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Patricia Kruglak
Recovery and the Role of the Certified Peer Specialist: An Historical Analysis of an Evolving Concept and Paradigm

## ABSTRACT

The last decade of the twentieth century signaled a major shift in United States' mental health care, with 'recovery-oriented care' the new paradigm for mental health policy and services. While there is a consensus on the need to focus on recovery, the concept of recovery remains an evolving construct. This study examined the evolving conceptualization of recovery, focusing in particular on the role of the Consumer/Survivor/Ex-Patient Movement in altering social discourses concerning mental illness, recovery and the power dynamics within the extant mental health system. This study concludes with an examination of the recent Certified Peer Specialist position, concluding that like recovery, peer support remains an evolving construct.

# RECOVERY AND THE ROLE OF THE CERTIFIED PEER SPECIALIST:

# AN HISTORICAL ANALYSIS OF AN EVOLVING CONCEPT AND PARADIGM

A project based upon an independent study, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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# CHAPTER I

## Introduction

The concept of 'recovery' in the context of serious mental illness has, historically, played a prominent role in the formulation of mental health care, policy and ideology. Over the course of the past three centuries, mental health care policy in the United States has undergone multiple reforms and revisions, often in reaction to the egregious practices and failures of the previous system, and reflecting the prevailing conceptualization as to what constitutes mental illness, as well as recovery. Historically defined by medical professionals and administrators, recovery was conflated with cure, measured in symptom abatement or remission, and a return to one's life *status quo ante*. The last decade of the twentieth century signaled the latest shift in United States mental health policy, reflecting a broader view of recovery.

The 1999 Surgeon General's *Report on Mental Health Care*, the first of its kind, called for all mental health care to be "consumer oriented and focused on promoting recovery", with recovery described as "not limited to symptom reduction but . . . restoration of a meaningful and productive life" (United States Department of Health and Human Services, 1999, p. 455). This more expansive vision of recovery reflects the fact that for the first time, members of the Consumer/Survivor/Ex-Patient (C/S/X) Movement were invited to the proverbial table. Thus, mental health care policy was articulated with the input and presence of people with 'lived experience' of mental illness, for whom recovery was allied more with the phenomenology of

learning to live meaningfully and well, and perhaps differently than before, despite continuing symptomology.

Since then, 'recovery-oriented care' has become the new paradigm for mental health policy and services. However, while there exists consensus on the need to focus on recovery, recovery remains a "concept under construction, one being formed by multiple negotiations over meaning" with "a multiplicity of expectations and assumptions . . . embedded in the concept" (Jacobson, 2004, p. xii-xiii). This paper is based on this premise: that recovery continues to be an evolving construct, where recovery is "not one thing, one reality but many . . . and thus its implications . . . would change as the perspective shifted" (Jacobson, 2004, p. xiii). This paper will explore the conceptualization of recovery from the 18th century to the present, keeping in mind the following issues: what is the reigning paradigm of mental illness and recovery; what expertise is privileged in defining recovery, what constitutes treatment, and in deciding that 'recovery' has indeed occurred. This paper draws heavily on prominent recovery author Nora Jacobson's premise of "recovery as evidence" for the brief historical overview (Chapter II), and "recovery as experience" for the section on the reconceptualization of recovery in the context of the C/S/X Movement (Chapter III) (Jacobson, 2004). This paper then extends Jacobson's premise to the discussion in Chapter IV of the evolution of peer-support programs in the context of the C/S/X Movement, "recovery as practice". This paper concludes with a discussion of the most recent incarnation of peer support in the position of Certified Peer Specialist, illustrating that like 'recovery', 'peer support' remains an evolving, ongoing, construct.

**Terminology**

An inherent conundrum for the researcher exploring the evolving construct of a concept involves consistency-or lack thereof-of terminology. Thus, in Chapter II, 'recovery' will be used

to connote 'cure' as was common practice of the time; 'functional recovery' will mean an ability to resume one's external life functions, as in livelihood, without any inference about one's thought processes. The term 'recuperate' will be used to describe more general processes of healing, as opposed to cure. In Chapter III's discussion of the reconceptualization of recovery, the evolving meaning of recovery will be clarified in the text.

Similarly, the paper will use the terminology 'Consumer/Survivor/Ex-Patient Movement' (or C/S/X Movement) to refer to the movement associated with the changing conceptualization of recovery that is the focus of this paper. This is done with the understanding that this is not a movement of unified views but an elision of ideological stances along a spectrum, from the more radical, militant 'survivor' roots, to the inclusion of the moderate 'ex-patient', and even more moderate 'consumer' elements. Individuals will be referred to as 'consumers/survivors'.

Finally, it is important to keep in mind that those whose voices have come to represent a movement might not be representative of the individuals comprising the movement. Movements are subtle mosaics of individual positions along a spectrum, although for convenience we tend to aggregate them at the ends and in the middle. Thus while there is an increasing number of groups proliferating along the Consumer/Survivor/Ex-Patient spectrum," it is safe to say that by far the largest number of patients and ex-patients are those who identify with none of these organizations- indeed most patients . . . probably have never heard of these groups" (Chamberlin, 1990, p. 335).

## CHAPTER II

### Historical Themes: Recovery as Evidence

The social construction and conceptualization of recovery has been closely tied to, and reflected in, significant mental health care developments and reform movements, both in the United States and abroad. The literature offers a variety of different demarcations of and designations for these periods, reflecting the authors' orientation and focus of their work (Everett, 2000; Davidson, Rakfeldt, & Strauss, 2010; Jacobson, 2004; Morrissey & Goldman, 1986; Rochefort, 1984; Slade, 2009). For the purposes of this paper, and based on Nora Jacobson's insightful 2004 work, *In Recovery: The Making of Mental Health Policy,* the following prominent mental health reform movements will be examined: *Traitement Moral/*Moral Treatment; the Mental Hygiene Movement; and the Era of Scientific Psychiatry and Recovery.

In examining the etiology of the Consumer/Survivor/Ex-Patient Movement's (hereinafter referred to as C/S/X Movement) discourse-changing views on recovery in the historical context of mental health reform, the following general pervasive themes emerge: while the operational definition of recovery most often meant 'cure', as in eradication of symptoms, its conflation with discharge from an institution obscured the frequency with which this occurred. Sometimes the notion of 'practical' or 'functional' recovery was introduced, connoting some improvement, but falling short of cure. While the former historically "has been modeled on the phenomenon of recovery from physical illness, and thus has been recognized by objective measures of diminution in clinical signs and symptoms, 'practical' recovery has always been more subjective"

(Jacobson, 2004, p. 51). Another pervasive theme has been that "the authority to define recovery, and identify recovery in individuals . . . rested with professionals" (Jacobson, 2004, p. 52). The designation of 'professional' emerged from the context of the treatment modality of mental illness at any given time. The power to define and subsequently identify recovery facilitated a self-serving tautology "that was used as evidence for the effectiveness of different approaches, for different audiences, with different purposes," which in turn privileged certain professions, therapeutic modalities, and/or ideologies embodied in movements (Jacobson, 2004, p. 52). While differential power relationships are embedded in the issues raised above, the concept of agency introduces yet another dimension, both with respect to the power to make the distinction between and designation of 'recovery' and 'cure', and the ability to effect either: "cure was what doctors did to patients; recovery was what happened to patients with the help of nature alone" (Jacobson, 2004, p. 50). This concept of 'agency' finds its political and ideological translation as 'empowerment,' one of the bedrock tenets of the current C/S/X Movement (Chapter III).

***Traitement Moral*/Moral Treatment**

Prior to the late 1700s, mental disturbances were understood primarily in theological terms (such as possession by demonic forces), moral lassitude, or metaphysical terms (such as an overabundance of certain "humours") (Jacobson, 1994, p. 33). By the late 1700s, views regarding the etiology of, treatment for, and thus the possibility of recovery from, mental disorders began to shift to a medical-psychological model (Morrissey & Goldman, 1986), with mental illness as a form of brain disorder or defect, arising from either, or both, physical or environmental causes. *Traitement Moral*, originating in the asylums of France and later translated as "moral treatment" in England and the United States, is viewed as the antecedent to modern psychological treatment and to which has been attributed the rise of psychiatry as a profession (Davidson *et al*., 2010;

Jacobson, 2004; Lamb, 1994). Treatment was to be delivered humanely, and "Directed at the mind . . . to alter the thoughts and behaviors of persons believed to be mentally ill" (Jacobson, 2004, p. 34).

The underlying principles of *Traitement Moral* emerged from the unlikely collaboration between renowned medical doctor Philippe Pinel, and the superintendent of the infamous Bicetre insane asylum, Jean-Baptiste Pussin. Their very different experiences with respect to mental illness brought them to the same conclusion: recovery (equated with cure) was possible with appropriate and humane treatment.

While Pinel historically has been credited with providing the foundation for *Traitement Moral* (Davidson *et al*., 2010, p. 32), much of his thinking was derived from the insights of Pussin, whose experience as 'recovered inmate' informed his views on what promoted recovery. Pussin hired former and currently convalescing 'mental patients' to help other patients, thus instituting what could be viewed as the first "peer support" program (Davidson *et al*., 2010, p. 9). Not only did this provide meaningful employment, to which he attributed his own recovery, but former patients who were themselves "Averse from active cruelty from the recollection of what they had themselves experienced" (Pinel, 1806, cited in Davidson *et al*., 2010, p. 34) were more apt to treat current inmates with empathy and respect, thus decreasing the stigma and dehumanization leading to iatrogenic traumatization, still described today as more entrenched and difficult to overcome than the original symptoms of the illness itself (Chapter III).

While Pussin's lived experience and expertise were valued by Pinel, it was the latter's medical credentials which made him publicly credible, and thus credited with, founding the therapeutic philosophy of *Traitement Moral*. "The fact that Pussin's central contributions . . . have not been fully acknowledged or appreciated . . . is possibly due to the needs of an emerging

medical specialty to emphasize and give credit to the investigations and innovations of physicians that the genius and discoveries of others who are perhaps less educated or well-trained have to be overlooked" (Davidson *et al*., 2010, p. 35). This tendency to privilege medical experience as expertise and to discount or devalue lived experience persists, despite inroads made by the C/S/X Movement in having their lived experience of mental illness validated as expertise.

Moral Treatment, as practiced in England at the Quaker-run York Retreat of Samuel Tuke, was the first to differentiate between the notions of 'recovery as cure' and 'functional' or 'practical' recovery, connoting some improvement short of cure. Tuke also introduced the idea of agency into his differential equation between recovery and cure, clearly taking it out of the realm of the patients: "cure was what doctors did to patients; recovery was what happened to patients with the help of nature alone" (Jacobson, 2004, p. 50). These fundamental issues of recovery versus cure, as well as the notion of agency, continue to resonate in the debate as to what constitutes recovery: the notion that doctors effect cure while patients are passive recipients in their own process of recovery is refuted by the C/S/X Movement.

One of the most enduring legacies of the British Moral Treatment era is the level system, in which patients whose behavior conforms to the program's expectations earned privileges and were rewarded by attaining higher 'levels', with the goal of eventually earning their release. Failure to behave accordingly meant denial or removal of privileges earned (many of which have since been classified as basic human rights). This creates a situation in which "only when one learns the rules of the game . . . that . . . punishment is called treatment–does the staff consider him or her to be on the road to recovery. The real lesson is that one must always hide one's true beliefs - hardly a prescription for emotional well-being" (Chamberlin, 1978, p. xiv). This type

of veridical coercion remains an "unquestioned foundational principle of many current mental health programs" (Davidson, *et al*, 2010, p. 55). When cure is conflated with and operationalized as discharge from the institution, then the presence of the level system obfuscates the distinction between cure and learned compliance.

In the United States, the philosophy of Moral Treatment, in confluence with Dorothea Dix's movement to provide humane residential treatment for the mentally ill, resulted in the building of state hospitals. Similar to the French system of *Traitement Moral*, cure, defined as alleviation of or relief from symptoms, became equated with and operationalized as discharge, and by implication, proof of the efficacy of treatment in the institution. Statistics of discharged patients, purporting to demonstrate the institution's curative efficacy, became the overriding preoccupation of hospital superintendents and other professionals in the nascent field of psychiatry, vying for public money, prestige, and power.

This "cult of curability" (a term coined by Pliny Earle, respected American psychiatrist and head of the Bloomingdales Asylum, who discovered the distorted statistics) rested on skewed statistics that inflated certain numbers and concealed others, including the fact that many of those counted as "recovered" came back to the institutions multiple times, with each successive discharge being counted as a successful cure. Thus, the "rates (of recovery/cure) became little more than tautologies, reporting recoveries among only those patients who had been discharged, when discharge was in effect the operational definition of recovery" (Jacobson, 2004, p. 36-37), bringing to mind Mark Twain's observation that there are "lies, damn lies, and statistics." Ironically, it was the perceived success of the institutions (based on their suspect statistics) that led to their demise: "ideas regarding economy of scale took over and altered the vision of asylums as small, architecturally superior homes located in the restorative countryside.

Instead they were usually built so as to constitute the largest building" (Everett, 1994, p. 57): the resulting overcrowding brought a rapid deterioration "into the kinds of abuses that had outraged its original champions. Like the infamous madhouses before them, asylums, in their turn, became the universal symbol for cruelty and neglect that formed the basis of a second generation of reforms" (Everett, 2000, p. 28).

**Mental Hygiene**

The Mental Hygiene movement (1908-1950) believed that "insanity was an illness which could be prevented or cured by clean living, defined as the promotion of a well-trained mind, devoid of impure thoughts. The movement's important additional goals were to enhance the status of the 'mentally ill', alter public attitudes, and improve conditions in asylums" (Dain, 1980, cited in Everett, 1994, p. 58). The Mental Hygiene movement emerged from another unlikely collaboration between an eminent psychiatrist, Adolf Meyer [considered by some to be the "father of modern American psychiatry" (Davidson *et al.,* 2010, p.11; Jacobson, 2004, p. 41)] and Clifford Beers, an affluent Yale University graduate who had been institutionalized for three years and then 'fully recovered' on his own. Though originally founded by Beers as a mental health reform crusade to expose the plight of, and to ameliorate the conditions and standards of care for, people still in mental institutions, it was Beers' own story of complete recovery that became the *cause célèbre* of the movement. What is notable about the Mental Hygiene movement is that the premise of complete and total recovery on which it was based was, in fact, false. Beers vacillated between periods of abject depression and wild mania; the moment he pinpointed as being his instantaneous return to reason was actually his first experience of mania. Herein lies what could variously be termed the irony or the hypocrisy, but certainly the tragedy, of the mental hygiene movement: Beers' history of mental illness, as well as his having

irrevocably 'recovered', created his "value as a spokesman for the cause of mental hygiene . . . his legitimacy depended both on his having had the experiences he described and on having left them behind forever: were the latter ever to seem uncertain, the truth of the former also would be called into question." Beer's recovery was a "publicly constructed phenomenon, a political necessity, without which the movement might be threatened" (Jacobson, 2004, p.43-45).

**Scientific Approach to Psychiatry and Recovery**

The emerging field of psychiatry (early1900s) and the development of psychopharmaceuticals (1950-on) figured prominently in the continuing discourse regarding the possibility and nature of recovery from mental illness. Whereas the Moral Treatment and Mental Hygiene movements were predicated on the possibility of total recovery from mental illness, the discourse emerging from the work of Emil Kraepelin and Eugen Bleuler, two eminent psychiatrists of the early 20$^{th}$ century whose detailed and seminal work remains influential, focused on the impossibility of 'cure'. Their prognoses for schizophrenia (originally called *dementia praecox*) of "inevitable deterioration resulting in 'profound' and 'terminal' dementia" (Jacobson, 2004, p. 46), continue to dominate present understanding of, and expectations for, those diagnosed, despite decades of evidence to the contrary (Davidson, 2003; Slade, 2009).

It is interesting to note that Kraepelin's own evidence undermined his prognostications, initially causing him to discount the significance of 'recovered' cases in his findings. His rigid adherence to the construction of recovery as cure, in conjunction with his continued categorical rejection of the notion of recovery from schizophrenia, later led him to account for the improvement by "pars(e)ing the meaning of recovery . . . to distinguish it from cure. A true cure . . . . . would necessarily constitute a *restutio ad integrum*, a complete return to normal" (Jacobson, 2004, p. 47). Kraepelin described what he saw as "recovery with defect"; the return to

one's functional capacity while retaining lingering effects of the illness (perceptible only to the psychiatrist, who in this case not only defines, but also identifies, 'recovery'). Bleuler coined the term "healing with scarring" to denote a return to health predicated on lowered expectations and aspirations for the remainder of the patients' lives (Jacobson, 2004, p. 47). These explicit distinctions between cure and recovery "formally bifurcated" the two notions of recovery "that had been implicit" since Tuke's era of moral treatment a century earlier. While the terminology was modified to allow for some notion of recuperation (as opposed to cure), Kraepelin's insistence on the superiority, and rarity, of recovery as cure, "maintained the foundational principle of inevitable deterioration along with its attendant pessimism" (Jacobson, 2004, p. 48). Further, the designation of 'practical' recovery as entailing 'defect', or 'scarring' relegated the more prevalent type of recovery, and unfortunately those able to achieve it, to the category of 'less than.' The ramifications of Kraepelin's and Blueler's pathologizing legacies persist.

In a beautiful turn of poetic justice, it was Bleuler's grandson that helped dispel the original fatalistic views of his grandfather. His research based on longitudinal studies showed a constant alternating between recuperation, improvement and deterioration, with long-term trends of significant improvement (Jacobson, 2004, p. 59). It is worth noting that some of the inspiration of the Consumer/Survivor/Ex-Patient Movement arose in defiance of the long-term pessimistic Kraepelian legacy perpetuated in the traditional mental health system

After World War II, advances in neuroscience, together with the development of the psychopharmaceutical industry, combined to cast mental illness as a biomedical disorder. The new drugs "promised to cure all but the most severe cases of mental illness. As a result, asylums were recast as hospitals where mental illness was equated with physical illness" (Everett, 1994, p. 59). The success of the new psychotropics was defined – and measured- by the absence or

abatement of symptoms, and "affected the climate of opinion in mental health care in a way that carried beyond their definitively proven value as medical application" by providing hope with respect to the chronically mentally ill, and by promoting "psychiatrists to physicians in the eyes of some of their colleagues, and the insane to the status of patients of many members of the public." This change in both the professional and public perception was due to a "change in the apparent nature of mental illness because of the efficacy of drug treatments . . . the disorder now seemed to belong . . more in the biochemical realm of modern science" (Rochefort, 1994, p. 6). This "operationalizing of cure as an improvement in symptoms" (Jacobson, 2004, p. 48), this time via medication, recapitulates several of the recurrent themes of the previous sections. The "portrayal of recovery as a real, discrete event characterized by the presence or absence of certain objective disease indicators" (Jacobson, 2004, p. 48-49) is reminiscent of the Moral Treatment era's equating cure with a singular event. The operational definition and identification of recovery as symptom abatement again rests with those— the drug companies and prescribing psychiatrists in this instance—profiting from those designations. Agency again continues to be denied to those experiencing mental illness, with the power to bring about recovery now shared between the administering doctor and a pharmaceutical substance.

The widespread use, and public perception of the success of psychotropic drugs, in treating mental illness was one of a number of factors contributing to the deinstitutionalization movement beginning in the 1950s, and shift in public opinion and policy towards community mental health centers (Davidson *et al*., 2010; Jacobson, 2004; Rochefort, 1984, 1988; Slade, 2009). Other factors contributing to the push for deinstitutionalization included: the far-reaching impact of the civil rights and liberation movements; public outrage concerning different exposes of the 'snake-pit' conditions within institutions; and the fact that "asylums had become money-

guzzling millstones and politicians longed for a cheaper alternative" (Heseltine, 1983, cited in Everett, 1994, p. 59). By 1971, hundreds of thousands of former mental health patients were released back to families or into communities that didn't want them, without adequate funding or services to support their needs. Exacerbating the problem was the fact that "psychotropic medication failed to produce the promised cures and as a result, thousands of people found themselves persistently psychotic, frightened and alone (Everett, 1994, p 59). Finding themselves in the community but not welcomed by it, and suffering from "a loneliness that humbled the spirit," groups of formerly institutionalized people began to meet in small groups (Campbell, 2005, p. 21). Deinstitutionalization thus unwittingly created "the structural conditions for mental patients to collaborate" by enabling those who had been institutionalized in various parts of the country (and world) to "come together, discuss their individual experiences, learn from one another, and put forward their ideas about how the mind works" (Hornstein, 2009, p. 165). Free from "the extremes of oppression within asylums (that) drove people apart while deinstitutionalization released them so that they were free to join in protest", former mental health patients "were well equipped to organize and lead their own protests, the consumer and psychiatric survivor movement" (Everett, 1994, p. 63 and p.61).

# CHAPTER III

## The Emergence of the C/S/X Movement and the Redefining of Recovery: Recovery As Experience

"Revolutions begin when people who are defined as problems achieve the power to redefine the problem" (McKnight, cited in Davidson & Tondora *et al*., 2007, p. 23).

"The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings" (Deegan, 1996, p. 92).

Beginning in the early 1970s, and coalescing out of a shared anger stemming from "the neglect, dehumanization, and outright brutality . . . experienced at the hands of the mental health system" (Chamberlin, 1978, p. xvi), "diverse groups of self-identified mental patients in different parts of the United States began to meet and develop strategies to change their status from powerless victims to agents of change" (Bassman, 1997, p. 238; Freese & Davis, 1997). Out of these groups emerged the psychiatric survivor/ex-patient movement (the precursor to what is now known as the C/S/X Movement), whose presence constituted the first time that those who had experience with, and treatment for, mental illness effectively joined together in demanding a voice in the social discourse on mental illness, recovery, and the mental health system. Realizing that "recovery as a concept . . . implicitly contains both an understanding of a problem and a solution to a problem" (Jacobson, 2004, p. xvii), including "a discussion and definition of what people were recovering from" (Onken, Craig, Ridgeway, Ralph & Cook, 2007, p. 10), members

of this nascent social movement set out to redefine the problem of mental illness. In doing so, they altered the social discourse around recovery, and power dynamics within the extant mental health system as well.

Inspired by the liberation rhetoric and political ideology of other social movements of the 1960s and 1970s, (the women's liberation and civil rights movements in particular) (Chamberlin, 1978, 1994; Clay, 2005; Everett, 1994, 2000; Davidson *et al.,* 2010; Slade, 2009), these "groups of 'ex-patients' and 'psychiatric survivors' used consciousness raising as a mechanism first for recognizing and naming their oppression (including the internalized oppression of self-stigma and the 'false consciousness' of insight') and then for placing this oppression in a larger social context" (Jacobson, 2004, p. 64). Consonant with these other social liberation movements, the psychiatric survivor/ex-patient movement was radical, "with a decidedly militant viewpoint against psychiatry and the established mental health system" (Van Tosh, Ralph, & Campbell, 2000, p. 384). The most militant and vocal members completely denied the existence of mental illness, and set their initial goals to "create a Liberation Movement – not to reform the mental health system – but to close it down" (Bluebird, p. 2-3). Language was an important instrument of consciousness-raising. Identifying themselves in opposition to the extant mental health system, this early militancy was reflected in the names of the initial groups that met throughout the United States; The Insane Liberation Front, the Mental Patients' Liberation Project, Psychiatric Patients' Liberation Movement, The Network Against Psychiatric Assault, the Psychiatric Survivors' Movement (Chamberlin, 1978, 1994; Jacobson, 2004; Van Tosh *et al.,* 2000).

Language also was used to highlight the ways in which the pervasive stigmatization of mental illness permeated the culture, reifying and perpetuating the stereotypes. Joining the

practice of other marginalized groups, the movement coined its own terms – 'mentalism' and 'sane chauvinism' (paralleling civil rights activists' 'racism' and the feminists' 'male chauvinism' and 'sexism'), exposing the degree to which words like "sick and crazy are widely used to refer to behavior of which the speaker disapproves" (Chamberlin, 1978, p. 66). In addition, they claimed as their own labels and language that in the past had been used pejoratively ('madman', 'nuts', 'insane'), analogous to the GLBQT Movement's reclamation and celebration of the word queer. Lastly, they demanded their full rights as citizens (Jacobson, 2004, 64; Jacobson & Curtis, 2000).

Believing that "power, not illness or treatment, is what the system is all about", and more particularly, that unequal power relationships "are at the heart of the present mental health system" (Chamberlin, 1990, p. 325), the movement organized its activities around the principles of self-help and advocacy (addressed in greater detail in Chapter IV) to redress the power imbalances inherent in the extant mental health establishment (Bluebird; Chamberlin, 1987, 1990; Jacobson, 2004; Van Tosh, *et al,* 2000; private conversation with Lyn Legere, April 4, 2011). The movement addressed the issue of power within the system by challenging the notion of expertise, and more specifically, the historical notion of expertise residing in the professional, whose "credentials conferred the power to name, to decide, and to act" (Jacobson, 2004, p. 67). Asserting that the affected individual's experience constituted "the most valid measure of whether a particular treatment is helpful or harmful" (Chamberlin, 1978, p. 68), 'lived experience' was recast as conferring expertise, not only with respect to "judging treatment effect" but also to "encompass the ability to define the problem, to choose the nature, extent, and timing of treatment, and to decide what constituted a successful outcome" (Jacobson, 2004, p. 67). The validation and privileging of lived experience as expertise brought into the discourse for the first time the voices of those who previously had been excluded, "rather than interested others acting

on their behalf" (Everett, 1994, p. 63). The ability to name what was for them 'problematical' about their experience of and with mental illness enabled these former patients to shift the discourse with respect to defining the 'problem' of mental illness, and by implication, the notion of recovery.

Historically, medical and mental health professionals considered symptoms to be the manifestation, and thus problem, of mental illness; recovery, equated with cure, was operationalized in symptom abatement or alleviation (see Chapter II). The new discourse divorced the issue of symptomology from the notion of recovery. Large proportions of "consumers/survivors attributed the most value to services that improved their quality of life and rated treatments designed to reduce symptoms as less important than self-esteem, housing and meaningful work" (Bassman, 1997, p. 240). One "can still have symptoms, but the hallmark of genuine recovery is the individual regaining control of his or her life and filling valued social roles" (Fisher & Chamberlin, 2004, p. 4). For many, requiring remission of symptoms before being allowed to participate in normal rhythms and activities of life cut them off from a vital avenue of or to recovery (Davidson, 2003; Davidson, Stayner, Nickou, Rowe & Chinman, 2001; Davidson, Shahar, Lawless, Sells, & Tondura, 2006; Leff & Warner, 2006; Slade, 2009).

For those with lived experience of mental illness, the most salient aspects of their experience have not been the symptoms but the iatrogenic traumatic effects of treatment by the mental health establishment, and the enduring impact of stigma and "the deviant status imposed by society" (Onken *et al*., 2007, p. 10). Indeed, many "who are recovered or recovering from their experience of being diagnosed and treated for major mental illness . . . believe it to be more difficult to recover from the treatment than the original condition" (Bassman, 1997, p. 241; Onken *et al*., 2007). Thus, recovery entails not only the process of recovering from mental

illness, but also overcoming the effects of being or having been a mental health patient, including rejection by society, recovering from the effects of poverty (including substandard housing and unemployment), second class citizenship, internalized stigma, loss of valued social roles and identity, and "abuse and trauma sustained at the hands of some 'helping professionals', and the spirit breaking effects of the mental health system" (Davidson, 2003; Deegan, 1987).

Since the late 1990s, there has been "a proliferation of all things recovery" (Jacobson, 2004, p. 150), including extensive literature describing the new conceptualizations of recovery, much of it written by those with lived experience, and based on evidence from both research, and anecdotal experience. Perhaps the most salient aspect of recovery is that it is a deeply personal, unique, descriptive rather than prescriptive "process, not an outcome, and that each individual defines recovery in his or her own terms" (Clay, 2005, p. 12-13; Bassman, 1997; Deegan, 1988); recovery does not represent "a cure, like an endpoint, but a state of being and becoming, a path rather than a destination" (Jacobson & Curtis, 2000, p. 335). The experience of recovery varies, not only among different people but also at different times in their lives (Bassman, 1997).

While each journey of recovery is unique, the following shared elements emerge from the extensive consumer literature, as well as literature reviews (Davidson, O'Connell, Tondora & Lawless, 2005; Jacobson & Curtis, 2000; Ralph, 2000; Young & Ensing, 1999). For many, "empowerment and recovery are virtually inseparable" (Bassman, 1997, p. 240; Deegan, 1997; Fisher & Chamberlin, 2004; Jacobson & Curtis, 2000; Slade, 2009); empowerment, hope, self-determination, and choice have been described as essential to recovery (Fisher & Chamberlin, 2004). While the term 'cure' does not appear in the literature, and indeed most consumers/survivors "don’t share the psychiatric faith that the 'cure' to 'mental illness' is soon to be found" (Chamberlin, 1978, p. xvi), the Empowerment Model of Recovery asserts that "people

with mental illness can completely recover by taking control of the major decisions of their lives and thereby assuming or resuming major social roles" (Fisher & Chamberlin, 2004, p. 4). Recovery is "active and requires that an individual take personal responsibility for his or her own recovery" rather than being a passive recipient of services (Jacobson & Curtis, 2000, p. 335). The ability to construct a life with personal "meaning . . . purpose and direction", however one defines that meaning, also emerged as a key theme (Jacobson & Curtis, 2000, p. 336).

Private conversations with individuals with lived experience of mental illness confirm the critical importance of individual choice, self-determination, hope, confidence and dignity, and the ability to live a full and meaningful life, irrespective of having to live with symptoms.

# CHAPTER IV

## Mental Health Self-Help and the Evolution of Peer Support: Recovery in Practice

The C/S/X Movement altered social discourses concerning mental illness, recovery and the power dynamics within the extant mental health system through the very act of challenging existing discourses, and in bringing forth new conceptualizations of recovery. In the process, the C/S/X Movement emerged as a "collective political force that has effectively joined societal debates about the future of mental health services for people with psychiatric disabilities" (Davidson, 2003, p. 380).

Advocacy and self-help are foundational principles underlying the C/S/X Movement's work to change the mental health system to reflect the reconceptualization of recovery. They reflect differing ideological stances amongst those in the C/S/X Movement. The more radical militant members, rejecting the notion of mental illness and thus the need for any mental health system, gravitated towards advocacy work promoting political changes in laws and practices "which induce discrimination towards individuals labeled 'mentally ill'" (Chamberlin, 1990, p. 329). These include such practices as 'forced treatment', considered a contradiction in terms (Bassman, 1997) and involuntary commitment.

On the more 'moderate' end of the spectrum were those seeking to mitigate the iatrogenic effects of traditional mental health treatment by calling for "compassionate alternatives to the mental health system" (Clay, 2005, p. xi). Comprising "equally strong voices among the

protesters who focused on self-help (defined as both personal and interpersonal help), and people's needs for supportive services", the notion of "ex-patient run alternatives was being conceived during this same period" (Bluebird, p. 2). In trying to promote a "recovery culture, peer support" was "seen as the central focus of the services and supports" (Fisher & Chamberlin, 2004, p. 4), with "extraordinary value" placed on " hope and recovery" (Van Tosh *et al.,* 2000, p. 393). Inspired by Alcohol Anonymous' prototype of peer-facilitated recovery, peer support became "the core and mainstay of any consumer-run program" (Clay, 2005, p. 12). Considered "one of the greatest contributions of the mental health consumerism movement" due to "the "impact they have had on the lives of thousands of consumers of mental health services" (Van Tosh, *et al*., 2000, p. 389), by 2006 the number of services for and run by peer-based groups, programs and organizations almost doubled those of traditional mental health organizations run by professionals (Goldstrom, Campbell & Rogers, 2006).

The following description of some underlying principles of 'mental health peer support' provides a foundation for this chapter's examination of the evolution of peer support in the C/S/X Movement. In the context of mental health, and this paper, *peer* refers to an individual who has personal lived experience of and treatment for a mental illness, and who has acknowledged it publicly (Clay, 2005; Chamberlin, 1978; Mead, 2005; Salzer, 2010). *Peer support* involves "an intentional relationship between individuals with mutually perceived similarities based on personal characteristics and experiences and the open acknowledgment and sharing of these experiences" (Salzer, 2010, p. 169). Peer relationships are based on the *peer principle*, characterized by reciprocity, mutuality, and "equality (versus the traditional unidirectional provision of professional services), along with mutual acceptance and unconditional respect" (Clay, 2005. p. 11; Mead, 2005). The corollary *helper's principle* reinforces the mutuality and

reciprocity of the exchange via "the notion that helping others facilitates one's own recovery. Peer support is a two-way process" (Clay, 2005, p. 264).

Peer support programs have been "at the cutting edge of exploring new practices. They are grounded in the knowledge that neither person is the expert, that mutually supportive relationships provide the necessary connections, and that new contexts offer new ways of making meaning" (Mead, Hilton & Curtis, 2001, p. 4). Mental health services users are drawn to the peer support model for various reasons, often linked to the validation and normalization of their experiences. Peer relationships are '"based on non-judgmental attitudes towards each other's problems. They don't pathologize, they focus on what might help someone to cope better with a specific challenge" (Hornstein, 2009, p. 205; Barnes & Shardlow, 1996). This includes considering members' feelings, particularly feelings of anger toward the mental health system, to be real and legitimate, not symptoms of illness (Chamberlin, 1978, 1994). Peer support provides a living role model of recovery, with the "value of being able to see that someone else is recovering, and that you can do it too. This was a way of challenging the prevailing assumptions of providers, and of the medical establishment, that you would be this way for the rest of your life" (Private conversation with Lyn Legere, April 4, 2011). Engaging in these mutually supportive peer relationships also provided opportunities to play valued social roles, increased feelings of self-efficacy, empowerment, and served as a mechanism for learning how to operate in the world, thus becoming a vehicle of their own recovery process (Mead, 2005, p. 17-18). In so doing, participants began to acquire social capital that had been lost due to their experiences with mental illness.

Shery Mead, a leading peer advocate, educator and author, contends that the political dimension of mental health peer support "grew out of a civil/human rights movement in which

people affiliated around the experience of negative mental health treatment . . . the shared experience has had more to do with responses to treatment than the shared experience of mental illness" (Mead 2005, p. 119-120; Barnes & Shardlow, 1996), in essence paralleling the C/S/X Movement's reconceptualization of mental illness and recovery. Thus, beyond building on the customary peer-based foundations of shared experiences and providing a role model of recovery, peer support in mental health incorporated an intentional development of critical self –awareness and a social and political identity, goals consistent with the origins of the C/S/X Movement. Starting with "the basic assumption that meaning and perception are created within the context of culture and relationships . . . Our self-definition, how we understand and interpret our experiences and how we related to others is created and developed from the direct and indirect messages we get from others and the messages we get from dominant cultural beliefs and assumptions" (Mead, 2005, p. 15). Exploring and questioning the epistemological roots and implications of those messages, intentional peer relationships help individuals "begin to understand change and learning not as an individual process, but rather one where we continuously construct knowledge from actions and reactions, conversations and the on-going building of consensus. Rather than thinking about personal symptom reduction we are talking about real social change" (Mead, 2005, p. 16).

The remainder of this chapter examines the evolution of peer support, from the loosely organized mutual support groups of the 1970s (based on symmetrical and reciprocal relationships) to a wide range of more structured, less reciprocal and more 'professionalized' peer roles, culminating in the position of Certified Peer Specialist. *On our own, together: Peer programs for people with mental illness,* a four-year federal study of the workings of peer-run programs written "by and for people who have experienced what is generally known as 'mental

illness'" demarcates this evolution into three distinct periods; separatism, inclusion, and vision of recovery (Clay, 2005). The developments within these periods not only have mirrored, but have also precipitated, developments and tensions in the wider C/S/X Movement.

**Separatism**

Eschewing the traditional mental health system's 'culture of illness' relying on psychiatric models or diagnostic criteria permeating the traditional mental health system, (Curtis, 1999, cited in Mead, Hilton & Curtis, 2001, p. 7) and propelled by the "desire and drive to develop alternatives to a system that had been demoralizing, stigmatizing, and at the hands of which they suffered" (Van Tosh *et al*., 2000, p. 385), the earliest mental health self help groups in the 1970s excluded all non-patients (including sympathetic professionals). Drawing inspiration from other extant liberation movements, among the major organizing principles of these groups were

> self-definition and self-determination . . . As these groups evolved, they moved from defying (sic) (defining) themselves to setting their own priorities. To mental patients who began to organize, these principles seemed equally valid. Their own perceptions about 'mental illness' were diametrically opposed to those of the general public, and even moreso to those of mental health professionals. It seemed sensible, therefore, not to let non-patients into ex-patient organizations or to permit them to dictate an organization's goals. (Chamberlin, 1990, p. 324)

Taking warning from previous mental health self-help groups' experiences with 'partnerships' with non-patients, there were also

> practical reasons for excluding non-patients. Those groups that did not exclude non-patients from membership almost always dropped their liberation aspects and became

> reformist. In addition, such groups rapidly moved away from ex-patient control, with the tiny minority of non-patient members taking leadership roles and setting future goals and directions. These experiences served as powerful examples to newly-forming ex-patient organizations that mixed membership was indeed destructive. (Chamberlin, 1990, p. 324)

Despite a wide range in structure, the initial self-help peer-run groups primarily were run and operated by former mental health patients, independent from the provider organization (including the administration, control of the board of directors, staff, budget and activities) and more loosely organized into mutual support groups and drop-in centers (Clay, 2005, p. 7).

**Inclusion**

Throughout the 1970s, the expanding activities and visibility of peer-run groups drew increasing attention from government groups and agencies, as well as mental health professionals and organizations. In 1976, a 20-member President's Commission on Mental Health acknowledged that "groups composed of individuals with mental or emotional problems are being formed all over the United States" (President's Commission on Mental Health, 1978, cited in Van Tosh *et al*., 2000, p. 388). By the 1980s, the federal government "began to take notice that ex-patients were organized and that they were operating successful programs independently without funds or outside support"; the National Institute of Mental Health began funding alternative programs through its new Community Support Program (Bluebird, p. 3; Chamberlin, 1990; Clay, 2005). While the original radical members of the C/S/X Movement maintained their stance of refusing to partner with the mental health establishment or accept money from the government, the more moderate founding members, as well as the expanding membership resulting from the increased government and popular attention, began to "sit at the

policy-making tables in order to have a voice and to get funding for drop-in centers and other types of alternative programs" (Bluebird, p. 3). Building a national presence within the public mental health sector, a growing number of peers was participating in planning, research and evaluation of public mental health services (Van Tosh, *et al*., 2000). Originally intentionally separate from traditional mainstream mental health systems, peer support systems " began to develop partnerships with traditional mental health providers" (Campbell, 2005, p. 27), with an increasing number employed in designated positions to provide a range of peer services based less on pure reciprocity. This development exacerbated extant tensions within the movement between the survivor/ex-patient 'liberation' and the more moderate 'reform' ideologies, symbolized, perhaps, by the entrance of the term 'consumer' into the mental health lexicon. For a movement that comprehended, and used, the power of language to reclaim their identity, the term 'consumer' was polarizing. In 1985, the National Alliance of Mental Patients (currently known as the National Association of Psychiatric Survivors) was

> formed specifically to counter the trend toward reformist 'consumerism,' which developed as the psychiatry establishment began to fund ex-patient self-help. Ironically, the same developments which led to the movement's growth and to the operation of increasing numbers of ex-patient-run alternative programs, also weakened the radical voice within the movement and promoted the view of the far more cooperative 'consumer'. The very term 'consumer' implies an equality of power which simply does not exist. (Chamberlin, 1990, p. 331)

It is significant to note that the term 'consumer' never has been embraced by the peer community. Coined by the provider community seeking to "cast peers in relation to providers

rather than in relation to the system", and subsequently adopted by the U.S. Government agencies working with the peer community, repeated use of 'consumer' in government reports and documentation has brought the term into *de facto* parlance (Private conversation with Lyn Legere, April 21, 2011). The movement (originally known by some as the Survivor/Ex-Patient Movement) now became the Consumer/Survivor/Ex-Patient, or C/S/X, Movement, with the term 'consumer' becoming the catch-all designation for people with a history of mental illness.

**Vision of Recovery**

The confluence of several factors in the 1990s led to the emergence of increasingly formalized uses of peer support in traditional mental health settings (Brown & Wituk, 2010; Davidson *et al.,* 2006; Jacobson, 2004; Salzer, 2010.) Adopting the South African disability slogan, "Nothing About Us Without Us", "people with mental illness began to organize nationally around issues of empowerment and strengthening the consumer voice" (Chamberlin, 1997, cited in Campbell, 2005, p. 25), with some consumer/survivor leaders beginning to advocate for consumers to be included in the administration, provision, and evaluation of mental health services as a means of reforming the mental health system (Campbell, 2005). At the national level of government, the term 'recovery' was increasingly "adopted by the mainstream organizations that make up the mental health establishment" (Jacobson, 2004, p. 152), including in 1999 the first-ever Surgeon General's Report on Mental Illness, and culminating in the 2003 final report of the President's New Freedom Commission on Mental Health. The latter had solicited input from consumer/survivor leaders on a Consumer Issues Subcommittee of the Commission (Jacobson, 2004, p. 153; Fisher & Chamberlin, 2004; Van Tosh *et al*., 2000) which was reflected in the Commission's final report's assertion that consumers will play a significant role in shifting to a recovery-oriented mental health system by participating in planning,

evaluation, research, training and service delivery (U.S. Department of Health and Human Services, 2003). Government agencies began to integrate "consumer/survivors in the development of training materials, research projects, in meetings on mental health issues and special initiatives" with the result that facilities began to "recognize the ability of persons in recovery to help transform systems into environments that replace historically rules-based treatment with treatment and environments that promote empowerment, hope, respect and healing" (Bluebird, p. 3)

At the state level, "the introduction of recovery concepts into mental health policy . . . coincided with a shift towards a managed care approach to services financing and system accountability" emphasizing measurable treatment outcomes, as well as "obtaining federal waivers to shift their Medicaid populations into managed care models of care delivery" (Jacobson & Curtis, 2001, p. 4; Jacobson, 2004, p. 155-156). Thus, "consumer/survivor's knowledge and experience of recovery became a sought-after commodity in a market that has demanded accountability as measured by outcome" (Van Tosh, 1993, cited in Bassman, 1997, p. 239). This "significant evolutionary step in the involvement of peers-as-staff in the traditional service system programs, and workforce" was taken when the "status and funding stability of peer support services took a revolutionary turn in 2001 when Georgia became the first state to specifically identify peer support as a Medicaid-fundable service" (Sabin & Daniels, 2003, cited in Salzer, 2010, p. 170). This new position, 'Certified Peer Specialist', required successful completion of a training program (determined by the individual state); currently six states receive Medicaid reimbursement of Certified Peer Specialist services and over 28 states offer Certified Peer Specialist Training Programs (Salzer *et al.,* 2009; Salzer, 2010, p. 170).

In Massachusetts, the Boston-based Transformation Center has been responsible since 2006 for all aspects of the Certified Peer Specialist (CPS) Training Programs within the state, the only completely consumer-operated organization in the country to do so. Lyn Legere, the Transformation Center's Director of Education and chiefly responsible for the state's CPS Training Programs, lists the three mutually-supporting "core competencies" of the CPS position: "Peer Support", "Change Agent", and "In But Not of the System." The CPS role encompasses two elements rooted in the C/S/X Movement's enduring organizing principles of advocacy (change agent) and self-help (peer support), and in doing so attempts to unite in one position the more radical (survivor) and more moderate (consumer) ends of the ideological spectrum of the C/S/X Movement. According to Legere, the Certfied Peer Specialist also is intended to have an impact on not only those using mental health services, but also the traditional provider organizations in which the CPS are employed (Legere, 2010, p.1-3). Thus, what distinguishes the CPS from its predecessors, according to Legere, is its role in bridging not only those two functions and ideological factions *within* the C/S/X Movement, but also *between* the movement and the extant traditional, hierarchical mental health systems in which they now work ("in but not of the system"). While the ideological implications of this are explored in Chapter V, functionally this means that the CPS role "is designed to stand out in its difference from traditional roles", neither duplicating nor aspiring to perform traditional mental health functions. "The Certified Peer Specialist is not a stepping stone to being a traditional provider. Once you become a more senior Certified Peer Specialist, it does not morph into another more traditional provider role. That implies that you are going through this just to be able to get a more 'professional' degree . . . the skills, paradigm, way of relating are different." Rather, Legere sees the value of the CPS model as having the possibility of moving the traditional model based on

professional and academic expertise model closer to the peer model of mutuality (Private conversation with Lyn Legere, April 21, 2011).

This "development of peer-based interventions outside of mutual support and peer-run program settings . . . has served to bring peer support closer to the mainstream of mental health practice", (Davidson & Chinman, *et al*., 2006, p. 444), exacerbating old divisions within the C/S/X Movement, and causing some backlash against the CPS position and the rigorous CPS Training Program. Even amongst those instrumental in pushing for Certified Peer Specialist designation, the following concerns have emerged. Certified Peer Specialists often are under or poorly utilized, given the premise of the CPS position and the rigorous training program. Many who have undergone the training and passed the rigorous exam either have not found employment, or have seen little change in their employment status resulting from the certification. In different states, adherence to rigorous, objective testing standards and procedures deemed necessary to maintain the integrity of the program with state sources of funding, has resulted in the inability of at least one of the long-time instrumental members of the C/S/X Movement to pass the final exam, bringing resentment within the community, along with concerns that CPS Training Program was replicating traditional hierarchical power structures rather than following tenets of the C/S/X Movement (based on private conversations with Certified Peer Specialists, and Lyn Legere). Finally, the increasing professionalization of peer support and "shift from reciprocity to receiver of care has been the source of considerable tension and debate within the consumer community, as peer staff have been viewed with varying degrees of suspicion concerning their having potentially been co-opted by the mental health system" (Davidson & Chinman, *et al*., 2006, p. 444).

The final chapter will explore some of the ideological implications of the third "core competencies" of the Certified Peer Specialist Position: "In But Not of the System."

# CHAPTER V

## Conclusion: In But Not Of the System

The rise of the consumer/survivor movement, its success in challenging the extant mental health system, and its shifting the language of and approach to recovery in mental health, provides a salient illustration of "how different discourses combine under particular social conditions to produce a new, complex discourse" (Fairclough, 1992, p. 4). As is true of much social discourse, power is the "disguised subtext of mental health discourse" (Everett, 2000, p. 60; a view shared by Bassman, 1997; Chamberlin, 1978, 1990; Everett, 1994; Fisher & Chamberlin, 2004; Mead, 2005; Slade, 1996). Norman Fairclough distinguishes between "power-in-discourse" and "power-over-discourse": the former involves the power to determine the terminology and rhetoric used in discussing either the historical or current situation; the latter concerns the longer-term "capacity to control and change the ground rules of discursive practices, and the structure of the order of discourse" (Fairclough, 1997, p. 273). These issues provide a backdrop for examining the shift in language from the original slogan "Nothing About Us Without Us!" to the current "In But Not of the System," reflecting what the movement has achieved, where it may be headed, and the challenges it faces.

Since the 1990s, increased and continuing presence of members of the C/S/X Movement at and participation in mental health policy fora, the changing focus in traditional mental health culture to recovery-oriented care, and increased acceptance of peer-provided services within traditional mental health facilities, (including the Medicaid-reimbursable position of the Certified

Peer Specialist) point to significant progress made in reaching the goals of the consumer/survivor movement's initial slogan: "Nothing About Us Without Us!" These achievements appear congruous with a primary tenet of the 'New Social Movements': symbolic change, often in the form of language and 'presence' (or representation) is an important precursor to real change (Melucci, 1989, cited in Everett, 1994, p. 61), while "Real change is expected to accrue over time, as members slowly make their presence felt" (Everett, 1994, p. 63).

The C/S/X Movement's success in shaping the rhetoric of, and securing their presence in, mental health discussions suggests their progress in achieving what Fairclough would identify as "power-in-discourse". However, what Fairclough would term the "power-over-discourse" remains under question; while it "appears that the new participants have shaped the rhetoric of reform . . . it remains to be seen if they can affect the reality" (Everett, 1994, p. 55). Having 'won' the initial struggles for symbolic change, what will happen when "the gaze of the government . . . rests upon these erstwhile outcasts, elevating their ideas and language to the exalted level of a guiding political discourse?" (Everett, 2000, p. 61). This final section addresses some of the ramifications of that 'government gaze' for the C/S/X Movement in the context of the slogan describing the Certified Peer Specialist position: "In But Not of the System."

The slogan "In But Not of the System," seems to reflect challenges brought with increasing government involvement (the "gaze") in the movement's work, as well as the internal challenges arising from the movement's greater collaboration with the government/mental health professionals in working towards establishing a recovery-oriented mental health system. For a movement that uses language politically and intentionally, the slogan appears not only an attempt to bridge (noted by Lyn Legere in the previous chapter) but also to remain credible in, not only the two worlds of the C/S/X Movement and the traditional purveyors of power in the mental

health system, but also within the C/S/X Movement itself. Regarding the former, the slogan appears to demarcate the presence and integrity (meaning both ethical/moral values and 'structural soundness') of the C/S/X Movement in relation to the traditional mental health providers, professionals and government agencies. With respect to divisions within the movement, "in" (the system) addresses the interests of the reformist 'consumer' end of the spectrum, while "but not of the system" suggests an attempt to assuage the concerns of the more radical survivor end of the spectrum's concerns of co-option by the system.

These are twin concerns shared by many social movements (Everett, 2000, p. 59-60). Internally, social movements are vulnerable to divisions and acrimonious polarization; the C/S/X Movement, by its own report as well as those of others, has seen its fair share of internecine feuding (Clay, 2005; Chamberlin, 1994; Davidson, 2006; Everett, 1994, 2000). Externally, they are vulnerable to being "pre-empted, meaning that their language is appropriated but real change never occurs" (Goldberg, 1991, cited in Everett, 2000, p. 60), or co-opted, being offered a "presence," participation or even 'partnership', which brings involvement in the process, with little beyond symbolic power (Leonard, 1994, cited in Everett, 2000. p. 60.) The issues of internal divisions, language appropriation (particularly with respect to the meaning of 'recovery' and use of the term 'consumer'; as well as concerns regarding 'co-option' of the movement (including the view that any cooperation 'with the system', including the new CPS, position and the collaboration preceding it, dovetails with the consumer agenda but ignores that of the survivor) have been the subject of extensive review (Bassman, 1997; Chamberlin, 1978, 1994; Clay, 2005; Fisher & Chamberlin, 2004; Slade, 2009).

It is beyond the scope, or intent, of this paper to draw any conclusions regarding pre-emption or co-option; this is a descriptive rather than prescriptive look at the still-evolving

construct of the discourse surrounding 'recovery' and its embodiment in the C/S/X Movement. However, if power is indeed the "disguised subtext of mental health discourse" (Everett, 2000, p. 60), what, if any, are the implications of being "in but not of the system"?

Skepticism has been expressed from inside the movement regarding the feasibility of providing credible peer support while being "in but not of the system": "While empowerment and self-advocacy are important tools one can learn from a peer provider, it is not likely that a conversation may entail the 'deconstruction' of the client's experience. One can't both work for the medical system and refute its very foundation . . . it is important that we don't lose sight of true peer support in our efforts to 'legitimize' it" (Mead, 2005, p. 128). Others have raised concerns that being "'In, but not of the mental health system' . . . leaves the peers near, but not at the table for major policy decisions; within sight of, but without true power to make change . . . If you don't want to be of it, don't be in it" (Shuer, 2010, p. 1).

This brings the discussion back to Fairclough's concept of "power-over-discourse," and whether it is possible to achieve power 'over' the discourse if one is "in but not of the system" in which the discourse is taking place. At this juncture, a "complete history of the mental patients' liberation movement is still to be written" (Chamberlin, 1990, p. 323), and the movement is still evolving. The dual role of Certified Peer Specialist (both providing peer support as well as of attempting to move the traditional expertise model closer to the peer model of mutuality) may best be understood as a current snapshot of a system and paradigm in flux. Rather than jockeying for power 'over' the system, perhaps it represents an attempt at sharing power 'within' the system, with the result echoed in noted advocate and author Patricia Deegan's words:

> They tell you that your goal should be to enter the mainstream. Don't enter the mainstream. Tell the mainstream to grow wider and more inclusive. We want a

'widestream,' not a 'mainstream' . . . our task is not be become normal. The task is to take up your journey of recovery and to become who you are called to be. (Deegan, 1997, p. 23-24)

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