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# What we talk about when we talk about recovery: A systematic review and best-fit framework synthesis of qualitative literature

*Running title: Recovery: A systematic review and synthesis*

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# **What we talk about when we talk about recovery: A systematic review and best-fit framework synthesis of qualitative literature**

## **Abstract**

**Background:** The recovery approach is increasingly popular among mental-health services, but there is a lack of consensus about its applicability and it has been criticised for imposing professionalised ideas onto what was originally a service-user concept (Beresford, 2015).

**Aims:** To carry out a review and synthesis of qualitative research to answer the question: ‘What do we know about how service users with severe and enduring mental illness experience the process of recovery?’ It was hoped that this would improve clarity and increase understanding.

**Method:** A systematic review identified 15 peer-reviewed articles examining experiences of recovery. Twelve of these were analysed using best-fit framework synthesis (Carroll et al., 2013), with the CHIME model (Leamy et al., 2011) providing the exploratory framework.

**Results:** The optimistic themes of CHIME accounted for the majority of people’s experiences, but more than 30% of data were not felt to be encapsulated. An expanded conceptualisation of recovery is proposed, in which difficulties are more prominently considered.

**Conclusions:** An overly optimistic, professionally imposed view of recovery might homogenise or even blame individuals rather than empower them. Further understanding is needed of different experiences of recovery, and of people’s struggles to recover.

**Declaration of interest:** None.

**Keywords:** Recovery, qualitative, synthesis.

## Introduction

Recovery from serious mental illness is not a straightforward concept. Davidson and Roe (2007) argue that it has become a conflation of two ideas: clinical recovery, or ‘recovery from’, defined by the amelioration of symptoms and a move towards what might be deemed normal functioning; and a person-focused definition, or ‘recovery in’. By this second conceptualisation, popularised by Deegan (1988), symptomatology can still be present and recovery is defined subjectively as an overcoming of difficulties to an extent that a person feels they have regained some control over life. Pilgrim (2008) describes a trichotomy: a biomedical/treatment approach about recovery from illness, a psychiatric/rehabilitation approach about recovery from impairment, and a personal/survivor approach about recovery from invalidation.

Anthony (1993) explored how the principles outlined by Deegan (1988) might be adopted by mental-health services through a focus not just on treatment but on collaborative efforts to develop and empower, giving rise to what has become popularised as the recovery model or recovery approach. Clinically, initiatives such as Wellness Recovery Action Planning (Cook et al., 2009) – a service-user-designed, manualised and copyrighted recovery plan – have been adopted; more generally, the recovery approach has gained traction among services and decision-makers in the UK and elsewhere, perhaps because it offers a collaborative and optimistic paradigm in which to work with people (Bradstreet & McBrierty, 2012; Roberts & Boardman, 2013). Anthony (1993) considered recovery in relation to people with severe and enduring mental illness, but the concept has been broadened to include such diagnoses as depression and first-episode psychosis (Stickley & Wright, 2011).

Perhaps because of the lack of consensus about both at whom the recovery approach is aimed, and what constitutes successful recovery within the paradigm, the concept has been criticised as ambiguous and vague (Beresford, 2015; Smith-Merry et al., 2011). In their review of implementation, Smith-Merry et al. (2011) also caution that a risk with the recovery approach is that, despite its collaborative nature, its application remains controlled by services. This consolidates power and might ultimately require people to conform to a professionalised idea of recovery: what Beresford (2015) summarises as the colonisation by services of progressive ideas. Furthermore, some service users have expressed fears that the individual-empowerment aspect of recovery might provide UK National Health Service providers with an excuse to make cuts in support (Bird et al., 2014; Roberts & Boardman, 2013). A clearer understanding of people’s experiences of recovery may therefore be of benefit, both to clarify the contemporary meaning of the recovery approach, and to guide services in how best it might be implemented. Such understanding might be improved by systematic reviews of individual service users’ narratives: this paper aims to provide such a review, in keeping with the original concept of recovery from severe and enduring mental illness (Anthony, 1993).

### ***Operationalising and measuring recovery***

In a systematic review of recovery literature – though one in which quality was not appraised – Stickley and Wright (2011) identified salient themes including hope, optimism and meaningful social activity. Warner (2010) offers a brief, selective review, concluding that empowerment is salient, while Roberts and Boardman (2013) suggest that the principal factors are hope, control and opportunity: nevertheless, this is a commentary, not a comprehensive review. Other reviews of literature exist (Andresen et al., 2003; Bonney & Stickley, 2008) but the selection of articles appears more subjective than systematic, and methods of analysis are unclear. Brown and Kandirikirira (2007) provide a report of the narratives of 64 people in Scotland who identified as being in recovery, from which is drawn a division between internal elements of recovery (e.g. belief in oneself) and external ones (e.g. community support). Once again, the method of analysis is unclear: furthermore, this is a non-peer-reviewed document which aimed to promote discussion, rather than provide scientific analysis.

A more rigorous review is that of Leamy et al. (2011). This is based on a systematic analysis of 97 published conceptualisations of recovery, with service-user input into the final modelling. Three overlapping models are presented: characteristics of the recovery journey, recovery stages and, primarily, a framework for recovery processes given the acronym CHIME after its five superordinate categories: Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment. The model has been used within various studies by the research group that created it: Shanks et al. (2013) employed CHIME to validate pre-existing measures of recovery; Slade et al. (2011, 2015) state that it informed aspects of the design of a randomised control trial to explore a recovery-focused intervention with staff; and Williams et al. (2015) used it as a framework for part of a measure of staff support for recovery, carrying out exploratory factor analysis with data from 92 service users. While the pattern of correlations observed for Empowerment appears unreliable, they suggest that a five-factor CHIME-based approach was appropriate. Bird et al. (2014) carried out a validation study of CHIME based on thematic analysis of data from focus groups (N=48) with diagnoses including schizophrenia, bipolar disorder, and depression. This supported the category structure but highlighted areas that were not included, such as a desire for practical support, issues around diagnosis and medication, and scepticism about the concept of recovery. This is pertinent, given that it has been observed that the CHIME categories tend towards the positive or optimistic (Connell et al., 2014). Researchers independent from the CHIME group have also considered and adopted the model (Brijnath, 2015; Eriksen et al., 2014).

Generally, assessing recovery is a complex concept (Roe et al., 2007). While attempts exist to produce reliable measures of individual recovery (Monger et al., 2013; Shanks et al., 2013), their construct validity is debatable: if recovery is entirely individual (Smith-Merry et al., 2011), against

what can it be normed? As might be expected for a concept in which symptom reduction is not paramount, correlations with traditional clinical outcome measures may be poor (Andresen et al., 2010) and convergent validity low. It is notable that the research group that constructed CHIME have proposed an individualised outcome measure with just two components: goal attainment and personalised primary outcome (Pesola et al., 2015). Nonetheless, researchers and services alike may require a more complex approach to personal narratives and construction of meaning if individual recovery is to be more clearly understood (Browne, 2006; Roberts & Boardman, 2013).

### ***Qualitative research and synthesis***

Slade et al. (2012) propose that to understand recovery, we have to understand lived experience. From a research perspective, qualitative methodology allows for exactly this: the exploration of individual experience in context (Barker et al., 2002), which may be particularly useful when the focus is on process rather than outcome (Poortman & Schildkamp, 2012). Qualitative synthesis – sometimes called metasynthesis, though this is contested terminology (Dixon-Woods, 2011; Thorne et al., 2004) – allows for the integration and contextual interpretation of existing qualitative studies (Dixon-Woods et al., 2006; Harden, 2010). While the findings of individual qualitative studies are not generalisable to a population (Malterud, 2001), through synthesis we can nevertheless explore and illuminate themes across a corpus of research. A body of work exists examining experiences of recovery from severe and enduring mental illness (SEMI), as considered by Davidson and Roe (2007), but the only systematic attempt to synthesise this evidence appears to be a review of narrative-inquiry studies (n=4; Rhodes & De Jager, 2013).

Various methods exist of synthesising qualitative data, many of which are adaptations of primary analytical techniques and all of which involve some form of ordering, describing, and integrating or re-interpreting existing studies (Dixon-Woods et al., 2005). Best-fit framework synthesis has been proposed as a pragmatic, flexible approach using an a priori framework, such as a published theoretical model which appears applicable to the area under review (Carroll et al., 2013; Carroll et al., 2011). A model can be applied, tested and if necessary refined to better integrate the data. As a succinct encapsulation of recovery processes which is increasingly well validated through its use in research endeavours, CHIME appears a promising model for best-fit framework synthesis.

### ***Aims of review***

The primary aim of this review was to employ a systematic approach to searching for and analysing published qualitative research in order to answer the question: ‘What do we know about how service users with severe and enduring mental illness experience the process of recovery?’ This is not a question which has yet been addressed by systematic literature review. The present work therefore has the potential to make a major contribution to the knowledge base around recovery, providing much-

needed clarity about the contemporary meaning of the concept, improving understanding for both services and service users. Additionally, it provides an opportunity to establish the extent to which the CHIME model (Leamy et al., 2011) accounts for people's recovery experiences; methodologically, it allows for further exploration of best-fit framework synthesis (Carroll et al., 2013).

## **Method**

Qualitative research is based on an interpretivist epistemology in which the goal is not to establish an objective 'truth' but to understand and interpret meanings in context (Walsh & Downe, 2006). In keeping with this philosophy, units of analysis were the results sections of published journal articles: in short, we did not try to divorce data from their interpretation.

### ***Search strategy***

The search was limited to articles available in English. To establish a workable boundary for a time-constrained review, only articles published in peer-reviewed journals indexed in the PsycINFO, Medline, Embase or Joanna Briggs Institute electronic databases were considered. It is noted that suboptimal indexing can affect systematic searches, particularly for qualitative studies (Dixon-Woods et al., 2006; Grayson & Gomersall, 2003; Papaioannou et al., 2010). The SPIDER strategy (Sample, Phenomenon of Interest, Design, Evaluation, Research type) offers a nascent standardised method of searching for qualitative material (Cooke et al., 2012), and a modified version was employed that prioritised sensitivity over specificity. The final search string applied to each database was: [("mental health" OR "service use\$") AND ("recovery" AND "disorders" OR "model" OR "approach")] AND "interview\$" OR "experien\$" OR "qualitative". Databases were searched in August 2014, from their inception. Searches were re-run in November 2014 to identify whether further eligible articles had been published.

The large number of records necessitated a lengthy manual screening process, though this was expedited by carefully selected reference-management software (Center for History and New Media, 2014). Figure 1 shows the process by which studies were appraised and selected. Twelve articles identified in the database search met the inclusion criteria. Reference lists were examined, and three further articles were identified, and subsequently assessed as meeting the inclusion criteria, which had not been found in the electronic searches.

<Figure 1>

Articles were considered for inclusion if they met the following criteria:

- Provided qualitative analysis of primary-source interview data from adult users (or former users) of mental-health services, who had experienced severe and enduring mental illness, e.g. schizophrenia, bipolar disorder or other psychotic condition, or severe depression, beyond a first episode;
- Directly addressed participants' experiences of recovery;
- Situated the concept of recovery within a person-centred model, e.g. as broadly defined by Anthony (1993) and Deegan (1988).

Articles were excluded if they were concerned primarily with the interaction of an external factor (e.g. employment or an intervention) with the recovery process; if participants were identified as recovering primarily from a non-SEMI condition (e.g. substance misuse or acquired brain injury); or if participants were also delivering services (i.e. peer providers).

### ***Quality assessment and framework synthesis***

Poor-quality research can distort a synthesis (Dixon-Woods et al., 2004). While some authors argue that studies should not be excluded based on a priori assessment (Carroll et al., 2011), we included only articles that were deemed to be of at least adequate quality (Estabrooks et al., 1994). A bespoke pro-forma<sup>1</sup> enabled assessment of design, methodology, analysis, reporting and overall contribution, informed by existing guidelines and literature (Campbell et al., 2003; Critical Appraisal Skills Programme (CASP), 2013; Dixon-Woods et al., 2007, 2004; Elliott et al., 1999; Yardley, 2000). All articles were rated for quality by the first author; five were selected using computerised randomisation and co-rated by the third author.

For the framework synthesis, coding of articles was based on the principles outlined by Carroll et al. (2011). Data were taken from Results sections, and consisted of direct quotations by participants, and of the authors' summaries of evidence. A line-by-line analysis of the data was conducted, facilitated by NVivo software (QSR International Pty Ltd., 2014). Discrete units of meaning were identified (Burnard, 1994) and coded according to the first- and second-order CHIME categories described by Leamy et al. (2011). Each unit of meaning was assigned one code only. Where units of meaning were not felt to be captured adequately by CHIME, additional themes were identified and iteratively applied using data-driven thematic analysis (Braun & Clarke, 2006; Carroll et al., 2011; Dixon-Woods et al., 2005). Coding was carried out by the first author; a sample of approximately half the coded data was audited by the third author.

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<sup>1</sup> Available on request from the corresponding author.



## Results

### ***Quality assessment: exclusions***

Table 1 is a comprehensive summary of the 15 papers reviewed, including a consideration of their strengths and weaknesses. Table 2 shows the quality ratings for each paper. Co-rating showed a concordance of 76% between the reviewing authors, which was deemed acceptable (Stemler, 2004). There was no disagreement about the overall quality of any study.

<Table 1>

<Table 2>

Three of the 15 papers were rated as being of limited quality and excluded from the framework synthesis: Smith (2000), Ochocka et al. (2005), and Pitt et al. (2007). In each, major limitations were a lack of information about how the analysis was conducted, and findings which were not clearly induced from the data (Tables 1 and 2).

### ***Quality assessment: inclusions***

Based on the modal rating of the 10 quality criteria, 12 papers were rated as being of acceptable quality for inclusion in the framework synthesis. Three were considered noteworthy overall: Thornhill et al. (2004); Armour et al. (2009), and Veseth et al. (2012). Spaniol et al. (2002) had an equal number of categories rated as limited and acceptable, but was rated very highly for clarity of research question, and statement and discussion of findings, and hence included. The 12 papers accounted for a total N of 236 participants from primarily community settings: see Table 1 for demographic details. Not all participant voices were reported: indeed, even in the highly rated Thornhill et al. (2004), some participants were not quoted. It was also noted that in certain papers, including the noteworthy Armour et al. (2009) and Veseth et al. (2012), individual participants were not differentiated, reducing transparency. However, findings were at least adequately supported by data in all 12 papers.

As shown in Table 1, various methods of qualitative analysis were used. It is perhaps notable that the three papers which scored most highly on method were the strongest overall (Table 2). In some cases (e.g. Piat et al., 2009) a method was not specified but analysis was nevertheless clearly described and appeared rigorous. Table 2 also shows that the addressing of context and reflexivity improved over time, perhaps as qualitative approaches have become more methodically formalised (Dixon-Woods et al., 2007). Ethical issues were poorly reported by the majority of papers but, again, there was a trend towards improvement over time. The four post-2009 papers contained reflections on their limitations: the omission of such reflection was deemed a flaw with many earlier papers.

### **Framework synthesis**

In total, the best-fit framework synthesis resulted in nine master themes: five from CHIME, plus four newly identified (Table 3).

<Table 3>

The CHIME master themes accounted for 68% of the data. Table 4 displays the nine themes in order of coding density. Given that coding was a subjective process, quantification is disputable; the shading of the table is therefore intended to give a broad impression of coding density. Shading was applied with a 5% leeway for error.

<Table 4>

### **The CHIME master themes**

#### **Empowerment**

Empowerment was the predominantly coded theme in this review, at 18.4% of the total data. It accounted for more than 20% of the data in one-third of the papers, and more than 30% of that in Marin et al. (2005). The only study in which Empowerment accounted for less than 10% of coding was Mezey et al., (2010), presumably because interviewees felt disempowered in forensic secure care. Second-order subthemes of Empowerment within CHIME are personal responsibility, control over life, and focus on strengths, to which this analysis added self-compassion, and exercise and maintaining good physical health. It should be noted that exercise is included as a third-order category of Empowerment in online supplementary data by Leamy et al. (2011). Much of the data coded at Empowerment support the idea that recovery is something which is ultimately up to the individual to pursue (Davidson & Roe, 2007). This might best be summarised by the participant Susanne, in Borg & Davidson (2008), who likens recovery to the sportswear slogan “Just Do It”; or Jan, in Marin et al. (2005), who states that his recovery began with the decision to get out of bed.

#### **Hope and optimism about the future**

This theme accounted for 14.6% of data. Participants talked of their hopes of better health, prosperity and relationships, and their beliefs that these were possible. Carol, in Davidson et al. (2005), described optimism that there would be an end to struggle:

*‘Hope of knowing that everything that is, that I go through, would not continue the rest of my life, that there would be an end of it; and just knowing that I knew that, I could keep going’ (p.184).*

This theme was particularly strong in Armour et al. (2009), accounting for 29.6% of coding. It is possible that the African-American participants in this study were more socially disadvantaged than

other interviewees, and therefore put more emphasis on hope for change: however, Armour et al. (2009) also query whether participants' optimism might be related to efforts to seem credible to a white interviewer. The theme appears disproportionately low in Jensen & Wadkins (2007), at 4.1% of coding: while this may be related to those authors' non-interpretative approach (Table 1), dynamic interplay between the CHIME themes might also render them difficult to delineate. For example, within the CHIME subthemes, motivation to change is an aspect of Hope, but interplay can be seen between this and the Empowerment subthemes of control and responsibility.

The original CHIME subthemes within Hope suggest movement towards a desired goal (Table 3). Our new subtheme of escape is aversive, but fits within a general theme of positively believing that one's life could be better. For example, Piat et al. (2009) report that 'several [participants] advocated forgetting the past and its negative connotations' (p.204).

### Meaning in life

This accounted for 14.1% of data, and was the most heavily coded theme in Borg & Davidson (2008) and Thornhill et al. (2004). It included the sense of meaning that comes from involvement with social groups and rewarding activities, including employment; and the meaning that can arise from a positive evaluation of the experience of mental illness itself. This latter process involved not just a realisation that psychosis might be rooted in previous aversive experiences – a recurring theme in Thornhill et al. (2004) – but a reconsideration of one's place in society:

*'I think it has to do with my learning to be a better person ... that I have to learn to appreciate those who are sick, those who have a hard time' (Marin et al., 2005, p.240).*

Several participants described finding meaning in helping others: for example the participants interviewed by Jensen and Wadkins (2007) who talked proudly of their advocacy work. An overlap with Empowerment can be observed: for instance, Marin et al. (2005) describe how two participants found new meaning in life after taking increased responsibility for their physical wellbeing.

### Connectedness

Just under 14% of data were coded at this theme: a similar density to the previous two themes. It was the most densely coded theme in Jensen and Wadkins (2007). Connectedness indicates that empowerment is not always self-empowerment, and that recovery is rarely a solo journey:

*'If I come here and see that there are others who have the same kind of life as me – well, we can help each other, give and take. That's how human relationships work' (Davidson et al., 2005, p190).*

Forensic inpatients interviewed by Mezey et al. (2010) talked of feeling valued by others:

*'When I was unwell I never had any kind of, any support from anyone, I was totally alone ... now I'm here it is important to have recognition and support by people because it helps'* (Mezey et al., 2010, p.690).

Non-human contact also matters: pets are discussed by participants in three papers (Armour et al., 2009; Borg & Davidson, 2008; Davidson et al., 2005). Participants in Jensen and Wadkins (2007) talked of the connections they felt from advocacy work, which was coded at Meaning: another example of the overlapping of themes.

### **Identity**

At 7.6% of all data and no more than 13.4% of any individual paper, Identity accounted for substantially less of the coding than the other CHIME themes. This is possibly because of further thematic overlap. For instance, one man quoted in Armour et al. (2009) talks about sticking with a job (social role; personal responsibility) in order to feel like a person again (reclaiming identity). Davidson and Strauss (1992) note that recovery is likely to involve the reconstruction of selfhood through activity and agency, suggesting that identity change might be a secondary process. Nevertheless, the theme sheds further light on what it means to be in recovery. For example, participants talk of being validated as an individual with something to offer the world (Davidson et al., 2005), of feeling a return to their former selves (Piat et al., 2009), and of overcoming stigma:

*'It wasn't until I started learning about my rights that I started searching for the ability to be treated as an individual'* (Jensen & Wadkins, 2007, p.332).

### **Additional master themes**

#### **Difficulties**

This theme emerged at 14.8% of all data: a similar density to the CHIME themes of Hope, Meaning and Connectedness. It accounted for no less than 6% of any paper, and in three cases it accounted for more than 20% (Mezey et al., 2010; Spaniol et al., 2002; Veseth et al., 2012). Indeed, 40.5% of data in Spaniol et al. (2002) was coded at this theme: the most of any theme in any paper. That study, in which two of the four primary themes proposed by the authors were overwhelmingly negative (Table 1), was a longitudinal design with research input from people with lived experience, suggesting ecological validity.

Participants in all papers described dealing with an array of struggles and concerns as part of the recovery process, including the intrapsychic, the interpersonal and the financial. Some appeared ambivalent about recovery; others were blunt. One participant in Mezey et al. (2010), asked about the importance of hope, replied: 'Hope will get you nowhere I don't think' (p.688). Piat et al. (2009) describe participants feeling like they were moving backwards in their recovery, and quote one, Janet,

as saying: ‘I don’t just take one step, two steps back, I take five or six’ (p.204). Davidson et al. (2005) note that the process of recovery is made more difficult by the deleterious effects of long-term psychotic illness upon cognitive ability: a challenge to the dominant theme of empowerment. The CHIME model may, then, be predicated on an optimistic view of recovery, and difficulties may in fact be a major part of the process.

### Therapeutic input

This theme, which accounted for just less than 7% of total data, could arguably be subsumed into Connectedness, and indeed Leamy et al. (2011) consider professional support as a third-order element of Connectedness in their online supplementary data. However, therapeutic input more generally was identified as a process in 11 of the 12 papers, with more than 20% of the data in Tooth et al. (2003) coded at the theme, suggesting particular salience. Concerns around therapeutic input, including problems with medication, talking therapy and staff attitudes, were identified in eight of the 12 papers. Participants in seven papers (Davidson et al., 2005; Jensen & Wadkins, 2007; Marin et al., 2005; Mezey et al., 2010; Piat et al., 2009; Spaniol et al., 2002; Tooth et al., 2003) talked explicitly about the positive aspects of medication, an aspect of their recovery process which is not adequately captured elsewhere.

### Acceptance and mindful awareness

Identified in 11 papers, but never at more than 8%, this theme accounted for just over 5% of total data. Those participants who endorsed it spoke of accepting limitations, having patience, and learning to focus their attention on the present, not the past or future. Leamy et al. (2011) consider acceptance as a third-order element of both Identity and Meaning in their online data, but it may be of more practical benefit to consider it as a theme which can inform every aspect of a person’s recovery.

### Returning to, or desiring, normality

Less than 5% of total data were coded at this theme, though it captured 11% in Borg & Davidson (2008). While it could be linked to the theme of Hope, it was sometimes expressed without optimism: for example, Marin et al. (2005) note that trying to live a normal life can involve ‘finding the strength to “fight twice as hard”’ (p.237). Davidson et al. (2005) describe participants’ ‘need for material resources and a sense of home’ (p.183). While there are echoes of the subtheme of rebuilding life within Meaning, this is more about a desire for the very basics, which may not be being met.

## Discussion

### *The master themes*

This review used best-fit framework synthesis to explore the question: ‘What do we know about how service users with severe and enduring mental illness experience the process of recovery?’ The framework employed was the CHIME model (Leamy et al., 2011). The results suggest that the five CHIME processes (Connectedness, Hope, Identity, Meaning and Empowerment) encapsulate the majority of recovery experiences, which in turn offers support for previous conceptualisations of the salient elements of recovery (e.g. Roberts & Boardman, 2013; Stickley & Wright, 2011). However, the five CHIME processes were not sufficient, and four further master themes were identified: these plus CHIME allowed for a comprehensive consideration of recovery processes as described by up to 236 participants in 12 peer-reviewed journal articles. Expansion of the CHIME model may therefore be warranted, perhaps also incorporating dynamic interplay both within and between themes. The construction of a dynamic model is beyond the scope of this review: however, we believe the present work provides an important step to further exploration.

Of particular note is the new theme of Difficulties. The wider conceptualisation of recovery by Leamy et al. (2011) acknowledges that it frequently involves elements of struggle, so it is puzzling that this is absent from CHIME, which seems to consider only positive aspects of the process. In a review of recovery literature, Onken et al. (2007) caution against celebrating only the strengths of those who appear successful, as this can perpetuate the idea that recovery is something achievable by everyone who simply applies themselves. An unintended consequence might be that people who struggle with recovery concepts are perceived as not trying hard enough, and become marginalised and even blamed for not conforming to a recovery ideal. This has been identified as a concern about services’ adoption of the recovery approach (Arenella, 2015; Rose, 2014): at worst, it might promote a neo-liberal narrative of responsibility in which the individual can always prevail, regardless of social or material circumstances. As noted above, Brown & Kandirikirira (2007) highlight a division between internal elements of recovery and external ones, and in the context of the current review we would echo the call by Harper & Speed (2012) to consider carefully the difference between empowerment as an individual process, and empowerment as a redistribution of societal power. Just as people might initiate their own recovery, communities and policymakers also have a vital role.

Although the theme of Returning to or Desiring Normality accounted for less than 5% of data, we would argue that it is essential in a critical consideration of recovery. In an echo of the hierarchy of needs (Maslow, 1943), Onken et al. (2007) propose that individuals cannot hope to gain control over their symptoms without basic needs such as housing, income and healthcare being met. However, while moving towards a concept of societal normality is likely to be an aspect of recovery for many

people, others might rightly reject the idea that they must conform to any expectation of what is normal (Rose, 2014). For services in the UK, this poses a fundamental question: do we focus resources on assisting people to conform to a society that, as Rose (2014) argues, fears mental ill-health; or do we divert resources to become more involved in challenging stigma (Arboleda-Florez & Stuart, 2012)?

The other two new master themes might be of particular interest to practitioners seeking to understand how to apply a workable recovery approach in clinical settings. Acceptance and Mindful Awareness are prominent components of third-wave cognitive-behavioural therapies, and there is ongoing research effort in this area (Hayes et al., 2013). It is also notable that self-compassion, which we propose as an additional Empowerment subtheme, may have clinical relevance in the psychological treatment of psychosis (Gumley et al., 2010): whether this involves a mediating relationship with empowerment might be an interesting hypothesis to explore. More generally, the dyadic theme of Therapeutic Input indicates both the value of positive relationships with different professionals, and the difficulties that can arise when such relationships are felt to be suboptimal. It also draws explicit attention to the value that many participants placed on medication, a topic which remains the source of considerable debate (DCP, 2014).

### ***Methodological considerations and limitations***

Best-fit framework synthesis was felt to be an appropriate and applicable technique for this review. In any qualitative synthesis, just as in primary qualitative research, there is subjectivity: while steps such as co-rating and audit do not remove this (Yardley, 2000), they offer a transparent and open account of the process, and we would argue that reflexive recognition of the partial and situated nature of knowledge is in fact a strength of the qualitative method (Malterud, 2001). We share the concerns of Cooke et al. (2012) and Dixon-Woods et al. (2006) about locating qualitative research in electronic databases. Manual screening was arduous, and it is concerning that an inclusive database search failed to identify three peer-reviewed papers (Smith, 2000; Spaniol et al., 2002; Tooth et al., 2003). Despite our rigorous search, it remains possible that a salient article did not come to light. If qualitative research is to improve its standing in relation to quantitative work, addressing the vexed issue of indexing is vital.

The use of a priori quality criteria allowed for the systematic consideration of rigour, credibility and relevance (Chenail, 2011; Dixon-Woods et al., 2007), and categorical rather than ordinal scoring was felt to provide some epistemological congruity with qualitative data. Nevertheless, this approach was arguably flawed by the use of a modal rating as an inclusion criterion, as each category was not of identical importance: for example, the clarity of a research question is not necessarily as significant as whether that question is suited to qualitative enquiry. While it might have been possible to construct

an algorithmic approach to category weighting (Boeije et al., 2011), it may have been preferable to avoid imposing quantification on the quality analysis altogether, and a post-hoc sensitivity analysis could instead have ascertained the contribution of studies identified as weaker (Carroll et al., 2013).

Including only peer-reviewed journal articles excluded a significant amount of what Grayson and Gomersall (2003) describe as ‘grey’ literature. Our exclusion of the service-user-led Pitt et al. (2007) on quality grounds is in the context of that paper appearing in a peer-reviewed journal: however, there is a wealth of service-user-generated data in non-scientific publications, in books, and published online. Further synthesis of such data would be a challenging task but a valuable critical step. Where a consumer-focused concept such as recovery is concerned, it might be argued that the definition of ‘evidence’ should be broadened beyond traditional paradigms.

The CHIME model was constructed using English-language data, predominantly from studies carried out in the USA and UK. The inclusion in the present review of non-USA and UK studies does not negate the fact that the overall synthesis represents a westernised view; as Slade, Leamy, et al. (2012) identify, cross-cultural exploration of recovery would be welcome.

### ***Conclusion and implications for research and practice***

Leamy et al. (2011) do not claim that CHIME is conclusive, and are clear that recovery will involve a different combination of processes for different individuals. Rethink (2005) suggest that recovery can often feel like two steps forward, one step back: in keeping with this observation, a key finding of this review is the omission from the increasingly prominent CHIME model of the difficulties inherent in recovery. We propose that it would therefore be beneficial to build on the work of Johnson and Montgomery (1999) and Topor et al. (2011), and to examine in more detail the specific difficulties described by people in different recovery situations. Clearer understanding of to what extent difficulties are contextually dependent would also be of value in ascertaining how services can best assist people. While part of this will be about improving psychological treatments that address both the symptomatology and putative underlying aetiology of psychosis (DCP, 2014; Gumley & Schwannauer, 2006), multi-systemic interventions promoting social inclusion will also be of practical benefit (Onken et al., 2007; Rhodes & De Jager, 2013; Smyth et al., 2011; Warner, 2010).

We suggest that the nature of the extended themes proposed in this review – again, in particular Difficulties – might also inform more collaborative research into understanding recovery as experienced by service users. The recovery approach has been criticised as overly professionalised and voluntaristic (Harper & Speed, 2012; Rose, 2014), and it is vital to heed service-user voices. The democratising effect of social media offers new potential for service users and professional researchers to work together, and efforts are being made to open mental-health research beyond



traditional paradigms (British Psychological Society, 2012; McKirdy, 2015). Ultimately, perhaps the goal of services should be to provide a choice of the best available professional or peer-led services to those that want them (Silverstein & Bellack, 2008). At present we are in danger of imposing professional ideas of recovery onto what was originally a service-user-led concept: it is time to redress the balance.

Finally, it might be incumbent upon clinicians and professional researchers to recognise the power and privilege of their positions, and to use that to more loudly challenge the social inequities which are repeatedly linked to serious mental ill-health (Dohrenwend, 2000; Hagan & Smail, 1997; Midlands Psychology Group, 2012). The simple expansion of the CHIME model of recovery into CHIME-D, more explicitly acknowledging Difficulties, might be a small step towards this end. Political engagement by mental-health professionals to expose and challenge the structural deficits that might be both causing distress and preventing recovery would be a greater one (Harper & Speed, 2012; Psychologists Against Austerity, 2015).

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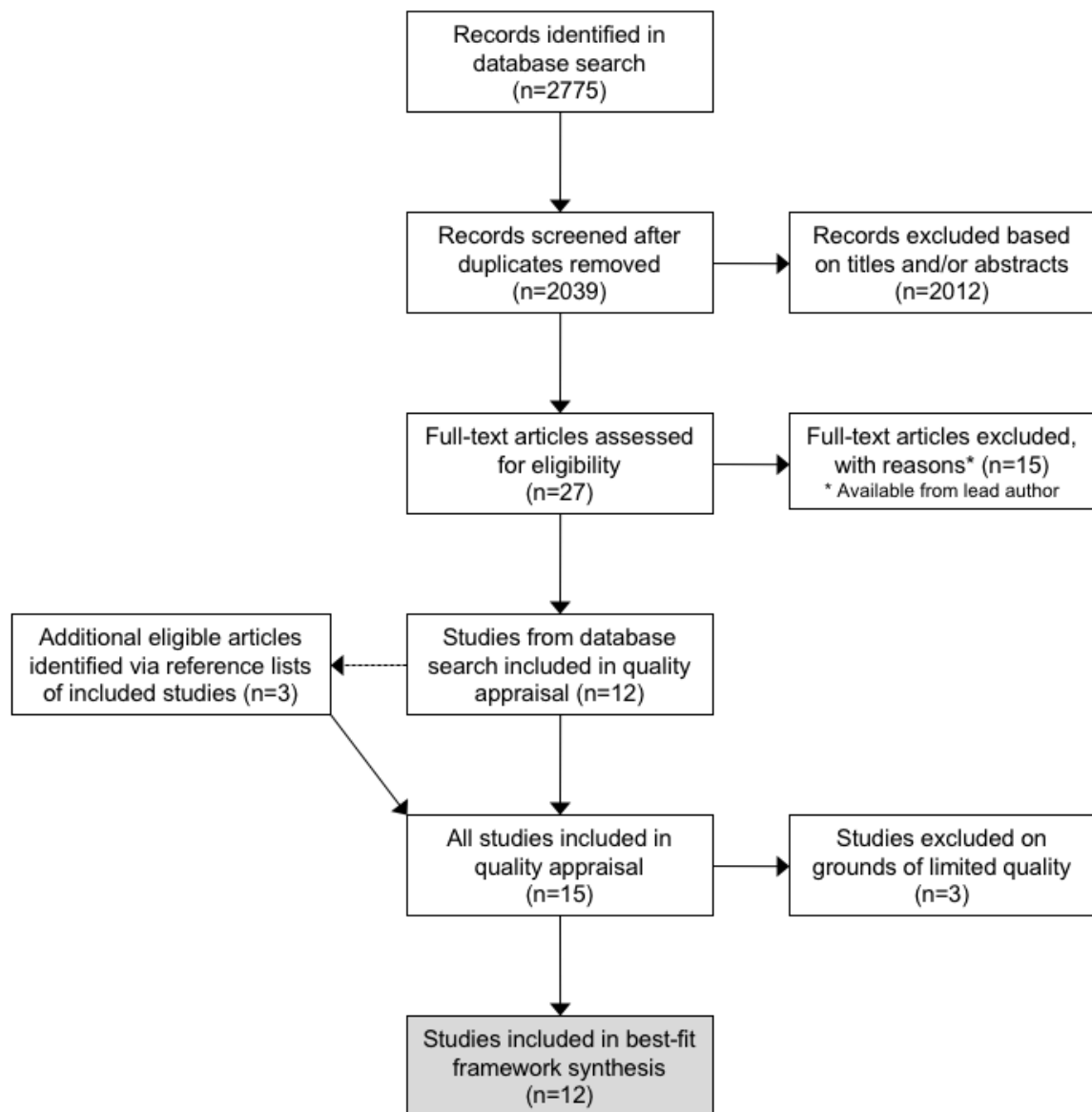


Figure 1: Flowchart showing the process by which studies were appraised and selected.

Table 1. Comprehensive summary of the 15 papers reviewed in the quality assessment.

Authors (year) and country	Primary aim	Participant information	Study design & stated method	Key findings & implications	Strengths	Weaknesses
<b>Young &amp; Ensing (1999), USA</b>	Explore service users' meanings of recovery	<ul style="list-style-type: none"> <li>• N=18 (6♂, 7♀)</li> <li>• Ages 26-59 (M=41)</li> <li>• 5 African American, 13 European American.</li> <li>• Various diagnoses</li> <li>• Recruited via local organisations</li> </ul>	<ul style="list-style-type: none"> <li>• Semi-structured individual interviews (n=7) and two focus groups (n=5 &amp; n=6)</li> <li>• Grounded Theory</li> </ul>	<ul style="list-style-type: none"> <li>• Five categories over three phases:               <ol style="list-style-type: none"> <li>1. Overcoming stuckness;</li> <li>2a. Fostering self-empowerment;</li> <li>2b. Learning and self-redefinition;</li> <li>2c. Returning to basic functioning;</li> <li>3. Improving QoL</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Wide range of quotes (though individual voices not differentiated)</li> <li>• Elucidation of themes such as basic functioning and spirituality</li> </ul>	<ul style="list-style-type: none"> <li>• Analysis does not follow GT principles</li> <li>• Possible normative effect of focus groups</li> <li>• Some analysis by uncredited junior researchers</li> <li>• Limitations not acknowledged</li> </ul>
<b>Smith (2000), USA</b>	Establish common elements among recovery stories, to inform services	<ul style="list-style-type: none"> <li>• N=10 (5♂, 5♀)</li> <li>• Ages 38-60 (M=48)</li> <li>• 1 African American, 9 Caucasian</li> <li>• 9 college educated</li> <li>• Various diagnoses</li> <li>• Recruited via consumer newsletter</li> <li>• Paid participants</li> </ul>	<ul style="list-style-type: none"> <li>• Semi-structured individual interviews</li> <li>• Method unclear: no approach named or described</li> </ul>	<ul style="list-style-type: none"> <li>• Five major themes:               <ol style="list-style-type: none"> <li>1. Meaning of recovery;</li> <li>2. Turning points;</li> <li>3. Critical factors;</li> <li>4. Barriers;</li> <li>5. Strategies</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Interesting quotes support the themes (though voices not differentiated)</li> </ul>	<ul style="list-style-type: none"> <li>• Highly educated sample does not match aim of finding 'common elements'</li> <li>• Findings are over-generalised</li> <li>• Unclear method</li> <li>• Limitations not acknowledged</li> </ul>
<b>Spaniol (2002), USA</b>	Describe the process of recovery, and its key dimensions and factors	<ul style="list-style-type: none"> <li>• N=12 (6♂, 6♀)</li> <li>• Ages 30-53 (M=41)</li> <li>• 7 African American, 1 south-east Asian, 4 Caucasian</li> <li>• Randomly selected from vocational study</li> <li>• Met DSM-III-R schizophrenia criteria</li> <li>• Educational diversity</li> </ul>	<ul style="list-style-type: none"> <li>• Series of open-ended interviews over four years</li> <li>• Non-specific method of inductive analysis; also refers to thematic analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Four-phase model:               <ol style="list-style-type: none"> <li>1. Overwhelmed by the disability;</li> <li>2. Struggling with the disability;</li> <li>3. Living with the disability;</li> <li>4. Living beyond the disability</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Input into design from people with lived experience</li> <li>• Phased model has face validity and is considered in social and clinical context</li> <li>• Consideration of themes including</li> </ul>	<ul style="list-style-type: none"> <li>• Methods of data collection and analysis unclear</li> <li>• As a longitudinal study there is maybe an imbalance between detailed and broad information</li> </ul>

		<ul style="list-style-type: none"> <li>• Paid participants</li> </ul>			race & disadvantage	
<b>Tooth et al. (2003), Australia</b>	Identify what service users consider important, compare with the literature & provide a definition	<ul style="list-style-type: none"> <li>• N=60 (44♂, 16♀)</li> <li>• Ages 21-60 (M=36)</li> <li>• Met DSM-IV criteria for schizophrenia</li> <li>• Educational diversity</li> <li>• 58% unemployed</li> <li>• Recruited via adverts and services</li> </ul>	<ul style="list-style-type: none"> <li>• Four-part interview including open-ended and semi-structured elements</li> <li>• Thematic analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Frequency analysis suggests most common thematic category relates to active sense of self</li> <li>• Key subthemes included determination to get better, and recognising need for responsibility</li> </ul>	<ul style="list-style-type: none"> <li>• Input into design from service users</li> <li>• Frequency analysis is clearly tabulated and is based on large N for qual. study</li> </ul>	<ul style="list-style-type: none"> <li>• Predicated on unusual idea that qualitative enquiry should be free of interpretation</li> <li>• Very short Results; few supporting quotes</li> <li>• Limitations not acknowledged</li> </ul>
<b>Thornhill et al. (2004), UK</b>	Explore genre, tone and narrative in accounts of people self-identifying as in recovery from psychosis	<ul style="list-style-type: none"> <li>• N=15 (6♂, 9♀)</li> <li>• Ages 30-70</li> <li>• Various diagnoses</li> <li>• 'Most' white European; two Asian</li> <li>• Recruited through advertisements and word-of-mouth</li> <li>• Mostly 'educated'</li> </ul>	<ul style="list-style-type: none"> <li>• Face-to-face interview</li> <li>• Narrative analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Three narrative genres: 1. Escape; 2. Enlightenment; 3. Endurance</li> <li>• Various tones identified, including protesting, resigned and disenfranchised</li> </ul>	<ul style="list-style-type: none"> <li>• Rigorous, coherent analytical approach</li> <li>• Attention to context and issues of power: participants asked to comment on analysis</li> <li>• Consideration of related clinical issues</li> </ul>	<ul style="list-style-type: none"> <li>• Four participants are not quoted, raising concerns about transparency</li> <li>• No mention of ethical issues</li> </ul>
<b>Davidson et al. (2005), Italy, Norway, Sweden, USA</b>	<ul style="list-style-type: none"> <li>• Delineate processes of recovery described by people with psychosis</li> <li>• Part of a multinational, multi-article study</li> </ul>	<ul style="list-style-type: none"> <li>• N=12 (5♂, 7♀)</li> <li>• Ages 29-55</li> <li>• Various diagnoses</li> <li>• None married</li> <li>• Range of current employment</li> </ul>	<ul style="list-style-type: none"> <li>• Open-ended interviews</li> <li>• Non-English interviews translated into English</li> <li>• 'Established qualitative procedures'</li> </ul>	<ul style="list-style-type: none"> <li>• Five salient themes: 1. How the person deals with their problems; 2. Material resources; 3. Health systems; 4. Significant others; 5. Social and cultural factors</li> </ul>	<ul style="list-style-type: none"> <li>• Ambitious international study</li> <li>• Substantial use of participant quotes</li> </ul>	<ul style="list-style-type: none"> <li>• Bespoke qualitative method is weakly evidenced</li> <li>• Does not seek to integrate with existing recovery literature</li> <li>• Limitations not acknowledged</li> </ul>
<b>Marin et al. (2005), Italy,</b>	As above, but focusing on	• As Davidson <i>et al.</i> (2005), above	• As Davidson <i>et al.</i> (2005), above	• Three superordinate themes:	Clear, thoughtful analysis of findings	• As above, method of analysis is opaque

<b>Norway, Sweden, USA</b>	people's role in their own recovery			1. Determination to succeed; 2. Self control; 3. New identity • Salient subthemes included symptom management, and social demands	in context of the aim posed by Davidson <i>et al.</i> (2005) • Participants clearly individuated • Summary offers pertinent points for clinicians	• Again, findings are not presented in the context of existing literature, and limitations are not acknowledged
<b>Ochocka et al. (2005), Canada</b>	Clarify the concept of recovery as experienced by people with SEMI	• N=28 • 12 active in consumer/survivor initiatives • No other information provided	• Semi-structured interviews at three time points • 'A grounded theory analysis'	• Multidimensional model with four main components: 1. Drive to move forward; 2. Spiral of life struggle; 3. Context of self and circumstances; 4. Negotiation between self & external factors	• Service users involved in development, data gathering & analysis • Proposed model has face validity; suggested interaction with health/social systems is well argued	• Sample unclear • Analysis unclear • Difficult to ascertain to what extent data contributes to the proposed model • Limitations not acknowledged
<b>Jensen &amp; Wadkins (2007), USA</b>	• Find out what it means to live successfully with SEMI and what contributes to recovery • In context of evaluating a community initiative, on which funding may have been contingent	• N=20 (9♂, 11♀) • Ages 19-64 • 14 from urban areas, six rural • Purposive sampling via community-based initiative • Various diagnoses • Paid \$10 stipend	• Semi-structured interviews • 'Editing analysis style'	Four common master themes: 1. Finding acceptance and understanding of illness; 2. Redefining identity & preventing relapse; 3. Finding a way to advocate and help others; 4. Barriers in the paths to recovery	• Clearly described, contextually aware research • Findings situated within wider context of recovery & care • Interesting points made, based on the data, about the value of integrating formal and informal services	• Individual voices are not differentiated, so contributions to each theme are not entirely clear • Analysis based on simple themes: a more interpretative approach may have been of benefit
<b>Pitt et al.</b>	Carry out service-	• N=7 (5♂, 2♀)	• Semi-structured	• Seven definitions of	• Service-user-led	• Actual method seems

<b>(2007), UK</b>	user-led research into recovery, exploring experiences and defining recovery	<ul style="list-style-type: none"> <li>• Ages 18-65</li> <li>• 6 white, one mixed-race</li> <li>• Recruited through mental-health groups</li> <li>• Personal experience of psychosis</li> </ul>	<p>interviews</p> <ul style="list-style-type: none"> <li>• Method is stated to be interpretative phenomenological analysis</li> </ul>	<p>recovery, plus three superordinate themes:</p> <ol style="list-style-type: none"> <li>1. Rebuilding of self</li> <li>2. Rebuilding of life</li> <li>3. Hope for a better future</li> </ol>	<p>project: first two authors, who conducted the study, were user-researchers</p>	<p>incongruent with IPA: themes appear to be decided by a committee</p> <ul style="list-style-type: none"> <li>• Evidence from less than 50% of sample is presented</li> <li>• Findings are discussed in terms of generalisability: not in keeping with IPA</li> </ul>
<b>Borg &amp; Davidson (2008), Norway</b>	Explore how individuals with SEMI experience their illness, and how they find a sense of meaning & purpose	<ul style="list-style-type: none"> <li>• N=13 (6♂, 7♀)</li> <li>• Ages 26-54</li> <li>• Two married, two engaged, two with children</li> <li>• Six higher educated</li> <li>• Various diagnoses and social situations</li> </ul>	<ul style="list-style-type: none"> <li>• Open-ended interviews, twice over one year</li> <li>• Narrative phenomenological approach, described as thematic and step-wise</li> </ul>	<ul style="list-style-type: none"> <li>• Four major themes:</li> <ol style="list-style-type: none"> <li>1. Being normal</li> <li>2. Just doing it</li> <li>3. Making life easier</li> <li>4. Being good to yourself</li> </ol> </ul>	<ul style="list-style-type: none"> <li>• People with lived experience had input into the design and were consulted during analysis</li> <li>• Detailed, interpretative analysis of experience is offered</li> </ul>	<ul style="list-style-type: none"> <li>• Two participants did not wish to be audiotaped: analysis of these interviews is based on written notes</li> <li>• Limitations not acknowledged</li> <li>• Findings possibly overstated based on the data presented</li> </ul>
<b>Armour et al. (2009), USA</b>	Understand the lived experience of recovery for African Americans with SEMI	<ul style="list-style-type: none"> <li>• N=9 (4♂, 5♀)</li> <li>• Ages 25-54 (M=36)</li> <li>• Various diagnoses</li> <li>• Part of sample recruited from a community programme</li> </ul>	<ul style="list-style-type: none"> <li>• Semi-structured interviews at three time points</li> <li>• Hermeneutic phenomenological method</li> </ul>	<ul style="list-style-type: none"> <li>• Four major themes:</li> <ol style="list-style-type: none"> <li>1. Striving for normalcy;</li> <li>2. Striving to stay 'up';</li> <li>3. Coping with consequences of illness;</li> <li>4. Leaning on support from others</li> </ol> </ul>	<ul style="list-style-type: none"> <li>• Culturally aware study with extensive contextual validation</li> <li>• Consideration of social &amp; care context</li> <li>• Suggestions made for future research</li> </ul>	<ul style="list-style-type: none"> <li>• Individual voices are not differentiated</li> <li>• Some themes and interpretations appear more descriptive than phenomenological</li> </ul>
<b>Piat et al. (2009), Canada</b>	<ul style="list-style-type: none"> <li>• Determine the understanding of recovery among a</li> </ul>	<ul style="list-style-type: none"> <li>• N=54 (26♂, 28♀)</li> <li>• Mean age 43.6</li> <li>• 47% had post-</li> </ul>	<ul style="list-style-type: none"> <li>• Semi-structured interviews over a two-year period</li> </ul>	<ul style="list-style-type: none"> <li>• Two meanings with three themes each:</li> <ol style="list-style-type: none"> <li>1. Recovery in relation</li> </ol> </ul>	<ul style="list-style-type: none"> <li>• Research overseen by an advisory committee</li> </ul>	<ul style="list-style-type: none"> <li>• Seems to have been conducted in both English and French: however, no</li> </ul>

	<p>sample of service users in Canada</p> <ul style="list-style-type: none"> <li>• Part of wider study exploring meaning of recovery for service users, providers and planners</li> </ul>	<p>secondary education</p> <ul style="list-style-type: none"> <li>• 45% in work</li> <li>• Various diagnoses</li> <li>• Recruitment by self-referral following awareness-raising</li> <li>• Small honorarium</li> </ul>	<ul style="list-style-type: none"> <li>• 'No pre-set theoretical framework influenced data analysis' (p.201)</li> </ul>	<p>to illness:</p> <ul style="list-style-type: none"> <li>i. Cure; ii. Medication; iii. Returning to former self; 2. Recovery in relation to wellness:</li> <li>i. Taking charge of life; ii. Process; iii. A new self</li> </ul>	<p>including service users</p> <ul style="list-style-type: none"> <li>• Very large sample for a qualitative study: a significant research undertaking</li> </ul>	<p>related interpretative issues are considered</p> <ul style="list-style-type: none"> <li>• Lack of any analytical framework reduces transparency</li> </ul>
<b>Mezey et al. (2010), UK</b>	<ul style="list-style-type: none"> <li>• Explore forensic inpatient perceptions of recovery &amp; identify whether these were different from others'</li> <li>• Extension of study including people with eating disorders and substance issues (Turton <i>et al.</i>, 2011)</li> </ul>	<ul style="list-style-type: none"> <li>• N=10 (8♂, 2♀)</li> <li>• Ages 24-56 (M=37)</li> <li>• Four white</li> <li>• Diagnoses of schizophrenia or schizoaffective disorder</li> <li>• Recruited from one medium-secure unit</li> <li>• Paid £20</li> </ul>	<ul style="list-style-type: none"> <li>• Face-to-face interviews in two parts: open-ended, then semi-structured</li> <li>• Preliminary thematic analysis using grounded theory coding tools; then directed content analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Three key areas: 1. Definitions and understandings of recovery; 2. What helps to bring about recovery; 3. Impediments to recovery</li> </ul>	<ul style="list-style-type: none"> <li>• Only study to include voices of forensic patients</li> <li>• Analysis &amp; discussion raise points about relevance of recovery model to different populations</li> </ul>	<ul style="list-style-type: none"> <li>• Directed-content-analysis element is not clear, reducing transparency</li> <li>• Despite aim, findings are not contrasted with other literature</li> <li>• Individual voices not differentiated</li> </ul>
<b>Veseth et al. (2012), Norway</b>	<p>Explore lived experiences of improvement in bipolar disorder, including what people do to promote their own recovery</p>	<ul style="list-style-type: none"> <li>• N=13 (6♂, 7♀)</li> <li>• Ages 27-65 (M=47)</li> <li>• Diagnoses of bipolar I &amp; II, plus comorbidities</li> <li>• Six employed</li> <li>• Various relationship statuses</li> <li>• Recruitment via newspaper advert (n=3) and outpatient clinic (n=10)</li> <li>• Paid participants</li> </ul>	<ul style="list-style-type: none"> <li>• Open-ended interviews</li> <li>• Hermeneutic-phenomenological approach</li> </ul>	<ul style="list-style-type: none"> <li>• Four major themes: 1. Handling ambivalence about letting go of manic states; 2. Finding something to hang on to; 3. Becoming aware of signals from self and others; 4. Finding ways of caring for oneself</li> </ul>	<ul style="list-style-type: none"> <li>• 12 service-user co-researchers very involved in designing and running study</li> <li>• Reflexively aware collaborative analysis with 'bias ... as an important focus' (p.130)</li> <li>• Detailed extracts</li> </ul>	<ul style="list-style-type: none"> <li>• Method of analysis is complex. Use of a more obvious model (e.g. IPA) may have increased transparency</li> <li>• Individual voices are not differentiated: unusual for such a person-focused study</li> </ul>

Table 2: Quality ratings for the 15 papers reviewed.

Study	Quality criteria										
	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	Overall
	Research questions are clear	Research questions are suited to qualitative enquiry	Participants are appropriate to the questions; recruitment is clearly described	Contextual and reflective issues are acknowledged appropriately	Ethical issues are acknowledged appropriately	Method of data collection is appropriate and is clearly described	Method of data analysis is appropriate and is clearly described	Data analysis is rigorous & supports interpretations made by the authors	Findings are clearly stated & discussed in the wider research context	The paper offers a useful contribution to the recovery knowledge base	Overall rating based on mode of the 10 criteria
Young & Ensing (1999)	++	+	+	—	—	+	—	+	—	+	+
Smith (2000)*	+	+	—	—	—	+	—	—	—	—	—
Spaniol (2002)	++	+	+	—	—	+	—	—	++	+	+
Tooth et al. (2003)	+	+	+	+	+	+	+	+	—	+	+
Thornhill et al. (2004)	++	++	+	++	—	+	++	+	+	++	++
Davidson et al. (2005)	+	+	+	—	—	+	—	+	—	+	+
Marin et al. (2005)	+	+	+	—	—	+	—	+	—	+	+
Ochocka et al. (2005)*	+	—	—	++	—	+	—	—	—	+	—
Jensen & Wadkins (2007)	++	+	+	+	++	+	+	+	+	++	+
Pitt et al. (2007)*	++	+	+	+	—	+	—	—	—	—	—
Borg & Davidson (2008)	++	+	—	+	+	+	+	+	—	+	+
Armour et al. (2009)	++	++	+	++	—	+	++	+	+	++	++
Piat et al. (2009)	++	—	+	+	++	+	—	++	+	+	+
Mezey et al. (2010)	++	+	+	+	++	+	+	+	+	++	+
Veseth et al. (2012)	++	+	+	++	++	+	++	+	++	++	++

\* Excluded from framework analysis after quality assessment.



Table 3: The original CHIME themes (Leamy et al., 2011) and newly added themes.

<b>Master theme</b>	<b>Prominent subthemes</b>
Connectedness	Peer support and support groups; relationships; support from others; being part of the community
Hope and optimism about the future	Belief in possibility of recovery; motivation to change; hope-inspiring relationships; positive thinking and valuing success; having dreams and aspirations <b>Escape from something undesirable</b>
Identity	Dimensions of identity; Rebuilding/redefining positive sense of identity; Overcoming stigma
Meaning in life	Meaning of mental illness experiences; Spirituality; Quality of life; Meaningful life and social roles; Meaningful life and social goals; Rebuilding life
Empowerment	Personal responsibility; Control over life; Focusing upon strengths <b>Self-compassion; Exercise and maintaining good physical health*</b>
<b>Difficulties</b>	<b>Ambivalence and contradiction; Disempowerment; Financial concerns; Loss and negative life changes; Stumbling, struggling and suffering; Substance use comorbid with mental illness</b>
<b>Therapeutic input</b>	<b>Benefiting from specific therapeutic or professional input; Having concern about specific therapeutic or professional input, including medication side-effects</b>
<b>Acceptance and mindful awareness</b>	<b>Acceptance; Grounding in present moment</b>
<b>Returning to, or desiring, normality</b>	<b>Return to or desire for normality, including symptom reduction; Having the basics</b>

**Key:** Roman type: Original CHIME theme or second-order subtheme      **Bold type:** New theme or subtheme

\* A similar subtheme was acknowledged in online supplementary data by Leamy et al. (2011) as a third-order category. In the present analysis, it appeared more prominent.

Table 4: The nine master themes in order of coding density.

<b>Empowerment *</b>	<b>18.4%</b>
<b>Difficulties **</b>	<b>14.8%</b>
<b>Hope and optimism about future *</b>	<b>14.6%</b>
<b>Meaning in life *</b>	<b>14.1%</b>
<b>Connectedness *</b>	<b>13.7%</b>
<b>Identity *</b>	<b>7.6%</b>
<b>Therapeutic input **</b>	<b>6.9%</b>
<b>Acceptance and mindful awareness **</b>	<b>5.2%</b>
<b>Returning to, or desiring, normality **</b>	<b>4.7%</b>

\* CHIME master theme

\*\* New master theme

> 251 units of meaning
201-250 units of meaning
151-200 units of meaning
101-150 units of meaning
< 101 units of meaning