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Reaching Self-Acceptance: The Experience of Individuals with Mental Illness of the Road to Recovery

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Abstract

Objective: When dealing with mental illness, the perspective on the problem can be a deciding factor in finding solutions.

Methods: In this phenomenological study, 17 individuals with mental illness were interviewed about their experience of mental illness and the road to recovery.

Results: Traumas were the beginning of their mental illness such as violence, separation, loss, bullying and long-term stress. The consequences of the traumas lead to impaired quality of life including personality changes, loss of self-esteem, loss of dreams, dysfunction, self-injurious behaviour, and suicide attempts. The recovery process was different between participants but reaching self-acceptance was the aim on their journey. The participants emphasized the outer resources which helped them recover such as: support from peers and positive health professionals, medications, having activities, tasks, and responsibilities; as well as inner resources such as positive attitude, knowledge about mental illness and self-awareness, dreams, goals, and hope. Each participant's recovery was a personal journey. However, most participants spoke about recovery as reaching self-acceptance. This involved just daring to be yourself with all your flaws and strengths, being comfortable in your own skin, the ability to participate in life, to have some quality of life, taking responsibility for your own life and health, and to have more balance in illness symptoms.

Conclusion: The study findings emphasize the importance of addressing mental health services in line with the aim of the client in an integrative and holistic manner and that when defining the recovery concept, it is necessary to make meaning of consumer experiences.

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Introduction

When dealing with mental illness, the perspective on the problem can be a deciding factor in finding solutions [1,2]. A common view is that mental illness is a biomedical condition, where disfunction of the brain is the cause. The biopsychosocial view surfaced in the 1970s and has become widespread [3]. Regrettably, as some have pointed out, the bio psycho-social view very easily becomes the "biobiobio" view on mental illness [4,5]. All the evidence we have, points to the fact that biomedical etiology should only be seen as a part of the cause and that it is necessary to consider, for example, social, cultural, and financial factors and their effects on the etiology of mental illness and the journey of recovery that then follows [6,7]. Clearly mental health and illness are related to inner and outer factors, and vice versa [8,9,2,10] and it is often hard to distinguish between cause and effect [11,12,10].

Mental illness affects around 38% of all the European Union's population (EU) every year. It is assumed that around 50% of the people living in the EU countries (65 years and younger) will be affected by some form of mental illness in their lifetime [13]. Anyone can find themselves developing a mental illness, but there are certain groups that are more vulnerable to it, such as trauma-inflicted individuals, people with long-term illness, convicts, those experiencing substance use disorders and those living in poverty [10]. Mental illness can diminish quality of life and decrease life expectancy [14,10] and cause stigma that can have serious adverse effects on individuals and their support systems [15,10].

The purpose of this study was to explore mental illness and the road to recovery of individuals with mental illness. The research question was: what is the experience of mental illness and the road to recovery from the perspective of individuals with diagnosed mental illness?

Materials and Methods

We used the Vancouver-School of doing phenomenology to answer the research question. It is a qualitative methodology based on the works of Spiegelberg (phenomenology), Ricoeur (hermeneutic phenomenology), and Schwandt (constructivism), with the aim of increasing knowledge and understanding of human phenomena for improving human services, such as healthcare or social services [16]. The Vancouver School is based on the philosophy of holism and existential psychology, as well as on the premise that reality is individually constructed because of lived experience. Conducting a study within the Vancouver-School usually involves speaking to 5 to 15 people or conducting at least 15 interviews. In this study, interviews were conducted with 17 participants. The first author, and primary researcher, conducted all the interviews. In the Vancouver-School participants become co-researchers and saturation was sought through dialogue until a clear picture of the phenomenon was obtained and the research question could be answered [16].

Participants

Purposive sampling was used through the help of employees of two different mental-health clubhouses. Participants were 17 individuals with mental illness, ten women and seven men. Their age-range was 27-64 years and mean age was 41 years. Participants had various mental illness diagnoses, and all but two participants had two or more diagnoses, including: anxiety disorder, depression, social-anxiety disorder, ADHD, bipolar disease, schizophrenia, dysthymia, OCD, PTSD, and substance use disorders. All but one participant, who was a fulltime student, were on disability pension or physiotherapy pension at the time of the study. Two of the participants had part-time jobs and eight were part time students.

Data collection and analysis

In the Vancouver-School the research process is divided into twelve steps **(Table 1)** and within each of them the researcher goes through the cognitive processes of silence, reflection, identification, selection, interpretation, construction, and verification **(Figure 1)**. Data was collected through semi-structured, in-depth, interviews, one with each participant. The interviews ranged from 43-112 minutes, with a median of 70 minutes. One interview was conducted through a secure online program, but all the others were face-to-face interviews. The interviews were recorded and transcribed verbatim, also noting non-verbal expressions. The method is based on analysis of individual cases (steps 1-7) and then an inter-cases analysis and comparison (steps 8-12). The results are extracted from the text (deconstruction) and then assembled into a single overall presentation of the results (reconstruction). To this end, researchers need to use abstract thought processes, especially reasoning, intuition, and introspection. Data saturation was achieved when enough data had been gathered so that the research question could be answered as deemed by all three researchers.

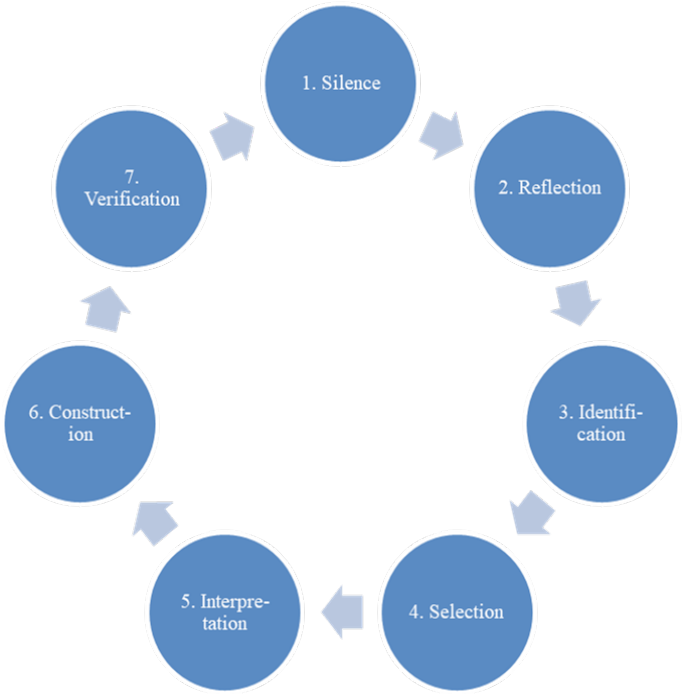

Figure 1: The process of doing phenomenology in the Vancouver School [Modified figure from Halldorsdottir, S. (2000) p. 56. Used with permission]. This cycle is repeated in every of the 12 steps of the Vancouver School.

Table 1: Steps in the research process described.

STEPS	ACTION	DESCRIPTION
STEP 1	*Selection of participants-* ***The sample***	The research question of the study, „what is the experience of the road to recovery from the perspective of individuals with diagnosed mental illness?“ guided the selection of the sample. Purposive sampling was used and 17 participants selected who had been diagnosed with mental illness.
STEP 2	*Preparation of the mind –* ***Making pre-conceived ideas visible***	Phenomenology begins in silence. Researchers paused and thought about their pre-understanding of the phenomenon. In the Vancouver School it is recommended that researchers write down their pre-conceived ideas to make them more visible. This was done.
STEP 3	*Participation in dialogues –* ***Data collection***	The first author, who conducted all the interviews, tried to maintain an open mind and stay in 'the now' during the interviews, being ready to hear something new. The first interview began with the main interview question, "Can you tell me about your personal experience of the road to recovery?" Then follow-up open questions were asked depending upon each participant's answers. The interviews took place where the participants wanted and took 43– 112 minutes, on average about 70 minutes. The interviews were recorded and after each interview, data processing began by writing it verbatim on a computer, after which transcripts were sent to a locked and access-controlled area. Care was taken not to include information about events, names of people or anything else that could identify the participants.
STEP 4	*Sharpened awareness of ideas and concepts -* ***Beginning data analysis***	As soon as an interview began, the data analysis began and continued throughout the data collection period. However, once all the interviews had been word processed, an analysis of the transcripts (written conversations) formally began. At first, the text was read carefully, without marking, to get a good sense of the content. Then the text was read several times over again and items marked that were considered part of answering the research question.
STEP 5	*Individual case analysis–* ***Individual theme analysis***	The transcripts from the interviews conducted with each participant were read repeatedly to begin to construct the essential structure of the phenomenon according to each participant. Markings were made into the transcripts regarding what was important considering the research question.
STEP 6	*Findings developed for each participant –* ***Case study findings***	After the thematic analysis of individual cases, an overview was constructed for each participant. The case-study findings differed for each participant, but care was taken that they were fully consistent with the experience of that participant and the relevant research data. The process of steps 1 to 6 is essentially as working on individual case-studies.
STEP 7	*Confirmation of the findings with each participant –* ***Verification I***	After the case-study findings had been constructed for each participant, they were verified with each one of them. Each participant received this overview of the individual case-construction, for review and approval. This is not only important for participants, but also to be sure that the story of every participants has been understood correctly. Individual verification of the findings fine-tuned the individual case constructions.
STEP 8	*The essential structure of the phenomenon –* ***The overall study findings***	When the findings had been constructed for each participant, researchers constructed the overall findings. In this step, it is important to ask again and again what the essential structure of the phenomenon itself is after repeatedly reviewing the individual case-study findings. The first author constructed the first draft of the essential structure of the phenomenon from all the individual case constructions and then the two other researchers joined in this data analysis work. Finally, all three authors worked together to refine the essential structure of the phenomenon.
STEP 9	*The findings compared to the data –* ***Verification II***	Once the results had been constructed, they were compared to the transcripts for confirmation to see if consistency existed. In this step, a good time was taken for reflection and comparison of transcripts and the results. This step was used to fine-tune the overall findings.
STEP 10	*Constructing the overall theme of the study –* ***Constructing the essence of the phenomenon***	In this step, the research findings must be carefully considered, and the essence of the phenomenon found. This includes finding the name of the study that best describes the phenomenon. The name of the study is: " *Reaching self-acceptance*", which describes the essence of the participants' experience of the journey on the road to recovery. It denotes their aim to be comfortable in their own skin.
STEP 11	*Confirmation of the overall results with some participants –* ***Verification III***	It is necessary to verify the results with some of the participants. In the Vancouver-School only a few participants (2-3) are required to verify the overall findings. The primary researcher verified the overall results with two of the participants, both of whom were satisfied with the results and verified them.
STEP 12	*Multi-voiced reconstruction -****Writing the results***	Care was taken that the voice of all participants was included in the writing of the results so that the text would be multi-voiced. Researchers tried to put the most important evidence from the data in the results that best described the phenomenon from the perspective of the participants and thus answered the research question.

Ethical considerations

Before data collection, IRB permission was obtained from the National Bioethics Committee (VS-16-162), and the study was reported to the Icelandic Data Protection Authority. The four main ethical principles of autonomy, nonmaleficence, beneficence and justice were emphasized in all aspects of the study and the participants of the study were given an introductory letter where the study was thoroughly introduced. All participants signed an informed consent prior to their participation, and all were given pseudonyms for the purposes of the study. All participants were informed that they could stop participation at any time without any consequences. Due to the sensitivity of the research topic, participants were given access to a psychotherapist for support if needed after the interviews. No one used that. Full anonymity was maintained throughout the study.

Results

The overarching theme of the study is *reaching self-acceptance* which is descriptive of the mindset that most participants were seeking on their road to recovery. Recovery was seen

differently between participants and their resources were entwined with the recovery process. Reaching self-acceptance also entails being accepting of one's own body, being able to protect oneself from negativity, and believing in oneself. This was very evident when participants were asked to describe their view on mental health. Twelve participants talked about, in one way or another, that being mentally healthy was being able to be true to oneself and being "self-accepting". This view was also pronounced when discussing different coping mechanisms or resources. Participants often articulated the idea that having a negative outlook impeded their recovery. When participants spoke of support as a resource, they talked of relationships built on the foundation of mutual respect and acceptance where participants could be themselves. Self-acceptance and recovery were mentioned by eight participants, where a positive outlook towards oneself and life in general was deemed important. An overview of the study findings is to be found in **Figure 2**.

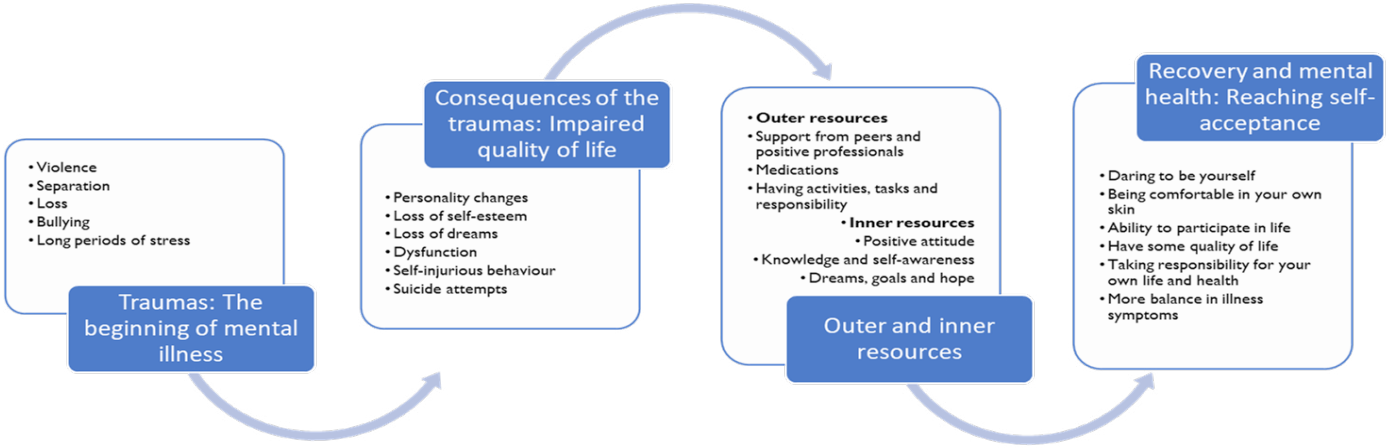

Figure 2: Overview of the study findings: Reaching self-acceptance on the road to recovery.

Participants spoke broadly about mental illness, recovery, and their experience with resources. What stood out was the diversity in the ways they used to obtain and maintain recovery from mental illness. Participants had many things in common, but it was obvious that each one of them was on their own personal road to recovery and used many ways to deal with the changed world view that accompanied their illness. Their resources were diverse and on a broad spectrum of inner to outer factors, from complicated to simple paths.

Trauma: The beginning of mental illness

Tracing the beginning of their illness, most participants went back to their childhood or adolescent years. Only two participants reported their illness starting after reaching adulthood. Out of the 17 participants, 13 shared experiences of trauma and/or of stress before the onset of their illnesses, or as a triggering factor for worsening of symptoms. These experiences included violence, separation, loss of loved ones, bullying and/or long periods of stress.

Consequences of the traumas: Impaired quality of life

Participants discussed the consequences of their traumas which were essentially *impaired quality of life*. The emotional and mental health consequences that participants mentioned were, for example, personality changes, loss of self-esteem, loss of dreams, dysfunction, and diminished will to live, characterized by suicidal thoughts and despair, self-injurious behavior, and suicide attempts. Other consequences that negatively affected their quality of life were anxiety, psychological distress, grief, loneliness, low emotional stamina, discouragement, pessimism, anger, and emotional numbness, problems focusing, procrastination, forgetfulness, difficulty with attaining jobs and learning issues, relationship problems, dysfunction, and self-prejudice. Olive for example talked about the impairment that accompanied her illness: „The misery and this, this great darkness that was just, darker than darkness, that you, you know... it was so tremendously limiting and paralyzing."

Mental illness is often accompanied with physical symptoms. The symptoms the participants mentioned included sleep problems and physical distress, such as unexplained pain, chronic pain, stomach aches, and vomiting.

Negative coping mechanisms were something that some of the participants turned to and included compulsive behaviors (to gain a sense of control), substance abuse, self-harm, food addiction, and extensive use of computers and television.

Outer and inner resources for healing

Participants resources for healing included *outer resources* such as support from peers and positive professionals, medication, having activities, tasks, and responsibility; and *inner resources* such as the importance of a positive attitude, knowledge, self-awareness, dreams, goals and hope.

Support from peers and positive professionals

All participants talked about the importance of support regarding their recovery emphasizing the importance of human interactions and social relations. It was for many seen as their most important resource. Support came in many forms. However, support from peers and positive professionals were most important.

Social relations were a strong positive factor for the participants. Where and how they were sought out varied between participants, but all were of great significance for their mental health. Social isolation was a problem many experienced, especially during periods of illness. Cultivating social relations was an aid, but more importantly was that those relations were on positive and supportive terms for the participants. Some participants had support from their families, but not all had a positive experience of that kind of support. According to the participants a lack of understanding of their mental illness from family members was the main limiting factor. As Frederic said: „There was a great lack of knowledge within the family when I started getting sick... ... but now, they understand. That there are some

things that I am not capable of doing."

Peer interaction was sought out by all participants within different settings such as various group therapies, 12 step groups, clubhouses, and in centers for violence survivors. In these places, participants often found a sense of safety and empathy that they didn't always find elsewhere. Fifteen of the seventeen participants attended clubhouses on a regular basis. There they experienced an atmosphere of love, understanding and equality. Most participants were active in the clubhouse programs, which for many was an empowering experience. Role models also played a big part, both having them and being one. Katy said about her experience of the clubhouse she frequented:

It´s speaking the same language. … I have always felt … always felt out of place, because … I am not on the same level as healthy people. … And when you come into a group of people like these, that are … dealing with the same, same as you. And have a similar life experience. … then you just (sighs). Wow! Yes!

All participants had sought professional help on their road to recovery. All but one participant spoke of having used the service of psychologists, and nine participants of psychiatrists. Other health professionals were mentioned but to a much lesser extent. It was very different among the participants how and if these professionals were helpful. Those participants that spoke of professionals as a positive component in their recovery, said that personal connection, being equal, having trust, and understanding were the deciding factors. Jo talked of her relationship with her psychiatrist:

And I tell him everything. … you express yourself and he understands. … I don't take on the role of a patient. I just.. we are equals and I tell him if I need something … because, you know, he is of course there to be of service to me.

Medications

All participants but one talked about taking, or having taken, some sort of psychotropic medication. Of those participants four were completely off psychotropic medication at the time of the interview. Participants' experience of psychotropic medications varied a great deal. The discussion around medication intake was mostly about the experimentation that it involved, number of medications, side effects, and usefulness. Finding the right medication was considered troublesome by many with side effects and lack of effectiveness often being mentioned. Four participants spoke particularly of medications as an important resource in their road to recovery and of how much they improved their quality of life. Carl said: „I have stopped taking medication in the past and I will never stop taking them again ... I went right back to my old symptoms once I stopped taking them."

Having activities, tasks, and responsibility

Most participants spoke of the importance of being active and having tasks and responsibilities. It was different among the participants how these factors emerged. For example, six participants mentioned routine as a big factor in keeping them active. Finishing projects, big or small, increased self-confidence and feelings of empowerment and hobbies played a big part for some participants and gave more value to life. Sadie talked about the importance of expanding her comfort zone when it came to activities and responsibility: „I am always like... trying a little bit more myself ... facing my fears a bit more ... trying to enlarge the tasks I take on ... and I am trying to, just, to do these tasks myself." For some, taking responsibility also meant taking care of their basic needs, such as nourishment, rest, and exercise, or as Jo said: "this is of course a cliché, but … it is important for me to stay active and to eat healthy."

Inner resources

The inner resources of the participants included having *positive attitude, knowledge, self-awareness, dreams, goals, and hope*.

The attitude and views of the participants had a lot to do with their recovery process. All participants talked of this factor in one way or another. It was important *to choose a positive, constructive attitude*, regarding oneself and all that life had to offer. It entailed factors such as taking responsibility for one's own recovery, self-love, perseverance, and positivity. Eleven of the participants had, for example, been through cognitive behavioral therapy (CBT) to be better able to deal with many of their thought problems and attitudes. Six of them talked of CBT as being a useful tool. Eight participants mentioned mindfulness as an important resource and helpful tool. It helped them with dealing with stress, increasing stability, and enhancing awareness of thoughts and emotions.

Knowledge and self-awareness were a resource that seven participants spoke of; how empowering it was to know oneself, the illness, and what solutions were out there and available. Olive said:

"…but now, after I got sick, I am so aware of myself. … I have read a lot regarding my [illness]... I of course know all this firsthand. ... I keep a close eye on myself. To be informed and just, about my illness and symptoms and, also what makes my illness worse."

Many participants talked about the importance of having *dreams and goals*, as well as the importance of *hope*. Often, it was the little achievements that were important and supported recovery. Dreams, goals, and hope were connected, but hope was the force pushing participants forward on their road to recovery. As Anna said:

I think that even when you are in that hopeless place, that trying… to hold on to your dream. It can of course change, like, its execution, on the way … I feel that it is a key factor that … that this hope and faith that your future dreams will be.

Recovery and mental health: Reaching self-acceptance

Each participant's recovery was a personal journey. However, most participants spoke about recovery as reaching self-acceptance. This involved just *daring to be yourself* with all your flaws and strengths and being comfortable in your own skin and the ability to *„participate in life* ", as Karl said, and doing so. This also involved having some quality of life and taking responsibility for your own life and health. For some this meant keeping up social relationships, and for others caring for their family, and/or taking responsibility for their own recovery. Here, the concept of attitude and views appeared again, where recovery had to do with how life and the self was viewed, but positivity was an important factor. Some participants talked about recovery being related to *more balance in illness symptoms*. It was not necessarily important to be symptom free or that every day would be a "great day". If we look at Julius´ outlook on recovery, it reflects the view of many participants: "For me it is really just... recovery as such is just being able to have some kind of quality of life... ... and the more days you have quality of life ...

the better you feel." When discussing what mental health entailed, different opinions emerged. Four participants said that no one was completely mentally healthy. Five others said that it was possible to be mentally healthy, regardless of a mental illness diagnosis.

Twelve of the 17 participants talked about being true to oneself/self-accepting as a part of mental health. To be „comfortable in your own skin" as Carl said. Seven participants talked about taking responsibility as part of their mental health. It involved taking care of yourself, your health and seeking solutions to your life's problems. Most of the participants spoke of balance as mental health; being able to deal with life on life´s terms and having control over your own life.

Discussion

The study's main theme is *reaching self-acceptance* and is descriptive of the mindset that most participants were seeking on their road to recovery. A dictionary definition [17] of self-acceptance is „the act or state of understanding and recognizing one's own abilities and limitations." It also entails being accepting of your own body, being able to protect yourself from negativity, and believing in yourself i.e., to realize, appreciate, and develop positive emotions and thoughts towards yourself [18]. This was very evident when participants were asked to describe their view on *mental health*. Twelve participants talked about, in one way or another, that being mentally healthy was being able to be true to yourself and/or being „self-accepting". This view was also pronounced when discussing different coping mechanisms or resources. Participants often articulated the idea that having a negative outlook impeded their recovery. When participants spoke of support as a resource, they talked of relationships built on the foundation of mutual respect and acceptance where participants could be themselves. Self-acceptance and recovery were mentioned by eight participants, where a positive outlook towards yourself and life in general was important. In their concept analysis, McCauley, McKenna, Keeney and McLaughlin [19] said that recovery was „the reawakening of hope and rediscovery of a positive sense of self". This appears to fit exceedingly well with the worldview described by many of our participants.

The participants' search was for self-acceptance, but not necessarily for a solution to all their mental challenges. Self-acceptance is the opposite of the shame and self-prejudice that can develop because of negative emotions against yourself [20,21]. Recovery is of course not to be simplified to just needing to have a change of attitude. But, in this study it seems to be a strong factor for the participants to keep a positive constructive outlook and find self-acceptance.

[22] conducted a qualitative study on, among other things, what individuals with mental illness thought was helpful in the recovery process. One theme that emerged had to do with surviving, perseverance, and hope. Many participants had gone through challenging times but showed great perseverance. The hard times were even an inspiration for change, where resilience and self-acceptance became pronounced coping mechanisms. Here, dreams and goals were helpful to keep going, even when times were hard.

Support was the most talked about resource in this study and many previous studies have come to a similar conclusion [23,24,25]. [26] did a systematic review on the link between loneliness and perceived support and its effect on mental health. People with depression, that considered their social support to be more lacking than others, showed poorer outcomes regarding symptoms, recovery, and social activity. There was also an indicator that increased loneliness was linked to increased symptoms of depression and anxiety. These results appear to fit well with the experiences of the participants in the present study. Support was looked for from family and friends, peers, and professionals. Interestingly, peers and positive professionals were the most important. Most participants had support from family and friends, but in some cases, they experienced negative feedback and prejudice which they linked to lack of knowledge of mental illness, which is consistent with [27] study. Support from positive and accepting professionals is most helpful if factors such as sense of equality, trust and collaboration exist in the relationships [28,29] as the participants in the present study described.

Psychotropics were an indispensable resource for some participants. But it was also hard for many to find the right combination of medications. There is, of course, an enormous cache of studies that demonstrate the importance of psychotropics in mental health services. It is, however, important to choose them carefully and with an individualized approach, considering individual symptoms and possible side-effects [30]. It is also clear from the participants' point of view that the therapeutic alliance played a key part in their relationship with all their mental health professionals, including their prescribers.

Empowerment can be defined as a process where hope, self-confidence, and encouragement are awakened within a person [31]. Being able *to be active, having tasks, and taking responsibility* was empowering for many participants. Being active surfaced in many ways, for example in studying, working, having hobbies, being active within a clubhouse, and in life in general. Studies have shown that, for people with mental illness, being active and taking responsibility for their illness is empowering, it increases self-confidence and the feeling of having a purpose in life [32,33,24]. In this context the responses of the participants in the present study are hardly surprising.

Changes in attitudes and views were an important factor for many participants. Not only towards life or recovery, but also towards yourself. Marino [34] explored the concept of social recovery in a qualitative study. Three main themes identified were community, self-concept, and capacities. Under the theme self-concept, there were a few sub-themes such as having the attitudes and feelings of being worthy, being able to connect to your own self, having inner motivation, and taking responsibility for yourself. Attaining social recovery also included (under the theme capacities) being able to let go of the past and to be in the present moment. Some participants talked about using CBT and mindfulness to obtain those changes needed for their way of thinking. Both CBT [35,36] and mindfulness [37,38,39,40] can potentially be of great help to many who deal with mental illness, especially those dealing with depression and anxiety.

Dreams, goals, and hope were tightly connected in this study. Hope can be described as an aspiration or longing for positive events in the future [41]. Participants had to work towards something that gave value to life. Hope was their driving force and gave them the purpose to move on. Hope appears as a strong positive factor in many recovery-related studies [32,41,34,42] and is a well-known concept within the field of empowerment [31].

Participants of this present study talked about what *recovery* meant to them. What stood out was reaching self-acceptance

and having the ability be active and to act. Having a positive outlook towards yourself and life and to have balance in emotions and symptoms was also frequently mentioned as a part of their view of recovery from their mental illness. When it comes to balance in emotions and symptoms the consumer perspective is not necessarily that there is a need for being completely free of all symptoms from mental illness to be in recovery, but rather to have more control over said symptoms [43,33,44].

In a qualitative study, [45] explored the effects of self-esteem and self-acceptance on mental health and found a link between those two factors. [44] examined the recovery concept among consumers, for them recovery entailed factors such as self-understanding, self-acceptance, self-control, and self-confidence. The inner process of recovery was a process where individual recovery could lead to transformation. The results indicate that it is necessary to stress the importance of the individuals' experience of the self in the recovery process.

Conclusions

The recovery process for the participants of this study seems to be a journey of reaching self-acceptance. It is dependent on inner and outer factors, but not just on the definition of different symptoms of different mental health problems. It is a personal process, defined by the individual him- or herself, and inner and outer resources are many and different. When defining the recovery concept, it is necessary to make meaning of consumer experience. It is empowering, but empowerment does not just give power back to the consumer, but also a feeling of responsibility and hope, which are the foundation stones of recovery, as this study has demonstrated.

The results also show us how much individual difference there is in the understanding of recovery. None of the participants used the absence of symptoms definition that is used in the mental health care system, rather they articulated the ability to hope, function and persevere as a key part of their definition of recovery. This is something that mental health professionals must consider.

It is also clear that the participants use diverse resources and coping mechanisms on their long road to recovery. These are both formal evidence-based interventions provided by the mental health care system such as CBT, mindfulness and psychopharmaceuticals. But also, other more informal resources that are clearly not less important to the participants than the more formal ones. These include social support and peer support, cultivating and growing personal relationships and finding meaning and using different approaches to maintain a positive and constructive outlook on life and illness. These results demonstrate that an integrative health approach to treatment planning for these clients could be extremely valuable, where both formal and informal resources are included and an integrative holistic view is employed to map out specifically and on an individual level what helps people suffering from mental illness get better and stay better, whatever that means for them. For this, mental health professionals are especially well equipped, with a holistic knowledge base in both physical, social, and psychiatric spheres, as well as strong educational foundation and constant presence and access to clients.

Limitations

This study only reflects the experience of 17 individuals of the road to recovery and what resources helped them on their journey, and it is impossible to generalize their experience to all individuals with mental illness. It does, however, give insight into those participants' experiences. The sample is homogeneous in a way that most participants were clubhouse users. Clubhouses work within a certain ideology that participants are more likely than not to adhere to. The participants were voluntary, and it is possible that the views of those who are less likely to participate in a study like this one, differ from those who do.

The results were interpreted by the research team of three with aid from the participants who were seen as co-researchers. Verification was sought by letting each participant read through and verify their own individual analytic framework and to have the overall analytic framework analyzed and verified by two participants.

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