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ORIGINAL PAPER

Family Influence in Recovery from Severe Mental Illness

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Abstract The aim of this study was to investigate the perceived influence of family on recovery from severe mental illness. 54 semi-structured interviews were conducted with a diverse sample of people with severe mental illness living in Montreal. Results indicated that family both facilitated and impeded recovery processes. Specifically, family facilitated recovery through providing (a) moral support, (b) practical support and (c) motivation to recover. However family impeded recovery through (a) acting as a stressor, (b) displaying stigma and lack of understanding, and (c) forcing hospitalization. The study indicates the importance of family psychoeducation in promoting recovery.

Keywords Recovery · Family · Severe mental illness · Canada · Quebec

Introduction

In recent years, definitions of recovery from severe mental illness (SMI) have shifted from clinical perspectives emphasizing symptom remission to more holistic perspectives that emphasize social and functional aspects of life (Whitley and Drake 2010). In this context, recovery has been defined as "living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems" (Mental Health Commission of Canada 2012, p. 15). In this sense, recovery is an ongoing individual process toward improved quality of life. This shifting perspective on recovery was led by consumer/survivor groups seeking greater empowerment, destigmatization and renewed hope for their future (Lefley 1997).

Much research indicates that aspects of the social environment impact recovery from severe mental illness (Schon et al. 2009; Topor et al. 2011). This research has focused on areas including employment (Becker and Drake 2003), housing (Padgett 2007) and social connectedness (Ware et al. 2007). One life domain which has received less attention in the literature is the role of family. This may represent an unwillingness amongst psychiatric researchers to reopen a line of enquiry that was historically criticized for implicitly stigmatizing, damaging and attacking family members of people with mental illness (Luhrmann 2007).

This includes the now discredited notion of the "schizophrenogenic mother", which attributed mental illness to maternal overprotection and rejection (Bateson et al. 1956; Neill 1990). These now outmoded views were rooted in Freudian notions of dysfunctional family relationships being critical to mental illness onset, as well as the post-war 'liberation' movements which perceived families, especially parents, as a poisonous influence on young adults (Laing 1967; Guarnaccia 1998). These notions were rendered obsolete by careful research examining the relationship between parenting style and schizophrenia (e.g. Hirsch and Leff 1975). That said, these theories have left a tainted legacy that continues to permeate the practice and theory of psychiatry, with researchers treading gingerly around family influences on mental illness.

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One area of the family that continues to be the object of some research efforts in psychiatry is the influence of "expressed emotion" on mental illness. Expressed emotion refers to criticism, hostility, and over involvement expressed by close kin toward a relative with schizophrenia (Jenkins 1991). EE reflects a shift "away from the prevailing psychiatric assumptions concerning the etiological relevance of psychopathological (i.e., so-called "schizophrenogenic") family features to the identification of everyday family features that might figure into the course of major psychiatric disorder" (Jenkins 1991, p. 391). This moved the focus away from investigating families as a risk factor for onset, instead examining the role families might play in perpetuating any psychiatric disorder. Indeed, some research does suggest that families reflecting higher levels of EE negatively impact the course of psychiatric disorder (Docherty et al. 2011; Pharoah et al. 2010). Indeed, EE continues to be a relevant concept among researchers, and has been used as a measure in other linkages between family and health. This includes studies of bipolar disorder, major depression, eating disorders, alcoholism, diabetes, childhood epilepsy, and myocardial infarction (Leff 2013).

Some parent and family members in the United States organized themselves into a national movement known as the National Alliance on Mental Illness (NAMI). This was partly because they were frustrated with the blame attributed to families by the psychiatric profession (Harrington 2012). As witnessed by their publicity material, NAMI advocates a biological basis of severe mental illness, focusing more on the idea that this is a "brain disease" as opposed to an illness with a biopsychosocial etiology (Harrington 2012). Some research suggests that many families remain invested in the biological model of SMI, often in a manner which diminishes the family's role in aetiology or course of the illness (Callard et al. 2012; Harrington 2012).

Until relatively recently, families have generally been under a pathological gaze when examined by psychiatric researchers. That said, researchers have begun to investigate family as a resource for recovery, with some promising results. For example, Guarnaccia and Parra (1996) argue that families often support recovery through the provision of "instrumental help", which can be funds, commodities, or logistical assistance to the family member affected by mental illness. Similarly, Schon et al. (2009) describe how families can provide practical assistance, such as taking over chore responsibility, offering temporary housing, or cooking meals. In their study of recovery from co-occurring severe mental illness and substance abuse disorders, EnglandKennedy and Horton (2011) discuss family support for recovery, including "intangible support," or "emotional, structural, moral, spiritual, or other interpersonal forms of encouragement" (p. 1225). EnglandKennedy and Horton (2011) also argue that families facilitate recovery by being available for their family member, providing transportation, and voicing encouragement. Topor et al. (2011) note that the simple continued presence of family members is a form of support for recovery as it is a "reminder of what the individual used to be like and evidence of the fact that there is more to the person than simply being a psychiatric patient" (p. 91).

With an increase in studies reflecting a more balanced understanding of the family role, researchers have begun identifying areas where family-related factors can both facilitate and impede recovery. EnglandKennedy and Horton (2011) argue that families can impede recovery when there is a breakdown of trust and communication between family members and their relation with SMI. Family members can also negatively affect their relation with SMI through negative actions and words. Some of these problems originate from lack of information or misinformation about mental illness among family members. Other studies have noted that families can be detrimental to the recovery process when they remain fixated on a helper role and are unable to support an individual's movement toward autonomy and reciprocal relationships (Bradshaw et al. 2007; Schon et al. 2009). In a study of individuals experiencing severe mental illness, substance abuse, and homelessness, Padgett et al. (2008) found that although many family members could be a source of warmth and nurturing, they could also reject and condemn their members with mental illness, with their acceptance only contingent on family notions of good behavior. Moreover, they reported that family relationships could be strained when a parent or sibling commits a participant for involuntary treatment. Similarly, Gehart (2012) argues that many individuals with mental illness are "estranged from family and friends because of problems and incidents relating to their symptoms, and often these support people are not willing, interested, or available to participate in the recovery process" (p. 452).

Some studies from different cultures have also shown family to be a protective factor in recovery. Bresnahan (2003) have argued that family involvement, acceptance and support of individual members who develop SMI reduce stress and increase resilience (Bresnahan 2003). A study at a Nigerian psychiatric hospital found that family involvement in treatment during hospitalisation was independently associated with greater post-discharge appointment adherence in individuals with SMI (Adeponle et al. 2009).

Evidence suggests that families which are supported and educated can better enhance their family member's recovery. One effective method for supporting and educating families is the family psychoeducation (FPE) intervention. This is an evidence-based practice that educates family members and

friends about mental illness and how to help someone with a psychiatric disorder. More than 30 randomized clinical trials have demonstrated reduced relapse rates, improved patient recovery, and improved family well-being for people with SMI participating in FPE (McFarlane et al. 2003; Lincoln et al. 2007; Lucksted et al. 2012).

In contrast to clinic-based FPE, there are also family-run interventions to support and educate families that have members with mental illness. Perhaps the most well-known family-run model is the National Alliance on Mental Illness' (NAMI) Family-to-Family (FTF) program. FTF is a 12-session course that covers a range of topics, including emotional responses to mental illness, current information on the major mental illnesses, research on the biology of mental illness, and information on the evidence-based practices that are most effective in promoting recovery (Burland 1998; Lucksted et al. 2012). This information is delivered to families by family members of an individual living with mental illness. Research indicates that FTF can reduce family anxiety, improve family problem-solving, increase positive coping, and increase family knowledge (Lucksted et al. 2012). Although the NAMI FTF program originated in the United States, it is implemented in some provinces in Canada, including Quebec (ASMFMH 2014).

This brief introduction indicates that the research literature on family influence on mental illness has evolved from a solely pathological emphasis towards examination of family as a resource for recovery. The present study is conducted in the spirit of this shift in emphasis. The aim of the study is to assess the perceived influence that family has on recovery from the perspective of people living with severe mental illness. Conducted from a position of equipoise, the study attempts to elicit perceived barriers and facilitators to recovery related to family, in a grounded qualitative investigation of people with severe mental illness.

Methods

Participants and Recruitment

54 people (26 women) living with a diagnosis of severe mental illness were recruited to partake in a semi-structured interview about recovery. Participants were recruited from three Montreal psychiatric outpatient clinics. Participant inclusion criteria included: (a) must have had a diagnosis of schizophrenia, major depression, schizoaffective disorder or bi-polar disorder during the last 5 years; (b) this must have lasted at least 3 years; (c) must currently be using mental health or rehabilitative services; (d) must be able to give informed consent; (e) must speak either English or French; (f) must be 18 years of age or older; and (g) must not currently be an in-patient.

Procedures

Mental health clinicians identified potential participants from their clientele who fell into the study inclusion criteria. They then asked the potential participants if they would consider being involved in a research study on 'recovery'. The details of those assenting were then passed on to a member of the research team, who contacted the person to further explain the study. Clinicians who assisted in the recruitment of participants were aware of the inclusion criteria of the study and used medical records and charts to ascertain diagnosis.

After a researcher completely explained the study to the participant, the participant was asked if he or she would like to participate. Those answering in the affirmative gave written informed consent for their participation. Consent forms and study protocol were approved by the McGill University research ethics board prior to the beginning of the study. All data were de-identified and pseudonyms were created for each participant. Participants were compensated $20 for their time.

Interviews were conducted at a time and place of participants' choosing between 2011 and 2013. Locations ranged from the participant's home, university/hospital offices, and neutral spaces such as a park or coffee shop. Participants also chose the preferred language of their interview (English or French). The aim of interviews was to elicit individual perspectives on recovery in general. Questions specifically probed for the role of family in defining, facilitating, and impeding recovery.

Research assistants were trained in semi-structured interview techniques, and they conducted the majority of the interviews. Through the data collection process, the second author (RW) listened to a sizable portion of the audio-recordings to give further feedback on interviewing techniques to the research assistants. In addition to the semi-structured interview protocol a small socio-demographics form was used to collect basic demographic data such as age, gender, marital status and parenthood. The research assistants were trained to quickly scan demographic responses in order to integrate them into the course of the interview—a recommended strategy in qualitative studies (Maxwell 2005). Interviews typically lasted from 60 to 120 min, with the scope and pace of the interview controlled by the respondent. For example, there were pauses and breaks during the interviews, if the participant so desired. All interviews were audio-recorded and transcribed.

Analysis

As already noted, the second author (RW) listened to portions of each interview directly after it occurred for

quality control and feedback purposes. The insights gained from this quality control served as the initial impetus for the further examination of family as an important aspect of recovery. Upon completion of data collection, we imported all interview transcripts into Atlas-ti qualitative data analysis software. Research assistants initially coded all transcripts for any themes falling under the broad category of "family". The first author (HA) then engaged in open-coding within the family categorization, marking any notable sub-themes for further examination. Both authors then utilized the code manager function in Atlas-ti to identify codes that occurred most frequently. Both authors then discussed the open codes in light of code frequencies and qualitative content of coded data and collectively distilled the most salient codes into the six themes presented below. Transcripts were then coded according to these six themes by the first author.

Results

As noted in the methods section, we recruited 54 people (26 women). Participants fell within four broad ethno-racial groups: (1) Anglophone Euro-Canadian (n = 10); (2) Francophone Euro-Canadian (n = 18); (3) Anglophone African/Caribbean (n = 15); (4) Francophone African/Caribbean (n = 11). Groups 3 and 4 contained a mixture of first and second generation immigrants. Participants' age ranged from 20 to 69 years with a mean age of 40. 37 participants (69 %) were single, 7 participants (13 %) were in a relationship (dating someone or engaged), 5 participants (9 %) were married, and 5 participants (9 %) were divorced or separated. 14 participants (26 %) had children. Interestingly, although the sample of participants was diverse across age, gender, and ethno-cultural background, we were unable to identify any discernible patterns specific to any one group related to family-related variables. Moreover, our data did not indicate key differences of family as a facilitator or barrier depending on family member type (e.g., spouse, sibling, parent); yet this may also be an important topic to examine in future studies. Rather, the themes given below were present across all of the participant characteristic groups, and represent common barriers and facilitators to recovery, as related to family.

For ease of comprehension, the results are divided into two separate sections. The first details significant ways in which family acted as a facilitator to recovery; the second details ways in which family acted as an impediment to recovery.

Facilitators

Three factors emerged as significant facilitators of recovery, as perceived by participants in this study. We label these factors (a) moral support; (b) practical support; (c) family as a motivating factor for recovery.

Moral Support

Moral support from family was manifested in a number of different ways in the recovery process for participants. First, respondents remarked that simply having family "there" for them (either physically present or otherwise in communication) was a positive influence on recovery. Family presence enabled participants to understand that they are not alone in their recovery efforts and that there are other people that care about them. This family presence appeared to provide the constancy and stability that many respondents reported as necessary for recovery. Participants cited the importance of being able to trust and confide in their family members throughout the recovery process. Respondents often characterized their family members as "loving" and "supportive". In the context of social support from families, many echoed Justine, a 20-year old francophone Euro-Canadian who said "if something happens, they're always gonna be there."

More tangibly, participants cited visits and phone calls from family in the hospital and in their homes as important forms of support. Interestingly, telephone conversations and visits were perceived to be of benefit to recovery by not addressing issues surrounding mental illness. Rather, conversations or mutual exchanges about everyday life helped many consumers feel "normal" or forget about their illness. As Alice, a 34-year old Anglophone African/Caribbean, remarked:

> I think definitely the support from friends and family helps a lot. When you get visitors, phone calls, like that is one thing for myself; typically when I am getting a lot better. I just spend time on the phone in the hospital; I literally sit down in the booth for like hours just talking on the phone because communication with the outside world, knowing that I have friends and family that care. Even if they can't come and visit, but just doing what I would do at home; talking on the phone. Just communicating, knowing what is going on in their lives, they know what I am doing. That support and just knowing that you have people that support you and care about you and love you. That helps a lot.

Oftentimes, participants, like John, a 41-year old Anglophone African–Caribbean, noted that in addition to visiting their member in the hospital, family members can assist recovery by getting their relation out of the house and better connected with the local community:

> My brother he take me out the other night, he take me out and buy me a beer, so next time I say I wanna go

> downtown, and play pool, just to be interactive with people make me feel alive again, not like a crazy person.

The data indicate that family can further provide social support for recovery through the rationalization or normalization of mental illness. Respondents argued that family members have helped them to put mental illness in perspective, to see it as any other type of health problem. Family members played an important role in helping participants understand aspects of their mental illness, oftentimes discussing family history to provide insight about potential genetic factors of mental illness. Many respondents noted their own surprise that their family members accepted the diagnosis of mental illness and either understood or made efforts to understand the mental illness and its appropriate treatment. As Jennifer, 48-year old Anglophone Euro-Canadian noted:

> You have to accept it, and you have to be happy. I could've had a house, I could've worked, but my mother-in-law said to me, "be happy with what you have" because I worked before, I worked for ten years, so I was able to get a little pension that I'm supposed to have to help my family. […] A lot of people are sick; it's not your fault she said.

Finally, further support from families is evidenced through the encouragement of consumers to continue with their treatment. This could be by advising the family member to continue taking his or her medication, telling him or her to continue attending psychiatric appointments or sessions at rehabilitation centers, or encouraging him or her to abstain from alcohol, drugs, or unhealthy relationships.

Practical Support

Although moral support was the most pervasive type of support provided by family that was cited in this study, many participants also highlighted practical support from family as key to their recovery. Family often provides practical support in the form of resources for participants during their recovery. Financial support came through the provision of housing, paying a separate rent for the individual, providing meals, giving pocket money, or buying the individual gifts. Financial assistance is often an important facilitator to recovery, given that many respondents were unable to obtain or hold a job. Michel, a 40-year old Francophone African–Caribbean notes that his family "always take me out to eat. […] They bought me things. They bought me presents. They have really helped me."

In addition to financial support, respondents noted that family provides other forms of practical support to aid in their recovery. This can be anything from providing transportation to the store or to doctor's appointments to helping the individual fill out forms or get registered in school programs. Participants also discussed when family members would take over their familial responsibilities and household chores during periods of illness when they were unable to do them. Adam, a 35-year old Anglophone African–Caribbean remarked: "They'll make sure that I have the support—the medical support—that my bills are paid, that my dog is taken care of, that if I need anything – well, everything. They do everything."

Family as a Motivation for Recovery

The data indicate that the mere presence of family can often influence recovery without explicit effort. Specifically, participants cited family as an intrinsic motivator behind their efforts toward recovery. In some cases, respondents like Peter, a 41-year old Anglophone African–Caribbean, focused on recovery because they saw this as a path to having a family in the future.

> It took me time because I don't want to marry somebody that will say 'I don't really know that I married a sick person,' do you understand because when I get sick, will that person really care for me? And will they say, ha, this guy. …Maybe one time I will go off, that is if I am kind of sick. So it took me time… But getting married…It excites me, it mean I want to have kids; I want to make family.

Results related to family as a motivator for recovery show that participants were not cynical about families and indeed saw the creation or maintenance of family as an important component of individual recovery. For example, some respondents aspired to having a spouse and/or children and believed that this would be the ultimate marker that they were in recovery. For others, like Joe, a 45-year old Anglophone African/Caribbean, it was the desire to provide for their existing family that motivated them to recovery.

> I am teaching them not to give up; you fight, fight, fight and fight. Until you can't fight anymore. Oh yeah, I have a reason to keep going: it is my kids. … And when they see me struggle, some days I struggle to go to work, to do that. I do it and then come back home. And they know how hard it is for me, but when I see their face and they smile, it helps me. Like I just didn't give up and say ok, fine I quit. No, I keep going. So, no, you need that. My motivation, you asked me that before, is my kids.

Participants in this study clearly showed that just as parents can have an influence on their children's health and wellbeing; children can also have an influence the health

and wellbeing of the adults in their family. Francine, a 61-year old Anglophone African–Caribbean told us about her ultimate motivator for recovery:

> I have a grandson, and my grandson is four years old. And I would like to know him more and do things for him and with him; you never know what can happen in life. You know, maybe his mother might get sick and never know what can happen. I want to be able to be there for him. So I want to keep myself healthy, so I am available if a problem arises and boom: there I am.

For still others, like Luke, a 37-year old Anglophone Euro-Canadian, recovery was a way to reconnect with family whom they had hurt during their experience with mental illness.

> I'd spend my days and nights drinking and smoking weed and cigarettes and getting into trouble and not having a very good relationship with my family and friends and it was the wrong path. It's the opposite of the path that I've been taking now. Making amends with family and friends and trying to be there for them and trying to stay out of trouble and be productive is just so much more important than it ever was before because I wasted so much time.

Barriers

Three factors emerged from the data as significant barriers to recovery. Barriers exist when family (a) acts as a stressor; (b) displays stigma and lack of understanding; or (c) forces hospitalization.

Family as a Source of Stress

The results indicate that stress from family can come from both intentional actions or from less intentional stressors. Participants noted numerous common sources of stress. These include family members being judgemental, making the individual feel weak or incapable, or speaking to the family member as if he or she is a child. Participants noted that they became stressed when family members saw different life paths for them, pushing them in directions they did not want to go, particularly as it relates to education, career, marriage, or children. Similarly, participants reported stress when family members disagreed with everyday choices, for example eating or dressing habits. Divorce and other family conflicts were also seen as stressful and an impediment to recovery. Some participants reported that their recovery gathered pace when family members moved out. Marie, a 58-year old Francophone Euro-Canadian stated:

> I got sick again after, because my sons came back to the house and that went very bad. It caused me to get sick again. […] Then, at a given moment, I was capable of saying to my son, "I will give you X many months to find an apartment." So, to find solutions to the problems I was facing. Then, when he left for his own apartment… he started doing better, and me as well. This was a something that really helped me.

Participants were influenced by the illness, suicide, or accidental death of family members, or the feeling of responsibility to provide and care for family members. Claire, a 42-year old Anglophone African–Caribbean, demonstrates an important theme: Family is important, but family responsibility can also become overwhelming.

> I would like more independence. It is not really preventing recovery, but I would like more independence but I am torn between like familial obligations cause my brother just went through a separation. My mother's health isn't the greatest. No I have a feeling like that they need me around, even though supposedly I am not all there or whatever that they think, if they need me. You know, I don't want to desert them. […]You know, it *is* my family.

Many participants reduced contact with stressful family members. However most participants (like Claire above) accepted family members as important components in their lives and did not see lessening responsibility or reducing contact with family as a viable option to facilitate recovery.

Stigma and Lack of Understanding

Some participants like Francine, a 61-year old Anglophone African–Caribbean, noted that within their family they felt stigmatized because of their mental illness and that this was a barrier to recovery.

> Now there is a big stigma of mental illness when you don't know about it. When you don't know about it, it is the end of the world for certain members of the family. And my daughter falls into that category. She has not educated herself in my illness. And she views it like a plague; like she gets too close to it she is going to get it. … She avoids me because she doesn't want to be associated with me. She thinks it is bad and she doesn't want people to know that her mother is sick. If she has a friend, if her friends see her with me, she doesn't want. She is ashamed if I would react in a way that would not be normal to her. … So when she sees me, she sees me in areas that are very remote; very, very, places where her friends wouldn't come to.

Because of the stigma associated with mental illness, participants reported that family members would be ashamed of their member in recovery, would deny that

member actually had a mental illness, and would try to hide the mental illness from the extended family or the wider community for fear of a ruined family reputation. Some participants noted that stigma may also have a cultural basis for them, as they experienced stigma among family in their community of origin (e.g. Haiti) more than in Canada.

Participants noted that they experienced barriers to recovery when their family did not understand or did not make efforts to understand their experience with mental illness. Family would deny that an individual had mental illness or would not believe that mental illness was the reason behind an individual's behavior. One participant noted that her father insisted that she was just "making it all up". Sometimes, participants reported that their family members would understand neither the etiology of the individual's specific diagnosis nor the individual's experience with the diagnosis and treatment. Anne, a 34-year old Anglophone African/Caribbean, notes.

> Like I invited my dad more than once to come to a doctor's appointment with me and he is always late and this and that. So he never made it. And it would be nice if my family could be more informative. Like get themselves informed, find out what the causes are of bipolarism, like how to deal with it. Like come, attend a workshop or whatever. Read stuff. Like I had my cousin, he was really helpful. And he still is. He went online and he read up about it. And he informed himself. Like do stuff like that. Don't just think it is because I am not taking my medication and that is where it all starts. And that is where it all ends. That is not it. Inform yourself and find out about the illness. See what causes it. See what cannot cause it and stuff like that and how you can help and how you can be supportive. And stop just passing the buck and thinking oh, it is because of your friends, oh it is because of whatever, past relationships. It is not, and don't take the blame on for yourselves, too. Because family stress also adds to it.

As indicated above, participants noted a need for increased family education about mental illness and how to best support the family member in his or her recovery. Although many participants noted a lack of understanding from family members, many others noted how their family truly made efforts to understand the mental illness by talking to doctors or looking things up on the internet. Others noted that their family members, to their surprise, did actually understand mental illness and this facilitated recovery.

Family Forcing Hospitalization

This is the theme which was the most difficult to classify as a facilitator or a barrier. Participants were quite divided about whether forcing hospitalization was a barrier or a facilitator, though many saw it more as a barrier. The data indicated that family members often play a key role in detecting mental illness symptom onset and/or initiating treatment. Participants that were forcibly or voluntarily hospitalized often noted that it was their family that either called the police or ambulance or drove the individual to the hospital to have them admitted. When it was considered a barrier to recovery, participants like George, a 40-year old Francophone African/Caribbean, believed that they had been unjustly hospitalized.

> I had an altercation with my two sisters and they conspired against me. They signed a paper that forced me to go back to the hospital. Just for a small discussion about nothing. It's my sisters who made me return to the hospital under a false motive.

Some participants admitted that they were more likely to talk to friends about their mental illness than their family as they feared that the family would rush to have them hospitalized, rather than just listen to them. Participants often indicated feeling a sense of betrayal when family members initiate treatment. This sentiment is well expressed by Anne below, a 34-year old Anglophone African–Caribbean.

> And my dad like dragged me back there one time. I went with my dad and my friend and my friend promised me that no, we are not going admit you back. And my dad is like 'yeah, we are not.' And then you are waiting in the waiting room and it was taking so long. And he went behind my back and he went in and he asked, he commanded to see my doctor. And she came out and he came out and they both dragged me basically like on my butt saying 'oh you are not taking your meds, you are not taking your meds and all.' And it is just like yes I am. They put me back in and they increased the dosage.

As we note above, although more respondents noted forced hospitalization as a barrier, other individuals were grateful to their family for taking them to hospital when in crisis. Jean-Claude, a 25-year old Francophone African/Caribbean, felt that such a hospitalization was a pivotal and positive force in his recovery.

> They brought me to the hospital because when my father saw that I wasn't leaving my room, and because I was keeping my distance from everyone, and because I hardly ever spoke. I wanted to flee, and I had just taken my things and ran outside. My father ran behind me, excuse me to say this, but he was in his boxers in the winter. He ran behind me. After, when he brought me back to the house, I became aggressive. Then, after that he was a little scared so he had no choice but to call the police or the

ambulance. Then the police came and they brought me to the hospital. It was that day that my recovery began.

Discussion

These findings demonstrated that family can be a facilitator of recovery by providing moral support, practical support, and by serving as an intrinsic motivation for recovery. Far from being cynical about family, most respondents in this study truly loved and appreciated having family in their lives and considered this as an essential aspect of recovery. Yet, family could also be a barrier through stress, stigma, and lack of understanding. Many participants reported that forced hospitalizations initiated by a family member were inimical to recovery, though others saw this as a positive nodal point in their recovery journey.

Participants in our study reported that criticism or over-involvement from family members increased their stress and worked against recovery. Contrariwise, warmth and positive regard from family members was considered as a facilitator of well-being. These findings are somewhat consistent with the extant literature on expressed emotion, indicating that emotional expression within families can indeed have an impact on recovery (Wearden et al. 2000). However expressed emotion theory is insufficient in explaining the complete findings from this study. We identified numerous facilitators to recovery unrelated to emotional expression, for example practical and instrumental support. As such, our results caution against an overreliance on theories of expressed emotion in explaining the relationship between family dynamics and recovery.

Findings around family as a barrier indicated that recovery-oriented concepts such as autonomy and agency can be complicated by family ties and family norms of reciprocity and duty. Likewise, some of the participants' reports of paternalistic and infantilizing family perspectives indicated that some families may still possess outdated notions of mental illness, believing in the limited capacity of the consumer to lead a self-directed life.

This demonstrated the ongoing need and desire for improved mental health literacy among family members. To date, families have gained knowledge of mental illness through various arenas, including interventions such as family psychoeducation and NAMI's peer-led Family to Family program. These interventions have been shown to be effective in increasing knowledge and improving mental health literacy (McFarlane et al. 2003; Lincoln et al. 2007; Lucksted et al. 2012). However critics of family interventions argue that they are often prescriptive, with some commentators noting that the "content of many of the most empirically validated family interventions were designed in the 1970 s and 1980 s and embrace more of a 'successful management of a chronic illness' theme rather than a recovery orientation" (Glynn et al. 2006, p. 455). Our findings, especially those regarding the importance of autonomy and agency, support the contention that family interventions must "consistently reflect the mental health recovery paradigm to ensure that the intervention…address consumers' and family members' real-life concerns and aspirations" (Lucksted et al. 2012, p. 112).

Our results indicated the importance of listening and honoring consumer preferences about family involvement in recovery, rather than assuming that family is either a universally positive or negative force. This finding converges with other studies showing that most people with severe mental illness desire some sort of family involvement, though a substantial minority do not (Cohen et al. 2013). When revising family interventions to better reflect a recovery orientation, it might be appropriate to put an even greater emphasis on the importance of consumer choice and agency regarding the involvement of family. Revised or novel interventions should include ways to assess how exactly consumers want their families to be involved in their recovery (if at all).

Our data also suggest that family interventions might better emphasize the importance of mutuality in relationships, highlighting the importance of contribution rather than just receiving aid in family relationships. Indeed, in one study, families that "emphasized the importance of giving rather than just receiving were related to increased optimism about recovery as well as increased self-confidence and self-esteem" (Pernice-Duca 2010, p. 22). Although we argue here that family has the potential to greatly impact individual recovery efforts, it is also important to note that an individual's recovery may, in turn, have great impact on the family. This can lessen family stress and caregiver burden (Lefley 1997) and enable the individual in recovery to contribute to overall family economics, wellbeing, and quality of life.

Consumer agency is also important in determining the most appropriate role for family involvement, given that our results demonstrated that the very same family of a consumer can function as both a protective and a risk factor for recovery. Related future research might examine how a provider, a consumer, and/or a family member could identify what is helpful or harmful within the family system. Emerging patterns will likely vary depending on individual-level factors, such as family characteristics or severity of illness and will in turn lead to new research questions that further research could examine. Finally, our data did not indicate key differences of family as a facilitator or barrier depending on family member type (e.g.,

spouse, sibling, parent); yet this may also be an important topic to examine in future studies.

Limitations of the Study

This study has numerous limitations. First, we did not complement our interviews with observational methods examining *in situ* interactions of participants with their family members. Additional observational methods would have allowed us to triangulate data to corroborate patient perspectives. Second, this study was conducted solely from the point of view of the consumers of mental health services. Thus, the findings presented in this article represent the viewpoint of one subset of the family. Further studies would be wise to interview both consumers and other family members in order to get a more balanced view of the role of family in the recovery process. Indeed, families may have very different perspectives on the facilitators and barriers that they may present in the recovery process, and this is an equally important perspective that we must take into consideration when evaluating and improving family and consumer interventions for recovery. Finally, we did not sample individuals based on experience of family interventions. Indeed none of the participants reported being involved in any form of family intervention. Further research may need to assess how far such interventions are consistent with the recovery model and related concepts such as agency, autonomy and choice. In spite of these limitations, we believe that this study provides useful insight about the role of family in the recovery process.

Conclusion

In conclusion, this article described family as a crucial component of recovery from severe mental illness. With this research, we strive to contribute to the ongoing shift in pathological-modeled research to focus on more positive, solutions-based scholarship, looking at how to build upon naturally-existing resources to facilitate recovery from severe mental illness. Our data indicate that family can provide important moral and practical support and can serve as a motivating force for recovery. But the data also indicate that family members can be a source of stress, lack understanding, and force their member with mental illness into the hospital against his or her will. We hope that this knowledge will be useful to clinicians working with patients and families, ultimately enhancing recovery and well-being for people with severe mental illness.

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