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ORIGINAL PAPER

Community Mental Health Care Providers' Understanding of Recovery Principles and Accounts of Directiveness with Consumers

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Abstract The present qualitative study examined community mental health providers' accounts of their therapeutic interactions with adults with serious mental illness in a recovery-oriented model of care. Ten long-time mental health care providers discussed their understanding of recovery principles, their use of directive practices, and factors that shape their work with consumers. Content analysis of mental health providers' accounts suggest that providers had no difficulty articulating basic principles of recovery-oriented care. Providers reported engaging in directive practices with consumers and described using traditional clinical factors such as level of functioning, degree of psychiatric symptoms, safety concerns, and legal status to assess consumers' ability for autonomous decision making. Providers generally did not express tension between their views of mental health recovery and their beliefs about utilizing directive approaches with consumers. Implications of present findings for research and practice are discussed.

Keywords Recovery · Directiveness · Community mental health · Adults with mental illness · Qualitative research

Recovery-oriented service delivery is now the preferred treatment paradigm in community mental health [31]. A recovery paradigm assumes that individuals' recovery from serious mental illness is possible [19, 30] and that consumers can live satisfying lives despite their disability [15]. A primary role of mental health professionals in providing recovery-oriented services is to help consumers to achieve a sense of personal autonomy, social connectedness,

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and community integration [20]. Recovery principles suggest that the therapeutic stance between mental health care providers and consumers is one of collaboration, where providers work together with consumers to identify consumers' personal goals to help them work towards their preferred futures [16, 25, 29]. A recovery-oriented model assumes a sharing of power between client and clinician to enact mutually agreed upon goals to facilitate a client-centered vision of recovery [1, 5, 28].

Provider directiveness is typically conceptualized as the "degree to which practitioners try to influence clients to accept a solution or course of action preferred by the practitioner" ([17], p. 72). Provider directiveness highlights the tension between a consumer's ability to make autonomous decisions and the provider's desire to make decisions for a consumer in his or her best interest [17, 27]. Qualitative findings from a study by Healy [17] suggest that providers intentionally engage in a number of directive practices with their clients. Research has found that providers' directiveness was associated with increased client resistance [6, 7] and poorer outcomes for some types of clients [18].

In a community sample of 105 multidisciplinary mental health providers who worked with adults who have a serious mental illness, Osborn and Stein [27] examined provider directiveness as the degree to which providers endorsed engaging in specific behaviors that limit the autonomy and choice of their clients. Providers' reports of directiveness with clients were negatively related to their reports of working alliance with their clients. Interestingly, providers' reports of directiveness with consumers were positively associated with their reports of their own personal growth as a result of their work with consumers. In other words, mental health care providers who expressed the most personal growth from their work with consumers also reported using the most directive therapeutic practices.

Unfortunately, the training of most current mental health professionals does not prepare them for the challenge of reconciling the expectations of a risk-averse society with those of encouraging client autonomy. This lack of training may lead practitioners to provide services that are sometimes paternalistic or neglectful [29]. Risk reduction strategies practiced by mental health professionals such as suicide contracts, court order medication or treatment, and temporary detention orders, reduce consumer autonomy [39]. Moreover, even well intentioned staff members may misjudge consumers' abilities and only see negative signs and symptoms of illness [13]. Corrigan et al. [11] write that many providers hold tenaciously to an outdated view that people cannot overcome mental illnesses. Further, Cook and Jonikas [10] contend that as a society we are still ambivalent about whether consumers with a psychiatric disability are capable of knowing what is best for them and have the ability to make informed choices.

Some writers claim that recovery-oriented principles in community mental health settings are often translated into existing clinical practice, resulting more in a change in therapeutic rhetoric than a change in therapeutic interactions between providers and consumers [26]. These scholars argue that rather than creating new recovery-oriented treatment approaches, community mental health agencies merely relabel existing medical model approaches as being recovery-oriented [8, 30]. The discrepancy between recovery rhetoric and the reality of providers' actual practices in the mental health system is seen as a barrier to consumers' self-determination [20]. The implication is that relatively little has changed in the distribution of power in professional relationships between providers and consumers as a result of recovery-oriented mental health policy [24].

In their qualitative study of nine adults with serious mental illness, McCann and Clark [20] examined consumers' perspectives on the strategies that nurses employ to enhance client self-

determination. Consumers reported that psychiatric nurses needed to know when it was appropriate to move the balance of decision making over to the client to facilitate client self-determination. Qualitative findings suggested that themes of dependence and powerless emerged in consumers' narrative accounts when psychiatric nurses did not facilitate a sense of self-control for consumers.

The present qualitative study asked mental health professionals about their understanding of recovery-oriented community mental health services and their use of directive practices in their work with consumers. The goals of the research were to understand how seasoned mental health professionals working in community mental health care describe factors that influence their use of directive practices with consumers and to explore possible tensions that providers may feel between directiveness in their interactions with clients and their facilitation of client self-determination. Understanding the lived experience of mental health care providers in their work with consumers is fundamental to the successful instantiation of recovery-oriented service delivery in community mental health.

The present study is guided by three main research aims. An initial focus of the study was on how mental health providers understood key aspects of mental health recovery and the role that assessment of individuals' stage of recovery played in their work with consumers. Secondly, we examined the extent to which mental health providers reported engaging in directive practices that impact consumers' self-determination. A third research aim focused on the extent to which providers described tensions between their understanding of recovery-oriented principles and their use of directive practices with consumers.

Method

Procedure

To be eligible to participate in the present study, mental health care providers needed to be at least 18 years old and specifically work with clients who have been diagnosed with a serious mental illness, as categorized by the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision (DSM-IV-TR; [2]). Further, providers needed to be licensed Master's or doctoral level clinicians (e.g., LPC, LCSW, Ph.D., Psy. D.) that have worked in the mental health field for at least 5 years in settings that practiced a recovery-oriented model of service delivery.

After institutional review board approval, two community mental health centers (CMHCs) in the Commonwealth of Virginia were recruited and interested mental health care providers voluntarily completed individual semi-structured interviews lasting between 60 and 90 min. The principal investigator conducted all interviews in person and participants received a $25.00 gift card to Amazon.com as a token of appreciation for their time. All interviews were audio recorded using an Apple iPhone and the CaptureAudio app. Interviews were then transcribed verbatim using Dragon voice recognition software. Each transcript was assigned a number and de-identified to protect the confidentiality of the participant. Transcriptions were entered into Atlas.ti for qualitative analysis.

Sample Characteristics

Participants in the present study included 10 licensed mental health professionals (5 women and 5 men) who work with consumers living with a serious mental illness.

Providers were employed in the professional roles of: Staff Psychologist, n = 4 and Clinician, n = 6 (i.e., clinical supervisor, clinician, emergency services clinician, forensic coordinating clinician, etc.). The sample identified their race as Caucasian (100%), was an average age of 50.2 (SD = 7.63) years old, and 70% reported that they were currently married. Participants in the sample reported that they had worked for an average of 21.9 (SD = 7.67) years in the mental health system and a majority of the sample (90%) earned between $55,000 – $64,999 or more. Half of the sample reported a caseload size of less than 25 clients and 70% of the sample reported they *agree* or *strongly agree* that they are satisfied in their current job. One-third (33.3%) of the present sample reported that they spend between 10 and 14 hours per week working directly with consumers and 40% worked greater than 15 hours per week directly with consumers. All of the study participants reported that they work primarily with consumers experiencing severe mood disorders (i.e., major depressive disorder, bipolar disorder) and 70% reported working with consumers with psychotic disorders (i.e., schizophrenia, schizoaffective disorder).

Materials

The interview protocol (available from first author) consisted of open-ended questions designed to understand participants' views of recovery and how they work with consumers. Specifically, the interview protocol was divided into four domains to understand providers' views about recovery and their assessment of consumers' stages of personal recovery. Next providers were asked about their views of consumer autonomy and how providers navigate differences in consumers' desires regarding their treatment. Lastly, provides were asked about their views and rationales related to directive practices that may impact consumers' self-determination within the context of a recovery paradigm.

Results

Data Analysis

Interviews were transcribed, placed in Atlas.ti qualitative analytic software, and analyzed using content analysis [9, 21]. A narrative or written report of the interviews was generated and the thematic experiences which emerged were compared and contrasted across and within participants' interviews. Through an iterative process, themes were continually refined or removed if not supported. Next, the interview protocol was used to generate a list of concepts used as preliminary codes linking all relevant provider utterances to appropriate codes. Finally, two independent raters coded a representative sample of 56 responses (46% of the total coded utterances) into theme categories to establish inter-rater reliability. Inter-rater reliability between two independent coders was 91%. Pseudonyms are used in reporting findings to protect the confidentiality of participants.

Providers' Understandings of Recovery

Table 1 details themes from the accounts of study participants about the meaning of recovery principles and recovery-oriented care. Specifically, these mental health care providers described the individualized nature of recovery for consumers, and their interpretation of

Table 1 Themes, definitions, and frequency of occurrence for providers' understandings of recovery

Theme	Definition	Percentage of participants who endorsed theme ($N = 10$)
Recovery is Individualized	Providers view recovery as an individualized process or journey.	60%
Recovery is not stage Dependent	Providers view recovery occurring in stages, but not according to a specific stage theory or model.	50%
Recovery exists on a Continuum	Providers view recovery occurring on a continuum with forward and backward movement.	50%
Recovery and Consumers' Functioning	Providers believe that the purpose of the recovery model is to increase consumers' functioning.	50%
Recovery as meaning in one's life	Providers believe that the purpose of the recovery model is to help consumers obtain a sense of meaning and purpose in their life beyond illness.	60%

recovery principles to help providers to facilitate increased mental health functioning, purpose, and meaning in the lives of consumers.

Recovery is Individualized Providers' accounts generally reflected mental health recovery as an individualized process or journey made by adults with mental illness. Providers in the sample were mixed about the extent to which there are "stages" of recovery from mental illness or the degree to which they view recovery as a "continuum" or relative to an individual. In describing the individual nature of recovery, James, a clinical social worker with 20 years in the profession, described, "I really feel strongly that we have to look at the person over all…[What] do they [consumers] need to be a successful individual?

Although all providers in the sample acknowledged that consumers move through stages of recovery, a majority of participants claimed that there were no existing stage models of recovery that could be applied to an individual consumer. As, David, a 56-year-old clinical psychologist who has worked in the mental health field for the last 33 years explained,

> "Everybody is not only different, but they [consumers] move in different ways through the process. You cannot expect to apply a model, "everybody is going to move this way, everybody is going to move that way." It really does not work that way in the real world. In other words, there are no neat stages of classification."

Participants also discussed the idea that consumers' recoveries existed on a continuum. As Lisa, a clinician for the last 10 years commented, "I think people continue in a continuum and swing back and forth, it's fluid."

Recovery and Consumers' Functioning Providers' interpretation of recovery involved helping consumers function as best as they can in the community given the demands of their mental illness. Many providers explained that the purpose of recovery is seen as increasing consumers' mental health functioning. For example, Christopher a 56-year-old clinical psychologist who has worked with consumers for the last 32 years shared his goal for consumers: "Each individual is able to maximize their functioning in all areas, cognitively, emotionally, behaviorally, socially, occupationally, given that there's a diagnosis and…going to be symptoms."

Recovery as Meaning Providers' accounts also reflected that mental health recovery is a process to help consumers obtain a sense of meaning or purpose in their lives beyond treatment focused aspirations. As William, a 53-year-old psychologist who has been working in the mental health system for the last 23 years, described: "Recovery from SMI means getting to a place in your life where your able to feel fulfilled, enjoy what you're doing, [and] pursue your goals and interests."

Providers Views of Their Work with Consumers

Table 2 summarizes themes and provides details of mental health care providers' accounts of their work with consumers in light of the principles of recovery-oriented mental health care. Four themes emerged about providers' views of their practice activities that included a belief in client-focused treatment, their assessments of client autonomy, identifying client deficits, and provider directiveness with clients.

Client-Focused Treatment Providers' accounts reflected their desire for their clients to take the lead in treatment and their wish not to interfere with client goals. All providers discussed their desire not to dictate treatment goals to their clients and how they encouraged clients to determine meaningful goals. As Jennifer a 40-year-old clinician who has worked with consumers for 15 years explained: "No absolutely, [I] do not want to get involved in their path. I want to be…someone who helps them along their path but I don't want to obstruct it." A majority of providers also talked about how they attempt to make the treatment process open and transparent. Providers' narratives reflect the belief that consumers can take the lead in their own treatment while still having symptoms of mental illness. A majority of providers explained that they felt consumers can still make informed decisions about their treatment goals and overall care while continuing to experience psychiatric symptoms.

Assessing Autonomy Providers' described factors that they use to assess consumers' ability to make autonomous decisions that included the *severity of consumers' symptoms*, *safety factors* (e.g., danger to self or others), and *consumers' legal status* (e.g., forensic client, probation, conditional release, registered sex offender). For example, James, a clinical social worker shared that he generally assesses whether his clients are, "[Are consumers] oriented, are they confused…what are their baseline symptoms, do their symptoms impact their ability to make good decisions?" All providers mentioned that safety concerns (e.g., dangerousness to self or others) may make them question consumers' autonomous abilities. A minority of providers also referenced that consumers' legal status may mitigate their assessment of consumers autonomy. For example, consumers' legal status as being on probation, conditional release, or registered sex offenders limited consumers' ability to make their own decisions about their treatment in the eyes of these mental health professionals.

Consumers' Skill Deficits All providers described consumers' skills deficits as the primary reason that providers needed to be directive in their work with consumers. Providers felt that they needed to be directive when they determined that various kinds of skills deficits prevented consumers from accomplishing their desired goals. For example, James who works daily with adults who have serious mental illness explained:

Table 2 Themes, definitions, and frequency of occurrence for providers' reported practices

Theme	Definition	Percentage of participants who endorsed theme ($N = 10$)
Role of Provider and Process of Treatment	Providers believe that consumers should take the lead in treatment and providers should not interfere with consumers' goals and wishes.	100%
Treatment is Open	Providers believe that treatment should be open, honest, and transparent.	60%
Consumers' decisions about treatment while still having symptoms of mental illness	Providers believe that consumers can still make informed treatment decisions while having signs and symptoms of mental illness.	60%
Autonomy and Consumers' Symptoms	Providers reported that they assess the severity of consumers' mental health symptoms to understand if they can make autonomous decisions and choices.	50%
Autonomy and Consumers' Safety	Providers reported that they assess if consumers are a danger to themselves or others to understand if they can make autonomous decisions and choices.	100%
Autonomy and Consumers' Legal Status	Providers reported that they assess if consumers are on probation, conditional release, or registered sex offenders to understand if they can make autonomous decisions and choices.	40%
Conversations with Consumers	Providers reported that when they assess that consumers are not capable of making informed decision, they have a conversation with consumers where they restrict consumers' recovery goals to those of symptoms, safety, and legal topics.	100%
Providers' Rationales	Providers reported that they engage in directive conversations because they believe consumers have a deficit of skills to accomplish their desired goals.	100%

> "It's hard because some of these folks, they want the American dream…if they had the American dream they would be satisfied, and that's a very difficult balance because you want to instill hope, and you hope that maybe one day they can have that, but even through recovery they may not have that. They may not have a significant other, they may not have a house with a white picket fence, they may not ever have a job…So I try not to get too far down the road, because it's also daunting."

Accounts typically reflected providers' general views that skills deficits which consumers experience as a result of their psychiatric disability often prevent them from living a "normal life." Narratives of providers reflected the belief that long-term cognitive or social skills deficits do not generally allow consumers to achieve their life goals and preferred futures.

Provider Directiveness Providers described actions that they take when they assess that a client is not capable of autonomous choices. When providers perceive that their clients' ability to make informed choices is limited, they say that they intervene on what they consider to be their clients' behalf. Providers' accounts generally characterized their interventions as *conversations* where the provider restricts consumers' goals in recovery to focus on safety or legal issues, or symptom/illness management. All providers freely acknowledged that these conversations with their clients direct the nature and scope of consumers' treatment. For example, Mary a 57-year-old psychologist who has worked with consumers for the last 18 years stated, "So I guess I try to talk them into seeing it my way and I use all the ways I can." Providers' conversations may be thought of as a form of risk reduction or contingency management strategies, which may limit client autonomy.

Understanding Provider Directiveness in Recovery-Oriented Care

Mental health care providers' narrative accounts suggest that they clearly understood and generally endorsed basic principles of recovery-oriented care. However, clinicians' accounts suggest factors identified as instrumental in dictating their level of directiveness with consumers. Traditional clinical assessment practices that included providers' judgments of consumers' symptom severity, level of functioning, safety concerns, and legal status were related to providers' reports of their directiveness with consumers. It also appears that when providers identify what they consider to be skills deficits in the consumers with whom they work, they are likely to limit consumer autonomy by selecting a directive treatment approach.

Overall, providers do not express tension between issues of consumer autonomy and client directiveness. Rather, providers' report engaging in directive practices with consumers when they believe that these adults do not have the capacity for autonomous decision making. Narrative accounts suggest that providers are more likely to consider issues of consumer autonomy in their therapeutic work when providers perceive their clients as relatively high functioning without major skills deficits and able to manage their symptoms.

Discussion

The present qualitative study examined mental health professionals' accounts of their therapeutic interactions with adults with serious mental illness in a recovery-oriented model of care.

Ten long-time mental health care providers discussed their understanding of recovery principles, provider directiveness, and factors that help them determine how best to work with clients. Content analysis of mental health providers' accounts suggest that providers had no difficulty articulating basic principles of recovery-oriented care. Provider accounts are testimony to their stated belief in the concept of client autonomy and individualized mental health care. Providers also reported engaging in directive practices with consumers and appeared to use traditional clinical factors to assess consumers' ability for autonomous decision making. Once providers viewed a consumer as unable to make an informed, autonomous choice based on their symptoms, safety, or legal difficulties, providers stated that they engaged in conversations with clients to direct or guide the focus of treatment. Present findings suggest that providers' reasons for their directive practices focus on their perceptions of client deficits and clients' inability to make autonomous decisions in life domains secondary to mental illness. Providers generally did not express tension between their views of mental health recovery and their beliefs about utilizing directive approaches with consumers.

Recovery-Oriented Beliefs

The present sample of mental health clinicians appeared knowledgeable and well versed on recovery-oriented service goals. Providers commented on the view that recovery from serious mental illness typically exists on a continuum. Providers also referenced the idea that recovery-oriented service goals should focus on increasing consumers' mental health functioning and providing a sense of meaning and purpose in life. These beliefs are consistent with the scholarly literature about the importance of approaching consumers as individuals and uniquely tailoring services to their preferences and needs [29]. In the present study, providers' reports were consistent with ideals of personal recovery [35, 38] and systemic recovery or supporting the value that consumers can achieve a life beyond their mental illness [15].

The present sample of mental health providers indicated that they felt a stage model of recovery was not helpful or applicable for working with adults with mental illness. This view is in direct contrast to research that suggests that mental health recovery likely occurs in measurable stages [3, 4]. It appears that these seasoned providers did not include the use of recovery stages in their individualized treatment approach. Rather, providers generally reported that they utilized a consumers' subjective level of functioning (e.g., signs and symptoms of mental illness) as a basic criteria for client progress or regress. Providers' accounts suggest that their assessment of client deficits and level of client functioning were important elements in their determination of client autonomy.

Understanding Provider Directiveness

Mental health providers' directiveness in their work with consumers is consistent with a medical model approach to mental illness. Seale et al. [34] found that psychiatrists used insight, severity of symptoms, and perceived dangerousness as criteria for when to engage in directive actions. Osborn and Stein [27] found that community mental health providers who expressed more personal growth working with consumers also reported being more directive with consumers. Findings from the present study are consistent with Sawyer's [32] caution that if community mental health continues to shift toward risk management rather than fully embracing recovery practices, service delivery options for consumers may be narrowed and clinicians may engage in defensive practices. The goal of self-determination may not be

afforded to consumers if clinicians continue to approach client care from a medical model that focuses primarily on consumers' deficits.

Consistent with a risk management approach to client care, repetitive deficit identification increases the possibility that providers' directiveness may become a reflexive and practiced therapeutic "skill." Consistent with research on confirmation bias [40], it is likely that providers who consistently seek to identify client deficits are likely to consistently find client deficits. Using similar logic, it is possible that using a strengths-based approach can enable providers to consistently identify and support consumers' abilities over their limitations. It is particularly telling that in the present study providers generally did not see any contradictions between recovery principles and directive practices with consumers.

Provider directiveness is a highly nuanced concept that is related to aspects of the working alliance between providers and consumers [27]. However well-intentioned providers' directive actions towards consumers may be, the clinician's role is inherently powerful [14, 22, 33]. Provider directiveness as reported by mental health clinicians in the present study closely resembles milder forms of coercion discussed in the literature that includes discussing, educating, and cajoling consumers [12]. Provider directiveness is necessary in times of crises in the lives of consumers [23, 37]. However, used as a continuous clinical intervention, provider directiveness seriously undermines consumers' autonomy and self-determination [37].

Study Limitations

The present research offers a number of important insights into mental health care providers' views of recovery oriented services and their use of directive practices with consumers. However, findings from the present study are limited in several respects. The research was conducted using a small sample of highly educated, self-selected participants who had been working as mental health care providers for many years. It is unclear the degree to which findings from the present sample can generalize to other types of mental health professionals who differ with respect to gender, age, ethnicity, and years of clinical experience. Moreover, all participants in the present study were employed in mental health settings in one area of the United States. It is likely that the implementation of recovery-oriented services differs significantly as a function of setting, geographical location, and resources allocated for community mental health care. Present findings need to be replicated using larger and more diverse samples to understand the extent to which providers' views about recovery and practice strategies are widely held. Moreover, the present study was limited to providers' views of their work with clients and no attempt was made to corroborate providers' reports using consumers' perspectives.

Future Directions for Research and Practice

Stein and Mankowski [36] contend that qualitative research provides a unique opportunity to engage with privileged groups in important social issues. By understanding the voices of privileged individuals, it is possible to systematically understand factors that may contribution to the oppression of marginalized groups. The present investigation purposefully used a qualitative methodology to assess the lived experiences of mental health providers who hold substantial power over consumers living with serious mental illness. Consequently, a rich and large data set (e.g., 10 to 15 pages of narrative per participant) was obtained from relatively few individuals. Study findings juxtapose

providers' views of recovery principles with their use of directive practices in order to shed light on providers' values and self-reported practices in their work with consumers.

The present study represents an important step in understanding providers' lived experience of working with consumers in a recovery-oriented mental health system. Arguably, clinicians' practices are contextually bound and reflect the values of their broader agencies and the mental health system. Although present findings must be interpreted with caution, it is clear that more work is needed to understand providers decision making strategies and ways that they implement recovery-oriented principles in their work with consumers.

Unquestionably, community mental health providers face many challenges in service delivery both within their agency systems and in their dyadic interactions with consumers. Moreover, agencies may not always provide formal supports for providers to regularly reflect on whether or not their day-to-day service delivery is aligned with their formal training and values. Findings in the present study suggest that providers may benefit from formal structures within their respective agencies which support opportunities for consultation with colleagues, regular evidence-based workshops and didactics, and case conferences. These agency structures can raise providers' awareness and foster comparisons between recovery principles and actual clinical practices.

The present research intentionally assessed the perspectives of mental health clinicians, but future research would do well to understand providers' therapeutic work with consumers from multiple perspectives. Research designs that include both providers' and consumers' views of their work together can offer powerful insights into provider-consumer exchanges. Present findings regarding provider directiveness are not meant to negate the importance of risk assessment or criticize providers' practices. Rather, the present study underscores the difficulties of navigating a mental health system where contradictory operating principles are common place. Present findings suggest that providers' knowledge of recovery principles does not necessarily impact their views of appropriate clinical practice. Future research is needed to identify individual and systems level factors that will enable mental health care clinicians to privilege consumers' autonomy and facilitate best practices in recovery-oriented community mental health care.

Compliance with Ethical Standards

Conflict of Interest Dr. Osborn declares that he has no conflict of interest.
Dr. Stein declares that she has no conflict of interest.

Research Involving Human Participants and/or Animals All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

References

1. Alverson, H.S., Drake, R.E., Carpenter-Song, E.A., Chu, E., Ritsema, M. & Smith, B. (2007). Ethnocultural variations in mental illness discourse: Some implications for building therapeutic alliances. Psychiatric Services, 58, 1541–1546. doi:10.1176/appi.ps.58.12.1541
2. American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
3. Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. Australian and New Zealand Journal of Psychiatry, 37, 586–594. doi:10.1046/j.1440-1614.2003.01234.x

4. Andresen, R, Caputi, P & Oades, L (2010). Do clinical outcome measures assess consumer-defined recovery? Psychiatry Research, 177, 309–317. doi:10.1016/j.psychres.2010.02.013
5. Anthony, W.A. (1993). Recovery from mental illness: The guiding vision of the mental health system in the 1990's. Psychosocial Rehabilitation Journal, 16, 12–23.
6. Beutler, L.E., Rocco, F., Moleiro, C. M., & Talebi, H. (2001). Resistance. Psychotherapy, 38, 431–436.
7. Bischoff, M.M., & Tracey, J. J. (1995). Client resistance as predicted by therapist behavior: A study of sequential dependence. Counseling Psychology, 42, 487–495. doi:10.1037/0022-0167.42.4.487
8. Borkman, T.J. (1998). Is recovery planning any different from treatment planning? Journal of Substance Abuse Treatment, 15, 37–42.
9. Casterlé, B., Gastmans, C., Bryon, E., & Denier, Y. (2012). QUAGOL: A guide for qualitative data analysis. International Journal of Nursing Studies, 49, 360–371. doi:10.1016/j.ijnurstu.2011.09.012
10. Cook, J.A., & Jonikas, J.A. (2002). Self-determination among mental health consumers/survivors: Using lessons from the past to guide the future. Journal of Disability Policy Studies, 13, 87–95.
11. Corrigan, P.W., Angell, B., Davidson, L., Marcus, S.C., Salzer, M.S., Kottsieper, P., Larson, J.E., Mahoney, C.A., O'Connell, M.J., & Stanhope, V. (2012). From adherence to self-determination: Evolution of a treatment paradigm for people with serious mental illness. Psychiatric Services, 63, 169–173. doi:10.1176/appi.ps.201100065
12. Davis, S. (2002). Autonomy versus coercion: Reconciling competing perspectives in community mental health. Community Mental Health Journal, 38, 239–259. doi:10.1023/A:1015267707856
13. Deegan, P.E. (1996). Recovery as a journey of the heart. Psychiatric Rehabilitation Journal, 19, 91–97.
14. Drake, R.E., & Deegan, P.E. (2008). Are assertive community treatment and recovery compatible? Commentary on ACT and Recovery: Integrating evidence-based practice and recovery orientation on assertive community treatment teams. Community Mental Health Journal, 44, 75–77. doi:10.1007/s10597-007-9120-9
15. Farkas, M., Gagne, C., Anthony, W.A., & Chamberlin, J. (2005). Implementing recovery-oriented evidence-based programs: identifying the critical dimensions. Community Mental Health Journal, 41, 141–158. doi:10.1007/s10597-005-2649-6
16. Green, C.A., Polen, M.R., Janoff, S.L., Castleton, D.K., Wisdom, J.P., Vuckovic, N., Perrin, N.A., Paulson, R.I., & Oken, S.L. (2008). Understanding how clinician-patient relationships and relational continuity of care affect recovery from serious mental illness STARS study results. Psychiatric Rehabilitation Journal, 32, 9–22. doi:10.2975/32.1.2008.9.22
17. Healy, T.C. (2008). Levels of directiveness: A contextual analysis. Social Work in Health Care, 40, 71–91. doi:10.1300/J010v40n01_05
18. Karno, M.P., & Longabaugh, R. (2005). Less directiveness by therapists improves drinking outcomes of reactant clients in alcoholism treatment. Journal of Consulting and Clinical Psychology, 73, 262–267. doi:10.1037/0022-006X.70.5.1161
19. Lysaker, P.H., & Buck, K.D. (2008). Is recovery from schizophrenia possible? An overview of concepts, evidence, and clinical implications. Clinical Focus, 15, 60–65.
20. McCann, T.V., & Clark, E. (2004). Advancing self-determination with young adults who have schizophrenia. Journal of Psychiatric and Mental Health Nursing, 11, 12–20. doi:10.1111/j.1365-2850.2004.00645.x
21. Miles, M. & Huberman, A. (1994). Qualitative data analysis: An expanded sourcebook, 2nd Edition. Thousand Oaks, CA: Sage Publications.
22. Monahan, J., Redlich, A.D., Swanson, J., Robbins, P.C., Appelbaum, P.S., Petrila, J., Steadman, H.J., Swartz, M.S., Angell, B., & McNiel, D.E. (2005). Use of leverage to improve adherence to psychiatric treatment in the community. Psychiatric Services, 56, 37–44. doi:10.1176/appi.ps.56.1.37
23. Muir-Cochrane, E., Gerace, A., Mosel, K., O'Kane, D., & Barkway, P. (2011). Managing risk: Clinical decision-making in mental health services. Issues in Mental Health Nursing, 32, 726–734.
24. Ning L. (2010). Buidling a 'user driven' mental health system. Advances in Mental Health, 9, 112–115.
25. Oades, L., Deane, F., Crowe, T., Lambert, G.W., Kavanagh, D., & Lloyd, C. (2005). Collaborative recovery: An integrative model for working with individuals who experience chronic and recurring mental illness. Australian Psychiatry, 13, 279–284.
26. O'Connell, M., Tondor, J., Croog, G., Evans, A., & Davidson, L. (2005). From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addictions system. Psychiatric Rehabilitation Journal, 28, 378–386. doi:10.2975/28.2005.378.386
27. Osborn, L.A., & Stein, C.H. (2016). Mental Health Care Providers' Views of Their Work with Consumers and Their Reports of Recovery-Orientation, Job Satisfaction, and Personal Growth. Community Mental Health Journal, 52, 757–766. doi:10.1007/s10597-015-9927-8
28. Peebles, S. A., Mabe, P. A., Davidson, L., Fricks, L., Buckley, P. F., & Fenley, G. (2007). Recovery and systems transformation for Schizophrenia. Psychiatric Clinics of North America, 30, 567–583. doi:10.1016/j.psc.2007.04.009

29. Randal, P., Stewart, M.W., Proverbs, D., Lampshire, D., Symes, J., & Hamer, H. (2009). "The Re-covery Model" - An integrative developmental stress-vulnerability-strengths approach to mental health. Psychosis, 1, 122–133. doi:10.1080/17522430902948167
30. Rodgers, M.L., Norell, D.M., Roll, J.M., & Dyck, D.G. (2007). An overview of mental health recovery. Primary Psychiatry, 14, 76–85.
31. SAMHSA: Recovery and Recovery Support (2015, October 5) Retrieved from http://www.samhsa.gov/recovery
32. Sawyer, A. (2008). Risk and new exclusions in community mental health practice. Australian Social Work, 61, 327–341.
33. Sheehan, K.A., & Burns, T. (2011). Perceived coercion and the therapeutic relationship: A neglected association? Psychiatric Services, 62, 471–476. doi:10.1176/appi.ps.62.5.471
34. Seale, C., Chaplin, R., Lelliott, P., & Quirk, A. (2006). Sharing decisions in consultations involving anti-psychotic medication: A qualitative study of psychiatrists' experiences. Social Science & Medicine, 62, 2861–2873. doi:10.1016/j.socscimed.2005.11.002
35. Sowers, W. (2005). Transforming systems of care: The American Association of Community Psychiatrists Guidelines for recovery oriented services. Community Mental Health Journal, 41, 757–774. doi:10.1007/s10597-005-6433-4
36. Stein, C.H., & Mankowski, E.S. (2004). Asking, witnessing, interpreting, knowing: Conducting qualitative research in community psychology. American Journal of Community Psychology, 33, 21–35.
37. Swanson, J.W., Swartz, M.S., Elbogen, E.B., Van Dorn, R.A., Wagner, R. Moser, L.A., Wilder, C., & Gilbert, A.R. (2008). Psychiatric advance directives and reduction of coercive crises interventions. Journal of Mental Health, 17, 255–267.
38. Swarbrick, M. (2006). A wellness approach. Psychiatric Rehabilitation Journal, 29, 311–314.
39. Wancheck, T. (2012). Reducing mental health civil commitments through longer temporary detention Periods. Developments in Mental Health Law, 30, 1–15.
40. Wason, P.C. (1968). Reasoning about a rule. Quarterly Journal of Experimental Psychology, 20, 273–281.

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