EXPLORING ALTERNATIVES TO THE MEDICAL MODEL OF MENTAL HEALTH CARE

By

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A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2018
To my mother, who is with me somehow
ACKNOWLEDGMENTS

I would like to acknowledge my loved ones who were supportive of me throughout my time in the Ph.D. program. I would like to thank all of the Vella’s and Greggo’s who were by my side with unconditional love as I completed this monumental task. I would also like to thank the Fraser’s and Ridaught’s for becoming my friends and family away from home and providing me with acceptance and support. I would like to specifically acknowledge my partner, Mike Ridaught, who has been a continuous stabilizing force in my life and whose support has made my completion of this degree possible. I would like to thank my many beloved friends in Gainesville and those who are far away; your presence in my life is a source of strength.

I would like to thank my chair, Dr. Kristina DePue for her guidance, support, and faith in me. Dr. DePue has shown me appreciation for my work, trust in me and my process, emotional support, and seemingly endless stamina for consultations, revisions, and encouragement throughout my time in the doctoral program and specifically towards this dissertation. I would also like to thank my committee members, Dr. Ana Puig, Dr. Jacqueline Swank, and Dr. Jeanne-Marie Stacciarini for their support, expertise, and constructive feedback. I would also like to thank our Counselor Education support staff who keep so many gears turning behind the scenes and provide the necessary structure and support for the completion of a dissertation.
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The harmful impact on mental health service users of medical models of care have been well documented in the literature. Individuals receiving medical services for mental illness have felt traumatized by the forced drugging, restraint, isolation, and emotional neglect that occurs in current mental health systems. Despite the documentation of such issues, mental health systems largely remain entrenched in a medical model where these issues persist. Yet, some practitioners provide services from a humanistic and wellness-oriented perspective that does not rely on diagnostics and medication management. The practices and experiences of these practitioners are not represented in the literature. Thus, the purpose of this study was to qualitatively explore the experiences and perspectives of practitioners who provide non-medicalized mental health services. Understanding the theoretical and pragmatic variables of continuously providing non-medicalized services from practitioners’ perspectives addressed a gap in the literature and can allow for mental health practitioners to consider the applicability, successes, and roadblocks of meeting the call from service users to provide non-medicalized support. Counselors who identify as non-medical
practitioners and who do not provide services in a medical or psychiatric facility were interviewed. Interviews and data analysis were conducted following a constructivist grounded theory methodology.

The results of this study manifested as a multilayer, systemic model representing the participants’ perspectives, where factors that influence the application of non-medical approaches were identified as follows: (a) counselor characteristics, (b) factors within the immediate community, (c) factors within general society, and (d) factors in an international context. Factors within the counselors included not viewing individuals with symptoms of mental illness as fundamentally different from themselves and seeing client issues in the context of lived experiences. Community variables included the availability of peer support within communities and having access to services that do not require insurance reimbursement. Factors within general society emerged as roadblocks to maintaining non-medical services, as society at large is still deeply entrenched in a medical model. On an international level, following examples set by other countries, who are forming policies around non-medical paradigms, emerged as a factor for implementing and maintaining non-medical approaches.
CHAPTER 1
INTRODUCTION

Currently, millions of Americans are diagnosed with mental illness (National Institute of Mental Health, 2017). Costs of treatment, government funded aide, and lost wages among those diagnosed with mental illness poses a significant economic burden (Insel, 2008). In addition to the cost, current mental health services are often falling short of providing supportive and humanistic services according to service users. Individuals receiving medical services for mental illness have felt traumatized by the forced drugging, restraint, isolation, and emotional neglect that occurs in current mental health systems (Adame, 2011; Adame, 2014; Burstow; 2004). There is likely to be compounding trauma in these instances, as individuals with mental illness are more likely to have experienced childhood abuse and are more likely to be victimized in adulthood (Chessen et al., 2011). These traumatic and marginalizing practices in the medical model of mental healthcare have given rise to the consumer/survivor/ex-patient (c/s/x) movement. Many people have reported that peer support and alternative services to the traditional medical approach have allowed them to recover from mental illness and resume meaningful lives as productive members of society (Cohen, 2005; Mancini, 2007).

Yet, concepts of mental health recovery, the c/s/x movement, and trauma in mental health exist in obscurity for some consumers, scholars, and practitioners. The concepts in these individual areas are powerful on their own, but these areas also overlap with each other in their goals, approaches to care, and perspectives on mental health. The following sections will discuss: a) the cost of mental illness and the promotion of wellness, b) trauma and health outcomes with specific attention to the
correlations between trauma and mental illness, c) the experience of trauma by patients in the medical model system of mental health care through the voices of the c/s/x movement with a social justice orientation, d) a critical examination of the medical model and epistemological inconsistencies between the medical model and the phenomena of mental illness, and e) mental health recovery and emerging models that facilitate recovery, are humanistic, and provide consumers with the ability to co-construct the experiences of their mental health. If service providers are prepared to adopt recovery-oriented practices, not only may our mental health services become more cost effective (Xi, 2013), but service users will benefit from a humanistic approach that spares them from further trauma and marginalization.

**The Cost of Mental Illness**

In 2016, 44.7 million adults in the United States, (18.3% of the population) had a diagnosed mental illness, or what the National Institute of Mental Health (NIMH) refers to as “any mental illness” (NIMH, 2017). Of the 44.7 million adults with a diagnosis, 10.4 million adults had a serious mental illness (SMI) (NIMH, 2017). The NIMH defines SMI as: “Any mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities” (NIMH, 2017 p. 4). Of the 44.7 million adults with mental illness in the United States in 2016, 19.2 million had received mental health treatment in the past year. Of the 10.4 million adults with SMI, 6.7 million received mental health treatment within the past year (NIMH, 2017). In other words, 64.8% of individuals with SMI had used mental health services within a year compared to the 43.1% of individuals with “any mental illness” who utilized treatment services. Direct services are costly on their own, but it is also important to consider the indirect costs of mental health disparities, which include
reduced labor supply, reduced education enrollment, incarceration, and homelessness (Insel, 2008).

An estimate of economic burden due to lost earnings in individuals with SMI was conducted in 2008 using National Comorbidity Survey Replication (NCS-R) data from 2002. A diagnosis of SMI within the previous 12 months predicted an average reduction in earnings of $16,306 compared to those without mental illness who provided the same data, for a societal-level loss of 193.2 billion dollars (Insel, 2008; Kessler et al., 2008). This loss of earnings excludes individuals who were hospitalized, homeless, or incarcerated (Insel, 2008; Kessler et al., 2008). When adding the loss of earnings to the direct cost of health care expenditure and disability benefits in 2002, the dollar amount of economic burden increased to 317.6 billion (Insel, 2008). Due to the excessive cost and prevalence of mental illness, mental health recovery has been suggested as a framework that could lead to cost-reduction and increased wellness for individuals labeled with mental illness (Knapp, McDaid, & Park, 2015; Xi, 2013). Key elements of recovery include peer support and self-management, which can incorporate working towards the attainment of employment goals and financial stability (Knapp et al., 2015).

**Promoting Wellness**

In addition to the potential for relieving economic burden, mental health recovery practices also seek to refrain from traumatizing or marginalizing individuals in treatment for SMI. The consumer/survivor/ex-patient (c/s/x) movement consists of individuals who have reported experiencing marginalization, abuse, and/or neglect in traditional medical models of mental health care (Burstow, 2004; Carr et al., 2014; Cohen, 2005; Joseph, 2015). In mental health recovery, a key underpinning is the belief that individuals in recovery should be empowered to strive for life goals and preferences in the same way
as those who are not diagnosed with mental illness (Carr et al., 2014). Programs such as Wellness Recovery Action Planning (WRAP) are designed for peers in the mental health system to work together in developing wellness plans and individualized courses of action to take during times of being unwell (Copeland Center, 2018). These types of models are favored in the c/s/x movement, as the focus of healing is shifted away from the medical model and towards the inclusion of family, community, empowerment, and hope (Ameil, 2013; Burstow; 2004; Carr et al.; 2014; Cohen, 2005). Individuals who identify with the c/s/x movement have failed to receive adequate help within the medical model of mental illness or have been traumatized through oppressive and coercive treatment methods (Burstow, 2004). Trauma is also connected to mental health recovery, as studies have been conducted to identify common aspects of recovery (Moran, 2016; Siu et al., 2012), In addition, trauma has been noted as a frequent theme in mental health recovery narratives (Cohen, 2005). In order to fully appreciate the impact of trauma on mental health, this paper begins with a discussion on the relationship between trauma and broader health outcomes.

**The Role of Trauma in Mental Health Outcomes**

Trauma has been increasingly identified with poor health outcomes, as indicated by the Adverse Childhood Experiences (ACE) study conducted by the Center for Disease Control (CDC) and Kaiser-Permanente (CDC, n.d.). Ongoing research in the areas of neurobiology and epidemiology suggests that childhood trauma induces changes in brain circuits that are correlated with disrupted wellness across the lifespan (Anda et al., 2006). The Adverse Childhood Experiences (ACE) study, a collaboration between the Center for Disease Control and Kaiser Permanente’s Health Appraisal Center, consisted of 17,337 participants and examined the association between
adverse childhood experiences and adult health outcomes (Anda et al., 2006; Dube et al., 2001; Edwards et al., 2003). Using data from the ACE Study, Anda et al., 2006, attempted to construct a dose-response curve of between the number of adverse childhood experiences (ACEs) and the prevalence of disordered brain function in adulthood (Anda et al., 2006). Note that the phrase “disordered brain function” is not a description of mental illness, but rather refers to the phenomenon that early stressors can influence the development of neural pathways. During child development, repeated, severe, or abnormal stressors can disrupt the behavior and development of neuroregulatory systems in ways that produce long-lasting and significant neurobehavioral consequences (Anda et al., 2006). In other words, childhood trauma can lead to differences in the structure of the brain and neuronal development compared to individuals without childhood trauma that affects a wide range of brain functions and behaviors (Anda et al., 2006).

The relationship between traumatic events and mental illness has been largely established as a correlation, rather than causation; although, some studies do indicate a rationale for recognizing a trauma-related subtype or onset of certain mental illnesses, such as schizophrenia and OCD (Fontanelle et al., 2011; Sar et al., 2010). Yet despite suggested trauma-related etiologies of symptoms of severe mental illness (SMI), helping professionals often fail to recognize the potential for patients to be traumatized by treatment itself (Adame, 2014; Joseph, 2015). The experience of being traumatized, oppressed, and marginalized in mental health treatment has been termed “psychiatric survivorship” – a movement led by individuals who identify with the c/s/x community and has been gaining traction since the 1970’s (Cohen, 2005).
Psychiatric Survivorship

The psychiatric survivorship movement is an international, political activist movement primarily made up of organizations dedicated to fighting for human rights in the mental (healthcare) system (Adame, 2014). Individuals who identify with the term “psychiatric survivor” have been oppressed or abused in the mental health care system, and thus, have survived mental health care, rather than the diagnosis of mental illness itself (Adame, 2014). While the movement is referred to as psychiatric survivorship, psychiatrists are not the only professionals encompassed in that term. Other mental health care practitioners, such as counselors, social workers, psychologists, and psychiatric nurses can contribute to or be complicit in the abuse and/or oppression experienced by clients in the mental health care system. Members of the survivorship movement reject the medical model of mental health and seek liberation from a system that insists on the validity of the medical model (Adame, 2014). Survivors have reported common experiences of oppression, traumatization, and marginalization as consumers of mental health care within the medical model. Survivors have been permanently altered and/or traumatized by electroshock treatment (Burstow, 2004), forced drugging, restraint, and verbal abuse while in psychiatric care (Cohen, 2005). There is a clash between positivism in the medical model of mental health care, and a call towards the recognition of mental illness as a social construct, which would allow mental health consumers to participate more fully in the pursuit of their own wellness. We can see from the narratives of individuals in psychiatric survivorship that top-down approaches in which medical professionals used coercive power to implement treatment could be traumatic and did not necessarily contribute to long term wellness.
Mental Health Recovery

The narratives of psychiatric survivors include descriptions of their recoveries from mental illness and/or the trauma they experienced during treatment (Cohen, 2005). Mental health recovery can be challenging to define. There are discrepancies in the definition of recovery between professionals and consumers, and recovery is a highly individualized process (McCauley et al., 2017). Some treatment consumers embrace the label of their diagnosis along with a biological explanation of their condition and accept consistence reliance on psychiatric intervention for stability (Lietz, Lacasse, & Cheung, 2014). While this may seem like a conservative estimate of recovery, there are many former mental health consumers who reject biological explanations of their mental illness and have achieved satisfying lives in which they function well without ongoing psychiatric intervention (Leitz, Lacasse, & Cheung, 2014). Regardless of the patients’ use of psychiatric services, generally agreed upon definitions of recovery encompass similar constructs to the following definition: “…the development of new meaning and purpose in one’s life, beyond the symptoms, disability, and stigma of mental illness…a process of healing physically and emotionally, of adjusting one’s attitudes, feelings, perceptions, beliefs, roles and goals in life” (Spaniol, 2002, p. 327). Or more broadly, the recovery movement “recognizes the ability of people with mental illness to participate in the mainstream of society” (Davidson, 2016, p. 1091).

In the context of SMI, social justice initiatives can be seen in the mental health recovery and psychiatric survivorship movements (Carr et al., 2014; Cohen 2005). Counselors are aware, by virtue of their training, that mental illness is stigmatized in the United States; however, the term “stigma” falls short of describing the traumatic and repetitive experiences of discrimination experienced by people with symptoms of mental
illness perpetrated by individuals and systems who exercise power over them (Bhui, 2016). Compared with other helping professionals (i.e., social workers, nurses, and psychiatrists, psychologists) counselors are proportionately less involved in serving individuals with symptoms of SMI (Carr et al., 2014). Counselors, themselves, may adopt stereotypes about people with mental illness, perpetuating the stigma that exists systemically (Overton & Medina, 2008). The way that counselors conceptualize clients with diagnosed mental illness reflects the negative beliefs about mental illness in the general population (Overton & Medina, 2008).

Within the medical model of mental health care, there exists a long history of systemic oppression and marginalization through the pathologizing of individuals based on race, sexuality, and gender (Joseph, 2013). Dating back to 1851, the disease of drapetomania was described by physicians as a diagnosis given to slaves who ran away, assuming that they did not have the volition to run away unprovoked (Joseph, 2013). This is the period of psychiatric treatment that is associated with Bedlam, using highly invasive, painful, and forced procedures to treat madness (Joseph, 2013). As recently as the 1950’s, lobotomies were a popular treatment due to the belief that cutting out pieces of the prefrontal cortex would alleviate symptoms of mental anguish; homosexuality existed in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 1980) through the 3rd edition (Joseph, 2013); and, differences in gender identity are still pathologized as gender dysphoria today (5th ed.; DSM–5; APA, 2013). Among psychiatry today, electroconvulsive therapy (ECT) is considered to be the most effective treatment option for individuals with medication-resistant depression (Joseph, 2013). It is this draconian history of mental health care,
which has morphed into current systems of oppression, marginalization, and forced
treatment of individuals with SMI, from which social justice efforts seek to create a
greater distance. Counseling training programs have acknowledged the harmful stigma
surrounding minority groups such as racial and ethnic minorities, and the LGBTQ
community, and the need for multicultural competence, yet the same multicultural and
advocacy-oriented perspective is not geared towards individuals with mental illness
(American Counseling Association [ACA], 2014; Overton & Medina, 2008).

Connections between trauma and health outcomes have become a highly visible
issue in our society (Anda, 2006). The ACE study has highlighted this phenomenon and
psychiatry and hospitalization practices have a long history of traumatizing patients. The
movement of psychiatric survivorship and the call towards social justice in mental health
culture is evidence that our current medical model and its standards of care are falling
short of providing safe, dignified, and healing environments for individuals with
symptoms of SMI. It is justifiable for helping professionals and society at large to adhere
so strongly to the medical model of mental illness? A critical examination of the medical
model suggests that we may benefit adopting a different frame through which to view
mental illness – a frame where we acknowledge mental illness as a construct, rather
than a medical phenomenon.

**Mental Illness as a Social Construct**

Social constructionism suggests that humans behave with intentionality and
construct meaning in their worlds (Creswell, 2013; Crotty, 2015; Merriam, 2009). This is
not to be mistaken with subjectivism, in which humans create meaning; in
constructionism, people construct meaning with materials that are already present,
namely the world and its objects (Crotty, 2015). Social constructionism, more
specifically, takes into consideration that humans are born into worlds that are already filled with meaning and symbols. The “social” aspect does not refer exclusively to knowledge being generated by people interacting with people. An interaction with objects and the environment is considered a social interaction because it is historical knowledge and culturally embedded meaning that teaches people how to interact with objects and the environment (Crotty, 2015).

There is a clash between positivism in the medical model of mental health care, and a call towards the recognition of mental illness as a social construct, which would allow mental health consumers to participate more fully in the pursuit of their own wellness (Hansen, 2017). We can see from the narratives of individuals in psychiatric survivorship that top-down approaches in which medical professionals used coercive power to implement treatment could be traumatic and did not necessarily contribute to long term wellness (Adame, 2014; Cohen, 2005). In the description of the history of oppression in mental health systems, we see individuals that exhibited disruptive behavior were labeled as ill, perhaps merely because their behaviors were inconvenient to others (Joseph, 2013). Modern science has been on a search for chemical imbalances that can describe the molecular and cellular causes of specific mental illnesses (Whitaker, 2014), yet despite sophisticated research efforts, we have yet to uncover unified theory of causation for any particular mental illness (Hyman 2013; Whitaker, 2014).

Literature is published, often qualitatively, about the narratives and lived experiences of individuals in the c/s/x movement. Within that literature, the importance of empowering, recovery-oriented practices, where individuals labeled with SMI enjoy
agency and humanistic approaches to their treatment, has been highlighted. Nationally, there has been an effort on the part of agencies to become more competent in providing recovery-oriented services, yet implementation can be challenging (Clossey & Reinheimer, 2014). There is a gap in the literature regarding the voices of the practitioners who provide mental health services that are alternative to the medical model. The purpose of this research is to qualitatively describe the practices, perceptions, and theoretical positions of practitioners who are mindful of the potential for the medical model to do harm to clients, and who intentionally provide clients with alternatives to the medical model of mental health care, with a goal of making alternatives to the medical model more accessible to practitioners. The research question guiding this study asked, what are the experiences, practices, and theoretical perspectives of counselors who provide alternative services to the medical model of mental healthcare?
CHAPTER 2
COMPREHENSIVE LITERATURE REVIEW

This review of the literature serves will highlight concepts of trauma and mental illness, systemic issues in mental health care, and the need for a social justice orientation towards those diagnosed with mental illness. The review will start with sections about childhood trauma and health outcomes, followed by subsections about the relationship between trauma and specific mental health issues. The correlation between trauma and mental health issues will be a foundational concept for the remainder of the material covered. The discussion about trauma and mental illness is followed by a section covering psychiatric survivorship and the consumer/survivor/ex-patient (c/s/x) movement, with a particular focus on the experiences of marginalization and trauma that those with mental illness have encountered during treatment. In order to contextualize the c/s/x movement in the counseling profession, a social justice lens is applied to the experiences of survivors and brief history of mental illness in society is provided.

Next, a discussion about mental health recovery is provided. Mental health recovery is a social justice-oriented movement that aims to amplify the voices of mental health consumers/survivors/ex-patients while empowering them to lead purposeful and fulfilling lives in the community (National Coalition of Mental Health Recovery, n.d.). The section on mental health recovery will include a discussion of peer support with some emphasis on Wellness Recovery Action Planning (WRAP) and Intentional Peer Support (IPS). Peer support has been identified as a key factor in mental health recovery (Cook et al., 2010; NCMHR, 2014). WRAP and IPS are two platforms that were created and
developed by peers and provide training to helping professionals and the general public. Lastly, related to mental health recovery, is a discussion about trauma informed care. In the first sections of the literature review, the connection between trauma and mental illness was described, as well as the experiences of trauma through treatment by those in the c/s/x movement. Trauma informed care is reviewed in the context of these issues and its clinical applicability for mental health professionals.

Finally, the review will end with a discussion about the appropriateness of an epistemological shift in the mental health systems. While specific biological causes of mental illness have not been identified, mental health care is embedded within a medical model that assumes a degree of authority about the causes and appropriate treatments for symptoms of mental illness (Hansen, 2016). The practices that take place in this medical model are the practices that individuals in the c/s/x movement have described as marginalizing and traumatic. This final section will present theory and recommendations for practice that support an epistemological shift from positivism to social constructionism in mental health systems. The medical model of mental health is critiqued and alternative views discussed. This section suggests that, with all of the proceeding information taken into account that a social constructionist perspective on mental illness would align with needed systemic change.

**Trauma and Health Outcomes**

This section will serve to establish a relationship between trauma and mental illness but will not include a review of literature about posttraumatic stress disorder (PTSD). Trauma is accepted as a direct cause of PTSD, and responses to specific traumatic events are acknowledged in the etiology of PTSD. What is less clear is the role that trauma may have in the etiology of other mental illnesses, such as
schizophrenia, borderline personality disorder (BPD), obsessive-compulsive disorder (OCD), and depression. The articles reviewed below describe the correlations between trauma, typically early in life, and adult onset mental illness, with many of the articles focusing on a specific mental illness.

A rudimentary understanding of the Adverse Childhood Experiences (ACE) study is particularly important in laying the groundwork for the relationship between trauma and mental health as a foundational concept in the current study. The ACE study sheds light on the vast impact of trauma on development and behavioral health, positioning trauma experiences as a public health concern that must be addressed at multiple levels of society. The ACE study conducted by the Center for Disease Control and Prevention (CDC) and Kaiser Permanente is one of the largest studies that explores the relationship between childhood abuse and neglect and adult health outcomes (Center for Disease Control and Prevention, n.d.). Reporting on the frequency and consequences of childhood abuse is not unusual in psychology and related fields, however; a single type of abuse or neglect is typically examined, and frequently in the context of adolescent health or adult mental health outcomes (Felitti et al., 1998). The ACE study was undertaken to evaluate the relevance of childhood abuse and neglect to adult medical issues and public health concerns, and the impact of co-occurring forms of abuse and neglect (Felitti et al., 1998). Studies addressing the impact of trauma on specific mental health outcomes will also be discussed.

Ongoing research in the areas of neurobiology and epidemiology suggests that childhood trauma induces changes in brain circuits that are correlated with disrupted wellness across the lifespan (Anda et al., 2006). The Adverse Childhood Experiences
(ACE) study, a collaboration between the Center for Disease Control and Kaiser Permanente’s Health Appraisal Center, consisted of 17,337 participants and examined the association between adverse childhood experiences and adult health outcomes (Anda et al., 2006). Using data from the ACE Study, Anda et al., 2006, attempted to construct a “dose-response” curve between the number of adverse childhood experiences (ACEs) and disordered brain function in adulthood (Anda et al., 2006). In other words, they were interested in establishing a relationship between increased trauma and increased disordered function. Note that the phrase “disordered brain function” is not a description of mental illness, but rather refers to the phenomenon that early stressors can influence the development of neural pathways. During child development, repeated, severe, or abnormal stressors can disrupt the behavior and development of neuro-regulatory systems in ways that produce long-lasting and significant neurobehavioral consequences (Anda et al., 2006). In other words, childhood trauma can lead to differences in the structure of the brain and neuronal development compared to individuals without childhood trauma that affects a wide range of brain functions and behaviors (Anda et al., 2006). The authors hypothesized that the damaging effects of adverse childhood experiences (ACEs) would be non-specific (i.e., impacting a variety of areas of behavior and functioning) because abuse affects a variety of brain structures. They also hypothesized that as the number of reported ACEs increased, so would the likelihood of any disturbance in function or behavior, and that the same would be true for the number of comorbidities. The researchers collected data from two waves of ACE study participation: 8,708 participants from wave 1 and 8,629 from wave 2, for a total of 17,337 participants. Using logistic regression analysis and
adjusted odds ratios, the researchers confirmed their hypotheses than a dose-response type relationship exists between ACE score and likelihood of non-specific disturbance in function and behavior, and also has a dose-response relationship with the number of comorbidities individuals experience. For example, participants with ACE scores of 4 or higher were between 2 and 4 times more likely to experience panic reactions, depression, anxiety, and hallucinations. These individuals were also more likely to experience substance abuse, sleep disturbances, difficulty controlling anger, and high levels of perceived stress (Anda et al., 2006). As the individuals’ ACE scores increase, so did the mean number of comorbidities. The observation of a dose-response (in other words, the adverse experiences have a cumulative effect) relationship between ACE scores and adult mental health outcomes has been echoed in the study reviewed in the following paragraphs.

Decrements in adult mental health scores were observed in a cumulative manner as the number of childhood abuse types increased in a study of 7,505 participants who provided data to the ACE study (Edwards et al., 2003). In the Edwards et al. (2003) study, the researchers explored the relationships between several types of childhood abuse (physical abuse, sexual abuse, emotional abuse, and witnessing of maternal battering). The authors hypothesized that when individuals experienced maltreatment in multiple categories, a dose-response curve relationship would exist to decrements in mental health. Respondents had completed a physical examination and completed the Medical Outcomes Study-SF, and a family health questionnaire (the authors do not specify if this questionnaire is standardized). The authors confirmed their hypothesis that experiencing abuse in multiple categories had a cumulative effect on mental health.
decrements, and also found that as emotional abuse increased within each physical abuse category, mental health scores declined. Results were determined by ANOVAs to account for adult mental health and abuse type, gender, and the contribution of childhood emotional abuse within the family to mental health outcomes.

Through ACE study data, a graded relationship between ACEs and self-reported alcohol addiction, illicit drug use, and depression as risk factors for suicide has also been established (Dube et al., 2001). Data was used from 17,337 participants across wave 1 and wave 2 of the ACE study. Suicide risk increased for participants with each of the 8 adverse childhood experiences accounted for in the ACE Study. Results indicated that the lifetime prevalence of at least one suicide attempt was 3.8%, and that prevalence increased by 2 to 5-fold when an ACE was reported in any category. The logistic regression model determined by Dube and colleagues (2001) suggested that self-reported alcohol addiction, illicit drug use, and depression were mediating factors in lifetime prevalence of attempting suicide; however, an increased risk is still present when not controlling for these variables. The authors again highlighted the recognition that adverse experiences rarely occur in isolation. An increased risk of attempting suicide, as well as suicide attempts across the lifespan, increased significantly as the number of adverse childhood experiences increased.

**Trauma and Specific Mental Health Issues**

While the ACE study data has garnered much attention from mental health professionals, many smaller scale studies in recent years have identified a correlation between trauma and specific mental illnesses. For example, researchers have demonstrated that a high number of people diagnosed with schizophrenia have also experienced significant trauma, both before and after the initial onset of their symptoms.
(Larsson et al., 2012; Lommen & Restifo, 2009; Lysaker et al., 2010; Lysaker & LaRocco, 2008). Similar correlations have been made in individuals who experienced childhood trauma and have been diagnosed with adult onset obsessive compulsive disorder (OCD) (Fontanelle, 2011), and in those who experience auditory visual hallucination (AVH) without psychosis (Daalman et al., 2012). This section will review literature that describes the subtle variances in certain mental disorders when they are preceded by childhood trauma. Such variances can have a significant impact on conceptualization, diagnosis, and treatment planning for individuals with mental illness and trauma history (the importance of which will be discussed later in the paper).

**Trauma and Psychosis**

Examining the role of childhood trauma in Schizophrenic (psychotic) symptoms, such as hallucinations, researchers of a recent study hypothesized that childhood trauma is related to adulthood schizophrenia and that polytraumatization, more specifically, is related to dissociative symptoms for individuals experiencing psychosis (Alvarez et al., 2015). The study included 123 participants, consisting of 45 people, diagnosed with either schizophrenia or schizoaffective disorder per the DSM IV (APA, 1994) criteria who were recruited from a community outpatient center, and 78 volunteer controls who were recruited by university students and colleagues (Alvarez et al., 2015). The *Childhood Trauma Questionnaire* (CTQ-SF) and *Dissociative Experiences Scale* (DES-II) were administered to both groups, with the control group having self-administered both and the treatment group self-administering the CTQ-SF. The DES-II was administered via an interviewer to the treatment group due to potential difficulties in focusing attention and increased need for clarification in this population. A criticism of this study design is the potential for unreliable trauma memory in individuals.
experiencing psychosis, although the authors cite a recent study that indicated strong reliability of trauma memory in individuals with psychosis, stating that trauma memory was stable over time regardless of symptom severity (Alvarez et al., 2015). Individuals in the treatment group reported more traumatization than the control group with higher physical abuse, physical neglect, and sexual abuse being statistically significant ($p < .05$) according to the Mann-Whitney U test. The treatment group had a statistically significant higher average of dissociative symptoms than the treatment group. When compared to types of trauma, the treatment group had significantly higher dissociation scores in the presence of emotional abuse, physical abuse, or sexual abuse, determined via the Mann-Whitney U test. Regarding polytraumatization (the presence of more than one type of trauma) both treatment and control groups scored significantly higher on the DES-II when polytraumatization was present (Alvarez, 2015). The researchers concluded that this study corroborates other studies (Sar et al., 2010) that point to childhood trauma in the etiology of adult schizophrenia, and that childhood trauma and neglect and adult dissociative symptoms can be mediated by polytraumatization (Alvarez, 2015). Due to this finding, the authors highlight the importance of assessing for trauma in individuals with schizophrenia. They recommend treating trauma and using therapies that integrate dissociative parts of the personality be incorporated into normal treatment.

Again, pointing to a relationship between childhood trauma and dissociative symptoms, individuals who experienced childhood trauma are also more likely to experience auditory visual hallucination (AVH) (Daalman et al., 2012). AVH may occur as a symptom of a psychotic disorder, or in the absence of a psychotic disorder
(Daalman et al., 2012). A study was conducted in 2012 to explore the rates of childhood trauma and auditory visual hallucination (AHV) in individuals with psychosis who experience AHV and individuals without psychosis who experience AHV compared to healthy controls (Daalman et al., 2012). Individuals without psychosis have more frequently reported their auditory hallucinations as non-malevolent while individuals with psychosis have more frequently reported that their hallucinations are malevolent (Daalman et al., 2012). Noting previous correlations between childhood trauma and the presence of AVH in individuals with psychosis, the authors hypothesized that trauma may influence the content of hallucinations, rather than the hallucinations themselves. The sample included 100 participants with psychosis who were out-patients at the University Medical Center Utrecht. Clinical diagnosis was confirmed by a third-party psychiatrist; the group consisted of individuals with either schizophrenia, schizoaffective disorder, disorganized schizophrenia, catatonic schizophrenia, and psychosis not otherwise specified. The sample included 127 participants who experienced AVH without psychosis and who did not meet diagnostic criteria for a mental disorder according to the DSM IV (APA, 1994). The sample also included 124 participants as the healthy controls without AVH, who also did not meet any diagnostic criteria per the DSM IV (APA, 1994). Drug and alcohol use were exclusion criteria, and individuals in all groups were screened for drug and alcohol use. Childhood trauma was assessed with the CTQ-SF and a cut-off score of “moderate to severe” to establish whether traumas were absent or present in the different categories (emotional neglect, physical neglect, emotional abuse, physical abuse, sexual abuse). The authors did not explain their decision-making process in using “moderate to severe” to indicate the occurrence of
The Auditory Hallucination Rating Scale was used to assess the phenomenological qualities of the hallucinations experienced by the participants. Results indicated that both groups experiencing AVH reported significantly higher (p < .01) sexual and emotional abuse compared to controls. Significant in prevalence of trauma between the two AVH groups was not observed and no correlations were found between sexual abuse, emotional abuse, and the qualitative phenomenon of the hallucinations (such as emotional tone and loudness). The authors concluded that childhood abuse may render adults more susceptible to AVH in general but does not determine the content of the hallucinations. Variations in the way that adults with childhood trauma experience AVH later in life are important to determine, as continuous efforts are made to propose mechanisms for how childhood trauma leads to adult psychosis (Daalman et al., 2012). Results from this study indicated that individuals with childhood trauma may experience AVH without psychosis, which is an important finding to consider during diagnosis and treatment planning.

Individuals with bipolar disorder (BPD) often report symptoms that overlap with psychosis, namely auditory hallucinations and paranoia (Kingdon et al., 2010). Individuals with BPD also frequently meet criteria for another mental illness, but little research has been done to examine the comorbidity of BPD and schizophrenia, which was historically referred to as BPD with psychosis (Kingdon et al., 2010). Researchers conducted an exploratory study that evaluated the similarities and differences in auditory hallucinations and paranoia in individuals with BPD, schizophrenia, or both, and the experience of childhood trauma in each of the groups. Participants were recruited through various mental health services in Dorset and Hampshire counties in
Southern England and whose diagnoses were confirmed by 3rd party psychiatrists using the Structured Clinical Interview for BPD and schizophrenia for the DSM IV (APA, 1994). Of 111 participants, 59 were diagnosed with schizophrenia only, 33 with BPD only, and 19 met criteria for both schizophrenia and BPD. Individuals diagnosed with BPD or BPD comorbid with schizophrenia reported significantly higher \( (p < .01) \) childhood trauma than those with schizophrenia alone. This was true for all five domains of the CTQ: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. A majority (90%) of individuals with comorbid BPD and schizophrenia reported experiencing auditory hallucination, while 50% with BPD alone and 63% with schizophrenia alone reported auditory hallucination. There were also significant differences between the groups regarding paranoia \( (p < .01) \). Specifically, those with schizophrenia reported the most paranoid delusion during the SCID interview; those with BPD alone reported the least. The authors concluded that this study reinforced the attention brought to the frequent reporting of trauma by individuals with schizophrenia and aligns with research that explores the potential of a subgroup of schizophrenia where psychosis is instigated by trauma. The authors also noted that childhood trauma was a frequent occurrence among the clients with BPD and that trauma and potential comorbidity with schizophrenia must be assessed for and incorporated into treatment planning.

**Trauma and Obsessive-Compulsive Disorder (OCD)**

Similar correlations between traumatic experiences and mental illness can be observed in clients with obsessive-compulsive disorder (OCD). In order to better clarify the possible relationship of trauma in OCD etiology, researchers compared the socio-demographic and clinical features within group of 1001 adults who concurrently
developed OCD and post-traumatic stress disorder (PTSD), OCD prior to the
development of PTSD, or OCD with no PTSD history (Fontanelle et al., 2011). The
choice to use PTSD as criteria, rather than client reports of a traumatic event, was done
to ensure the etiological relevance of the traumatic events. Statistical data from this
study indicated that clients who developed OCD after PTSD have a unique clinical
presentation, including a later age of onset of OCD and a more severe clinical
presentation. This observation is consistent with vulnerability-stress models that have
shown late onset OCD is more likely to be triggered by trauma than early onset OCD,
which is more likely to be genetically linked (Fontanelle et al., 2011).

In a study with a similar query, Cromer, Schmidt, & Murphy (2006) investigated
the presence of traumatic life events and OCD symptom severity and symptomology in
265 adults diagnosed with OCD via Structured Clinical Interview for DSM-IV. The
researchers did confirm their hypothesis that traumatic life events were associated with
increased symptom severity, as indicated by the Yale-Brown Obsessive-Compulsive
Scale (Y-BOCS) for both total scores and obsessive and compulsive scores (Cromer,
Schmidt & Murphy, 2006). In order to assess the unique role of traumatic life events, the
researchers conducted a covariance strategy with depression, using scores from the
Beck’s Depression Inventory (BDI). Results showed that traumatic life events were a
significant predictor of increased Yale-Brown Obsessive Compulsive Scale (Y-BOCS)
scores when controlling for age, age of onset, and BDI scores.

Cromer and colleagues (2006) noted the positive correlation between childhood
trauma and adult onset OCD, and also observed via literature that individuals with
childhood trauma more frequently report insecure attachment, and that individuals with
OCD also frequently demonstrate symptoms of alexithymia. The authors developed a path analysis where childhood trauma would be positively correlated to attachment insecurity, attachment insecurity would be positively correlated to alexithymia, and that a positive correlation would exist between alexithymia and both the severity and number of OCD symptoms experienced by the participants. Participants consisted of 174 individuals recruited from online self-help groups and also using snowball sampling. Individuals were placed in the OCD group if they scored 8 or higher on either of the severity scales of the Y-BOCS-SR, where the highest score is 40 and 8-15 is the range used to indicate mild OCD. A total of 82 participants met criteria for mild OCD and formed the OCD group, and the remaining 92 participants formed the comparison group. Participants completed the Y-BOCS-SF, the CTQ-SF, the Experience in Close Relationships Inventory (ECR), and the Toronto Alexithymia Scale (TAS-20). The authors used t-tests to compare subscales of each of the instruments between the two groups, partial least squares analysis to evaluate interrelationship between the constructs in the model, and the Sobel test to determine mediational relationships in the model. Results confirmed the hypothesized path; thus, the authors concluded that there is a relationship between childhood trauma and OCD, although it is not a direct one.

Nearly half of individuals with OCD demonstrate what is considered to be treatment resistance, which is generally accepted as a failure of at least two trials with an SSRI to decrease symptoms (Semiz, Inanc, & Bezgin, 2014). An adequate reduction in symptoms in clinical trials is considered to be a 25 – 35% reduction in Y-BOCS scores (Semiz et al., 2014). Researchers investigated whether childhood trauma and dissociation are related to the severity of OCD symptoms in adults and hypothesized
that childhood trauma and dissociation would be related to treatment resistance. Dissociation has been correlated to increased OCD symptom severity, and childhood trauma has been reported more frequently in individuals with OCD than in those without (Semiz et al., 2014). The sample included 100 participants who were outpatients and 20 inpatients with OCD, both recruited from a psychiatric research and education hospital. Of the 120 participants, 58 were considered treatment resistant due to the failure of psychodynamic therapy, CBT, or two trials of medication. Those who were considered treatment responsive had a 35% or greater reduction of Y-BOCS scores that was maintained for 12 months. Participants completed the Y-BOCS to assess symptom severity, the Traumatic Experiences Checklist (TEC) to assess for childhood trauma history, the BDI, the Beck Anxiety Inventory (BAI), and the Dissociative Experiences Scale (DES) to assess for dissociation. Logistic regression analysis was used to determine the relationship between the severity of OCD symptoms and the BDI, BAI, TEC, and DES scores. The treatment resistant group demonstrated significantly ($p < .01$) higher OCD symptom severity, depression and anxiety scores, trauma scores, and dissociative experiences. Yet, the relationship between childhood trauma and treatment resistance was found to be indirect, as significance was no longer noted after controlling for gender, duration of illness, anxiety, depression, insight, and dissociation. Dissociation had a significant relationship to treatment resistance and was determined to be the most important mediating factor between childhood trauma and OCD. These results extend previous research finding that symptom severity is related to dissociation in individuals with OCD. Furthermore, childhood trauma is indirectly related to OCD and creates a general vulnerability towards the development of psychopathology.
The literature summarized above on trauma and specific mental health issues emphasize the intricacies of the relationship between trauma and mental illness. Rather than leading to broad conclusions about health, as the ACE study does, the studies about trauma and specific mental illness refine our focus to subtle but appreciable differences in symptomology. The body of research described in the above section sheds light on subtle variations in symptomology, treatment resistance, and age of onset in relation to childhood trauma. On the other hand, the ACE study highlights the impact that trauma can have on individuals’ total health. The correlations between trauma and health disparities are evident. Moving forward, this paper will assume that the vast impact of trauma on wellness is appreciated and agreed upon.

The following section will describe trauma in the mental health care system through a social justice lens. Many individuals with SMI report traumatization, marginalization, neglect, and dehumanization in their experiences of hospitalization and participation in the mental health system (Adame, 2011; Burstow, 2004; Cohen, 2005; Kaplan, 2010; Spiro, 2010). Considering the impact of trauma on health outcomes, it is important to understand the ways in which individuals are marginalized and harmed within our current mental health systems in order to prevent further traumatization. Individual experiences of traumatization in treatment will be discussed, as well as social justice implications and systemic issues related to harmful practices in the mental health care system.

**Psychiatric Survivorship and Social Justice in Mental Healthcare**

The psychiatric survivorship movement is an international, political activist movement, primarily made up of organizations dedicated to fighting for human rights in the mental healthcare system (Adame, 2014). Individuals who identify with the term
“psychiatric survivor” have been oppressed or abused in the mental health care system, and thus, have survived mental health care, rather than the diagnosis of mental illness itself (Adame, 2014; Spiro, 2010). While the movement is referred to as psychiatric survivorship, psychiatrists are not the only professionals encompassed in that term. Other mental health care practitioners, such as counselors, social workers, psychologists, and psychiatric nurses can contribute to or be complicit in the abuse and/or oppression experienced by clients in the mental health care system. Members of the survivorship movement reject the medical model of mental health and seek liberation from a system that insists on the validity of the medical model (Adame, 2014; Kaplan, 2012). Literature in peer reviewed journals about psychiatric survivorship is sparse and consists of mostly qualitative work and conceptual articles. The following section will review literature about the experiences of psychiatric survivors and also review some relevant conceptual articles about the c/s/x movement.

**Experiences of Psychiatric Survivors**

Experiences of psychiatric survivors are not typically represented in the literature thus explanations of the psyche and effectiveness of treatment protocols are usually described by psychiatrists who are less likely to critique current medical practices (Cohen, 2005). A qualitative analysis of the oral histories of psychiatric survivors was conducted to capture the voices and experiences of psychiatric survivors in their own words. The oral histories were collected through the MindFreedom International Oral History Project from June 2001 through September 2001. The study included 33 participants, and data collection consisted of 22 interviews, 4 written submissions about the experiences of survivorship and recovery, and survey data from others. Seventy percent of the participants were diagnosed with schizophrenia, and about half were
diagnosed with more than one mental illness. Other diagnoses included bipolar disorder and depression. Of the 33 participants, 26 had been 5 or more years without a hospitalization. Most of the participants described that their recovery from mental illness, or the traumas they considered during treatment (e.g., forced drugging, electroshock, restraints, seclusion, verbal abuse) was a process. A few participants maintained that they had nothing to recover from, or that their recoveries are now complete. Themes that emerged from the data analysis included that there was no “magic bullet” for recovery; participants relied on several methods, including social support, counseling, exercise, and psychiatric drugs. Another theme was empowerment, which encompassed self-esteem/self-efficacy, actual power, and community activism. Due to the emphasis on having support of friends and family in the narratives of the participants, the author addressed the importance of support as its own theme. The author concluded that people recovered or stayed in recovery when they were able to have autonomy in their treatment choices, yet there continues to be a gap between funding sources and alternative treatments (i.e., dollars spent on pharmaceutical companies versus funding for an alternative treatment program).

The previous study indicated that self-efficacy is an important part of recovery in psychiatric survivorship. The role of self-efficacy in recovery was explored explicitly in a study by Mancini (2007) who described self-efficacy as a view of the self as competent and agentic. Seeking to explore the subjective factors related to self-efficacy in recovery among psychiatric survivors, Mancini (2007) conducted a qualitative study in which 15 participants were interviewed who identified as both consumers and providers of mental health services. A grounded theory approach, as described by Glasser and Strauss,
was used for data analysis. The author recruited participants from a state department of mental health through her working relationship with consumer advocates. All of the participants were members of a consumer advisory advocacy panel, identified as psychiatric survivors, and were currently providing services to consumers in the form of advocacy. Diagnoses disclosed by the participants included schizophrenia, schizoaffective disorder, BPD, and major depression; however, many had received a variety of diagnoses over the course of their treatment histories. Data was analyzed via open coding as described in grounded theory methodology, and then themes and categories were refined through memo-writing and theoretical sampling. The author immersed himself in the interview data by reading each interview three to four times and taking memo notes throughout the process. Common codes were collapsed into broader categories, resulting in 4 main categories: recovery definitions, recovery turning points, recovery barriers, and recovery facilitators. The categories and subcategories were then repositioned under the framework of the social cognitive theory of self-efficacy. More specifically, the author presented the factors that facilitated recovery through the lens of self-efficacy. All participants reported egalitarian relationships, self-help peer role models, meaningful activities, and choice among combinations of traditional and alternative treatments. Framed in the four sources of self-efficacy, the categories the following categories were created to encompass the data: (a) social persuasion via egalitarian relationships, where relationships with providers were not coercive; (b) vicarious learning through peer role models where participants developed positive beliefs about their own recovery through peer support; (c) mastery experiences via meaningful activities where engaging in work, school, or hobbies promoted self-
efficacy; and (d) well-being via varieties of wellness enhancing tools where participants relied on a variety of approaches to wellness and had agency in their choices of interventions. While it may seem self-evident that helping professionals would encourage people in recovery to find meaningful activities, this is often not the case (Mancini, 2007). Participants shared that they were often discouraged from taking a class, finding work, or picking up new hobbies, because helping professionals feared that the stress of new activities would cause a relapse in symptoms. Helping professionals should be willing to let their clients take risks and trust their desire to pursue meaningful activities in order to facilitate recovery (Mancini, 2007).

Peer support is another factor that has emerged as facilitative of mental health recovery (Adame, 2011; Adame, 2014; Cohen, 2005; Mancini, 2007). In one qualitative study, the author chose to focus on the subgroup of survivor-therapist within the psychiatric survivorship movement (Adame, 2014). The author sought to better understand how individuals who self-identify as survivors understand their identities in the context of working within the mental health system as therapists, and how they negotiate the potentially contradictory roles of survivor and therapist within their clinical and advocacy work. Interviews were conducted with 5 individuals who self-identify as psychiatric survivors and who work as mental health professionals. The author did not provide an epistemological or theoretical framework to support his methodology. The participants were recruited via word of mouth. Interviews were semi-structured and lasted between 2 and 3 hours each and were transcribed and analyzed via holistic-content analysis – a hermeneutic form of narrative analysis (Adame, 2014). Participants
reported a lack of compassion and human connection within the mental health system.

One participant stated,

…you were made to feel as if you were irreparably damaged inside of your brain. And that you couldn’t trust yourself anymore because you might become ill again…it was extremely damaging. And just coupled with that was the fact that nobody really made, attempted to make any human contact with me…it took me a long time to recover from that (p. 460).

Regarding the combined roles of survivorship-therapist, themes of mutual support, parallel process, and non-pathologizing emerged. Interview data included descriptions of providing people in altered states of consciousness with the human contact and support that the interviewees did not receive when they were in an altered state, and that providing support to individuals in those states is also healing for the survivor-therapists. Interviewees noted that the survivorship movement overlaps with humanistic work and ideologies, in that there is an emphasis on healing through relationship. Interviewees all agreed that forced treatment is inherently untherapeutic and should end, and that while they are a part of the machine of the oppressive medical model, they work to maintain alternative forms of treatment and to maintain activism within the mental health community (Adame, 2014).

Another qualitative studied specifically examined experiences of poverty and social exclusion of psychiatric survivors using a capabilities approach to social justice. The capabilities approach has been applied to populations with disability and is a social-justice-oriented framework that focuses on quality of life (Benbow, Rudnick, Forchuk, & Edwards, 2014). The authors used participatory action research as the methodological framework for the study. The study took place in Ontario, Canada, and psychiatric survivors, consumer-rights organizations, and helping professionals of psychiatric survivors participated in the research process, which included generating the publication
of this particular study. The study included 380 participants who were between the ages of 18 and 75 years old and had been diagnosed with mental illness for a minimum of one year. The authors did not state participants’ diagnoses. It is also noteworthy that the authors were not using the definition of “psychiatric survivorship” that has been indicated previously in the current study. Benbow and colleagues (2014) did not indicate an element of recovery outside of traditional medical model methods of treatment. The authors defined psychiatric survivors as the following two conditions: (a) individuals who were subject to societal abuse, and (b) individuals who were prevented from reaching their full potential in society due to unjust social structures related to psychiatric disability. Interview questions were developed by considering the purpose of the study, social justice theory, existing literature, and input from the participants. A majority of the participants (67%) had experienced homelessness at least once in their lives, and 75% of the participants were unemployed at the time of participation in the study. Thematic analysis resulted in 4 main themes: poverty, stigma, belonging, and shared concern and advocacy. Poverty was encapsulated in the statement, “you just try to survive.” Participants shared the experience of losing the ability to work or attend school as a result of psychiatric disability, and then having to make financial choices about basic necessities, such as paying a bill or buying groceries. The stress of struggling with basic survival contributed to worsening mental health. An example of how the theme of stigma was phrased from one participant was stated as, “people treat you like trash.” The participants discussed the presence of stigma in terms of societal and individual responses to mental illness, psychiatry, education level, and homelessness; however, the intersection of stigma of psychiatric disability and poverty was perhaps the most
prominent. Another theme, belonging, was captured with the phrase, “you feel like you
don’t belong.” Participants expressed feelings of rejection and isolation from family,
community, and society, and also a desire of having somewhere to belong. The final
theme of shared concern and advocacy was described by “everyone deserves housing.”
The participants shared concerns about agencies being understaffed, and thus,
available treatments were limited. They also noted a need for increased outreach by
nonjudgmental helping professionals. Peer support was also identified as an important
method of inclusion and shared concern. The authors stated the need for further
research but did not state implications for policy and practice. This study sheds light
again on the experience of psychiatric survivors as being one of marginalization,
neglect, and lacking in autonomy over choosing resources and treatment options.
Again, this draws our attention to the need for rights-based support among those with
SMI.

Conceptual Contributions to the Literature on Psychiatric Survivorship

Meaningful conceptual articles have been written that amplify the voices of
psychiatric survivors and their allies. In her 2004 article about the c/s/x movement and
progressive psychotherapists, Bonnie Burstow identifies herself as a radical, humanist,
therapist who has been dedicated to the c/s/x movement for two decades. Burstow
describes how humanistic therapists share values with the c/s/x movement, such as:
non-reductionism, empowerment, the importance of choice, dignity, and self-
determination. Furthermore, both radically humanistic therapists and psychiatric
survivors are critical of the psychiatry industry as a system that violates the
aforementioned values in a vulnerable population (Burstow, 2004). The c/s/x movement
invites helping professionals to hear and act on the needs of consumers and align with
them around values. Since the c/s/x movement is a community, Burstow recommends that therapists use that community as a reference point for those in treatment. Within the c/s/x community, individuals can benefit from peer support among those who identify with each other and do not stigmatize symptoms of mental illness (Burstow, 2004). Clinicians can also become more acquainted with the literature and organizations that support the movement and disseminate this information to clients and other practitioners. For example, if a client has been told by a psychiatrist that electroshock does not cause long term damage and is considering the treatment, it would be equitable to also provide the client with information from those who have been treated by electroshock and feel that they were permanently altered (Burstow, 2004). Finally, Burstow recommends that c/s/x movement representatives are included in clinician initiatives that originate in professional circles.

As Burstow (2004) mentioned, dissemination of information plays an important role in facilitating the impact of c/s/x movement. The impact of the psychiatric survivor movement in the United Kingdom was theoretically examined using a framework developed for the examination of social movements (Bowl, 2002). Social movements seek to influence policy and practice, and also to expose underlying oppressive systems that have maintained non-inclusive policy and practice. Nelson’s five-fold approach to evaluating the effectiveness of social movements assesses the following areas: changes in public policy, changes in who is creating policy, changes in the allocation of resources, changes in the collective consciousness, and the development of organizational structures that allow for mobilization. The author noted that it is difficult to point to specific policy changes and changing allocation of resources on a systemic
level. On a small scale, allocating resources for increased service hours and hiring mental health staff can be seen as a result of consultation efforts. However, a difficulty in determining direct changes in service as a result of consultation is a failure of researchers to report on outcomes of consultations. Furthermore, individuals who use mental health services are often deemed as incompetent to participate in decision making, and so, cannot readily influence policy and resource allocation. In the domain of changing the collective consciousness, research in the United Kingdom indicates that service users, mental health professionals, and the public reports positive changes in perception of service users. Service users themselves report increased confidence in their experiential knowledge, mental health professionals and administrators are appreciating service users as experiential experts, and a person-centered approach is being increasingly recognized by the general public as a desirable option. The psychiatric survivorship movement has been particularly successful in developing organizational structures that accommodate the philosophical differences of survivors, consumers, and subgroups of these populations. There are also federal organizations and international networks that provide training and information for furthering survivorship efforts. The author concludes that the movement has had limited impact on policies and resource allocation but has been successful in developing organizational structures, influencing the collective consciousness, and has established greater representation in decision-making bodies. In order to shift policy and resource allocation, public expenditure and tailoring of services towards the demands of service user movement will need to happen, yet there is still formidable resistance in these areas (Bowl, 2002).
A Call for Change

The proceeding sections illustrated the vast implications of the relationship between trauma and mental illness, the potential for additional trauma and marginalization to occur during medical treatment of mental illness, and the relevance of mental health recovery practices in these issues. Considering the high prevalence of trauma among individuals with mental illness, and the relationship between trauma and health outcomes, helping professionals should advocate for humanistic practices in mental health systems. The c/s/x movement has a growing voice about the ways in which individuals with mental illness are dehumanized in mental health systems, and those who identify as survivors have become change agents. Helping professionals and survivors alike have called for change in the how current mental health systems operate. The following sections will discuss the history of oppressive practices related to treatment of people with mental illness, and the relevance of expanding social justice initiatives into mental health systems.

Brief History of Mental Illness in Society

A rudimentary understanding of the history of the medical model of mental health care can help to better appreciate the historical trauma and origins of currently oppressive systems. In a 2013 article, Joseph describes the long history of systemic oppression and marginalization through the pathologizing of individuals based on race, sexuality, and gender (Joseph, 2013). Dating back to 1851, the disease of drapetomania was described by physicians as a diagnosis given to slaves who ran away, assuming that they did not have the volition to run away unprovoked (Joseph, 2013). Within psychiatric hospitals, cruel and torturous “treatments” can be traced back to early 18th century England, where society developed a growing intolerance for bizarre
behavior in individuals and laws were enacted that allowed for people considered “rogues” or “vagabonds” to be forcibly restrained and confined (Joseph, 2013, p. 268). This is the period of psychiatric treatment that is associated with Bedlam and highly invasive and painful, forced procedures to treat “madness” (Joseph, 2013). As recently as the 1950’s, lobotomies were a popular treatment, due to the belief that cutting out pieces of the prefrontal cortex would alleviate symptoms of mental anguish; homosexuality existed in the Diagnostic and Statistical Manual of Mental Disorders (APA, 1980) through the 3rd edition (Joseph, 2013); and, differences in gender identity are still pathologized as gender dysphoria today (i.e., DSM–5) (APA, 2013). Among psychiatry today, electroconvulsive therapy (ECT) is considered to be the most effective treatment option for individuals with medication-resistant depression (Joseph, 2013).

**Moving into Action – A Social Justice Approach**

Counselors are aware, by virtue of their training, that mental illness is stigmatized in the United States; however, the term “stigma” falls short of describing the traumatic and repetitive experiences of discrimination experienced by people with symptoms of mental illness perpetrated by individuals and systems who exercise power over them (Bhui, 2016). Compared with other helping professionals such as social workers, nurses, and psychiatrists, psychologists (counselors) are proportionately less involved in serving individuals with symptoms of SMI (Carr et al., 2014). Counselors themselves may adopt stereotypes about people with mental illness, perpetuating the stigma that exists systemically (Overton & Medina, 2008). The way that counselors conceptualize clients with diagnosed mental illness reflects the negative beliefs about mental illness in the general population (Overton & Medina, 2008).
Yet, counseling has been concerned with social justice for many years (Carr et al., 2014). Social justice competencies have been set forth that include, but are not limited to, multicultural competence, an understanding of the impact of discrimination that occurs in micro and macrosystems and at individual, institutional, and societal levels, and the ability to reflect on one’s own power and privilege (Carr et al., 2014). Clinicians should adopt roles in addition to counselor, such as change-agent, advocate, consultant, and advisor must be adopted to put these competencies into action (Carr et al., 2014). In the context of SMI, social justice initiatives can be seen in the mental health recovery and psychiatric survivorship movements (Carr et al., 2014; Cohen, 2005). Just as with other social justice initiatives, the history of the medical model of mental health care must be considered to better appreciate the historical trauma and origin current oppressive systems. Carr, Bhagwat, Miller & Ponce (2014) have called for specific social justice training and recovery-oriented perspectives by mental health practitioners towards those labeled with mental illness. Individuals with SMI experience unemployment, poverty, and homelessness at disproportionate rates compared to individuals without SMI (Carr et al., 2014). Specific training related to SMI and social justice would prepare newer generations of helping professionals to provide recovery-oriented practices that address marginalization and discrimination to those labeled with SMI. An example of such training is the postdoctoral program at the Connecticut Mental Health Center hosted by Yale University School of Medicine’s Department of Psychiatry. The training is based on foundational concepts of community citizenship, equitable access to resources, and the support of self-determination of those in recovery. In their clinical work, the fellows learn strengths-based approaches and focus on the
empowerment of individuals in recovery through the lens of trauma-informed care. They also practice interdisciplinary consultation where they may develop recommendations for improving staff relations and building morale in psychiatric inpatient units or collaborate with institutions that work with individuals labeled with SMI on homelessness and unemployment. Fellows develop theoretical foundations for recovery-oriented care and social justice and are expected to demonstrate an ability to integrate theory into their understanding of public mental health systems. A limitation of such training is that concepts of social justice may not be well received or effectively conceptualized across systems. Ensuring continuous financial support for the training program is also a constraint. The authors note that psychology training programs are underrepresented among helping professionals who are making advances in recovery-oriented practices that take a social justice approach to helping individuals labeled with SMI (Carr et al., 2014). Recommendations for future directions include expansion of existing training programs into psychology, and expansion into advocacy in public mental health policy.

Connections between trauma and health outcomes has become a highly visible issue in our society. The ACE study has highlighted this phenomenon and psychiatry and hospitalization practices have a long history of traumatizing patients. The movement of psychiatric survivorship and the call towards social justice in mental health culture is evidence that our current medical model and its standards of care are falling short of providing safe, dignified, and healing environments for individuals with symptoms of SMI. In this section about psychiatric survivorship and social justice in mental health systems, the word “recovery” has appeared in the context that those in
survivorship have recovered or are in recovery from their mental illness. Literature about mental health recovery is reviewed in the following section.

**Mental Health Recovery**

The National Coalition of Mental Health Recovery (NCMHR) represents people who are recovering or who have recovered from mental illness (NCMHR, n.d.). The NCMHR maintains that recovery is real and possible for everyone and promotes individual rights in recovery (NCMHR, n.d.). The issue of being denied rights to treatment options was discussed in the previous section, as psychiatric survivors described the trauma of forced treatment and generally dehumanizing practices they had experienced (Adame, 2014; Burstow, 2004; Cohen, 2005; Mancini, 2007). The following section will address challenges with defining recovery, factors that facilitate recovery, and some barriers to recovery.

**Defining Mental Health Recovery**

“Mental health recovery” can be challenging to define. There are discrepancies in the definition of recovery between professionals and consumers, and recovery is a highly individualized process (McCauley et al., 2017). Some treatment consumers embrace the label of their diagnosis, along with a biological explanation of their condition, and accept consistent reliance on psychiatric intervention for stability (Lietz, Lacasse, & Cheung, 2014). While this may seem like a conservative estimate of recovery, there are many former mental health consumers who reject biological explanations of their mental illness and have achieved satisfying lives in which they function well without ongoing psychiatric intervention (Lietz, Lacasse, & Cheung, 2014). Regardless of the patients’ use of psychiatric services, generally agreed upon definitions of recovery encompass similar constructs to the following definitions: “…the
development of new meaning and purpose in one’s life, beyond the symptoms, disability, and stigma of mental illness…a process of healing physically and emotionally, of adjusting one’s attitudes, feelings, perceptions, beliefs, roles and goals in life” (Spaniol, 2002, p. 327). Or more broadly, the recovery movement “recognizes the ability of people with mental illness to participate in the mainstream of society” (Davidson, 2016, p. 1091).

Qualitative studies have attempted to generate models for universal aspects of mental health recovery. Results from such qualitative analyses suggest that unconditional acceptance from peers, processing of traumatic experiences, community and familial support, and empowerment are some shared processes of recovery (Cohen, 2005; Gehart, 2012; Moran & Russo-Netzer, 2016). Self-transcendent experiences where patients shifted from hopeless perspectives to a sense of greater life purpose and existential peace have also been identified as universal experiences of recovery (Gehart; 2012; Moran & Russo-Netzer, 2016). Mental health recovery is also identified as a consumer-driven process that embraces social justice and rights for those living with mental illness (Gehart, 2012). Yet, despite efforts to find commonalities in clients’ recovery processes and recovery models, one barrier to working toward recovery is a lack of cohesive understanding of recovery-oriented practices among clinicians and care givers (Kartalova-O’Doherty et al., 2012). Nonetheless, the c/s/x movement has resulted in the organization and implementation of recovery-oriented practices, which will be covered below as as a part of the discussion on factors that facilitate recovery.
Factors Influencing Recovery

Peer support

Some key factors that facilitate recovery are peer support, psychological well-being (having a sense of purpose and realizing one’s potential), and organizational culture. First, one factor that continuously stands out as an important factor in recovery is peer support (Beehler, Clark, & Eisen, 2014). A study was carried out in the Veteran’s Health Association (VHA) to evaluate the differences in recovery processes between peer-led recovery-oriented groups and a clinician-led recovery-oriented group. The group model used was the Vet-to-Vet educational support group, which was followed by both the peer facilitated and the clinician facilitated groups. Each of the groups had a foundation in workbook style recovery materials, such as the Spaniol Recovery Workbook, but facilitators could improvise the introduction of other activities as long as they were considered to be recovery oriented. Participants had been diagnosed with at least one psychiatric condition and had taken part in mental health services at the participating VA within the previous 12 months but were not attending Vet-to-Vet groups at the time of the study. The peer group consisted of 13 participants and the clinician facilitated group consisted of 11 participants. Data was collected through semi-structured interviews and was analyzed via grounded theory as described by Strauss and Corbin. Participants from both groups reported that they were engaged in recovery experiences; however, the clinician-led group members indicated that there were more variations in activities and in the quality of communication. Descriptions of the clinician facilitators ranged widely from extremely positive to extremely negative. An important factor in group satisfaction is whether or not the facilitator was a peer with mental illness, as the participants felt it was beneficial to work with someone who had an
intimate knowledge of recovery based on lived experiences. Participants indicated that
the facilitator did not need to be a veteran in order to be helpful. Those in the peer-led
group reported an ability to open up in group more quickly than in the clinician-led
group. This sort of subtle dynamic points to the complexity of group process and the
strengths and weaknesses of either a peer or clinician facilitator. The authors
recognized that group participants may have been reserved in the candor of their
responses during the interviews out of respect for group norms and confidentiality. The
authors recommend that additional research be conducted on the interaction of peer
facilitators and clinicians in order to optimize benefits to veterans through their
collaboration (Beehler et al., 2014).

Wellness Recovery Action Planning (WRAP)

WRAP was developed in 1997, largely by Mary Ellen Copeland, who had been
living for years with debilitating anxiety, depression, severe mood swings, and had
encountered repeated hospitalizations and had become critical of traditional psychiatry
(Copeland Center for Wellness and Recovery, n.d.). WRAP is a recovery-oriented, self-
management program that incorporates peer support is widely disseminated in the
United States (Cook et al., 2010). In WRAP programs, people develop their own
recovery plan by identifying internal and external resources (Cook, 2010), identifying
and coping with triggers, early warning signs of symptom exacerbation and crisis, and
how to implement their recovery plan in their daily lives (Cook et al., 2012). People
typically develop their individualized WRAP plans by attending groups that are led by
certified WRAP educators (Cook et al., 2012). Specifically, from the Copeland Center
for Wellness and Recovery website, “The Wellness Recovery Action Plan (WRAP®) is a
personalized wellness and recovery system born out of and rooted in the principle of
self-determination. WRAP® is a wellness and recovery approach that helps people to:
1) decrease and prevent intrusive or troubling feelings and behaviors; 2) increase
personal empowerment; 3) improve quality of life; and 4) achieve their own life goals
and dreams.”

WRAP participation and training has grown significantly in recent years, yet
outcome studies were lacking (Cook et al., 2010). Focusing on peer-led WRAP groups,
Dr. Mary Ellen Copeland partnered with researchers from the National Research and
Training Center on Psychiatric Disability at the University of Illinois at Chicago (UIC) and
two state-wide organizations: Vermont Psychiatric Survivors and the Minnesota
Consumer/Survivor Network. The research team sought to examine the effectiveness
of WRAP when it is implemented on a large scale and if participants in larger initiatives
experience the same positive outcomes as participants in individual WRAP groups
(Cook et al., 2010). Pre- and post-test comparisons were made for 381 participants (234
from the Minnesota group and 147 from the Vermont group), and participants were
individuals who participated in peer-led WRAP groups (Cook et al., 2010). Three
dimensions of self-management were assessed during pre and post-test: attitudes (i.e.,
hope for recovery and assumed responsibility for wellness), knowledge (i.e., symptoms
triggers, early warning signs of decompensation), and skills (i.e., use of wellness tools,
recognizing social support networks) (Cook et al., 2010). The researchers found that
within both states, WRAP participants reported significant increases in several
constructs, including hopefulness for their own recovery, awareness of early warning
signs of decompensation, having a crisis plan in place, and having a greater awareness
of triggers (Cook et al., 2010).
In a study with hypotheses specifically about depression, anxiety, and self-perceived recovery in individuals with severe mental illness, Cook in collaboration again with UIC sought to test the effective of WRAP from clients from community agencies in 6 Ohio communities (Cook, 2012). A total of 519 participants completed the baseline interview and were randomly assigned to WRAP groups or the typical agency mental health services. WRAP groups were held weekly for 8 weeks and were facilitated by peer survivors who were also certified WRAP educators. Individuals in the control group received services such as individual therapy and medication management and were wait-listed for WRAP groups being offered after the study concluded. Interviewers who conducted baseline, 2-month, and 8-month interviews were blind to the treatment statuses of the participants. Individuals in the WRAP groups reported significantly greater reduction over time in depression and anxiety symptoms using the Brief Symptom Inventory depression and anxiety subscales, and also reported significantly higher total scores over time on the Recovery Assessment Scale, and in particular in the personal confidence and goal orientation subscales (Cook, 2012).

**Intentional Peer Support (IPS)**

Intentional peer support is a model that focuses on trauma-informed relationship building in which people are encouraged to challenge how we know what we know, and to use relationships to look at how we have come to be in the world as we are to help both participants in the relationship to step outside of their current stories. Peer support does not adhere to a psychiatric models or diagnoses (Meade, 2014). Intentional Peer Support was developed by Shery Meade, who experienced the medical mental health system for the first time as a teenager. The environment consisted of over medicated patients, routine electroshock treatments, and general messages of hopelessness
where a significantly limited life in a halfway house was a reasonable future (Intentional Peer Support, n.d.). Eventually, despite enjoying extended periods of wellness, Shery’s psychiatric diagnosis threatened her custody of her children. This prompted Shery to create a peer organization where individuals could “unlearn the mental patient role.”

She went on to create New Hampshire’s first peer-run respite program and has trained mental health professionals at local, national, and international levels (Intentional Peer Support, n.d.). In Shery Meade’s book, *Intentional Peer Support* (2014) she describes 4 tasks of peer support: (a) connection, which was considered to be the core of peer support, (b) worldview, which was defined as helping one another understand their meaning making around experiences, (c) mutuality, which was a step towards reframing the notion of help as a collaborative and growth oriented process, and (d) moving towards, which was the final step in moving forward towards goals and moving away from unwanted experiences.

Research is lacking in assessing Shery Meade’s IPS. Broadening literature searches to just “peer support” yields vast results that include weight loss and peer support for individuals diagnosed with mental illness, computer use in peer groups for individuals diagnosed with mental illness, and potentially many articles that define peer support casually and do not refer to specific training programs. Yet, if we look at the previously provided information about psychiatric survivorship and WRAP, peer support is an integral part of these movements and models. WRAP groups are facilitated by certified WRAP educators who are often peers within the mental health care system. Peer support has been identified as a healing factor in the oral histories of psychiatric survivorship and recovery (Cohen, 2005). In *Narratives of Recovery from Mental Illness*:
The Role of Peer Support, Watts and Higgins present in detail the recovery narratives of 26 individuals who received diagnoses of “mental illness.” They argue that while the medical model may play a role in an individual’s wellness, symptoms of “mental illness” can be resolved through supportive peer and community relationships (Watts & Higgins, 2016). The 26 individuals described in this book participated in a mutual help group called GROW (Watts & Higgins, 2016). Thus, we can see that peer support has been meaningful to recovery in general – not just as a result of specifically IPS as described by Shery Meade. The common thread, however, is that individuals in mental health recovery heal through compassionate relationships and connectedness to individuals and communities (Watts & Higgins, 2016).

**Other facilitating factors of recovery**

As peer support is a consistent factor thought to impact mental health recovery, psychological well-being has also been connected to recovery, as it refers to people experiencing meaning and a sense of purpose in life through realizations of their potential (Brown et al., 2017). Research was conducted with the specific objectives of examining the impact of treatment in the NAVIGATE program on psychological well-being and the mental health recovery process, the impact of duration of untreated psychosis on recovery outcomes, and to examine the relationship between psychological well-being, mental health recovery, and quality of life. The NAVIGATE program is a recovery-oriented program for individuals who have experienced first-episode psychosis (FEP) and was developed under the Recovery After an Initial Schizophrenia Episode Early Treatment Program (RAISE ETP). In this particular study, the authors sought to examine a subset of measures that were initially used in the RAISE ETP, and thus did not include every measure used in the entire NAVIGATE program.
program. Participants were 404 individuals who had experienced FEP and were randomized into NAVIGATE or Community Care. The authors did not describe characteristics of the Community Care model, which was designated as the control group. The instruments used, which focused on elements of RAISE ETP, were the Scales of Psychological Well-Being – ETP Modification Version (SPWB), a modified version of the Mental Health Recovery Measure (MHRM), the Quality of Life Scale (QLS), and the Calgary Depression Scale for Schizophrenia (CDSS). Multilevel modeling was used as the participants were nested in clinics that were providing NAVIGATE treatment or were providing Community Care. Results indicated that psychological well-being increased over 24 months without significant differences between groups. Duration of untreated psychosis was significantly related to time in both groups, indicating that the shorter time of untreated psychosis was associated with higher scores on the Mastery of Environment subscale of the SPWB. Quality of life, psychological well-being, and recovery were all significantly correlated when controlling for depressive symptoms. The authors suggested that increases in psychological well-being and progress in recovery are reasonable treatment goals after FEP, and that the duration of untreated psychosis may have important implications for some facets of psychological well-being and recovery. This study adds to the literature on psychological well-being as a factor related to recovery, and also the need for timely treatment for individuals with psychosis.

Lastly, organizational culture is an important factor in agencies promoting mental health recovery. Provider attitude and staff attitudes have been noted to affect consumer outcomes (Clossey & Rheinheimer, 2014). Nationally, agencies have been
responding to the movement of mental health consumer advocates by adopting recovery-oriented practices. A recovery-oriented agency must provide consumer-driven choices in treatment options that consumers are empowered to choose autonomously. Since agencies often seek advice about implementing recovery-oriented practices, the authors compared organizations’ cultures around mental health recovery to consumers’ perceptions of support for recovery. Twelve agencies in a rural area of Pennsylvania agreed to participate in the study. Researchers attended agency staff meetings, obtained informed consent, and administered surveys. Measures for consumers to complete were left at each agency and the staff were asked to recruit the response of clients. It should be noted that the power differential between the agency staff and the clients may have compelled the clients to respond, even though they were reassured that participation was voluntary. The instruments used were the Recovery Oriented Services Indicators (ROSI), the Organizational Social Context (OSC), and the American Association of Community Psychiatrists Recovery Oriented Service Environment (AACP ROSE). ROSIs were completed by the consumers, which totaled 188 responses. OSCs were completed by staff members, which totaled 94 responses across the 12 agencies, and administrators from 11 of the 12 agencies completed the ROSE, resulting in 32 responses. Client scores on the ROSI were correlated with agency scores on the OSC. Note that the authors do not specify data analysis for the ROSE. Results indicated that higher consumer perceptions of agency support were significantly correlated to higher ratings of agency constructive culture, per the OSC. These results highlight that agency culture is an important aspect of mental health recovery and is an important variable to address when implementing recovery-oriented practices (Clossey et al., 2014).
As indicated above, recovery is a highly individualized practice. Elements of recovery are often described by psychiatric survivors. Peer support, agency over treatment choices, rights-based services, and empowerment continue to emerge as important characteristics of mental health recovery. Efforts to quantitatively assess characteristics of agencies that use recovery-oriented practices indicate that there are many levels across individual interactions and agency culture that contribute to facilitating mental health recovery. The following section will review trauma-informed care. Previous sections have described how individuals with mental illness have experienced trauma at much higher rates than individuals without mental illness, and that individuals with mental illness have been traumatized in treatment. Trauma informed care provides helping professionals with guidelines for humanistic, non-traumatizing practices that may also facilitate recovery.

**Recovery Practices and Trauma Informed Care**

Considering that traumatic experiences have repeatedly been correlated with poor mental health outcomes, and that processing trauma has been identified as factor in establishing mental health recovery, trauma-informed care may provide an accessible set of guidelines for offering support to individuals who are suffering from mental illness and are also seeking recovery. Trauma-informed care (TIC) follows a specific set of principles. These principles provide a framework for trauma-informed services which are not designed to treat specific symptoms or mental illnesses but are informed by a sensitivity to trauma and the issues that trauma presents in the lives of survivors (Ardino, 2014). The following is a list of trauma-informed care principles adapted from Elliot et al. (2005) as described in Ardino (2014):
1. Trauma-informed services recognize the impact of violence and victimization on the development of coping strategies and the need of addressing long-term impact

2. Trauma-informed services identify recovery from trauma as the primary goal.

3. Trauma informed services empower the client.

4. Trauma informed services are based in a relational collaboration

5. Trauma informed services create an atmosphere that is respectful of the survivor’s need for safety, respect, and acceptance.

6. Trauma informed services strive to maximize the client’s choices and control over his/her recovery.

7. Trauma informed services emphasize the client’s strengths, highlighting adaptation and resilience over symptoms and pathology

8. Trauma-informed services strive to be culturally competent and to understand each individual in the context of his/her life experiences and cultural background

9. Trauma-informed agencies encourage service-user involvement in designing and evaluating services.

In application, trauma-informed care utilizes a relational approach, as healing occurs through relationship rather than in isolation. The clinician must do what he/she can to minimize the power imbalance in the therapeutic alliance. Trauma victims have experienced a loss of power and that power imbalance should not be replicated in the therapeutic relationship (Ardino, 2014).

The veteran population is particularly suited for the application of trauma informed care, as they experience high rates of PTSD and other trauma related concerns, many of whom have sought care for deployments to Iraq and/or Afghanistan. Yet, the VHA is overburdened with increasing need for services (Currier, 2017). In a conceptual article (Currier, 2017), authors discussed the relevance of providing TIC to veterans in agencies outside of the VHA, as trauma specific and trauma sensitive services would meet the needs of veterans who have experienced traumatic events.
Recent data from the Department of Defense indicates that approximately 1 in 5 service members experienced some form of childhood abuse (Currier, 2017). Trauma-informed care for veterans in community agencies would foremost include a trauma-sensitive environment. Characteristics of a trauma-sensitive environment include the following characteristics: (a) ensuring privacy when asking individuals to complete forms related to trauma or mental health symptoms, (b) allowing the clientele to choose where to sit in a waiting or consulting area, and (c) ridding the environment of undue noise pollution, including loud and unpredictable noises (Currier, 2017). The authors suggest that organizations follow 5 principles of TIC organizations: safety, trustworthiness, choice, collaboration, and empowerment (Currier, 2017). Safety is promoted by creating a physically and emotionally safe environment by, for example, not insisting that a client perform a relaxation exercise with closed eyes, not putting a client in a position to have to recall a traumatic event multiple times through paper work and verbal descriptions to staff, and proactively inquiring about triggers and perceived safety as treatment develops. Through a TIC lens, trust is granted to organizations by veterans; it is not created within veterans by the organizations (Currier, 2017). Agencies should be transparent and honest in behaviors and procedures across all levels of the agency. The agency should be consistent in its use of language and should avoid obscurity about policies and procedures. Choice and collaboration each emphasize the inclusion of veterans in treatment decision making in terms of values and preferences, while providing access to the treatments deemed most effective by outcomes. For example, exposure therapy has a large body of evidence in treating PTSD, but counselors should be prepared to adjust protocols for exposures based on the client’s level of distress,
preferences, resources, and trauma triggers. Empowerment includes encouraging self-advocacy for veterans within and between organizations (Currier, 2017). Often, veterans may be using or seeking out assistance from multiple service providers in the community, and these providers may be within the VHA or in the community (Currier, 2017). TIC agencies become familiar with the services provided in other agencies used by the veterans and cultivate ties with these agencies to promote advocacy. The authors note that while the scientific underpinnings of TIC are well-documented, TIC is largely a theoretical model in practice and application. Yet, keeping dialogue about TIC on the forefront may concretize practical approaches or research efforts and thus lead to beneficial shifts systemic culture and service delivery for veterans with PTSD.

As stated previously in a review of the ACE Study, childhood trauma is a significant public health issue. Approximately 6 million children per year are involved in a report of abuse or neglect to child protective services (Bartlett et al., 2016). The impact of abuse or neglect is often compounded by disruption to families, including separation and loss through the delivery of child welfare services. The Massachusetts Child Trauma Project (MCTP) is a 5-year effort to implement and sustain TIC in within child welfare and child mental health network. Researchers drew data from a mixed methods study to examine child outcomes in the implementation of key aspects of TIC under the MCTP project (Bartlett et al., 2016). The authors hypothesized that MCTP’s TIC approach would have measurable benefits after 6 to 12 months of project implementation. Data was collected for 16 area offices’ Trauma Informed Leadership Teams (TILTs), 20 senior leaders from community mental health agencies who participated in learning collaboratives in the first 12 months of the project, 185 clinicians
across several agencies who completed surveys assessing TIC practices and policies before training in MCTP and one year after, and 326 children who received evidence-based therapies. To examine the implementation of TICs among TILTs, the researchers reviewed meeting documentation and conducted interviews regarding first-year implementation. Senior leaders also completed interviews and completed measures assessing for trauma screening practices, referral practices, outreach to child welfare, and MCTP implementation. The Trauma Informed System Change Instrument was used to assess clinicians. Higher scores are indicative of more trauma informed policies and practices. The Young Child PTSD Checklist and the Child Behavior Checklist were used to assess child outcomes; the University of California Los Angeles Post Traumatic Stress Disorder Reaction Index (UCLA PTSD-RI) was used to assess trauma in children aged 7 – 18 years of age. To analyze interview data from TILT leaders, the interviews were coded from audio recordings and analyzed for themes. Senior leader and clinician data were analyzed by reviewing online survey results and using t tests to assess changes in trauma informed policies practices prior to MCTP training and one year later. Child outcome data was assessed via multivariate analysis. Results showed that children aged 8 – 18 years self-reported reduction of PTSD symptoms on all subscales of the UCLA PTSD-RI and had fewer behavioral problems than were reported at baseline. TILTs emerged as a key component of implementing TIC in the child welfare system. The authors suggested that future research should be conducted to examine variations in TIC across service systems (Bartlett et al., 2016).

TIC has shown to be an effective treatment model for individuals with trauma history who are at risk or who are already showing poor mental health. One study used
an interdisciplinary TIC program with urban youths who experienced behavior or mental health issues (Becker, Greenwald & Mitchell, 2011). The participants came from one urban community and scored an average of 5.2 items on the Lifetime Incidence of Traumatic Events (LITE) scale, and 6.9 items on the Urban Trauma Index (UTI). Note that the LITE scale and UTI are 16 and 21 item measures, respectively, with a parent and self-report sheet and the items are tallied by clinicians as a screening for exposure to traumatic events (Becker et al., 2011). Average post-test scores (compared to pre-test) on the Impact of Events Scale, Child Report of Posttraumatic Symptoms, and the Parent Report on Posttraumatic Symptoms, all showed a statistically significant improvement. Anecdotally, children who were using classroom accommodations in school were observed to require less accommodations, medication adherence improved, and parents reported that they had begun to appreciate the impact of traumatic events on their children’s behaviors rather than seeing the children as bad (Becker, Greenwald & Mitchell, 2011).

As we can see from the literature reviewed in this section, trauma informed care values client empowerment and consumer-driven treatment. It is also sensitive to previous traumas that mental health services users may have experienced and aims to minimize the power dynamic between the consumer and the provider so as not to replicate a power imbalance that triggers a previous trauma. The following section will address the need for an epistemological shift in mental health systems. Material covered in previous sections has indicated that trauma and mental illness are highly correlated and that the medical model can be as damaging as it is helpful. Some scholars and practitioners believe that we need an epistemological paradigm shift in
order to facilitate systemic changes in mental health care. A description of mental illness as a social construct will be discussed, as well as current critiques of the medical model.

**Epistemological Issues and the Concept of Mental Illness: A Paradigm Shift**

In *The Foundations of Social Research*, Michael Crotty (2015) describes positivism as a theoretical framework that can operate under the umbrella of an objectivist epistemology, and constructionism (rather than constructivism) as an epistemology. For the purposes of this review, positivism will be described generally and there will be no distinction made between positivism as a theoretical framework or as an epistemology, and “constructionism” as described by Crotty can be used interchangeably with “constructivism” as an epistemology described by other authors. In a positivist orientation, reality is measurable, discoverable through objectivity, and humans may uncover an unambiguous knowledge of the world (Crotty, 2015; Merriam, 2009). Knowledge obtained through positivism is understood as accurate, scientific, and is embraced with a strong sense of conviction (Crotty, 2015; Merriam, 2009). Knowledge acquired through positivist pursuits is often considered to be superior or “factual” knowledge, compared any knowledge that is acquired in “non-scientific” ways that gives rise to opinions, beliefs, assumptions, and feelings (Crotty, 2015).

Social constructionism suggests that humans behave with intentionality and construct meaning in their worlds (Creswell, 2013; Crotty, 2015; Merriam, 2009). This is not to be mistaken with subjectivism in which humans create meaning; in constructionism, people construct meaning with materials that are already present, namely the world its objects (Crotty, 2015). Social constructionism, more specifically, takes into consideration that humans are born into worlds that already filled with meaning and symbols (Crotty, 2015). The “social” aspect does not refer exclusively to
knowledge being generated by people interacting with people. An interaction with objects and the environment is considered a social interaction because it is historical knowledge and culturally embedded meaning that teaches people how to interact with objects and the environment (Crotty, 2015).

There is a clash between positivism in the medical model of mental health care, and a call towards the recognition of mental illness as a social construct, which would allow mental health consumers to participate more fully in the pursuit of their own wellness. We can see from the narratives of individuals in psychiatric survivorship that top-down approaches, in which medical professionals used coercive power to implement treatment, could be traumatic and did not necessarily contribute to long term wellness. In the description of the history of oppression in mental health systems, we see that individuals who exhibited disruptive behavior were labeled as ill, perhaps merely because their behaviors were inconvenient to others. Modern science has been on a search for “chemical imbalances” that can describe the molecular and cellular causes of specific mental illnesses (Whitaker, 2014), yet despite sophisticated research efforts we have yet to uncover unified theory of causation for any particular mental illness (Hyman, 2013; Whitaker, 2014).

The voices who are challenging the positivist worldview of mental illness belong to psychiatrists, counselors, scholars, and mental health consumers. The current author will discuss some common criticisms of the medical research that has been done to pinpoint discrete causes of mental illness. This is not to say that scientific research has no place in the pursuit of answers for individuals who suffer from symptoms of mental illness. Rather, from a constructionist perspective, scientific knowledge is also a type of
constructed knowledge that serves a purpose when applied appropriately; information gathered from other means than scientific research is also valued and considered equally (Crotty, 2015). Individuals who are critical of the medical model, as it exists today, believe that the human element of mental health care has been lost and that the top-down medical model of care can be harmful, but also that we are lacking in evidence to support the medical model compared to how tightly we hold onto it (Hansen, 2016; Whitaker, 2014).

Opinions and criticisms of the medical model of mental illness in this section are presented to familiarize readers with the some of the voices that have been significant in the call for a paradigm shift in treating mental illness. It is neither the opinion of the current author, or of those referenced, that medication is completely inappropriate. Rather, this section presents observations from research and reviews of previous research that raise questions about the effectiveness of the medical model and the view that SMI s are chronic, lifelong conditions in which individuals will require constant maintenance on medications that have their own host of side effects. As previous sections have presented information the medical model from the consumer’s perspective, this section presents information from those who are allies in the movement towards more humanistic and constructivist systems of mental health care.

In his seminal work, *Meaning Systems and Mental Health Culture: Critical Perspectives on Contemporary Counseling and Psychotherapy*, James T. Hansen (2016) diligently established the relevance of humans as meaning-making beings and the importance of meaning systems in psychological suffering and healing. He argued that by adopting a medical model, contemporary counselors have essentially discarded
the importance of meaning systems in psychology and helping encounters. Through postmodern frames, specifically social constructionism, many assumptions that have become standard in the medical model of psychology come into question. Therapists work in relationships with individuals and their non-material meaning systems; not in the material realities of the field of medicine (Hansen, 2016). Why, then, does the counseling community continue to be complicit in upholding the medical model of mental health? As Hansen (2016) pointed out: “Conducting relational therapy with clusters of symptoms, instead of human beings, is about the worst fit imaginable” (p. 87). There is clearly an economic issue in the adherence of the counseling profession to the culture of medicine: third party payers dictate courses of therapy from the frame of the medical model, and there is no money to be made in challenging the larger systems that keep the medical model in place. Hansen (2016) also suggested that counseling and medicine are so disparate in their frameworks that counselors may end up embracing the medical model out of cognitive dissonance.

Another prominent figure in the advocacy for mental health reform is Robert Whitaker, an investigative journalist who specializes in covering issues in medicine (“Mad in America”, n.d.). His critical investigations of the culture of modern psychiatry have garnered a lot of mainstream attention. His works have been recognized with a George Polk Award for Medical writing and National Association for Science Writer’s Award. His 1998 co-authored series on psychiatric research was a finalist for the Pulitzer Prize for Public Service; Discover Magazine named his first book, Mad in America, as one of the best science books of 2002; and his latest book, Anatomy of an Epidemic, was awarded with the 2010 Investigative Reporters and Editors book award.
for best investigative journalism ("Mad in America" n.d.). In Anatomy of an Epidemic, Whitaker presented readers with the historical look at the development of the serotonin hypothesis of depression and the dopamine hypothesis of schizophrenia and extensively reviews clinical studies from the 1960’s and 1970’s that examined those hypotheses and failed to find corroborating evidence (Whitaker, 2014). Whitaker critically examined the long term outcomes of individuals with schizophrenia as neuroleptics became available as a first line of treatment, and argued that relapse rates of psychotic episodes and hospitalizations were no better before neuroleptics became evident than they were after (Whitaker, 2014). He is also critical of medical researchers for failing to implement well-designed, long term outcome studies for individuals who were diagnosed with schizophrenia and maintained on neuroleptics for months, if not years, after diagnosis (Whitaker, 2014).

Whitaker’s criticisms of modern psychiatry were shared by Dr. Loren Mosher, whose life’s work revolved around the development of more humanistic care of individuals with schizophrenia (Lenzer, 2004). Mosher, an honors graduate from Harvard University, served as the first chief of the Center for Schizophrenia Studies of the National Institutes on Mental Health from 1968 to 1980. Dr. Mosher was influenced by R.D. Laing, a British psychiatrist who believed that schizophrenia is a response to unbearable circumstances (Lenzer, 2004), and who wanted to make the process of “going mad” comprehensible and felt that the care of individuals in psychiatric wards was barbaric (Brocklehurst, 2017). In seeking more humane treatment for those with schizophrenia, Mosher developed the Soteria Project – a residential treatment program where staff members were encouraged to treat residents as peers by sharing household
chores, respecting individual differences, and promoting autonomy (Lenzer, 2004). Mosher was not an extremist in his rejection of standard psychiatry. He believed that medication could be appropriate, but as a last resort and at more conservative doses. If, after 6 weeks in the Soteria program without progress, the residents consented to treatment with neuroleptics, they would be prescribed medications at a low dose (Lenzer, 2014).

The goal of the Soteria program was to provide individuals early in their diagnosis of schizophrenia with intensive psychosocial treatment that was community based and relationship-focused, and last-resort use of antipsychotic medications (Bola & Mosher, 2003). A two-year follow up study reported on outcomes of 179 participants in Soteria: 79 of which participated in a quasi-experimental design from the first cohort, and 100 from the second cohort who participated in an experimental design (Bola & Mosher, 2003). The control group consisted of individuals who were treated in general psychiatric units using a model of rapid evaluation, 94% of whom were continuously given antipsychotics, and were referred to outpatient facilities with a continued prescription for antipsychotics (Bola & Mosher, 2003). Using multivariate analysis, the researchers found that, when adjusted for attrition, participants in the Soteria program had significantly higher composite outcomes, and specifically significantly better outcomes on the measures of psychopathology and readmissions to hospitals (Bola & Mosher, 2003). Regarding medication, only 58% of the Soteria project participants received antipsychotic medications during the follow-up period, and only 19% maintained a continuous use of antipsychotics (Bola & Mosher, 2003). Statistically, participation in the Soteria group did not reduce duration of medication compared to the
hospitalized control group among those receiving medication during follow-up but did show a reduction in the amount of total patients receiving medication (Bola & Mosher, 2003).

In more recent years, scholars and industry leaders have continued to investigate and criticize the strong commitment to the medical model. Thomas Insel was the director of the National Institute of Mental Health (NIMH) from 2002 – 2015 (National Institute of Mental Health, n.d.). During his tenure, Insel maintained a public opinion that antipsychotic medications are useful in reducing the scary and sometimes dangerous symptoms at the onset of psychosis, but that continuous long-term use of antipsychotics is not the correct course of action for every individual who has experienced psychosis (Insel, 2013). What we refer to as schizophrenia may be an initial onset of psychosis that has very different long-term trajectories for different people; for some individuals, long term continuous use of antipsychotics may impede a recovery to a fully functional and meaningful life (Insel, 2013a). Insel has also been openly critical of the DSM, stating that it is a reliable source in that it provides consistency with language and diagnostic criteria, but lacks in validity as the symptom clusters are not based on any objective measure as they are with medical conditions (Insel, 2013b). Under Insel’s leadership, the NIMH discontinued funding research studies with DSM criteria as its foundation (Insel, 2013b). Rather than pursue research that perpetuates a classification system that lacks objective measures, the NIMH launched the Research Domain Criteria project with goals of beginning a new classification system that incorporates information from multiple levels, such as genetics, imaging, and cognitive science (Insel, 2013).
We may also turn our attention, epistemologically, to Eurocentrism and colonization in the development of meaning systems in mental health. As mentioned previously, the medical model of mental health can be described as a positivist paradigm. The traditions of positivism have been handed down to modern Western society from the enlightenment era of the middle ages in Europe and philosophers such as Kant and Descartes, who influenced the process of inquiry toward skepticism, a search for objective realities, and empiricism (Joseph, 2015). Eurocentrism imposes a view that issues of society at large, or even globally, can be solved by the adoption Western culture (Joseph, 2015). In the quest for universal and medically quantifiable causes of mental illness, psychiatry has stood on a foundation of Western philosophy using positivism and undervaluing information that is not gathered through scientific method in its effort characterize symptoms that are associated with one’s state of being (Joseph, 2015). Being in the world is inexorably tied to culture and histories of cultures, and the Eurocentric approach to objectively discovering mental illness has not allowed for meanings and histories in mental health systems from other cultures to become relevant (Joseph, 2015). The narratives of psychiatric survivor have indicated that being epistemologically singular, regarding mental illness, is hazardous as individuals have been dehumanized and oppressed through medical treatments (Joseph, 2015; Rose, 2017).

An epistemological shift towards a collective co-construction of knowledge about mental illness would alleviate the oppressive trappings of primarily Eurocentric and positivist meaning systems in mental health care. Considering mental health as a construct, rather than as a medical fact, loosens the rigidity of the thinking that is
inherent within the medical/deficit model. Existing in the medical model tends to permit certain beliefs about mental illness, namely that pathology is permanent across the lifespan and that mental illnesses are all-encompassing of an individual’s life experience. Consequently, that leaves little to no room for recovery. Yet recovery rates of individuals with symptoms of schizophrenia – full or partial recovery – range from approximately 45 – 65% and are an even higher 80% for individuals with symptoms of depression (Davidson, 2004). Symptoms of mental illness arise out of “normal” people, meaning humans are not born with mental illnesses or obvious deficiencies that give rise to them. The majority of people who fall into a state of psychosis do not stay in psychosis for their lifetimes; and even for those who are in psychosis more often, their lived experiences are still constituted of competence and periods of health (Davidson, 2004).

This review has covered a broad range of topics that hopefully now seem relevant to one another in terms of mental health practices at individual and systemic levels. Through the ACE study we can see that trauma has relationships to mental health outcomes, but also to an array of health outcomes in general, highlighting the far-reaching impact that trauma can have on individuals. Some researchers have focused their efforts on potentially distinguishing subtypes of certain mental illnesses such as OCD and schizophrenia and have suggested that trauma-induced manifestations of these conditions exist with distinct clinical characteristics (Fontanelle et al., 2011; Fuller 2010). Yet despite the high correlation between trauma and mental illness, clinicians often overlook the need to assess for trauma or incorporate trauma treatment when working with individuals with SMI (Chessen et al., 2011). Furthermore, the c/s/x
movement is a massive, international movement that brings to light the extent to which traditional treatment in the medical model of mental health has been traumatizing through oppression, neglect, forced drugging and restraining, and electroshock therapy (Burstow, 2004). Surely if there is a statistical likelihood that individuals with SMI have experienced trauma at some point in their lives, the treatment itself should not be additionally traumatic and marginalizing.

Much of the criticisms of the medical model of mental illness surrounds the observation that cellular and molecular explanations for mental illness have not been established and that the treatment of those with mental illness has developed in a system that takes an inappropriately positivist perspective (Davidson, 2004; Hansen, 2016). When we apply a positivist lens to matters of the psyche and of being in the world, we erroneously overlook knowledge that is gathered in ways that do not support positivism (Hansen, 2016). The c/s/x movement is telling the mental health industry that people with mental illness are traumatized and oppressed in the system and that consumers need to be able to co-construct their own mental health by having other options than being thrust into traditional psychiatry. As counseling has acknowledged with other minority populations, individuals with mental illness face discrimination, oppression, and stigma and are equally as deserving of social justice efforts and should be included in multicultural competencies (Overton & Medina, 2008). Shifting the paradigm of mental illness towards a social constructionist perspective would honor the ability of consumers to be informed by their own experiences and value information gathered through non-scientific means.
The c/s/x movement is related to mental health recovery as the movement seeks to empower individuals with mental illness towards a functional and meaningful life where they are not the passive recipients of treatment with intolerable side effects and neglectful practices. Mental health recovery does not have a discrete definition but does suggest that individuals with mental illness should have the same hope, aspirations, and meaningfulness in life as those without mental illness (Carr et al., 2014). For some, this may happen with the support of psychiatry while others define recovery as a total separation from medications and hospitalizations. Recovery is an individual process, pointing again to a constructivist paradigm where individuals can identify their own process rather than participating in a prescriptive, top-down approach to wellness. The current author has also acknowledged that people respond differently to treatment and that SMI can have very different trajectories for different people. Not everyone responds the same way to medications, and not everyone experiences the same intensity, frequency, or duration of symptoms (Insel, 2013a).

As stated earlier, it is not the position of the author or necessarily the scholars and practitioners cited in this article that modern psychiatry is completely inappropriate. Certainly, hospital stays and medications have been and will continue to be helpful for individuals experiencing acute symptoms of SMI. Yet a critical perspective on the medical model has indicated that we may not know as much as we think we do about the origins of mental illness. What can counselors do about the backlash toward the medical model and the call for more humane and constructivist treatment? Counselors can train in WRAP and IPS programs with a goal of incorporating peer support and individualized wellness plans into their work. WRAP and IPS also have a goal of
societal change and are oriented towards social justice practices for those with SMI. Counselor educators can include people with SMI as a minority population that faces oppression and stigma and help students challenge their assumptions about those with mental illness. Lastly, social constructionism is not a perspective in which “scientific” knowledge is valued above other forms of knowledge. By becoming attuned to epistemological tendencies, counselors and counselor educators can examine and question information that we may take for granted as being “true” because it came from a “scientific” study. The voices of consumers are equally as valuable as data, and since counselors are in the business of hearing and helping others, it is pertinent that we stay attuned to the rights of our consumers to co-construct their processes.
Mental health concerns are prevalent and costly in the United States. In 2016, 44.7 million adults in the United States, (18.3% of the population) had a diagnosed mental illness, 10.4 million of who were diagnosed with serious mental illness (SMI) (NIMH, 2017). The NIMH defines SMI as: “Any mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities” (NIMH, 2017 p. 4). Over half of individuals with SMI (64.8%) had used mental health services within a year compared to the 43.1% of individuals with “any mental illness. Direct services are costly on their own, but it is also important to consider the indirect costs of mental health disparities, which include reduced labor supply, reduced education enrollment, incarceration, and homelessness (Insel, 2008). When adding the loss of earnings to the direct cost of health care expenditure and disability benefits in 2002, the dollar amount of economic burden increased to 317.6 billion (Insel, 2008).

Due to the excessive cost and prevalence of mental illness, mental health recovery has been suggested as a framework that could lead to cost-reduction and increased wellness for individuals labeled with mental illness (Knapp, McDaid, & Park, 2015; Xi, 2013). Key elements of recovery include peer support and self-management, which can incorporate working towards the attainment of employment goals and financial stability (Knapp et al., 2015). Mental health recovery is also related to the psychiatric survivorship movement, or the consumer/survivor/ex-patient (c/s/x) movement. The c/s/x movement consists of individuals who report experiencing marginalization, abuse, and/or neglect in traditional medical models of mental health
care (Burstow, 2004; Carr et al., 2014; Cohen, 2005; Joseph, 2015). In mental health recovery, a key underpinning is the belief that individuals in recovery should be empowered to strive for life goals and preferences in the same way as their non-diagnosed counterparts (Carr et al., 2014). Mental health recovery and the c/s/x movements are embedded in strengths-based (rather than deficit-based) approaches that lessen distress and stigma for individuals with mental health concerns, and thus contributes to higher functioning and improved health (Xi, 2013). As such, the aim of this study was to better understand the practices and perspectives of counselors who are non-medical in their approach to helping and share values with the recovery and c/s/x movements.

**Promoting Wellness and Recovery**

In addition to the potential for relieving economic burden, mental health recovery practices seek to refrain from traumatizing or marginalizing individuals in treatment for SMI. Mental health recovery can be challenging to define, as it may be a highly individualized process, and discrepancies exist in the definition of recovery between professionals and consumers (McCauley et al., 2017). For some treatment consumers, recovery includes embracing the label of their diagnosis along with a biological explanation of their condition and accepting continued reliance on psychiatric intervention for stability (Lietz, Lacasse, & Cheung, 2014). While this may seem like a conservative estimate of recovery, there are many former mental health consumers who reject biological explanations of their mental illness and have achieved satisfying lives, where they function well without ongoing psychiatric intervention (Leitz, Lacasse, & Cheung, 2014). Regardless of the patients' use of psychiatric services, generally agreed
upon definitions of recovery encompass similarities found within the following definition: “…the development of new meaning and purpose in one’s life, beyond the symptoms, disability, and stigma of mental illness…a process of healing physically and emotionally, of adjusting one’s attitudes, feelings, perceptions, beliefs, roles and goals in life” (Spaniol, 2002 p. 327). Or more broadly, the recovery movement “recognizes the ability of people with mental illness to participate in the mainstream of society” (Davidson, 2016 p. 1091). Programs such as Wellness Recovery Action Planning (WRAP) are designed for peers in the mental health system to work together in developing wellness plans and individualized courses of action to take in times of being unwell. Models such as these are favored in the c/s/x movement, as the focus of healing is shifted away from the medical model and towards inclusion of family, community, empowerment, and hope (Ameil, 2013; Burstow; 2004; Carr et al.; 2014; Cohen, 2005). Individuals who identify with the c/s/x movement have failed to receive adequate help within the medical model of mental illness or have been traumatized through oppressive and coercive treatment methods (Burstow, 2004). Trauma is also connected to mental health recovery as studies have been conducted to identify common aspects of recovery (Moran & Ruzzo-Netzer, 2016; Siu et al., 2012); trauma has been noted as a frequent theme in recovery narratives (Cohen, 2005).

Paying Attention to Trauma

Trauma has also been increasingly identified with poor mental health outcomes, as indicated by the Adverse Childhood Experiences (ACE) study conducted by the Center for Disease Control (CDC) and Kaiser-Permanente (Anda et al., 2006; Dube et al., 2001). Childhood trauma can lead to differences in the structure of the brain and
neuronal development compared to individuals without childhood trauma that affects a wide range of brain functions and behaviors (Anda et al., 2006). Additionally, some studies indicated a rationale for recognizing a trauma-related subtype or onset of certain mental illnesses, such as schizophrenia and OCD (Fontanelle et al., 2011; Sar et al., 2010). Yet, despite suggested trauma-related etiologies of symptoms of SMI, helping professionals often fail to recognize the potential for patients to be traumatized or triggered by treatment itself (Adame, 2014; Joseph, 2015). The experience of being traumatized, oppressed, and marginalized in mental health treatment has been termed “psychiatric survivorship” – a movement led by individuals who identify with the c/s/x community,” and has been gaining traction since the 1970’s (Cohen, 2005).

**A Call for Social Justice**

In the context of SMI, social justice initiatives can be seen in the mental health recovery and psychiatric survivorship movements (Carr et al., 2014; Cohen 2005). Counselors are aware, by virtue of their training, that mental illness is stigmatized in the United States (Overton & Medina, 2008); however, the term “stigma” falls short of describing the traumatic and repetitive experiences of discrimination experienced by individuals with symptoms of mental illness perpetrated by people and systems in positions of power (Bhui, 2016). Compared with other helping professionals (i.e., social workers, nurses, psychiatrists, psychologists) counselors are proportionately less involved in serving individuals with symptoms of SMI (Carr et al., 2014). Counselors, albeit unintentionally, might also adopt stereotypes about people with mental illness, perpetuating the pre-existing, systematic stigma (Overton & Medina, 2008). The way that counselors conceptualize clients with diagnosed mental illness could reflect the
negative beliefs about mental illness in the general population (Overton & Medina, 2008). Understanding how counselors perceive mental illness is tantamount to future education programs and best practices in the treatment of clients with SMI.

Within the medical model of mental health care, there exists a long history of systemic oppression and marginalization through the pathologizing of individuals based on race, sexuality, and gender (Joseph, 2013). As recently as the 1950’s, lobotomies were a popular treatment due to the belief that cutting out pieces of the prefrontal cortex would alleviate symptoms of mental anguish; homosexuality existed in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 1980) through the 3rd edition (Joseph, 2013); and, differences in gender identity are still pathologized as gender dysphoria today (5th ed.; DSM–5; APA, 2013). Among psychiatry today, electroconvulsive therapy (ECT) is considered to be the most effective treatment option for individuals with medication-resistant depression (Joseph, 2013). It is this draconian history of mental health care, which has morphed into current systems of oppression, marginalization, and forced treatment of individuals with SMI, from which social justice efforts seek to create a greater distance. Counseling training programs have acknowledged the harmful stigma surrounding minority groups (e.g., racial and ethnic minorities, the LGBTQ community) and the need for multicultural competence, yet, the same multicultural and advocacy-oriented perspective is not geared towards individuals with mental illness (American Counseling Association [ACA], 2014; Overton & Medina, 2008).

Literature is published, often qualitatively, about the lived experiences of individuals in the c/s/x movement, and the importance of empowering, recovery-oriented
practices, where individuals labeled with SMI enjoy agency and humanistic approaches to their treatment. Nationally, there has been an effort on the part of agencies to become more competent in providing recovery-oriented services, yet implementation can be challenging (Clossey & Reinheimer, 2014). There is a gap in the literature regarding the voices of the practitioners who provide mental health services that are alternative to the medical model. As such, the purpose of this study was to qualitatively describe the practices, perceptions, and theoretical positions of practitioners who understand the potential for the medical model to do harm to clients, who intentionally provide clients with alternatives to the medical model of mental health care, and aim to create alternatives to the medical model more accessible to practitioners. The research question guiding this study is as follows: what are the experiences, practices, and theoretical perspectives of counselors who provide alternative services to the medical model of mental healthcare?

**Methods**

This study utilized a grounded theory methodology to explore the experiences of mental health providers who practice from a recovery and wellness-oriented perspective, providing alternatives to the medical model. Constructivist grounded theory, developed by Kathy Charmaz, was the framework in which the researchers can be viewed as co-constructors of data (Higginbottom, 2014). Constructivist grounded theory maintains that researchers will always make interpretations about data that are rooted in their own perspectives and experiences (Higginbottom, 2014).

**Participants**

Participants in this study were 7 clinicians who self-identified as non-medical practitioners, working from a wellness-oriented perspective and practiced in a setting
that did not require diagnostics. Of the 7 practitioners, 2 worked exclusively in organizations that did not require diagnoses; 5 were in private practice and preferred to not diagnose and had prior experience working in agencies that did not require diagnoses. All participants had either a Master’s degree or Ph.D. in counseling or counseling psychology. Six participants graduated from either CACREP or APA accredited programs; one graduated from an unaccredited program and obtained licensure as a mental health counselor. The age of the participants ranged from 36 – 66 years, with years in practice spanning from 10 – 40. Of the 7 participants, 5 identified as women, 2 identified as men; 6 identified as Caucasian or white, and one identified as Latinx.

**Procedures**

After receiving Institutional Review Board approval, 7 participants were recruited through purposive sampling. The sample size was determined by the concept of saturation, which means that as data is being collected, no new findings that introduce a different theme or category are emerging from subsequent data collection (Charmaz, 2014). The researcher conducted simultaneous data collection and data analysis and noticed saturation after 7 interviews. The researcher was familiar with the body of work of regional counselors in a southeastern community and identified 3 practitioners that might meet inclusion criteria for the study. The researcher then used snowball sampling from the initial participants and identified 6 other practitioners counselors in the area who were likely to meet inclusion criteria. Of the 6 suggested counselors, 4 agreed to participate, for a total of 7 participants. Participants completed a screening questionnaire to ensure that they met inclusion criteria for the study. The inclusion criteria were as follows: (a) currently practicing in a non-medical setting, (b) licensure to
practice counseling in their state as a licensed psychologist, mental health counselor, or marriage and family therapist, and (c) self-identified as having a non-medical approach to counseling. Exclusion criteria were as follows: (a) provided services within a medical facility, such as a hospital, psychiatric inpatient or outpatient facility, or any other facility that provided treatment to involuntary patients, (b) treatment planning was contingent on diagnosis, and (c) if they relied on diagnostics regularly in order to receive payment through insurance companies.

Theoretical sampling was also incorporated into data collection. Theoretical sampling is a data-driven method where emergent categories and themes are identified in early data collection, and then additional data is collected to explicate those themes and categories (Charmaz, 2014). In this study, theoretical sampling was used in the later recruitment of participants and also through follow-up interviews. After initial coding, the researcher conducted follow-up interviews that lasted approximately 20-30 minutes with each participant. The follow-up interviews served as a measure of trustworthiness (i.e., member checking), as well. During the follow up interviews the researcher shared the emerging themes and categories of the initial coding. The participants were asked if the emerging themes and categories appropriately captured their responses and were invited to give feedback to the researcher about the themes and categories. Participants were also asked follow-up questions that became relevant during subsequent interviews with other participants (see Appendix B). The follow-up interviews allowed the researcher to continue the process of simultaneous data collection and analysis by providing an opportunity to use the feedback to guide future analysis (Charmaz, 2014).
Data Sources

Participant demographic form

Participants completed a demographic questionnaire containing questions about gender, age, race/ethnicity, and spiritual/religious affiliation which were optional to answer. The form also contained questions about type of degree program from which they graduated, type of license carried, length of time in practice, and theoretical orientation, which were required responses.

Semi-structured interviews

The researcher conducted semi-structured interviews with each participant that lasted approximately one hour each. All interviews were conducted, transcribed, and analyzed directly by the researcher. As all of the participants were practicing counselors, interviews were conducted in the offices of each participant where they hold their counseling practice.

Data Analysis

The researcher conducted initial coding via incident-by-incident coding as described by Charmaz (2014). An additional part of the open coding process was coding with gerunds. Applying codes as gerunds kept the researcher close to the data by framing the codes as something that is being done, rather than by using passive or abstract phrases for initial codes (Charmaz, 2014). Axial coding followed open coding, in which codes were organized into categories, redundant codes were condensed into single codes, and larger were generated to capture concepts within categories.

Trustworthiness

The researcher recorded spontaneous memos throughout the data analysis process to ensure that the researcher had an organized and traceable way of
comparing data, locating themes, and building theory. Memos allow researchers to capture their own thought processes throughout data analysis that they can revisit as the analysis becomes more layered (Charmaz, 2014), and allows the researcher to keep track of theory development (Higginbottom, 2014). Memos also provide an interactive space in the data for the researcher as a co-constructor of the emergent themes and concepts. The researcher also recorded reflexivity voice memos after each interview. The function of this was to manage any reflexive responses that the interviews may have triggered in the researcher (Charmaz, 2014). Trustworthiness was also established through member-checking through follow-up interviews, as mentioned above.

**Results**

The data revealed four broad categories related to the experiences and practices of the counselors interviewed in this study who practice from a non-medical model, which were as follows: 1) characteristics of the counselor and the counseling relationship, 2) factors in the immediate community, 3) factors in society at large, and 4) global and historical position of counseling in the United States. More specific themes were constructed within each of the categories, which will be described in detail below. An multilayer systemic model that reflects the counselors perspectives was developed (Fig 3-1) as the counselor is situated within and influenced by the immediate community, which is situated within and influenced by society at large, which is a part of a global community among other countries that also provide mental health services.

**Characteristics of the Counselor and Counseling Relationship**

This category describes characteristics and themes that relate to the individual participants’ perspectives on and approaches to counseling and the counseling
relationship. The main themes of this category are: the counselor is trauma-informed; the counselor is humanistic; the counselor critically examines attitudes, values, and beliefs; the counselor engages in harm reducing practices; the counselor prioritizes the therapeutic alliance; and, the counselor is not anti-medical model.

**The counselor is trauma-informed**

Member checking confirmed that participants were comfortable with their practices being described as trauma-informed. The theme of being trauma-informed arose in several ways. Participants spoke to the impact of trauma on mental health and seeing symptoms of mental illness as a response to traumatic or adverse life events. For example, one participant stated, “A lot of issues come up as survival strategies that aren’t needed anymore, that maybe they’re getting in the way now, and were reactions to trauma or to developmental issues or family circumstances.” This perspective was maintained even when conceptualizing individuals with SMI:

> People display those kind kinds of symptoms (psychotic) where it is trauma based or it has been that part of their coping has been those voices and so to suddenly label it as dysfunctional – to label it as some severe psychiatric disorder – sometimes is not helpful because you’re not fully understanding.

Additionally, participants spoke to the high incidence of trauma among individuals with SMI: “I remember a study where 93% of women in a psychiatric hospital who were schizophrenic or psychotic labeled had been physically or sexually abused as children.” Participants were also trauma-informed in the sense that they did not define trauma for their clients and believed that trauma has a broad definition and is not limited to obviously tragic events, such as sexual assault or natural disasters, “People think of trauma as assault or abuse or a really bad accident. There’s actually a lot of other things that fit for trauma or can be traumatic to someone’s system that don’t necessarily
look like those things.” This recognition of the impact of trauma on mental health overlapped with the theme of the counselors being humanistic, which is described in the following section.

**The counselor is humanistic**

The theme of “the counselor is humanistic” refers to qualities of the counselor that fit under general humanistic theory, namely: having a phenomenological orientation, valuing authenticity, being wary of reductionist tendencies (Winston, 2015), believing in the critical role of empathy, and that individuals inherently know how to create meaning and move towards growth in their own lives (Perepiczka & Scholl, 2010). In response to conceptualizations of mental health issues, all participants expressed that people must be considered in their developmental and environmental context. This speaks to the holistic approach of humanistic counseling. As stated succinctly by one participant, “I see people as inseparable from the environmental conditions in which they have evolved.” This relates to the concept of being trauma-informed, as the trauma-informed approach considers the context of the client’s lived experience and values non-reductionist and empathic relationships. Noticing how professional counselors sometimes apply developmental and environmental contexts to the diagnosis of PTSD but not to other diagnoses, a participant shared that:

> PTSD is a great example…We start talking about the symptoms associated with PTSD, then they begin to realize that ohhhh, that’s trauma and there’s reasons that these symptoms come up and they’re all related to this trauma that occurred. And I think that’s no different than schizophrenia. Or whatever symptom it is. Where did it develop? How did it develop? How do you tune in? So, you begin to notice the etiology of it, which is very pivotal.
Other humanistic qualities indicated in the responses of participants were that the counselor seeks to empower the client, the counselor does not pathologize the client, and the counselor sees even symptoms of mental illness as coping mechanisms:

What I think is helpful in healing for people is to be able to view people that it's not that there's something wrong with them but that based on your lived experiences that a lot of times people will cope in whatever way they can and that they're surviving and however they do that is pretty incredible.

**The counselor thinks critically about attitudes, values, and beliefs**

Maintaining a humanistic approach to counseling does not suggest passivity as a characteristic embodied by the participants. While the participants seemed to vary in their levels of being directive or non-directive with clients, they collectively described that they reflected on and critically examined themselves, counseling models, theories, and systems. Participants indicated that it has been important for them to stay open to the influence of socio-political factors on their clients and also to remain open to the complexity of people and to facilitate wellness and healing by not adopting a singular theory or model of helping. A majority of the participants described that they came into the counseling profession already with a propensity towards reflecting, questioning, and having an awareness of socio-political variables. One participant stated:

I came into the counseling program with a background in political science and especially studying the politics of poverty and race…I already, without realizing it, had an affinity for ways that culture, society, life experiences shape people and their way of being.

This data also aligns with the theme of humanistic theory as humanistic practitioners are non-reductionist and take a phenomenological approach to conceptualizing people, thus appreciating the complexity of people and the presentations of issues.
The counselor engages in harm reducing practices

The term “harm reduction” was recommended during a member-checking follow-up interview with a participant who is familiar with the c/s/x movement and peer support. The participant commented that these movements are not anti-medical, but instead, are pro-choice and aim for harm-reduction in the pursuit of mental health care. The theme of harm reduction in the responses of the participants speaks to their practices that aim to decrease the amount of harm a client may experience through receiving a diagnosis, having to be hospitalized, or by facing stigma and dehumanization in the mental health care system. Participants spoke to the lasting impact of diagnosis, and how they aimed to be the least invasive as possible if they must give a diagnosis for reimbursement or in order to help a client access accommodations, as indicated by the following: “I know how diagnoses stick. I don’t want to go and diagnose someone with major depressive disorder and have it follow them through life. I’m not okay with that.” Furthermore, a participant addressed the stigma that comes with certain diagnoses even among other helping professionals in saying, “Even stigma within the mental health field. There are disorders that are highly stigmatized for proprietors, like personality disorders, and I always take that into consideration.”

Other aspects of harm reduction also included having candid conversations with clients about what they can expect when considering using certain facilities, such as low-funded psychiatric hospitals. A participant stated the following:

We can also educate our clients on ‘Okay, community agency X is there if you need something.’ If you need medication and you can’t afford it, and you can go there if you’re feeling unsafe, but it’s not going to be a pleasant experience. It might be more traumatic to go there but you get medication and you’ll talk to a psychiatrist.
In this way, clients can make a more fully informed decision on when and how to access resources that may be frightening, but ultimately, necessary. Participants also indicated preferred characteristics of psychiatrists who they refer to in the community. These psychiatrists tend to spend more time with their patients, are willing to collaborate with patients and counselors, and uphold the patient’s dignity and voice in treatment planning. The participants thought that clients would be less likely to feel dehumanized or pathologized and would have a more healing experience in working with such psychiatrists, as indicated by the following data segment: “They look at the least invasive diagnosis, the least invasive medications. They are willing to give their clients time. They are willing to confer. So it’s more of a collaborative effort and the clients know that too.” Taken together, these harm-reducing practices will increase the likelihood that clients will have a more wellness oriented treatment plan and that they will be less likely to experience shame, alienation, systemic, and interpersonal consequences as a result of using mental health services.

**The counselor is not anti-medical model**

Participants were asked about their experiences of observing detriment and helpfulness in the medical model. All participants stated that they are not opposed to the use of psychiatric medications, and that wellness, and what is needed to pursue wellness, is defined by the clients. A particular participant identified as a part of the peer movement and clarified that, “…being a part of the peer movement is not anti-medication. It’s prochoice and harm reduction.” Other participants shared sentiments around recognizing the necessity for hospitalization at times, even though it was not a
first line of helping in their practices. On clients needing to go to the hospital to stay
safe, one participant said,

I am open to the idea the possibility that people can feel so out of control
and so helpless that they may resort to some type of dramatic intervention
and having it available at that point may be really critical.

Participants also addressed the point that clients may benefit from using psychiatric
medications if they are so clouded by symptoms that they cannot make great use of
therapy until they begin to experience some relief: “If someone is so depressed that that
they can’t engage in therapy then it might be where medication might be important just
to get you to a place where you’re able to use therapy.”

**Factors in the Immediate Community**

Factors in the immediate community were identified as aspects of the community
that people directly engage. These factors included: (a) community agencies and
support systems, (b) counselor training programs, and (c) cultural variables related to a
specific community rather than society on a larger scale. Counselor training programs
were included in this category as counseling students gain their practical experiences
within the community, and available training sites are a product of the communities in
which the programs are situated. Having peer support available in the community was
the most recurrent theme in this category.

**Peer support in the community**

Participants expressed an appreciation for peers as individuals with expertise in
mental health issues and mental health recovery, and felt that peer support has become
an essential aspect of mental health support. Participants identified peer support as a
way for people struggling with mental health issues to build connections with others who
have had similar experiences, as described in the following data segment:
One of the benefits of peer support is hopefully you build friendships with people who have been through some version of this themselves, and so there are people it’s safe to break down around who aren’t going to necessarily panic and take control away from you.

One participant talked about a peer-led community center that employed a strengths-based and empowerment model to promote the wellness of struggling individuals. The community center offered opportunities for people to contribute to the community through volunteering and forming connections. Peer support groups and centers were also identified as a places where individuals with lived experience can provide safety and support for people as an alternative to hospitalization:

Peer respite is a lovely example. The concept is perfect. It’s something that breaks out of that – because hospitalization is, by definition, so extreme. Do you want to eliminate the availability of it? Of course not, but its usage is so over used.

**Having a supportive community with alternative resources**

In addition to the role of peer support in wellness, participants addressed the importance of having a supportive community with alternative resources. Specifically, it can be helpful to have supportive colleagues as one participant said, "Enough of my colleagues are trauma informed at least, if not familiar with the c/s/x stuff. They recognize the impact of adversity on people’s mental health." Crisis response can also serve as an important community resource that can provide support to those in distress and advocate for people who are in crisis and/or suicidal.

That’s why our organization (crisis agency) often advocates in this community to help be the in-between where we can step in and work with the person on other options or work with them to agree to go (to the hospital).

Furthermore, it is helpful for community stakeholders to find value in providing certain services to the public as a part of the tax structure of the community. Speaking again to
crisis stabilization and suicide prevention, one participant shared of how a county had justified funding such a community resource on an ongoing basis: “They compared it – they said in a community – communities need law enforcement, fire rescue, and crisis response. So that is simply a basic understanding that if you live here this is a part of what your taxes go for.” One participant shared about using a volunteer crisis response model, and also about having counseling sites host practicum and internship counseling students as a way to expand services.

**Training experiences**

Participants were asked open ended questions about what can be done to facilitate the growth and development of the wellness and mental health recovery movements, and how mental health professionals can contribute to a paradigm shift, where counseling is not as entrenched in solely the medical model. In response to these questions, many of the participants spoke to counselor training. Some participants suggested that conversations about mental health recovery be integrated into training programs so that counseling students do not develop such a singular perspective on the trajectory of someone with SMI, and would be able to appreciate the concept of mental health recovery:

“There’s such a comprehensive indoctrination into that world view (deficit-oriented)...even though I came through probably the most humanistic wing of the mental health helping profession that exists, I still wasn’t ever exposed to the idea that people could actually live well with those experiences (with SMI).”

Referring to clinical training, another participant noted that, “…depending on what setting you’re in, you may never have access to people who are experiencing a major mental illness.” As a recommendation for this issue, the participant suggested that it
would be beneficial to have counselor education students engage in the community with people living with SMI through various organizations.

**Factors in Society at Large**

Societal themes were developed around variables that influence people that are pervasive in general society and are not necessarily a product of the immediate community. These are factors that people will likely encounter across communities. Themes included in this category are the limitations of the medical model, clients experiencing detriment through the medical model, the influence of positivism on processes and policies, and the health of general society. The medical model is the predominant system of mental health care in the United States, and so, themes related to the medical model were included in this category. Participants addressed the issue of having hierarchies among helping professionals and the influence of having singular narratives that are seen as correct. Issues related to these responses were themed as “the influence of positivism.”

**Limitations of the medical model**

Participants were asked to speak to their concerns about the medical model. In response, they described systemic limitations of the medical model but also ways in which people may experience detriment while receiving services in the medical model. One of the more recurrent limitations of the medical model that participants highlighted was the lack of time that doctors and psychiatrists can spend with their clients. The participants shared about psychiatrists having 15-20 minute appointments with patients, and that it is very difficult, if not impossible, to consider someone’s environmental and developmental context in that amount of time. Furthermore, this lack of time may present clinicians with fewer options for intervention:
When somebody is in, let’s say, full crisis, and you feel the only option is that we need to work with this person quickly because we have other people coming in, so Baker Act and involuntarily hospitalize. And I think that’s unfortunate because we know the hospitalization, especially involuntary, can be extraordinarily traumatic.

Another identified limitation was that there are significant insurance limitations on lifetime uses of mental health services, when some mental illnesses are considered chronic, but not other chronic medical conditions: “Obviously for almost every insurance company, there are limits on psychiatric care and psychological care. They don’t limit heart care.” Other participants shared that being in network on insurance panels causes practitioners to spend significantly more time doing administrative work to justify treatment to the insurance companies, thus, negatively impacting practice.

**The influence of a positivistic framework**

The previous theme of limitations in the medical model overlaps with the issue of how a positivistic framework perpetuates limitations within the mental health industry. Participants identified the issue of non-mental health professionals in insurance companies requiring justification for providing services from practicing mental health professionals, and how this can undermine the knowledge and experience of counselors: “The fact that an outside agency or managed care people are telling practitioners how they should practice doesn’t allow for clinical judgment necessarily.” Some of the participants noted that within our current epistemological paradigm, clients are taught to believe what doctors say immediately and not to question a doctor’s clinical decisions. For example, a participant stated, “I think we put doctors in these positions, or psychiatrists, where it’s like they know all and are gods in a way…But people don’t question what they say to them or prescribe to them.” This can be problematic because clients do not know to, or do not feel that they can, use their own
experiences and knowledge of themselves to help inform decisions about their mental health care. As one participant said, “I’ve seen people even start to question their own credibility, and start to question their own voices and their own intuition.” Participants also discussed how many people do not know that there are other, more wellness-oriented ways to conceptualize mental health problems, as a medical and deficit-based explanation is perpetuated by pharmaceutical companies advertising directly to consumers.

**Experiencing detriment in the medical model**

In addition to systemic issues that serve as a barrier to providing consistent and humanistic care in the medical model, participants also shared about the ways in which they have observed that medical mental health practices have been detrimental to clients. As mentioned above, the participants in this study were not opposed to the medical model and appreciated that medications can be helpful and hospitalizations may be necessary at times. There was, however, a general concern expressed by all participants that the current existence of the medical model can lead to dehumanizing or hurtful practices towards people struggling with mental health concerns, and that this approach is not necessarily conducive to holistic wellness or recovery. One participant, commenting on the ways that people have been indoctrinated with a deficit based medical perspective upon being diagnosed, said that people are

“…going through an extremely distressing time in their lives and were responding to it the best they could and were told they have an incurable brain disease, will never recover, and will need to accept reduced options for their lives.”

Other participants spoke to the impact of spending time in a psychiatric facility or crisis stabilization unit: “In a typical psychiatric unit, there’s going to be everything from floridly
psychotic to somebody who has suicidal ideation…and I had a client like this very recently…the psychiatric unit left him with PTSD.”

The health of general society

Participants also shared about their perspectives on the health of society in general and the impact of socio-political factors and societal trends on mental health. Some participants discussed the influence on mental health of marginalization and oppression from dominant society towards minority groups, and the negative emotional consequences of the current political climate in the United States. Participants also stated that current American culture is anxiety provoking due to being fast-paced, reactive, and under high political tension. Other participants noted that there have been some positive changes in access to care for society as a whole. The Affordable Care Act was given as an example of positive policy change that has increased the accessibility of mental health services on a national level, which was partly due to ending the ability of insurance companies to deny coverage based on a preexisting condition.

Finally, participants talked about the impact of social media on mental health. Several participants commented on the correlation between time online and negative mental health consequences, for example a participant stated that, “There’s some research coming out now in terms of the impact of social media on all of us, especially youths. And the more time spent online, the higher the rates of depression, which doesn’t shock me at all.”

Factors Globally and Historically

Some participants spoke to issues that place counseling in a global and historical context. These factors include movement towards certain paradigms over time within
the profession, and where the United States stands compared to other countries that are incorporating non-medical models for mental health care. Most of the participants spoke to the ways in which American culture views different states of consciousness and emotionality compared to some cultures around the world that do not pathologize certain symptoms. This point came up several times through the observation that a phenomenon like hearing voices or experiencing visual hallucinations is not a pathology in every part of the world, as represented by a participant saying, “There are some cultures where people with schizophrenia are looked at as having a higher powers or as having access to different parts of their brain.”

A majority of the participants were familiar with international movement around wellness, mental health recovery, and the c/s/x movement. These participants spoke to the progressive steps that are being taken in other parts of the world in response to the movements. Some of these steps involve the implementation of interventions that do not require the segregation of people with SMI from society, as indicated by the following statement: “All of the stuff from Northern Europe makes such great sense because it’s the concept of keeping people within the community. You’re still a part of the community (with SMI). You’re not segregated.” Another participant spoke directly to the epistemological challenges with which global organizations are confronting the positivistic paradigm: “The British Psychological Association and UN Human Rights Council, that there have been major systemic acknowledgments of the lack of scientific validity to that model.”
Discussion

The goal of this study was to better understand the practices and perspectives of counselors who are non-medical in their approach to helping and who share values with the mental health recovery and c/s/x movements via a constructivist grounded theory methodology. This study fills a gap in literature regarding mental health recovery and the c/s/x movement. Literature is available that captures the experiences of mental health service users who identify with recovery and c/s/x movements (Bola & Mosher, 2003; Cohen, 2005; Xi, 2013), yet there is no literature describing the practices of non-medical approaches from counselors’ perspectives. Four categories, described in a multilayer systemic model, emerged from the data, each with related themes. The 4 categories were: 1) characteristics of the counselor and the counseling relationship, 2) characteristics of the immediate community, 3) Characteristics of society at large, and characteristics of the counseling profession in a global and historical context. The categories along with their related themes are discussed in the following paragraphs.

In the category of counselor and counseling relationship characteristics, the main themes were: The counselor is trauma-informed; the counselor is humanistic; the counselor thinks critically about attitudes, values, and beliefs; the counselor engages in harm reducing practices; and, the counselor is not anti-medical model. Participants described how they believe that symptoms of mental illness are arguably responses to traumatic life events, that they do not define trauma for clients, and that they are conscientious about the potential for extreme medical interventions to be traumatizing. The participants also described humanistic principles as they discussed their approach to helping and their relationships with clients. Humanistic characteristics described by
participants included empowering clients, seeing them in developmental and environmental context, and allowing clients to have agency over their counseling experiences. This finding is also particularly relevant to the c/s/x and recovery movements as psychiatric survivors have indicated that being robbed of their agency in medical settings has been dehumanizing and traumatic (Adame, 2014; Cohen, 2005).

Harm reduction was identified by one participant as a term used in the c/s/x community which refers to the ways that helping professionals attempt to minimize the damage of being diagnosed and receiving treatment for a mental illness.

Participants described using minimally invasive diagnoses, referring to psychiatrists who share similar values in client relationships, and keeping clients fully informed about the risks and benefits of certain treatment options. This is reflective of the goal of upholding clients’ dignity in wellness and recovery models (Xi, 2013). Many of the participants noted during interviews or upon member checking that they appreciate the functionality and availability of medical approaches to mental health. While they may be reserved about the ways some interventions are carried out, and the positivistic messages within the medical model, they are not against the medical model and do not want to be perceived as such.

In the category of factors of the immediate community, the availability of peer support was the most frequent and extensively occurring theme. Peer support has been documented in the literature as an important factor in mental health recovery (Beehler et al., 2014). Participants of this study identified peer support as an opportunity for individuals with mental illness to connect with others who share similar concerns, stay engaged in the community, and advocate for each other within the mental health
system. Several participants commented on the effectiveness of peer respite as an effective alternative to hospitalization as respite provides an opportunity for individuals to recuperate among peers who have had similar experiences. The theme of counselor training experiences was also conceptualized in this category because clinical training is situated in specific communities. Participants noted that it is possible to complete a graduate program in counseling without engaging with individuals with SMI. One participant noted in particular that even though she was mentored and educated under fairly humanistic theory, it was still not obvious that people with SMI could attain the quality of life that has now become evident in the recovery movement.

The prevalent themes regarding factors of society at large were the limitations of the medical model, clients experiencing detriment in the medical model, the influence of positivistic paradigm on counseling, and the health of society in general. Participants noted that the ability to bill insurance companies does not lead to a more efficient practice, as being in network on insurance panels means that they would spend a significantly greater amount of time doing administrative work to justify treatment to insurance companies. The pressure on psychiatrists to treat people within 15-20 minute appointments was also commented on numerous times during interviews. Some participants felt that the inability to spend time with patients in the medical model leads to more reactive decision making, such as rushing to hospitalize people in crisis. The influence of a positivistic paradigm was another salient theme. Participants expressed concern about the hierarchies imposed by the medical model among helping professionals and the information they provide. Medical doctors and psychiatrists are given more value by insurance companies than clinical psychologists; clinical
psychologists are seen as having more monetary value than counselors, and so forth.

Participants felt that within this positivistic approach to mental health care, medical providers often lose the context of the people they are treating and are also likely to adopt the singular chemical imbalance theory of mental illness. These concerns echo the work of some scholars and researchers who believe that the scientific evidence behind chemical imbalance theories is not as concrete as we are led to believe, and that a paradigm shift away from positivism would better serve the complex needs and presentations of clients (Hansen, 2016; Whitaker, 2014). Participants’ perspectives on clients experiencing detriment in the medical model also echoed literature about the trauma and oppression that individuals have self-reported, as indicated in Cohen’s (2005) analysis of the oral histories of psychiatric survivors. Lastly, some participants spoke to the counseling profession in its historical context. These responses were provided by participants who have been in the profession for longer periods of time. Participants observed that it used to be more normal to do therapy with individuals who suffer from SMI and that psychiatrists were historically involved in providing therapy; now the focus has shifted towards symptom reduction through medication management. Participants also noted that in other parts of the world, wellness-oriented programs and models are being implemented for people who are living with mental illness and/or are in crisis. Participants felt that these alternatives to medicalizing mental health issues reduce stigma and allow people to stay connected to their communities. Additionally, many participants challenged the meaning that our culture makes of mental illness symptoms. For example, in other cultures experiencing AVH may have a spiritual, not a pathological, connotation.
Implications for Practice

Several implications for counseling practice and counselor education emerged from the findings of this study. The theme of being trauma informed is particularly salient in terms of implications as the relationship between trauma and mental health outcomes has become increasingly visible through studies such as the ACE study (Anda, 2006; Dube, 2001). Furthermore, treating trauma in individuals diagnosed with mental illness is conducive to symptom reduction and general wellness (Lietz et al., 2014). Participants spoke to a need for more pervasive trauma-informed perspectives among counselors. Counselors may choose to pursue trainings in trauma-informed services and bring training and consultation from trauma experts into their practices and organizations.

The peer community of individuals who identify with the c/s/x movement has been recommended as a reference point for clinicians in understanding the needs and preferences of individuals living with mental illness (Burstow, 2004). As a part of being trauma informed, counselors can also learn from the c/s/x community about harm-reducing practices when working with individuals labeled with mental illness. Participants also recommended an increase in awareness of and training in peers support models within the counseling community. Counselors can advocate for the creation or expansion of peer-led respite centers in their communities. Furthermore, any members of the counseling community can pursue training in peer support models.

Participants also noted that the concepts of mental health recovery and the c/s/x movements are not incorporated into counseling training programs. Taken together, these points speak to a recommendation to increase conversations about movements
and alternatives to the medical model within counseling communities, and to advocate for the dignity and humanization of individuals living with a label of SMI. Participants also recommended an effort towards increased interdisciplinary collaboration between counselors and psychiatrists. Counselors may consider advocating for increased contact with the psychiatric community to facilitate collaboration and continuity of care. Regarding national issues, participants suggested that counselors may also consider adopting a more public voice about humanizing mental health concerns as there is a large, national, deficit-based voice about mental health symptoms, as can be seen (for example) in advertisements for psychiatric medications. The American Counseling Association Code of Ethics states in standard A.7.a. that, “When appropriate, counselors advocate at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients.” (ACA, 2014). As mental health service users continue to organize and express the barriers and obstacles in the medical model that inhibit their growth and development, counselors should be prepared to advocate for more humanistic alternatives that can either replace or supplement medical treatment. On a global level, participants recommended that counselors in the United States look at the structure and cost of non-medical alternatives that exist in other countries and consider implementing similar models here. Counselors and counselor educators may consider becoming involved in international organizations that address the rights of individuals with labeled with mental illness. They may also seek out content or experts on the non-medical models of care that are sustainable and effective in other countries.
Limitations and Directions for Future Research

This study was conducted in the South Eastern region of the United States and consisted of counselors who were close geographic proximity. The results of this study may vary if it were replicated in another region of the United States. The participants were diverse in age and years of practice, but the sample did not provide a great deal of ethnic or racial diversity. This sample is not representative of diversity of the counseling community at a regional or national level. Participants self-selected to take part in this study, and so the perspectives of counselors who did not respond to the researcher’s recruitment efforts are not represented by this data. The sampling methods of this study may be considered a limitation as the researcher used snowball and theoretical sampling. Future research may include the use of an open-call to participate based on inclusion criteria. In this particular study, a single researcher conducted the interviews and data analysis. Even though the researcher conducted member checking, this may be considered a limitation compared to studies that use teams for coding and have multiple interviewers. Having multiple coders and interviewers could increase rigor by allowing the co-constructed data to emerge from multiple individuals who bring their unique experiences and perspectives into the research process.

This study was a broad exploration of non-medical approaches to mental healthcare and as such, the breadth of the inclusion criteria and interview responses may be considered limitations. Future research may include studies that focus on specific categories within these findings and/or focus on more specific inclusion criteria. For example, research may be conducted specifically about the characteristics of the counseling relationship for non-medical practitioners who are culturally diverse.
Similarly, this study may be replicated in other regions of the United States and specifically in communities that are considered trauma-informed. Researchers may also consider replicating a similar study with other types of helping professionals such as psychiatrists who maintain a more humanistic approach, or social workers, as individuals in these professions are also a part of the larger mental health system. Further research may also include examining the effect on counselors in training of introducing concepts of trauma-informed practice, the c/s/x movement, and mental health recovery into counselor training programs.

Mental health concerns continue to have a significant impact on a large number of Americans and on society as a whole. The medical model has been the predominant approach to treating mental illness, yet unfortunately service users are harmed by dehumanizing and oppressive practices in the medical industry. These service users have called for systemic change in the mental health care system. Mental health recovery and c/s/x movements have provided a voice for the social justice of individuals with mental illness. Since these are grassroots movements that amplify the voices of mental health service users, this study aimed to explore the perspectives and practices of counselors who share values with these movements. The results of this study corroborated results of studies that qualitatively examined the experiences of those who identify with the c/s/x movement. Hopefully, these findings will encourage counselors and counselor educators to familiarize themselves with these movements and adopt some of the suggestions made by the participants of this study on both individual and systemic levels.
Figure 3-1. Model of resulting categories
Table 3.1. Themes arranged by category

<table>
<thead>
<tr>
<th>Category</th>
<th>Related themes</th>
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</table>
| Characteristics of the counselor and counseling relationship | The counselor is trauma-informed  
The counselor is humanistic  
The counselor thinks critically about attitudes, values, and beliefs  
The counselor engages in harm reducing practices  
The counselor is not anti-medical model |
| Characteristics of the immediate community   | Availability of peer support in the community  
The community is support to and provides alternatives  
Training experiences in the community          |
| Characteristics of society at large          | Limitations of the medical model  
Influence of a positivistic paradigm  
Experiencing detriment in the medical model  
Health of society in general                   |
| Characteristics of counseling in a global and historical context | Counseling in a global community  
Counseling in its historical professional context |
### Counselor and counseling relationship

### Community resources and training programs

### Societally systemic factors

### Global and historical factors

#### A-1 Open and axial coding

<table>
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<tr>
<th>Open Coding Theme</th>
<th>Supporting Data</th>
<th>Axial Coding</th>
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<tbody>
<tr>
<td>Connecting trauma and mental illness</td>
<td>Bob “And again for the most part the people I see, I’m not seeing people – in my mind – with mental illness. I’m seeing folks that have been injured through their experiences, or traumatized.”&lt;br&gt;&lt;br&gt;Tom, “I remember a study where 93% of women in a psychiatric hospital who were schizophrenic or psychotic labeled had been physically or sexually abused as children.”&lt;br&gt;&lt;br&gt;Beth “A lot of issues come up as survival strategies that aren’t needed anymore, that maybe they’re getting in the way now, and were reactions to trauma or to developmental issues or family circumstances.”&lt;br&gt;&lt;br&gt;Beth “I recently saw some research about how actually a lot of it might be trauma related. Like, those symptoms (of mental illness) are mimicking developmental trauma. It’s not a diagnosis. People will just label these kids as bipolar or ADHD when really it is adaptive. It’s trauma symptoms that they’re responding to.”&lt;br&gt;&lt;br&gt;Prudence “People display those kind kinds of symptoms (psychotic) where it is trauma based or it has been that part of their coping has been those voices and so to suddenly label it as dysfunctional – to label it as some severe psychiatric disorder – sometimes is not helpful because you’re not fully understanding.”</td>
<td>Counselor &amp; relationship 1:&lt;br&gt;The counselor is trauma informed</td>
</tr>
<tr>
<td>Topic</td>
<td>Quote</td>
<td>Notes</td>
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<td>Believing that doctors have the right answers</td>
<td>Beth “I think we put doctors in these positions, or psychiatrists, where it’s like they know all and are gods in a way, and some of them I think really buy into that. But people don’t question what they say to them or prescribe to them.”</td>
<td>Society at large 4: The influence of positivism</td>
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<td></td>
<td>Prudence “I’ve seen people even start to question their own credibility and start to question their own voices and their own intuition, and I think we’re in a world where we’re supposed to trust doctors the moment they start to treat us in a certain way.”</td>
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<tr>
<td>Seeing clients in environmental and developmental context</td>
<td>Sally “I see people as inseparable from the environmental conditions in which they have evolved.”</td>
<td>Counselor and relationship 2: The counselor is humanistic</td>
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<tr>
<td></td>
<td>Jane “We are all very different, and yet if I’m only looking at things from one perspective, one theory, then I’m missing who is sitting in front of me....I think from a very holistic point of view.”</td>
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<td></td>
<td>Jane “I’m looking at what’s the family history? What’s the trauma history?”</td>
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<td></td>
<td>Bob “I wonder if what happened to you, as you tell me about your experience, and wonder how that might be impacting you today. And is it possible that when you were 8 years old the way you took care of yourself, which was the best you could do, made great sense.”</td>
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<td></td>
<td>Tom “PTSD is a great example...We start talking about the symptoms associated with PTSD, then they begin to realize that ohhhh, that’s trauma and there’s reasons that these symptoms come up and they’re all related to this trauma that occurred. And I think that’s no different than schizophrenia. Or whatever symptom it is. Where did it develop? How did it develop? How do you tune in? So you begin to notice the etiology of it, which is very pivotal.”</td>
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<tr>
<td></td>
<td>Beth “It may look like other disorders. Dissociation is a way to distance from something or create a sense of safety. If it</td>
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</table>
Prudence “Most of the time I feel like you can make sense of people’s symptoms. Usually I find that there is some context for it. Rarely is it somebody who’s had the perfect life, zero trauma, zero stress and suddenly they have symptoms.”

Seeing mental illness as a social construct

Bob “I am open to the possibility that in 20 or 30 years it will be much clearer but right now, other than maybe schizophrenia or bipolar, I don’t see much else that even has very good biological markers. So then everything else I think is really not – we’re not even close to calling it anything that medically fits under some kind of illness, and so they’re social constructs.”

Tom “My own sense is that most if not all psychological issues are related to being out of touch with who you really are.”

Non-pathologizing

Bob “I don’t think much about mental illness. I do talk a great deal with folks that I think the idea of mental trauma makes a lot more sense.”

Tom “What first came to mind is what I tell my graduate students: Don’t you ever try to fix or change a client. So for me the purpose of therapy is to help a client become who they really are.”

Empowering clients

Jane “First of all, I don’t have to fix you because you’re not broken.”

Bob “The clients know where they need to go (in therapy). It’s just simply genuine when tell folks I’ve seen, I can maybe predict where you want to go but I don’t know. And it’s not my place to tell you where you want to go.”

Tom “For me, in therapy, if a client says “do you have the answers?” I say absolutely not. The answers are in you. They’re all in you. I’m going to help you find them. Or I’m going to help you figure out how to find them.”

Navigating insurance companies with a non-medical perspective

Jane “There may be a divorce or a loss or an existential crisis and those are all things that with the right space people can move through. Those are all issues of trying to adjust and so that’s a very appropriate diagnosis.” (On using adjustment disorder as a minimally invasive diagnosis).

Bob “If I felt like it was productive I don’t have any aversion to putting something down (a diagnostic code). But it has to be productive. But it has to have some
productivity to it. So yeah the fact that 80 percent of the folks that I see are adjustment disorder, but I think because of the way I’m looking at them that it’s genuine that they are adjusting to something.”

<table>
<thead>
<tr>
<th>Harm-reducing practices</th>
<th>Jane “I know how diagnoses stick. I don’t want to go and diagnose someone with major depressive disorder and have it follow them through life. I’m not okay with that.”</th>
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<tbody>
<tr>
<td></td>
<td>Tom “So I would say that in 35 years of practice, 98 percent of my diagnoses for insurance companies are 309.28. Adjustment disorder. And then if the insurance company argues with me I’ll give a diagnosis that’s as safe as possible.”</td>
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<td>Beth “Even stigma within the mental health field. There are disorders that are highly stigmatized for proprietors like personality disorders, and I always take that into consideration. Like I don’t blatantly give someone a diagnosis. If I have to diagnose I usually go with adjustment disorder.”</td>
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<td>Beth “That’s a very heavy diagnosis to give someone (bipolar disorder). We can add it as a rule out so that it’s something to keep an eye on but not wanting to just put that label on someone because providers will see that and make a lot of assumptions.”</td>
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<td>Beth “We can also educate our clients on “Okay, community agency X is there if you need something.” If you need medication and you can’t afford it, and you can go there if you’re feeling unsafe, but it’s not going to be a pleasant experience. It might be more traumatic to go there but you get medication and you’ll talk to a psychiatrist.”</td>
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<tr>
<th>Being eclectic</th>
<th>Jane “I’ve done years of breath work. It’s about looking at all of these possibilities that may be very helpful not only just for my own path of healing but for what I can bring to my clients to really look at something in depth. And so I study all kinds of things.”</th>
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<td></td>
<td>Bob “The client must believe that the therapist is able to do something for them. It doesn’t matter what therapeutic models – all models will have value if the client believes that it makes sense and they can utilize it in some way.”</td>
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<td>Topic</td>
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<tr>
<td>Honoring the distress of clients</td>
<td>Sally “Often folks that I encounter who are having those extreme states (e.g., psychosis) are in distress.”</td>
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<td>Jane “Whatever the issue is, here’s this person who is in distress. That’s how I approach people. Let’s hold space for this distress. Let’s see what needs to happen.”</td>
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<td>Beth “People think that the mob is after them or something, so looking at what kind of distress is this causing this person? I can’t imagine what it would be like to experience something outside of the realm of reality or not being sure of what’s real and what’s not. I imagine that would be terrifying.”</td>
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<td>Prudence “Honoring for folks that the trauma of suddenly being in an environment that you can’t leave. You can’t walk out...we’re going to tell you when to eat, who you can talk to, and you can’t leave. I don’t care who you are, that’s going to be traumatic. It’s going to be difficult.”</td>
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<td>Prioritizing safety</td>
<td>Jane “I’m going to do everything I can to make that connection and allow you to be open and allow you to feel safe and maybe trust me.”</td>
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<td>Bob “If people were ever in a safe place and they were safe enough to look at themselves they might know (how they can heal), but most of the time they may not even feel safe enough to even look.”</td>
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<td>Seeing symptoms as coping mechanisms</td>
<td>Sally “We are all living organisms whose inner and outer life, if it is troubled, seems to really reflect ways of coping with adversity...even things like seeing things that aren’t a part of consensual reality.”</td>
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<td>Bob “we’ve become disconnected from ourselves, or unable to trust ourselves and so that when we are in that type of incongruent space that’s where so much of what is termed a mental illness – and so our coping strategies, our coping skills, our strategies for living end up having a socially unacceptable behavior or thoughts or feelings attached to them.”</td>
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<td>Beth “What I think is helpful in healing for people is to be able to view people that it’s not that there’s something wrong with them but that based on your lived experiences that a lot of times people will cope in whatever way they can and that they’re surviving and however they do that is pretty incredible.”</td>
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<td>Bob “The loss of safety puts them into a dangerous place and to regain a sense of safety and security they have to do some things that then may be perceived as symptomatic by society or themselves.”</td>
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<td>Humanizing mental illness and crisis</td>
<td>Prudence “Sometimes they’re not even symptoms. They’re just ways of coping that they’ve had to develop that may have functioned for some period of time and may not be working anymore.”</td>
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|  | Jane “Just like me, people are searching for peace. Just like me, people are searching for connection. And so when I bring it back to that – just like me – then that puts a whole different flavor to things.”  
Bob “…the people in the depths in the back wards of a psychiatric hospital are still 90 percent the same as those of us that are walking around out there. What happens is that we become so fixated on the 10 percent difference that that’s what we judge people on.”  
Bob “I think it forced me into acknowledging that wait a minute, maybe my walls – I’m not able to be different. You know, that we’re all in this one together and that I had to learn how to risk being vulnerable.”  
Beth “What I really focused on was trying to help the students understand what it would be like to experience that as a person, if something like this (becoming psychotic) would happen, what would that be like for you as a person. What impact would that have on your relationships? So helping to personalize that experience rather than just seeing the symptoms list that you would go through.”  
Prudence “When I think about just life being really hard and coming at us full force sometimes and suddenly taking things and people away from us, immediately that brings me closer to them. That brings me to this is just a person. This is someone no different than I except for the timing of their life right now is such that they are in the midst of great pain and suffering. And that could be me tomorrow.”  
Prudence “It immediately removes shame, it immediately removes stigma, it immediately removes judgment when we imagine that this could be absolutely us, no matter the issue.” |
| 2: The counselor is humanistic |
| Healing through connection with therapist | Tom “The research is revealing that the most significant factor of successful therapy is the relationship between the therapist and the client. More and more evidence that everything is about connection.”
Prudence “I think for me the approach is really focused on building that connection and really sitting with people in their pain.” | 5: The counselor prioritizes the therapeutic alliance |
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<td>Having investors in the community</td>
<td>Bob “They compared it – they said in a community – communities need law enforcement, fire rescue, and crisis response. So that is simply a basic understanding that if you live here this is a part of what your taxes go for.”</td>
<td>Community factors 1: The community is supportive</td>
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<td>Counseling profession in a specific historical and global context.</td>
<td>Tom “Back then, thirty/fourty years ago, it was very common to do therapy with schizophrenic people, or psychotic people. No problem at all. And now we’re just lumping them into a category using the medical model, and the medicalization of psychology is probably one of the worst things that’s happened in this culture.”</td>
<td>Global and historical factors 1: Counseling in its historical context</td>
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<td>Being harmed by a diagnosis</td>
<td>Tom “They can get accommodations, they can get access to resources; however, they need to know that there are repercussions. There was a divorce and in the custody hearing it comes up that she’s been for psychological treatment. Depression and anxiety. She loses custody because she has a psychiatric record. And that’s a comment on the whole system.”</td>
<td>Society at large factors 1: Experiencing detriment in the medical model</td>
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<td>Insurance as a complicating variable in treatment</td>
<td>Jane “Working in addictions, I’ve worked in a private facility that was private pay. And I know that might sound exclusive and yet there were always ways to be able to do that. There were scholarships and all kinds of stuff. And they didn’t take insurance. But then they started taking insurance for residential treatment and the clinicians were spending so much more time on the phone trying to justify why the client needed to be there.”</td>
<td>Society at large factor 2: limitations of medical model</td>
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<td>Funding/promoting prevention</td>
<td>Bob “Let’s make for healthy children because, hey, I bet they’re more likely to become healthy adults. Where gosh, we can predict – we know it would be so valuable.” Bob “Prevention is really hard to fund because it’s really hard to show with prevention that you’ve actually reduced something.” Prudence “All the numbers absolutely show that when we’re working on prevention and giving people the ability to get care up front in the long run it’s going to be so much better for both the health and wellness of the community but also financially. It costs significantly more to hospitalize someone involuntarily than it does to offer them that front end support when crisis hits.”</td>
<td>5: Health of general society</td>
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<td>Having crisis sites and counseling services with volunteers and interns</td>
<td>Bob “…admittedly it was incredibly inexpensive because of the volunteer model.” Bob “So the whole use of pracs (or interns) and so forth expanded dramatically.”</td>
<td>Community factors 2: The community provides alternatives</td>
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<td>Meaning and healing is different across cultures</td>
<td>Bob “I mean, people make fun of shamans who have cure rates for mental health illness. Shamans don’t work well within our culture.” Tom “But what came to mind when you said that was in many, many cultures, somebody who has the ability to make contact with other types of consciousness would be called a shaman. In this culture they’re locked up on a ward.” Tom “A book I read in grad school which was very influential to me was called The Social Construction of Reality where anthropologists said we’re one of the few cultures in the world where there’s only one valid version of reality.”</td>
<td>Counseling in a global/historical context 2: Counseling profession in a global and multicultural context</td>
</tr>
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</table>
| **Lacking time and personnel in the medical model** | **Jane** “Having a decent enough amount of clinicians to handle all the people coming in to be able to be with them...having enough time I would see people run through and see the psychiatrist every 10 or 15 minutes. There’s no way you can get a picture of what is truly happening with this person in 10 or 15 minutes.”  
Jane “They’d been to a primary treatment previously for addiction and they came to see us for trauma resolution. And that’s not something that happens overnight. And you get an insurance company going “oh well they tried to kill themselves 3 weeks ago. That should be good now.””  
Tom “You can do a 15 minute session, get paid 150 dollars, or you can do a one hour session and get paid 200 dollars.”  
Beth “You get in a room with a psychiatrist and you feel bad taking up their time. You have 15 minutes.” | **Society at large factor 2: Limitations of medical model** |
| **Focusing on symptom reduction and medication management** | **Jane** “It’s that whole mindset of “let’s just get people through”. I mean, they need to make money to survive (psychiatrists). And yet so often the client is really attended to in the ways that they need to be tended to.”  
Bob “The DSM became a more powerful tool, financially. Still from a treatment standpoint I struggle to see how much for the most part the diagnostic code I put down and the treatment that I choose and how I’m going to intervene with somebody doesn’t – the code doesn’t tell you much.”  
Beth “And then I think in the medical model too, there’s so much focus on just symptom treatment. It’s very kind of – just treating the symptoms but not looking at all the other elements like family relationships, or social (elements), being able to connect people to peer support, or seeing what is possible with proper treatment and proper resources for people.” | 4: Influence of positivism |
| **Prudence** | "I think the minute you give someone a label it becomes easy to just see them as a collection of symptoms versus a person." |
| **Advocating for clients/teaching self-advocacy** | Sally "Really validating the extent of the distress and sometimes advocating for people to have accommodations and sometimes access to medications while still not viewing them as pathological."
Beth "That provider went to medical school and they have a lot of knowledge but you are an expert on you and your body...just because they have this outside knowledge doesn’t mean they know better than you what feels right or doesn’t feel right." |
| 2: The counselor is humanistic | Facilitating agency, responsibility, and self as expert via advocacy |
| **Living in an unhealthy society** | Sally "A lot of the technological advancements of this generation have, I think, kind of one upped the amount of social comparison that people are doing, and comparison as we know is pretty highly correlated with shame."
Prudence "There’s some research coming out now in terms of the impact of social media on all of us, especially youths. And the more time spent online and on social media the higher the rates of depression, which doesn’t shock me at all." |
| 5: Health of general society | |
| **Having low tolerance for discomfort** | Sally "Anything that’s unpleasant now seems to be categorized as a symptom. If you feel anxious for more than two weeks you might need a medication" (referring to commercial ads for psychiatric medications) |
| 5: Health of general society | |
| **Trauma resulting from inequities** | Sally "I’ve never seen such a polarized political situation and it seems to be getting worse for people who are not white, heterosexual, cis gender, so there’s a lot of trauma that comes from those inequities." |
| 5: Health of general society | |
| **Healing happens when client is considered and worked with holistically** | Sally "Healing seems to happen more often when all of those other contextual factors are considered and explored with a person." |
| 2: The counselor is humanistic | |
| **Labelling mental illness does not necessarily facilitate healing** | Sally "I have seen people who have really felt oppressed by those labels and that those labels have not helped people recover."
Beth "I don’t think that most disorders really fit for the way the medical model would like to make it. And so the way that I view mental health issues is looking at how people have been adaptive." |
| 2: The counselor is humanistic | Specifically, not-reductionist in context of diagnosis |
Prudence “They often don’t need someone to give them a label. You don’t need somebody to be able to find out what’s going on with them in a book. What they need is to feel heard and feel like despite everything happening around them they’re still a human being worthy of attention and connection and worthy of being heard.”

Prudence “I think I’m going to be open to all possibilities and just because they are disconnected from our perceived reality it doesn’t mean necessarily that a quick label or diagnosis explains it.”

Sally “So I was there seeing clients for 7 years and never diagnosed a single person and saw people with all kinds of severe and intense coping strategies and presentations and saw people heal in some pretty incredible ways without ever giving them a diagnosis.”

| Appreciating multiple and systemic perspectives | Sally “I came into the counseling program with a background in political science and especially studying the politics of poverty and race…I already without realizing it had an affinity for ways that culture, society, life experiences shape people and their way of being.”

Jane “I don’t want to look at this just from this rigid medical statistical type of stuff. I wanted to look at and study some history and I wanted to study some gender issues.”

Tom “And so from the very beginning (of graduate education) we were taught to question what this thing is that we call mental illness and to see that there were cultural and organizational, political factors at work.”

Prudence “so I was in this grad program and I was already prepared to fight the power. I just wasn’t going to accept blindly everything that was given to me and so I kinda came in with a little bit of that attitude. It really allowed me as I was learning all those theories to think critically.”

Prudence “Having people, as they’re learning these different approaches, really think critically about what they mean personally and how they impact our relationship with clients.”

Prudence “I think those kinds of exercises (experiential) are really invaluable to really think about the ways in which our unconscious biases show up in working with those who are struggling.”

3: The counselor thinks critically about attitudes, values, and beliefs.
| Community factor 3: Peer support facilitates wellness and recovery | Sally "When I was exposed to the world of peer support and people who had felt really harmed by the medical model, I really was able to develop more of an informed philosophy around why I didn’t want to diagnose.” |
| Questioning disseminated medical information | Sally "Modern psychiatry has repressed some of the other findings about the potential damages of medications and really a lack of scientific validity to these discrete categories of so-called mental illness.” |
| Not defining trauma for the clients | Jane “It doesn’t matter whether it’s something that we’d put a huge T on that trauma or whether it’s something that’s only perceived as traumatic. That deep mind doesn’t know the difference.” 
Beth “People think of trauma as assault or abuse or a really bad accident. There’s actually a lot of other things that fit for trauma or can be traumatic to someone’s system that don’t necessarily look like those things.” |
| Being traumatized or dehumanized in the medical model | Jane ”First of all there needs to be a safe space and you need to build those trusting relationships or none of that’s gonna come out. And then you get an insurance company going, we’re not paying anymore. You’ve gotta leave. I mean that’s traumatizing all over again. I’ve seen lots of people relapse in their addiction because of that.” 
Jane “Yeah, ok, I opened up. You told me I could trust, you told me that this would get better and here I am back on the street again, or my meds have failed, or I’ve been raped. And then the tendency towards trusting again – that’s going to be less and less.” 
Tom “Well, it’s largely inhumane treatment. You have 15 – 20 minutes “How is your medication working.” I’ve talked with people who say their psychiatrist didn’t even look them in the eye because they were on their computer. It’s just very dehumanizing. Very rarely a discussion about what’s going on in your life and even the nuances of medication.” 
Tom “In a typical psychiatric unit there’s going to be everything from floridly psychotic to somebody who has suicidal ideation. Oftentimes, in my experience, and I had a client like this very recently, was that the experience in the psychiatric unit left him with PTSD.” 
Beth “I worked over at a crisis stabilization unit for a little while which was pretty horrible and terrifying, and really also horrible to see the way that people were treated in a really low funded psychiatric facility.” 
Beth ”Everybody is in there together so you may be super depressed and there’s someone who is floridly psychotic and you’re in the same space with them. It can be really
kind of scary. Or you might be sharing a room with someone who is manic. I've had clients that have been in and they were more traumatized getting out of there than actually going in.

Sally "Violated their human rights. They were going through an extremely distressing time in their life and were responding to it the best they could and were told that they have an incurable brain disease and will never recover and will need to accept reduced options for their lives."

Beth "She felt really betrayed by this provider that hadn’t really listened to her. And we did some work through that of: you are the expert on your body. You know what’s going on. Trust that.”

Sally "So I learned that there is an international movement of people who consider themselves psychiatric survivorship...and by survivor meaning traumatized by the psychiatric system and survived it.”

The medical model is limiting

Sally “Over time found the mental health system extremely limiting and found that they wanted to heal. That wasn’t really given to them as an option in the mainstream medical model”

Jane “And you (clients with mental illness) want to thrive, just like me. And if you can’t have a safe place to be with what’s happening, chances are that’s not going to shift and change for you. So they may be on something that stabilizes them but they will not necessarily be thriving or reaching the highest potential for wellness that they could have.”

Jane “It takes time to build trusting relationships. It’s got to feel right. And if those things aren’t in place or if you have – say in a psychiatric hospital – constantly changing faces – if you have somebody who is just there to do a job and that’s it. I mean there are so many factors that go into if you need to take medication and that medication isn’t helpful to you and nobody is willing to take more than 10 minutes with you, you still have to have that sense of trust and knowing that this person is there to walk with you.”

Jane “If you’re looking just at medicine you’re missing all of the rest of the aspects of someone and if you’re waiting to be able to prove it in order to believe it, you have missed the boat.”

Bob “I trust that you’ve heard people clients say “I’ll kill myself if I have to go back,” which is not necessarily true but it’s a powerful statement. I think the bottom line is Society at large factor 2: limitations of the medical model
nobody said it necessarily is a healing place. It may be an effective intervention to give them a place where they can calm down in a safe environment. But the only problem is a hospital is a pretty extreme place to have to do that.”

Tom “Obviously for almost every insurance company there limits on psychiatric care and psychological care. They don’t limit heart care.”

Prudence “When somebody is in, let’s say, full crisis, and you feel the only option is that we need to work with this person quickly because we have other people coming in, so Baker Act and involuntarily hospitalize. And I think that’s unfortunate because we know the hospitalization, especially involuntary, can be extraordinarily traumatic.”

| Positivism creating a hierarchy | Jane “Because insurance companies focus on the medical model, there’s a hierarchy. I am a mental health counselor. Clinical social workers are looked at as more valuable, more knowledgeable. Clinical psychologists have more value than social workers. Medical doctors have more value than that.”

Beth “Managed care, the fact that an entity that’s outside of mental health is managing how people are diagnosed and what is medically necessary...so that insurance also creates a barrier or dictates how mental health providers should be practicing or diagnosing and that’s a problem.”

Beth “The fact that an outside agency or managed care people are telling practitioners how they should practice doesn’t allow for clinical judgment necessarily.”

Beth “It feels like in order to feel legitimate that we have to buy into this medical model, and it’s like, well wait: don’t you trust your clinical judgment?”

| 4: Influence of positivism | Theme occurs when types of knowledge are deemed hierarchical or reductionist application of knowledge and application is noted |

| Having alternative resources available in the community | Sally “Where services can be offered without having to bill insurance companies, whether that’s private practice or an agency that’s funded in other ways, that’s a huge way of side stepping the diagnostic framework”

Tom “When I was a grad student and intern, if there was a student who was psychotic or suicidal, there was a floor in the student health center where they could go and stay. And nurses were there and there was a doctor that monitored it.”

Prudence “That’s why our organization (crisis agency) often advocates in this community to help be the in between where we can step in and work with the person on other options or work with them to agree to go (to the hospital).”

<p>| 2: The community provides alternatives | |</p>
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<th>Having supportive colleagues</th>
<th>Sally “Enough of my are trauma informed at least, if not familiar with the c/s/x stuff. They recognize the impact of adversity on people’s mental health.”</th>
<th>1: The community is supportive</th>
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| Shifting paradigms in other countries | Sally “The British Psychological Association and UN Human Rights Council, that there have been major systemic acknowledgments of the lack of scientific validity to that model.” (referring to DSM categories)  
Bob “Which is why all of the stuff from Northern Europe makes such great sense because it’s the concept of keeping people within the community. You’re still a part of the community (with mental illness). You’re not segregated”  
Beth “I’ve heard of programs in places in Europe where really powerful treatments for things like schizophrenia are very focused on having family involved and having these very therapeutic environments.” | 2: Counseling in a global/multicultural context |
| United States as being slower to make change | Sally “My sense is that the US is behind. Britain, Australia has been doing a ton with IPS. Finland has the longest rate of recovery from first break psychosis through their Open Dialogue process. Those are at least 3 industrialized countries that are doing much better than we are.” | 2: Counseling in a global/multicultural context |
| Having tolerance and appreciation for distress and intense states | Sally “Hearing voices might be an incredibly creative response...well if you tell your psychiatrist that you’re in trouble”  
Bob “People have much more power than they realize and I don’t want to immediately become their advocate and say “you poor thing, you’re out of control. Let me take responsibility for you; I’ll get you hospitalized and medicated.”  
Bob “When people cry with that abandon – wailing individuals terrify most people and yet if you’re around it very much you know that people who wail do not do it indefinitely. It may be quite cleansing if you allow them. If you don’t try to intrude upon it they can move through it. It may be a very efficient model of getting stuff out.” | 5: The counselor prioritizes the therapeutic alliance  
Specifically, seeing wisdom and elegance in extreme states. Not distancing from or judging extreme states. |
| Broadening training experiences | Sally “There’s such a comprehensive indoctrination into that world view (deficit-oriented)...even though I came through probably the most humanistic wing of the mental health helping profession that exists, I still wasn’t ever exposed to the idea that people could actually live well with those experiences” (referring to people who experience extreme states). | Community factors 4: Counselor training  
Counselor training is situated within the communities that provide training sites |
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<th>Topic</th>
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<td>Seeking certain characteristics in a psychiatrist (harm reduction)</td>
<td>Sally “I would hope that they would be willing to entertain the complexity and to be curious rather than afraid...And to believe fundamentally that even if they can’t understand where it’s coming from on some level it makes sense to the other person”</td>
<td>Counselor and relationship 4: Harm reduction</td>
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<td>Jane “They look at the least invasive diagnosis, the least invasive medications. They are willing to give their clients time. They are willing to confer. So it’s more of a collaborative effort and the clients know that too.”</td>
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<td>Prudence “They happened to find this person (psychiatrist) who sat with them for a couple of hours and gave them in fact all of this paperwork around the importance of their voice in the treatment and was almost hesitant to prescribe or do anything until they fully got to know them and made sure that they had full voice in what was happening.”</td>
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<td>Being impacted by the digital age</td>
<td>Sally “Just with anxiety, which is the number one presenting concern I see, people come in having already diagnosed and pathologized themselves. They’ve googled it or they’ve gone to WebMD.”</td>
<td>4: Influence of positivism</td>
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<td>Allowing clients to maintain agency</td>
<td>Sally “And I may not even be very explicit about my position because the research is also supportive that people heal in the ways they believe will be healing.”</td>
<td>2: The counselor is humanistic</td>
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<td>Jane “I think in whatever the path of healing is I think people need to have their own sense of agency in that.”</td>
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<td>Perpetuating a single narrative</td>
<td>Sally “There are so many people who have been through that (medical model) system who have never been exposed to another way of looking at what’s going on for them”</td>
<td>4: Influence of positivism</td>
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<td>Recognizing appropriateness of the medical model</td>
<td>Sally “Being a part of the peer movement, which is not anti-medication. It’s prochoice and its harm reduction.”</td>
<td>Counselor and relationship factors 6: The counselor is not anti-medical model</td>
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<td>Healing qualities of peer support</td>
<td>Sally “One of the benefits of peer support is hopefully you build friendships with people who have been through some version of this themselves, and so there are people it’s safe to break down around who aren’t going to necessarily panic and take control away from you.”</td>
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<td>Jane “Some of the most powerful moments happened when one client would be telling their story or doing their homework and we’re all processing it and another client is like: I never knew anybody else felt like that. It was all about connecting with their peers.”</td>
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<td>Bob “Peer respite is a lovely example. The concept is perfect. It’s something that breaks out of that – because hospitalization is by definition so extreme. Do you want to eliminate the availability of it? Of course not, but it’s usage is so over used.”</td>
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<td>Beth “It’s not mental health focused at all. It’s very much peer run and a peer support model. Members can come in and they clean, cook, provide meals, help with job searches or resumes. It’s sort of an empowerment model. The center, and a lot of peer support programs are about what can you provide? Looking at strengths and talents.”</td>
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<td>Beth “I think that’s another asset of the peer support movement is that it’s taking down that stigma for people who feel ashamed.”</td>
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**3: Peer support as facilitating wellness and recovery**
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<tr>
<td>Having support from society at large</td>
<td>Prudence “My sense of the consumer movements and the peer led movements is fighting for that voice back and saying this mental health concern has been a part of somebody’s life but it’s not all of who they are.” Sally “Maybe a job or educational setting that had sick leave or some security. Lots of supports. Certainly education. There’s some online resources where you can read about people’s experiences.” (referring to wellness planning and deciding to come off of meds). Tom “You know, Obamacare (Affordable Care Act) was a big step forward in for mental health treatment. It opened psychiatric care, psychological care, to a lot of people - people who had never had access to treatment before. So to me that’s a really great example of a policy change that can make a huge difference.”</td>
<td>5: Health of general society</td>
</tr>
<tr>
<td>Bringing peer support and lived experiences into communities</td>
<td>Sally “There are a number of mental health agencies that are training people in the peer support model and are paying peers to come in and be a part of the services. There is some research coming out that it’s cost effective to have peers.” Beth “We need more peer support programs and peer respite and resources, and I think empowering peers to provide more services, helping to empower people with mental illness that they can offer support. They are really the experts.” Prudence “I also think that all of these movements, and even in the suicidology world, there’s a huge movement towards lived experience. The annual American Association of Suicidology conference has a whole division devoted to survivors and giving a very big platform to: let’s hear your voice and be able to understand.”</td>
<td>3: Peer support as facilitating wellness and recovery</td>
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<td>Defining wellness is done by client</td>
<td>Sally “give people a chance to define it for themselves. What I have found really helpful is stories of people who fought their way back through all kinds of mental health and life challenges who were told they weren’t expected to. For one person its joining a choir and having a relationship. For another person its going back to school and becoming a psychiatric nurse.”</td>
<td>2: The counselor is humanistic</td>
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<td>Listening to clients</td>
<td>Sally “We need to listen to their experiences to hear what hasn’t been helpful. I think that mental health professionals I know would not want to go to a medical model practitioner if they were having a mental health crisis so what does it say if we don’t want to use our own services?” Prudence “Listening to consumers, listening to clients in terms of what they need and encourage therapists to”</td>
<td>2: The counselor is humanistic</td>
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<td>Bringing wellness and recovery conversations into training</td>
<td>Sally “We’re told to take this Hippocratic oath to do no harm. Well why was it that 10 years out of my education I learned that there are people who felt extremely harmed by things that I was told was the correct way to practice? And so the more we can begin to get these lived experiences into the conversation in training programs, I think that would help.”</td>
<td>4: Counselor training</td>
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<td>Teaching the historical movements of the profession</td>
<td>Tom “When I teach psychotherapy courses I try to go back and give a little history and show people the evolution (of psychology) even in the 20th century and into the 21st century. And if you think about psychology, what it really means is study of the soul. It doesn’t mean study of the mind.”</td>
<td>4: Counselor training</td>
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<td>Following in the footsteps of countries that are implementing a paradigm shift</td>
<td>Sally “We need to look at systems in countries that are successfully implementing alternatives, like with the UN human rights charter that says we need genuinely recovery oriented peer alternatives and we need to move towards the ending of involuntary interventions for people in distress.”</td>
<td>2: Global context of counseling profession</td>
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<td>Becoming institutionalized</td>
<td>Bob “The us/them mentality has always been – there’s two mentalities I think – one of them is us/them and the other one is the institutionalization model for the staff. That they become institutionalized to the rules and to the “this is just the way it is” and the assumptive quality of people not necessarily being capable because just by definition they are here.”</td>
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APPENDIX B
INSTITUTIONAL REVIEW BOARD DOCUMENTS

Informed Consent

University of Florida
School of Human Development and Organizational Studies in Education (SHDOSE)
Counselor Education Program

Title of Study
Exploring Alternatives to the Medical Model of Mental Healthcare

Dear Counselor,

You are being asked to participate in a research study being conducted by a doctoral candidate, Jillian Vella, of the Counseling and Counselor Education program at the University of Florida in the Department of Human Development and Organizational Studies in Education. This study is being conducted to better understand the experiences, beliefs, and practices of professional counselors who have intentionally adopted a non-medical approach to their professional practice. Approval of this study was obtained through the University of Florida Institutional Review Board. This study is being conducted under the supervision of Dr. Kristina DePue, Assistant Professor of Counselor Education.

Purpose
The purpose of this study is to explore how professional counselors apply the theoretical frameworks of their non-medical approach in practice, and also the pragmatic factors of maintaining a practice that does not engage in medical ideologies.

Procedure
If you agree to participate in this study, you will be participating in a semi-structured interview, meaning that the interviewer will have a guideline of questions to follow, but the interview is flexible in the order that the questions are asked and will have a conversational quality. The interview will be conducted by a Ph.D. candidate in Counseling and Counselor Education who is under the supervision of Dr. Kristina DePue, Assistant Professor of HDOSE.

The interview is expected to take between 60 and 90 minutes to complete. Interviews will take place in your private office or in the Counselor Education counseling labs if your office space allows for others to see or hear the interview taking place.

The interviewer will contact you within 30 days of your interview, after a cursory analysis, for a follow up that would serve the purpose of adding clarification to your interview and/or elaboration to your interview responses. Any follow up questions would
take place under all of the same conditions provided in this informed consent, unless you agree to have the follow up conversation via phone. In this instance the interviewer will conduct the phone conversation with you from a personal office or counseling lab that provides privacy. It will be up to you to ensure privacy on your end of the phone call should we conduct the follow-up via phone.

Risks
There are no more than minimal risks associated with this study. While you will be asked questions about your professional practice, but not about your personal life. If you feel that any personal experiences are relevant and would like to disclose them in your responses, you may do so at your discretion. In the event that you experience any distress as a result of the interview, you may debrief with the interviewer.

Benefits
There are no direct benefits to participating in this research. Your participation will contribute to scholarly knowledge and may allow for the publication of information that will help to further practices in the counseling profession.

Confidentiality
Your interviews will be audio recorded on a audio recording device and then moved onto a password protected computer and stored in an encrypted folder. During data analysis, your interview will be given a pseudonym. This research may result in a publication in an academic journal. If publication is granted, no identifying information about you will be provided in the published article.

No one else besides the interviewer will have access to the audio recordings of your interview. When data analysis is complete and a working draft of an academic paper is generated, the audio recording of your interview will be deleted from storage. Data will be shared with the interviewers supervisory committee during the doctoral dissertation defense. No identifying data will be included in the dissertation defense. The same confidentiality practices apply to any potential follow up questions that may take place after the initial interview. Your identity will be kept confidential to the extent provided by law.

Compensation
There is no compensation provided for participating in this study.

Voluntary Participation
You have the right to withdraw from the study at any time (before, during, or after the interview) without consequence. You do not have to answer any questions that you do not wish to answer. Your participation in this study is strictly voluntary.
You may contact the supervising faculty member, Dr. DePue, with any questions about this study even after your participation is complete. You may reach Dr. DePue by email at kdepue@coe.ufl.edu, or by phone at (615) 403-3003.

You may also contact the University of Florida IRB Office at (352) 392-0433, or irb2@ufl.edu

**Agreement:** I have read the procedure described above. I voluntarily agree to participate in the procedure and I have received a copy of this description.

______________________
Print Name

______________________  ________________
Sign Name  Date
DATE: 4/10/2018
TO: Jillian Vella
7004 SW 49th ave
Gainesville, Florida 32608
FROM: Ira Fischler, Ph.D., Professor Emeritus
Chair IRB-02
IRB #: IRB201800814
TITLE: Exploring Alternatives to the Medical Model of Mental Healthcare

Approved as Exempt

You have received IRB approval to conduct the above-listed research project. Approval of this project was granted on 4/10/2018 by IRB-02. This study is approved as exempt because it poses minimal risk and is approved under the following exempt category/categories:

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey or interview procedures, or the observation of public behavior, so long as confidentiality is maintained. If both of the following are true, exempt status can not be granted: (a) Information obtained is recorded in such a manner that the subject can be identified, directly or through identifiers linked to the subject, and (b) Subject's responses, if known outside the research, could reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing or employability or reputation.

Special Notes to Investigator:

In the myIRB system, exempt approved studies will not have an approval stamp on the consents, fliers, emails, etc. However, the documents reviewed are the ones to be used. Therefore, under ATTACHMENTS you should find the document that has been reviewed and approved. If you need to modify the document(s) in any manner then you'd need to submit to our office for review and approval prior to implementation.

Principal Investigator Responsibilities:

The PI is responsible for the conduct of the study.
- Using currently approved consent form to enroll subjects (if applicable)
- Renewing your study before expiration
- Obtaining approval for revisions before implementation
- Reporting Adverse Events
- Retention of Research Records
• Obtaining approval to conduct research at the VA
• Notifying other parties about this project’s approval status

Should the nature of the study change or you need to revise the protocol in any manner please contact this office prior to implementation.

Study Team:

Mary DePue Co-Investigator

The Foundation for The Gator Nation
As an Equal Opportunity Institution
Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of the intended recipient(s), and may contain legally privileged or confidential information. Any other distribution, copying, or disclosure is strictly prohibited. If you are not the intended recipient, please notify the sender and destroy this message immediately. Unauthorized access to confidential information is subject to federal and state laws and could result in personal liability, fines, and imprisonment. Thank you.
Interview Screening Questions

1) Do you currently provide mental healthcare within a medical facility (such as a psychiatric unit in a hospital, psychiatric outpatient facility, or public agency that provides psychiatric services, etc)?

2) Do you currently diagnose mental illness in your practice? If yes, please describe the frequency and purpose for your diagnoses (ex. Insurance reimbursement).

3) Are you familiar with the concepts of psychiatric survivorship, the consumer/survivor/ex-patient movement, mental health recovery, and peer support? Indicate which ones.

4) Do you and/or the organization you currently work for intentionally use a non-medical approach to counseling or any other mental health related services?

5) Do you consider yourself to be an ally or advocate for consumer-led and rights based mental healthcare?
Demographic Questionnaire

1) Gender (optional): ________________________

2) Age (optional): ___________________________

3) Race/ethnicity (optional): __________________

4) Spiritual/religious affiliation (optional): _________________

5) What degree program did you graduate from? Indicate the accreditation of the program:

6) What is your current job title? Indicate whether this is a private practice or a position within an agency or organization:

7) How many years have you been in the counseling/psychology profession? ________

8) How many years have you been licensed and what is your license? (LMHC, licensed psychologist, LMFT, etc).

9) What is your theoretical orientation in counseling? _________________
Semi-structured Interview Questions

1) Describe your approach to counseling, including your perspectives on what mental illness is or is not, and how people become well.

2) Describe your theoretical perspective on mental illness and mental health recovery.

3) Describe what led you into working from a non-medical approach to mental health counseling?

4) In your experience, what are some barriers that you have encountered in maintaining a non-medical approach?

5) What has facilitated your ability to maintain a non-medical approach?

6) What are some systemic issues that might hinder a wider application of medical alternatives to mental healthcare?

7) What are some systemic factors that facilitate a wider application of alternative approaches?

8) In what ways do you see the current medical system approach as being helpful to individuals with mental illness?

9) In what ways do you see the current medical system as being harmful to individuals with mental illness?

10) How have you been able to facilitate recovery for individuals with mental illness?

11) What suggestions do you have about how counselors and psychologists can promote the integration of alternative treatments and better facilitate mental health recovery on a systemic level?
LIST OF REFERENCES


BIOGRAPHICAL SKETCH

Jillian Vella is a dual citizen of Canada and the United States. Born in 1981, she was raised primarily in areas outside of Toronto, Ontario until her family moved to Ocala, Florida upon her high school graduation. Initially intent on starting a career in veterinary medicine, Jillian completed a bachelor’s degree in microbiology and cell science in 2005. After working as a veterinary technician for 2 years during her undergraduate work, she became wary of pursuing veterinary college and began working for a biotechnology company where she was employed as a microbiologist for 6 years. During that time, she encountered struggles in her personal life and began to recognize the value of working with a counselor to maintain wellness. Having struggled to find a true sense of calling as a microbiologist, Jillian decided to pursue a master’s degree in mental health counseling. With an ongoing inclination towards critical inquiry and with the encouragement of some mentors, she continued into the University of Florida’s doctoral program in Counseling and Counselor Education immediately following the completion of her master’s degree.

During her work in the doctoral program, Jillian maintained a focus on the impact of trauma on mental health, multicultural and diversity issues, and on growing her skill set as a clinician. She is proud to be moving on to a clinical assistant faculty position where she will be able to regularly use her clinical skills as well as her scholarly knowledge. She hopes to continue contributing to a growing professional emphasis on the impact of trauma, and also contribute to the community throughout reach and the supervision of counselors in training.