecting with family (and especially children), being "honest and compassionate", and trying "to give peace". Recovery to her means living a new ethic of compassion and altruism (based on Judeo-Christian values), as much as functional improvement in domains such as employment or housing. These ethical (and religious) dimensions of recovery have been raised before by African-American participants in recovery research (Whitley, 2012). Recovery to Latoya also means the *absence* of certain factors in her life, rather than the presence of new "recovered" factors. Recovery means "no fighting, no confusion", difficulties that she encountered frequently in the tough inner-city milieu which she used to inhabit. The quiet life was indicative of recovery, again something rarely alluded to in Euro-American notions of recovery.

Implications of a cultural perspective for recovery

Euro-American notions of the person are implicit in psychiatric nosology and influence decision making in everyday clinical practice (Gaines, 1992; Kirmayer, 2002). Current notions of recovery and consumer-oriented views of "being in recovery" are also built on the Euro-American individualist and egocentric concept of the person, as well as on the values of neoliberal capitalism. The two clinical vignettes described above show that such notions may be less important for other ethnocultural groups, who may instead value altruism, social and familial connections, and embeddedness in a wider community as better indicators (and manifestations) of recovery. 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 for understanding individuals' illness trajectories, modes of adaptation, preference for and response to common recovery interventions, and definitions of positive outcome. For example, although "independent living" may be a worthy goal for people with SMI in the USA who subscribe to a rugged individualistic ethos, others may prefer the communal

atmosphere of congregate housing or emphasize maintaining interdependent relationships with extended family. Indeed, in some cultural contexts, such as Hong Kong, it is expected that adult children will live with their parents until marriage, and accommodation is expensive (and there is no social housing), so "independent living" is only the privilege of the elite. In this way, structure and culture interact to narrow the horizon of possibilities, which in turn fashions a sense of agency. This relationship between structure, culture, and agency has a heavy influence on what is possible and what is desirable vis-à-vis recovery processes and outcomes, and this will vary according to place, culture, and societal configuration.

These concerns are highlighted in the study by Lavallee and Poole (2010) of Aboriginal perspectives on recovery as shared in the stories of clients attending an Aboriginal Friendship Center in Toronto. While acknowledging the role of white racism in the relative lack of participation of Aboriginal people in the Canadian recovery movement, Lavallee and Poole (2010) note the inadequacy of some contemporary views of recovery to address Aboriginal experience. For many Aboriginal people, notions of mental illness are entwined with recovery from the impact of colonialism, historical trauma and loss, and the legacy of the Indian Residential School system with its policies of cultural suppression and forced assimilation (Kirmayer and Valaskakis, 2008). A focus on integrative health or holism may be more central to many Aboriginal traditions. In pan-Indian spirituality, this is often conceptualized in terms of teachings about the Medicine Wheel, which hold that health and well-being depend on a balance between four interconnected realms—the physical, mental, emotional, and spiritual. Aboriginal peoples in Canada have favored a language of well-being rather than recovery, but many have been influenced by AA or other 12-step programs and use the notion of a healing journey as a process in much the same way as "being in recovery" (Waldram, 2008). Other key domains in Aboriginal conceptions of healing relevant to recovery identified by Lavallee and Poole (2010) include concern with transgenerational connectedness and continuity of identity and community, restoring and reclaiming Aboriginal identities that were denigrated and suppressed by processes of colonization and dispossession, and combating the social and self-stigma and discrimination associated with Aboriginal identity. In an account that clearly diverges from the emphases of individualistic, Euro-American notions of recovery, Lavallee and Poole (2010, p. 275) assert that:

> *Ill health, including what the West calls mental ill health, is a symptom of the attack on cultural identity [of Aboriginal peoples]. Treating the symptoms of ill health, including addiction and mental health, is a band-aid solution that does not treat the root causes—colonization and identity disruption. If one recognizes that the assault on cultural identity has played a significant role in the ill health of Indigenous people and that the spirit has been wounded, then healing activities need to include rebuilding the individual and collective identity of Indigenous peoples.*

Thus, for many indigenous peoples, current notions of mental health recovery are limited or reductionist, failing to take into account the historical and socio-political origins of despair that have made recovery difficult for Aboriginal peoples, as well as ignoring or minimizing present-day structural barriers that impede participation and

acceptance in the wider community. Delivering on the recovery vision of a full life in the community will require the addressing of these social, structural, political, and economic dimensions of suffering that affect the life course and outcomes of Aboriginal people with mental disorders.

The importance of reframing recovery in terms of cultural contexts and values, clearly articulated for Aboriginal peoples in Canada, also applies to other ethnocultural communities. For example, in a study of responses to mental health services among African-American, Latino, and Euro-American inner-city residents in Hartford, Connecticut who had been diagnosed with SMI, Carpenter-Song et al (2010) found that, compared with Euro-American respondents, African-American and Latino participants were deeply embedded in networks involving family and friends that emphasized non-biomedical interpretations and explanations of behavioral, emotional, and cognitive problems. Psychiatric stigma was not a core theme in the narratives of Euro-Americans, whereas stigma was central for African-American participants, who considered SMI to constitute private "family business." For Latino participants, the cultural category of *nervios*, with which they were labeled, appeared to carry little stigma, whereas psychiatric diagnostic labels, and the use of mental health services, were seen as damaging to their social identity. Similar issues were identified by Whitley and Lawson (2010) in a review of research on the experience of African Americans in psychiatric rehabilitation. The review found five factors that probably contribute to lower rates of utilization and satisfaction with mental health services:

1. cross-cultural communication barriers that create distrust between service providers and the African-American community
2. African-American people holding explanatory models that frame their suffering as a moral or religious problem rather than as a medical or psychiatric one
3. community perceptions that services are discriminatory, with consequent mistrust of service providers' motives
4. psychiatric stigma
5. lack of family involvement, which is discouraged in US care delivery systems that remain firmly individualist in orientation.

Addressing these issues would require cultural competence training for service providers, opening services to alternative world views and practices outside the Euro-American mainstream, development of a more ethnically diverse pool of service providers, engagement with African-American community organizations to combat stigma, and close collaboration with families as a therapeutic strategy.

Recovery in global mental health: the context of low- and medium-income countries

The recovery movement emerged in wealthy countries of the West. Findings of a better course and outcome for people with SMI in some other countries raise questions about the cross-cultural applicability of recovery views. In addition to cultural differences, many countries face challenges with regard to the implementation of conventional mental health service strategies, due to lack of economic resources and infrastructure.

At the same time, the recovery movement may have much to learn from the experience of resilient individuals and communities across the globe.

In low-income and middle-income countries (LMICs), there is a huge gap between the mental health needs of the population and the available services, with less than 1% of national health expenditure allocated to mental health services in some countries (Kleinman, 2009). In LMICs, mental disorders account for about 11% of the total burden of disease, and contribute to the risk of other major public health concerns, such as maternal and child illness and HIV/AIDS. Related to these issues, key social determinants of mental disorders in LMICs include poverty, low levels of education, social exclusion, gender inequality, armed conflict, and disasters (Patel, 2007). In addition to the scarcity of economic resources, LMICs also face problems of grossly inadequate human resources and infrastructure for mental healthcare, and absent or outdated mental health policy and legislation, especially in Africa and South-East Asia (Jacob et al, 2007; Miller, 2006).

The majority of people with mental disorders in LMICs do not have access to effective interventions, or are unable to access psychiatric care in a timely fashion, resulting in illness persistence, suffering, poverty, and homelessness. The other major toll is increased costs of care, placing huge emotional and financial burdens on families (Patel, 2007; Miller, 2006). Often, because community and follow-up services are absent or non-existent, services must rely on families as agents of continuing care outside of the hospital (Adeponle et al, 2009). Although this may be culturally compatible and desirable, it puts further strain on families with limited resources.

Psychiatric stigma is another major issue that hinders effective and adequate delivery of mental health services in LMICs. At the institutional level of governmental decision making, the impact of such negative attitudes toward mental illness is seen in the low priority accorded to mental health services in resource allocation, despite evidence that investing in treatment of an illness such as major depression has benefits comparable to the treatment of illnesses such as diabetes and hypertension, which have received support (Miller, 2006). In part, this reflects a pessimistic view of the value of treatment of mental illness. Indeed, in African countries "policy-makers are often of the opinion that mental illness is largely incurable or, at any rate, unresponsive to orthodox medical practices" (Gureje and Alem, 2000), and there is little indication that attitudes have changed significantly in the past decade. At the individual level, stigma often follows from societal attitudes that have been strongly influenced by lay beliefs about illness causation, and in many LMICs, beliefs in supernatural causation of mental illness may result in unhelpful or health-damaging societal responses, reluctance or delay in seeking appropriate care, and are a leading cause of service disengagement and discontinuation of care (Adeponle et al, 2008).

Another prominent feature of mental health services organization in many LMICs is the plurality of mental healthcare providers, from traditional healing practices and religious healing, to more cosmopolitan "New Age" practitioners. In Nigeria, for example, alternative practitioners, traditional and religious healers, medicine men, and spiritualists are ubiquitous and attend to the mental health needs of 70% of the population (Ayonrinde et al, 2004). The illness explanatory models of alternative practitioners tend to coincide with lay and popular explanations, and their treatments and

expectations for recovery may be consistent with local cultural views. In some LMICs, traditional healing systems receive state recognition and support. A case in point is India, where Ayurvedic practitioners enjoy widespread official recognition. However, in other LMICs, alternative practitioners do not have state recognition, and fierce rivalries exist between traditional and Western medicine practitioners, with patients caught in between and often unable to gain maximum benefit from either system of care. The diversity of healing systems may allow individuals to find a fit with their needs and expectations (Halliburton, 2004). At the same time, traditional healing systems may have undesirable effects, conferring stigma and negative expectations and undermining recovery.

For many policy makers and advocates in LMICs, ensuring delivery of basic mental healthcare is of more pressing concern than refining the system to support recovery. Nevertheless, there are wide variations across LMICs both in the quality of mental health services and in the level of engagement with the community (Jacob et al, 2007). In some settings, a version of the consumer-driven mental health recovery approach that is dominant in the Western world may have an important role to play. More broadly, mental health services provision in LMICs can learn from the focus in the recovery movement to guarantee full citizenship and civil rights for individuals with mental illness (Ware et al, 2007). This includes the right to participate in the choice of treatments and interventions. All too often service providers use the excuse that "any kind of service provision is better than none" to sanction treatment practices that undermine individual rights and empowerment. Having policies in place that guarantee patients' rights, and empowering their implementation, would minimize such authoritarian practices, and serve as a basis and stimulus for self-advocacy by people living with mental illness in these countries.

The recovery movement may also have something important to learn from the experience of people with SMI in LMICs. The finding of better outcomes for people with schizophrenia in some LMICs, as compared with the developed world, in WHO longitudinal studies may help us to learn what processes operating in the social environment may influence recovery (Myers, 2010). Along with efforts to improve service delivery in LMICs (Patel et al, 2006), our understanding of processes of recovery can be advanced by cross-cultural longitudinal studies that employ current clinical, epidemiological, and ethnographic methods.

Conclusion

Although framed in the universalist language of human rights, recovery is rooted in specific Euro-American concepts of self and personhood. The US 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. However, in other cultures, sociocentric, ecocentric, or cosmocentric conceptions of personhood may have greater salience. These differing cultural concepts of the person may influence trajectories of illness, modes of adaptation, treatment preferences, responses to interventions, and definitions of positive outcome. In particular, cultural notions of the person influence the importance that is given to connections to family,

community, and spirituality as key dimensions of recovery for diverse cultural groups.

Current notions of recovery had their origins in civil rights and independent living movements in the USA, and arose in part as a reaction to perceived attitudes of pessimism and paternalism inherent in conventional psychiatric care. The notion of recovery helps to envision a reassertion of the rights of individuals with mental illness to live a dignified and meaningful life in the community, and to have a renewed sense of agency, with an active say in the direction of their own healthcare. These are humane, ethical values with broad appeal that can reorient and support the delivery of services both in wealthy societies and in low- and middle-income countries. For this vision to be realized, recovery requires careful consideration of social context and cultural systems of value and meaning. The values of recovery can only be translated into meaningful practices if attention is given to the local contexts and values that define healthy and fulfilling life goals, roles, and trajectories. At the same time, like other elements of human rights discourse in relation to mental health, recovery holds the promise of raising awareness of what is possible for individuals with SMI, and of challenging oppressive social structures, therapeutic nihilism, and limiting expectations. With sufficient attention to social, cultural, and political contexts, the recovery movement can deliver on its promise of a full life in the community for individuals with SMI.

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