

**Dimensions of Meaning-Making Among Serious Mental Illness to Inform Mental Health
Services, Clinical Practice and Public Policy Approaches in the United States.**

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ABSTRACT

Aim

The aim of this study is to examine how contemporary scholarship conceptualizes meaning-making among individuals with serious mental illness (SMI), with particular attention to schizophrenia. The study seeks to identify how meaning-making is described, facilitated, and operationalized within therapeutic frameworks, and to analyze gaps in the literature that hold implications for recovery-oriented systems of care and public policy in the United States.

Background

Recovery has become the central organizing framework in U.S. mental health policy, formalized through SAMHSA's Ten Principles of Recovery and its Four Dimensions of Recovery. Despite similar recovery models across high-income countries, meaning-making remains inconsistently defined across clinical and academic literature. Historical shifts in mental health care, including deinstitutionalization and neoliberal policy reforms, further shape the structural context in which meaning-making occurs.

Methods

A systematic review was conducted following PRISMA 2020 guidelines. Searches were performed through the University of Washington Libraries using the terms “schizophrenia and meaning making”, and filtered for peer-reviewed English-language articles published between 2016 and 2026. Fifty-three articles were identified; after applying inclusion and exclusion criteria, focusing on studies involving insight into illness, existential distress, and therapeutic engagement, and ten articles were retained for full review. Articles from low-income countries were excluded to maintain policy comparability across high-income nations with established disability systems.

Results

Four central themes emerged. 1) therapeutic approaches such as Dignity Therapy, Humanistic Psychiatry, and Open Dialogue Therapy support meaning-making by centering narrative identity, existential reflection, and relational dialogue; 2) meaning-making is nonlinear and deeply shaped by extrinsic supports; familial connection consistently facilitated recovery, while loneliness, stigma, and economic precarity hindered it; 3) studies rarely incorporated recovery policy or structural determinants such as poverty or downward economic mobility despite their documented influence on recovery trajectories; and 4) post-traumatic growth and identity reconstruction were common outcomes, with hospitalization and psychosis often described as traumatic events that disrupted but also reshaped self-understanding. Across studies, recovery was characterized not as symptom reduction but as an existential, social, and narrative process requiring dignity, agency, and opportunities for meaning-making. Policy recommendations rest on best practices for a holistic, integrated study and view of intrinsic and extrinsic support, alongside standardized definitions for what characterizes and facilitates recovery for a more comparable view and for pathways towards policy advocacy.

CHAPTER 1 – PURPOSE OF THE STUDY

Over the past several decades, *recovery* has emerged as the central organizing framework in U.S. mental health policy. With the publication of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Ten Principles of Recovery in 2010, the field gained a formalized definition anchored in concepts such as hope, person-driven change, multiple pathways, holistic care, peer support, relational connection, cultural awareness, trauma responsiveness, strengths, responsibility, and respect (*About Recovery*, 2024). SAMHSA positions these guiding principles as the foundational values and conditions that shape recovery-oriented practice, while its Four Dimensions of Recovery (health, home, purpose, and community) serve as the structural pillars that describe the core elements necessary for sustaining a life in recovery. Both the principles and pillars SAMHSA has adopted encapsulate overlapping components and definitions of recovery found in a recent systematic review done by Ellison et al. (2018). These 4 critical components are “individualized/person centered”, “empowerment”, “purpose” and “hope”.

Like the concept of recovery, meaning-making itself is multifaceted and cannot be reduced to a single construct. Across the literature, it is variously described as a process of reformulating identity, reestablishing personhood, cultivating purpose, mitigating existential distress, and identifying psychosocial markers that support recovery. It is inherently subjective and shaped by lived experience, particularly given for instance the heterogeneity of SMI; consequently, no singular definition captures its full complexity. Qualitative studies that center around lived experience are therefore essential for understanding the psychosocial factors that facilitate recovery and for illuminating commonalities across diagnostic categories.

Commonality of experience and recovery can help ground public policy in a way that supports a larger subset of the population than the absence of such a grouping. SAMHSA's

reference to “meaningful daily activities” further clarifies the role of purpose within recovery, defining it as “engagement in activities such as employment, education, volunteerism, caregiving, or creative pursuits, alongside the independence, income, and resources necessary for full participation in society” (*About Recovery*, 2024). In this paper, meaning-making is defined as the process of mitigating stressors and existential distress in ways that reduce vulnerability, support psychological stability, and strengthen the pursuit of purpose within recovery.

Investigating the process by which practitioners and patients formulate what facilitates meaning-making, even if it is a non-linear process helps to create a holistic view of the concept and in turn forms the basis of better rounded public policy and supports in the field of mental health services. There are many forms of (SMI), ranging from mood and anxiety disorders to psychotic and personality disorders. Research across clinical, policy, and academic fields demonstrates that although the term SMI is widely used, it is not consistently or uniformly defined (Gonzales et al., 2022). For the purposes of this paper, I use SMI or serious mental illness with psychotic features (SMIWPF) to refer to mental health conditions that significantly disrupt functioning, interfere with major life plans, and require substantial support and resources to maintain stability and quality of life. SMI exists on a spectrum, and the term severe and persistent mental illness is sometimes used in the literature to capture the chronic, severe, and episodic nature of these conditions.

Whenever possible, this paper focuses on schizophrenia because it exemplifies an illness that is often episodic, initiates a severe traumatic event requiring recovery-oriented intervention such as first-episode psychosis care, and confers a chronic vulnerability that necessitates robust foundational and psychosocial supports and overlaps with other SMI such as schizoaffective disorder, major depression with or without psychotic features and bipolar disorder. Schizophrenia

illustrates the precarious material and emotional journey particularly around meaning and purpose that many individuals with SMI experience, making it a useful case example for discussing recovery. Many studies include mixed samples of individuals with various SMI (including those in the subsequent systematic review in this paper) diagnoses rather than schizophrenia alone, both because other SMI conditions can involve psychotic features and because broader inclusion criteria increase sample size, especially in qualitative research where perceived stability is essential for capturing lived experience through first-person interviews.

The purpose and structure of this paper is 1) to understand how contemporary scholarship conceptualizes meaning-making among individuals with SMI, and as mentioned, with particular attention to schizophrenia whenever possible (the study of SMI across research often includes related disorders with mania or psychosis); 2) to recognize meaning-making as a varied construct and leverage a comparative view of recovery discourse (history, critiques and common frameworks) over the last 50 years; 3) analyze contemporary formulations of how meaning-making is described, facilitated, and operationalized within therapeutic frameworks; and 4) consider gaps in research and the implications of these findings for policymakers working within recovery-oriented systems of care. In order to accomplish the aims of this paper, the paper is organized into 5 chapters: Chapter 1 is to describe the purpose of the study; Chapter 2 is to review the literature focused on meaning-making and SMI; Chapter 3 documents the methodology employed to complete a systematic review; Chapter 4 documents the results of the systematic review and re-occurrent themes; and Chapter 5 discusses the results in the context of the paper's aim to inform public policy. Chapters 2 through 5 document the historical context in which lived experience comes to inform empathy in the fields of psychiatry and is the basis for referencing

lived experience as a valid and valuable reference point and critical aspects to understand the deep dive of meaning-making as a part of recovery and therapeutic approaches.

CHAPTER 2 – REVIEW OF LITERATURE

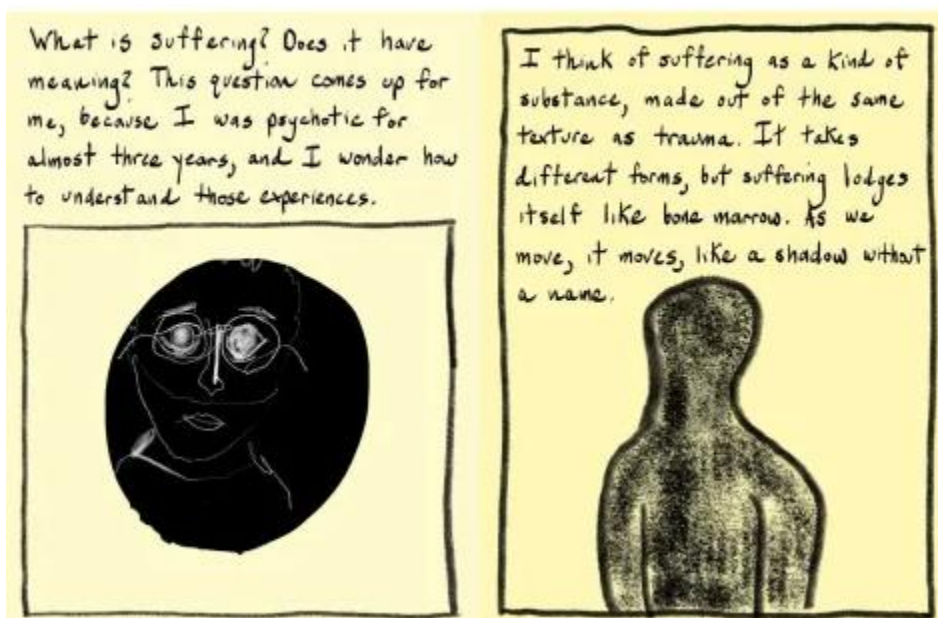
The foundations for listening to patients: the establishment of lived experience as meaningful data.

In the early 20th century, Karl Jaspers, a German-Swiss psychiatrist and philosopher adopted the term phenomenology to advocate for an empathetic understanding of a patient's perspective and the coherence of their experience in the context of patient's lives and in the face of perceived mental illness (Beaumont, 1992). The discourse of empathy, consciousness of experience and personal distress permeate modern psychiatry, public policy and social movements around mental health today. The early thinkers in the fields of psychiatry, philosophy and sociology in the 20th century such as Jaspers, Eugene Minkowski and Michael Foucault helped deviate from preoccupations with the somatic causes of "mental illness" and laid the foundation for mental health practitioners, critics and advocates to look at the intersectional, personal and social realities of those deemed mentally ill.

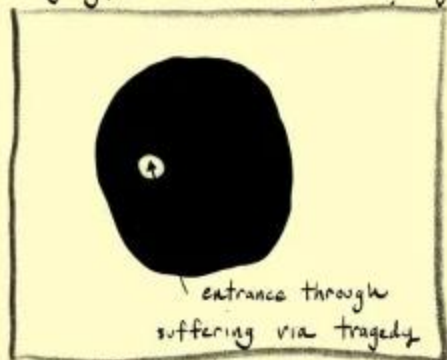
Mental illness diagnoses have evolved over time. The Diagnostic and Statistical Manual of Mental Disorders (DSM) has historically added, modified and retracted diagnoses and their diagnostic criteria since its inception in the 1950s. It is not uncommon for those with SMI to experience co-morbid diagnosis as the exact biological mechanisms underlying distress and disease overlap and are not entirely known and evolving. The brain health of patients can also shift and move from improvement to deterioration. Mental health critics stress the relevance of disease reframed as distress given the structural barriers people with SMI face (Hay et al., 2026). Mental illness and distress exist on a spectrum with varying degrees of impairment. The reference and study of identity in reference to mental illness helps to emphasize that formulations of personal identity are as complex and the influences on them are multi-factorial just as they are in the general population and distinct from mental illness even when illness is present. Therefore,

the distinction between disease and distress is an important one, in that, it is person-centered. One artist with schizoaffective disorder illustrates the intersection between trauma, identity, distress and meaning-making in his autobiographical drawing in Figure 1 (Andrewfield48, 2026). The illustration shows the distress experienced with schizoaffective disorder and how meaning-making is a non-linear and extended process with no particular end and is continually contested as life circumstances evolve and trauma is identified and named.

Figure 1: Autobiographical view of meaning-making, trauma and struggle while living with schizoaffective disorder.



I wonder if I'm a better person for having been sick for so long. There is something tragic about how far gone I was. The tragic - is that how I learned the -a- meaning of tragedy? And is that important? Why?



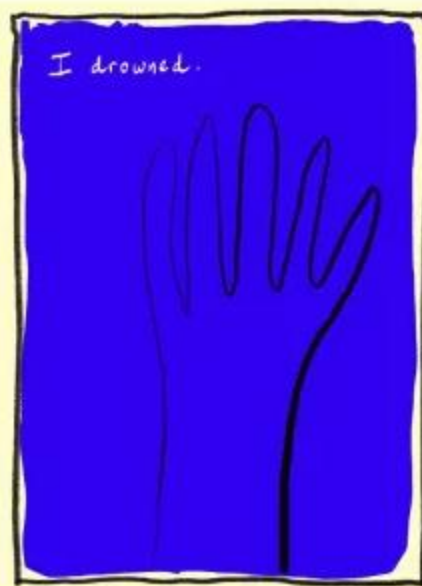
What is tragedy? I'm picturing someone frozen. The possibilities for their life are also frozen. Someone not being able to become their best self - that's tragic.

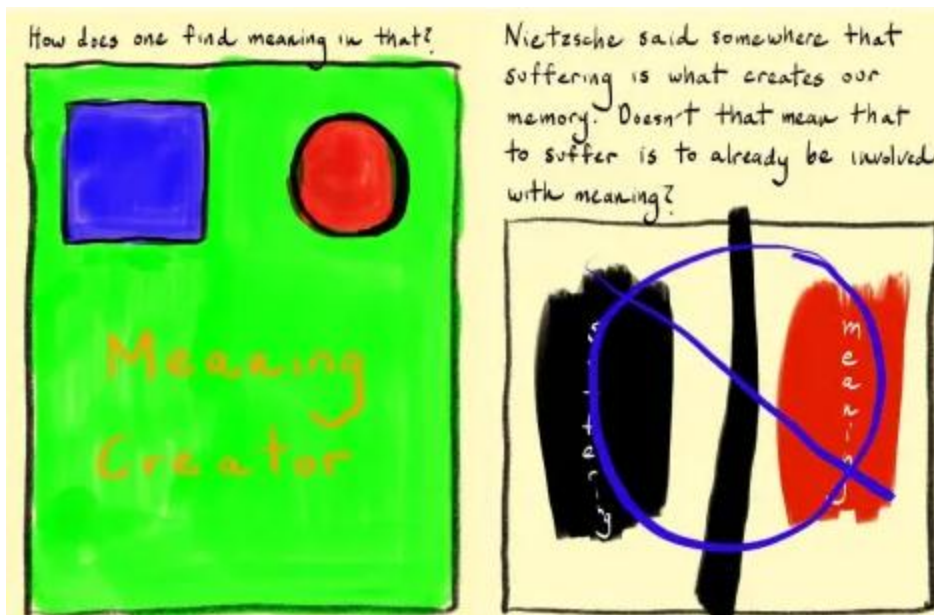


I witnessed my own life vanish.



I drowned.





Historical overview of how we arrived at community care.

The Community Mental Health Act of 1963 (CMHA), also called the Mental Retardation and Community Mental Health Centers Construction Act Pub. L. No. 88-164, 77 Stat. 290 (1963) set the stage for how mental health care in the United States looks today. The goal of the law was to move people out of large psychiatric hospitals and instead provide treatment in community-based mental health centers. This shift, known as “de-institutionalization”, happened during the civil rights era, when the public was becoming more aware of the mistreatment of psychiatric patients and the ways in which mental illness had been racialized. The CMHA is often described as both a hopeful step toward more humane care and a major failure in providing the basic supports needed for people with SMI to live safely in the community (Lost Patients, 2024). As such, public policy in its implementation has been ineffective in providing reliable and accessible structural support pathways into stability, medical care and recovery for people with SMI.

At the time, the legislation had strong support from medical professionals, Congress, and mental health advocates. New psychiatric medications were showing promise in treating

psychosis, creating optimism that people with SMI could live and work more independently (Erickson, 2021). President John F. Kennedy Jr. championed the law in part because of his personal experience: His sister had undergone a lobotomy in a psychiatric institution, leaving her significantly more impaired than prior to the procedure. Although diagnoses and treatment options have expanded since then, including more effective medications; psychosocial supports, housing programs, a continuum of care and disability benefits have not kept pace with these advancements (Erickson, 2021). Kennedy's assassination in 1963, soon after signing the act into law meant the loss of a key advocate for building a strong community-based mental health system. As a result, the vision for community mental health centers was never fully realized. Only about half of the 1,500 centers promised under the CMHA were ever built (Erickson, 2021).

While the number of people in state psychiatric hospitals dropped by 90% by the 2000s, compared to a peak of more than 558,000 patients in 1955 progress was disorganized and continues to be disjointed (Erickson, 2021). No single agency took responsibility for implementing the law, leaving many people without guaranteed access to basic needs or coordinated care. Many individuals also did not qualify for Medicaid or Medicare after those programs were created in 1965, due to financial and bureaucratic barriers. Families and friends became the default support system, and people without such networks or problematic family systems often cycled through emergency rooms, jails, prisons, and forensic hospitals (Erickson, 2021).

The prevalence and features of schizophrenia and SMIWPF.

A meta-analysis study estimates that SMI or psychotic spectrum disorders, such as schizophrenia affect about 1 in 150 people worldwide, although rates vary depending on

diagnostic criteria (Moreno-Küstner et al., 2018). A second meta-analysis study found that psychosis is far more common among people experiencing homelessness: About 21% of homeless individuals met criteria for psychosis, compared to earlier estimates of around 12% in Western countries (Ayano et al., 2019). Psychotic disorders often occur alongside other psychiatric and medical conditions, are often episodic in nature and there can be significant side effects with antipsychotic medications: See Figure 2 (Stevens, 2020) for a brief overview of these illnesses and symptoms, an occupational view of impairment and chronic struggle. The often prolonged timeframe for receiving support, limited extent of services and bureaucratic challenges in acquiring foundational supports impact the ability of people impacted by these illnesses to stabilize (Lost Patients, 2024).

Figure 2 – A brief overview of SMI, features, impairment and functional impact.

**A CARLAT PSYCHIATRY
REFERENCE TABLE**

Psychotic Illnesses: A Snapshot					
	Symptoms	Prevalence	Sex Differences	Usual Age of Onset	Developmental Considerations
Brief Psychotic Disorder	1 or more of: •Delusions •Hallucinations •Disorganized speech •Disorganized behavior or catatonia 1–30 days, no other diagnoses & return to pre-morbid function	•Accounts for 9% of first-onset psychosis •Higher in developing countries	Twice as common in females	•Any age starting in adolescence •Average onset is in 30s	Visual hallucinations more common in children than adults (up to 50% in some cohorts)
Delusional Disorder	1 or more delusions lasting for 1+ month, never met criteria for schizophrenia	0.2% (persecutory is most common)	•Roughly equal •Women more jealous	May occur in younger age groups, though more prevalent in older adults	Consider normal magical thinking in differential
Mood Disorders (BPD, MDD) With Psychotic Features	Primary mood disorder meeting criteria for MDE or mania with psychotic symptoms	•1% general population for bipolar disorder •Rarer in childhood •10%–20% of adults have MDD at some point in their lives	•About equal for BPD •MDD is 1.5–3x more common in females from teens onward	•BPD mean onset at 18 with 2nd peak in middle age •MDD onset increases markedly in puberty and peaks in 20s	•BPD in children and adolescents: judge irritability and agitation against own baseline •Delusions and hallucinations tend to be mood congruent
Neurodevelopmental Disorders (ASD, IDD, Communication Disorders)	Overlapping symptoms: perceptual abnormalities, thought disorder, catatonia, deficiencies in reality testing	1% prevalence of IDD and ASD in general population	Males more likely to be diagnosed with mild (1.6x) and severe (1.2x) IDD than females	Onset is in the developmental period, though diagnosis may be delayed until academic or social impairment becomes apparent	•High risk of psychosis and misdiagnosis as well as sensitivity to medication •Genetic syndromes increase risk of psychosis (ie, DiGeorge syndrome)
Personality Disorders (Borderline Personality and Cluster C PDs)	Psychotic symptoms with less functional impairment than primary psychotic disorders; possibly transient in crisis or magical thinking	•Varied rates in community, inpatient samples •15% of adults have at least 1 PD	Borderline PD more common in women	May emerge in adolescence and progress through young adulthood, though may not always be recognized until adulthood	•Diagnoses in children/adolescents often change over time •BPD frequently diagnosed in adolescent females
Schizoaffective Disorder	Mood episode & 2 or more psychotic symptoms AND psychotic 2+ weeks apart from mood episode	0.3% of general population	More females	•Early adulthood •Older patients may be more likely to have depressive type presentation	•Youth may be more likely to have bipolar type presentation
Schizophrenia	2 or more psychotic symptoms present for a significant portion of time in 1 month & 1 symptom for over 6 months	•Childhood onset schizophrenia is very rare (1/10,000) •1% of general population	•Roughly equal •Males: More negative symptoms, longer duration	•Typically emerges in late teens and mid 30s •Early/mid 20s peak in males •Late 20s peak in females	•Premorbid social & motor problems •Earlier onset has poorer prognosis •1/3 of adults report their illness started before age 18
Schizophreniform Disorder	2 or more psychotic symptoms, at least 1 month & less than 6 months	•0.2% in developed world •Higher in developing world •2/3 transition to schizophrenia	Roughly equal	•8–24 for males •24–35 for females	Youth: attenuated symptoms and provisional diagnosis may be provided initially
Substance/Medication Induced	Typically acute onset, often resolves after withdrawal, may persist for weeks or longer	•7%–25% of first-episode psychosis attributed to substance/medication use •Prevalence unknown	Unknown	Occurs at any age, though elderly may be particularly vulnerable due to polypharmacy and medication exposure	Cannabis-induced psychotic symptoms may persist in heavily using adolescents for up to 1 year following cessation, in some studies
Traumatic Disorders	Traumatized youth may report hallucinations in PTSD	•US lifetime prevalence is 8.7% •Prevalence lower in children and adolescents	More common in females across the lifespan	Can occur at any age	Children and adolescents: limited ability to express symptoms, which may be nonspecific

Interrupted lives: the unique struggles and health outcomes of schizophrenia.

Yadav et al. (2025) highlight schizophrenia usually begins early in life, most often in the late teens or early twenties. Many people experience their first symptoms before age 25. About one percent of people worldwide live with schizophrenia, and it is one of the leading causes of

disability. It also shortens life expectancy by roughly 15 to 20 years. People with long-term, severe mental health conditions tend to live significantly shorter lives than the general population. For schizophrenia specifically, research shows that people lose an average of more than a decade of potential life, with men losing slightly more years than women. In addition, Yadav et al. (2025) document large studies also show that people with schizophrenia face a much higher risk of dying early compared to those without the illness. Younger people with schizophrenia are especially vulnerable, and their deaths are more often linked to physical health problems, especially heart disease rather than to suicide.

Medication is essential for treating schizophrenia and is effective for symptoms like hallucinations and delusions, but it is less helpful for problems such as lack of motivation or cognitive difficulties. Several factors contribute to early death in schizophrenia, including lifestyle patterns, limited access to medical care, other chronic health conditions, and inconsistent use of prescribed medication. Although it is well known that schizophrenia increases the risk of early death, researchers still do not fully understand how this risk changes between people who are newly diagnosed and those who have lived with the illness for many years (Yadav et al., 2025).

In addition to shortened life span and comorbidity, other quality of life factors include material standing and how it is impacted. The private economy of people with schizophrenia and SMI is most commonly severely compromised at any age with the onset of illness (Topor et al., 2016)). Being shut out of stable employment or constantly pushed to its edges, and relying on public assistance is closely tied to living in poverty. This pattern appears not only in high-income countries but also in nations known for strong social welfare systems introducing additional life stressors in the management and care of schizophrenia spectrum disorders (Topor et al., 2016).

Ways to think about recovery and recovery policy, including disability movements and other critiques of recovery models.

There is no standardized definition of *recovery* governing the literature on SMI and meaning-making or identity. There are, however, a few central themes and some outlying observations that organize subjective experiences into potential objective pillars of recovery. I believe a comprehensive review of these “pillars” can help to establish a cross-reference checklist to round out studies more completely and make them more comparable. Asbo et al. (2025) make an important dialogical choice when they decide to distinguish between “characteristics” and “facilitators of recovery”. This distinction allows a more specific way to locate what *aids* recovery and what is meaningful to recovery itself. They apply this distinction in their discourse when qualitatively interviewing study participants with SMI. In their study, the primary indicator of what aided or facilitated recovery was participants themselves over therapeutic interventions. This implies the relational shift in language helped to emphasize agency in narratives about recovery. Generally, the literature identifies the key determinants of recovery in schizophrenia as familial structures (and the associated resources, intrinsic and extrinsic provided by family networks) and peer support. Because the definitions of recovery and SMI both are disparately used, this does not mean the evaluation of SMI versus schizophrenia would not result in a different emphasis in what aids meaning-making or recovery.

Alternatively, Harper & Speed (2012) reframe the discussion of recovery as a struggle for recognition rooted in identity politics that shifts attention away from the social, political, and economic changes needed to address the deeper causes of emotional distress. They argue that genuine recovery can only occur when the collective and structural realities of inequality and injustice are directly connected to the ways emotional distress develops and is experienced.

A central theme across the literature reviewed, is that modern recovery frameworks throughout high income countries are built on the assumption that individuals must take responsibility for their own distress. Harper and Speed (2012) argue that contemporary recovery discourse individualizes social problems, shifting attention away from poverty, discrimination, trauma, and structural injustice. They indicate that definitions of recovery are framed as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. This shift reflects what Harper and Speed (2012) call "responsibilization": placing the onus of personal well-being and advancement on individuals, according to them, a hallmark of neoliberal governance. Neoliberalism encourages people to see social harm, such as unemployment, housing insecurity, racism, and trauma as personal challenges requiring self-management. In this model, the role of the state shrinks, and individuals are expected to take responsibility for their own well-being. They argue that SAMHSA's principles of "person-driven" recovery, "many pathways," and "strengths/responsibility" fit neatly into this logic, encouraging individuals to adopt a mindset of self-improvement even when their suffering is made bigger by structural forces beyond their control.

Braslow (2013) provides historical context for this shift. He argues that recovery emerged during the same period as neoliberal welfare reform in the United States. Recovery advocates harmfully argued that the mental health system created hopelessness and dependency, echoing Reagan-era rhetoric about welfare recipients. In this context, recovery became a way to "transform" dependent patients into independent citizens, aligning psychiatric policy with broader political efforts to reduce public spending and promote individual responsibility. SAMHSA's earlier definitions of recovery emphasized the right to community inclusion and the need for social supports. But the 2010 definition reframed recovery as a process of change

through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. As Davidson and colleagues note (2021), this definition appears to apply to those with a mental illness or substance use disorder, making recovery a universal individualized self-help journey rather than a collectivistic response to oppression or injustice. Together, these authors argue that SAMHSA's principles reflect a worldview in which individuals must adapt to harmful conditions and bolster their intrinsic resources rather than society changing to reduce harm (a paradigm advocated by early disability rights movements).

Davidson et al. (2021) highlight how SAMHSA's shift from a disability-rights framing to a "self-actualization" model removes the recognition that people are recovering from a broad range of social harms. Furthermore, they argue without acknowledging what people are recovering from, recovery becomes a personal project rather than a response to structural deficiencies. This shift has political consequences: it reduces pressure on governments to address inequality, diminishes the political will to push on public policy that funnels grants and funds, shapes research design and shifts responsibility onto individuals.

CHAPTER 3 – METHODOLOGY

Information Source and PRISMA Methods

A systematic review was chosen to review articles studying meaning-making and schizophrenia. A systematic review helps to illuminate current scientific trends in understanding the intersection of meaning making (recovery) and psychosocial supports and provides a snapshot of the challenges, gaps and outcomes associated with these supports in the context of the literature review. Study identification, screening, and reporting followed the PRISMA 2020 framework, and the PRISMA flow diagram (see Figure 3) was used to document the selection process (Page MJ, 2020).

Figure 3: Prisma workflow for identifying, screening and including research criteria.



Electronic Search Strategy

The following steps were taken to conduct an online search: University of Washington Libraries databases was conducted with the search terms "schizophrenia and 'meaning making'" on June 22, 2026 which yielded 53 articles total; this search was also filtered for "available online", "peer

reviewed journals", "English", and "articles" format with the date range, "2016 - 2026"; the electronic search conducted yielded articles on psychotic spectrum illnesses or SMIWPF and meaning making and was included given the overlapping symptomatology between these illnesses and schizophrenia; the date range of 2016 – 2026 was chosen to capture a recent analysis of trends in the field regarding the research topic and question.

Eligibility - Text based inclusion and exclusion criteria and limitations.

Of the 53 articles found, article titles and abstracts were read and excluded if central themes centered around art, music, medical adherence, lack of insight into illness and spiritual or religious components of recovery based on this preliminary textual analysis. A full read through was conducted of 14 remaining studies where study participants had insight into their illness, and were considered stable, existential distress were explored and a therapeutic approach accompanied whenever possible the studied cohort. This process led to the exclusion of 4 additional articles in that they emphasized medication usage, insight into illness and personal identity among youth to the exclusion of a broad spectrum cohort or 43 articles in total excluded of the initial 53 reviewed. Although there are correlations to concepts of the self, therapeutic frameworks and purpose and meaning found in the association with art, music, age of onset, youth identity and spirituality, these explorations were too specific in their concentration to be broadly applied against the literature reviewed for overall reconciliation of existential distress.

Articles from “low” income nations were not included to allow for greater analogy between countries that offer disability insurances, services and allowances in the space of public policy.

Electronic Tools:

The Zotero application was utilized to organize and store articles online. This web library is not published publicly and is stored privately.

CHAPTER 4 – RESULTS AND DISCUSSION

A thematic analysis of systematically reviewed articles yielded several central themes. These themes include 1) therapeutic approaches to mean-making and recovery as approaches to reclaim personhood; 2) the non-linear and subjective experience of mean-making and associated supports; 3) connection between recovery public policy definitions and recovery frameworks; and 4) connection between personhood and post-traumatic growth (PTG). Below is an explanation of these themes and how they appeared in the literature.

Theme 1 - Therapeutic approaches focused on open-ended questions to focus on the reconciliation of meaning-making and purpose and help reclaim personhood with those meeting loosely defined criteria for functional recovery and are considered essential for recovery.

Dignity Therapy is grounded in palliative care practices that support patients as they engage in existential reflection, seek reconciliation, and articulate meaning at critical points in their lives (Grassi et al., 2022). PTG refers to the inward shift in perspective and personal development that can emerge after trauma or other profoundly difficult experiences (Bergström et al., 2019). Humanistic psychiatry centers holistic healing by emphasizing self-actualization, subjective experience, and an understanding of the person as an integrated whole (Eneman et al., 2019). Flow Theory, drawn from occupational therapy, helps individuals identify attainable goals and activities that allow them to enter an immersive state in which distressing symptoms recede into the background (Tepavicharov et al., 2022). Open Dialogue Therapy approaches psychological crises as relational and socially embedded experiences, prioritizing open, collaborative conversations with the person in distress and their support network rather than immediate diagnostic labeling or medication. It also underscores transparency in the therapeutic process, encouraging patients to inquire about and understand the reasoning behind clinical

decisions. Another strategy involved including people with SMI as contributors in a research project from its inception and conducting a qualitative analysis of their experiences sharing lived expertise (Thai et al., 2021). Although not framed as a therapeutic intervention, this participatory approach fostered a sense of inclusion that participants affirmed in qualitative surveys. Across all studies, the central shift in approaching psychosis lies in creating space for meaning-making through narrative identity, a process that appears most feasible when patients or participants meet criteria for functional recovery, broadly defined as having insight into their illness. The emphasis of these approaches together is a relational dialogue that allows for personhood, the core aim of all therapeutic approaches found in the review. A potential therapeutic insight that emerged from the qualitative analysis was the concept of “intentional solitude,” a deliberate practice of spending time alone to soften or counter the effects of social isolation (Grunfeld, 2026). The authors note that empirical research on this approach remains limited.

Theme 2 – Narrative identity and meaning-making is not a linear path, is a highly subjective and highly influenced by extrinsic supports.

Familial support consistently emerged as the most influential factor in fostering social inclusion and helping individuals regain a sense of self, meaning, and purpose. Peer support also emerged as a central component of “recovery” specifically and was not as nuanced in its meaning, that is if it specifically contributed to a return to self, versus as a counter measure to social exclusion. Across all studies, a persistent combination of loneliness, social exclusion, self-stigma, and social stigma appeared as deeply painful experiences that complicated the recovery process. In a longitudinal study in which participants were interviewed 20 years after their first episode of psychosis (FEP), several individuals described economic barriers that limited their ability to pursue recovery goals, and desires and dreams rooted in pre-illness such as

forming relationships or achieving a sense of accomplishment (O’Keeffe et al., 2021).

Researchers acknowledged personal economic constraints as relevant to recovery, though they did not identify them as a primary barrier. Reconciliation as an ongoing process appeared consistently across longitudinal studies, underscoring that working through trauma, making meaning, and confronting barriers such as stigma and social exclusion remain lifelong realities for people living with SMI. Although qualitative surveys suggest that participants with greater resources, such as strong family support or financial stability tend to articulate more cohesive narratives of recovery, the research designs across all studies did not explicitly include for instance economic factors as part of their survey criteria. This absence is notable, given that most studies acknowledge in their concluding sections the need for future research that incorporates the economic dimensions of recovery. Contemporarily, studies continue to exclude economic dimensions of recovery as a part of recovery studies unless economy or poverty are the primary focus of the study. The primary benefit of localizing research terms like meaning-making has been in the discovery of therapeutic interventions that center themselves around identity, trauma and personal narratives. There has not been a shift towards blending studies more intrinsically with material and correlated emotional conditions as a *best practice*.

Theme 3 – Studies did not consistently reference recovery policy as a key influence on study design and recovery discourse.

Together, the systematic review in this paper drew primarily from high-income countries that operate recovery-centered systems of care and provide foundational disability supports, such as housing assistance and food stipends (Berstrom et al., 2019; Eneman et al., 2016; Grassi et al., 2022; Grunfeld et. al, 2026; Jordan et al., 2020; Mazor et al, 2017; O’Keeffe et al., 2021, Tepavicharov et al., 2022, Thai et al, 2021 & van Sambeek et al., 2023). However, these studies

did not examine in depth or with consistency the limitations embedded in formal recovery-oriented definitions posited by key governance bodies globally or within home countries of each study. Notably absent was critical attention to the individualized framing of recovery described by activists and researchers, as well as the downward economic mobility shaped by public policy that people with SMI are widely documented to experience.

Theme 4 - PTG and meaning-making helps people reclaim personhood.

Many individuals describe psychotic related illnesses and their associated traumas as shattering core beliefs about themselves and the world. For instance, hospitalization after a first-episode psychosis often surfaced as a traumatic experience. Yet this disruption can also create space for a renewed sense of identity, often characterized by greater self-knowledge or a recognition of personal strength, noting that identity change is not merely a consequence of psychosis but sometimes a meaningful reorientation that people value. Research implies this may be particularly true for onset of psychosis early in age. The studies reviewed did not investigate how age or more established lives and identities as a consistent variable impact the process of meaning-making and reconciliation of identity. Findings challenge psychosis limits insight and that trauma exploration is unsafe or can bring on psychosis and facilitates positive re-framing (Jordan et al, 2020)

Although the studies identified in the systematic review used different methods, specifically, qualitative interviews, narrative analysis, surveys, clinical notes and integrative reviews, they consistently highlighted key themes, namely that meaning-making, relationships, dignity, opportunity and agency to discuss meaning and purpose are central to recovery. Findings challenge traditional biomedical assumptions that psychosis limits insight or that trauma exploration is unsafe (can bring on psychosis). All studies acknowledge the limited opportunity

for patients to find services and opportunities to explore meaning-making in relation to trauma and existential crisis and meaning.

Connection repeatedly emerged as a protective factor and a source of meaning. Study participants described romantic and significant relationships as key sources of purpose. Across studies, connection with others, community, and supported recovery and reduced alienation. The majority of studies relied on functional recovery cohorts and very few recognized that stability is critically promoted by material resources and positionality that allowed support and medical resources early on while all studies recognized the material and social inequalities of those with SMI as a footnote for further research.

Study participants described recovery as reclaiming identity, dignity, and control over their lives. Dignity therapy helped people with SMI reflect on legacy, personhood, and stigma, highlighting that dignity is often threatened by psychiatric labeling (Grassi et al., 2022). Study participants described reclaiming power, repairing reputation, and “relinquishing the sick role” as essential steps (O’Keeffe et al., 2022). Study participants emphasized being seen as whole people, not problems to be solved, and valued environments that allowed trial and error without judgment (Tepavicharov et al., 2022). Recovery was described as a dynamic process of rebuilding agency, not simply managing symptoms.

Recovery extends far beyond the reduction of symptoms; it is an existential, social, and narrative process shaped by time, relationships, dignity, and personal agency. Clinical systems that center these deeper dimensions rather than narrowly emphasizing pathology are more closely aligned with how people actually heal. Much of the literature highlights how individuals cultivate inner resources to endure periods of existential or phenomenological distress. Yet no study, including those using Open Dialogue as a foundation for connection and support,

incorporated a baseline of globally recognized psychoeducation on the meaning of recovery to help guide reflection. Introducing such a framework could strengthen participants' ability to imagine what recovery might entail. Similarly, the absence of discussion about the impact of depressed personal economies risks constraining what individuals perceive as possible and may limit opportunities to foster advocacy and awareness for more equitable public policy and relevant, robust mental health services, supports, access to disability services and medical needs that extend life-span and quality of life and body.

Eneman et al. (2016) findings are a degree apart because they argue that the effort to make sense of events that wound or destabilize us lies at the heart of human life. The authors argue that *demoralization* is a useful way to understand the existential suffering that can arise for people, especially those living with schizophrenia. Feelings such as doubt, discouragement, or even despair and the search to understand what is happening should not be treated as symptoms of illness or as psychiatric disorders. Instead, they reflect the healthy, striving part of a person attempting to orient themselves in the face of overwhelming experiences. They also present an opportunity to validate what was and some parts that might still be. Recovery, they suggest, requires balanced attention to several domains: staying engaged with treatment and preventing relapse, strengthening coping abilities, supporting rehabilitation, and allowing space for mourning and demoralization. At the center of all of this is the individual's ongoing work of creating meaning, which should guide the entire therapeutic process. This approach recognizes the whole person, the person who suffers from the condition and the person who suffers from knowing they have the condition. The demoralization sometimes seen in people with schizophrenia deserves thoughtful and sustained attention from clinicians and researchers. This attention is not meant to treat a pathology but to honor the person's struggle to build a

meaningful life, a struggle that is part of what it means to be human. In accepting the universalism of this argument and the experience of mean-making in the face of traumatic events and even hopelessness, the idea of economic and quality of life parity become potential important extrinsic pillars for the recovery model and perhaps a dialogue for public education and relational understanding to combat stigma.

One treatment approach often used with people experiencing severe mental health challenges is Dialectical Behavior Therapy (DBT), created by Marsha Linehan. DBT includes the idea of “building a life worth living,” which focuses on skills for emotional regulation, managing chronic suicidal thoughts, achieving life goals and outcomes and improving relationships (Linehan, 2018). Although DBT is a clinical model, its core idea of building a life worth living could also guide public policy. DBT is a treatment modality that could benefit by developing a relationship to structural realities and barriers since it is increasingly being used for an array of “disorders”. Given its prolific use and foundational principal of a “life worth living”, it has the potential to be an organizing principle and to offer in a more robust way for advocates, patients and practitioners to think about what people with SMI need to improve their quality of life and how systems can support their recovery and meaning-making. The idea of intentional solitude as a therapeutic reality also begs the question of adequate material supports where the social contract with society at large reflects dignified living conditions and transformation in and out of intentional solitude of so desired and deserves additional study.

CHAPTER 5 – CONCLUSIONS

The findings of this systematic review demonstrate that meaning-making is not a peripheral or optional component of recovery from serious mental illness (SMI), but rather a central psychological, social, and existential process that shapes how individuals reclaim identity, dignity, and purpose. As described in the literature, meaning-making encompasses reformulating identity, reestablishing personhood, cultivating purpose, mitigating existential distress, and identifying psychosocial markers that support recovery. Gaps uncovered by the systematic review point to problematic research designs that exclude psychoeducation and relationship to extrinsic supports that compromise the range of reflections that inform a potentially more holistic and relational view of meaning-making. Meaning-making is inherently subjective and deeply influenced by lived experience, particularly given the heterogeneity of SMI and the episodic, disruptive nature of illnesses such as schizophrenia. This complexity underscores the need for recovery-oriented systems of care to adopt frameworks that honor narrative identity, and existential inquiry connection as core therapeutic elements rather than adjunctive supports.

Across the reviewed studies, therapeutic approaches that emphasize open-ended dialogue, existential reflection, and narrative reconstruction consistently supported participants in reclaiming personhood. Approaches such as Dignity Therapy, Humanistic Psychiatry and Open Dialogue Therapy all share a commitment to centering the individual's lived experience, fostering agency, and creating space for meaning-making within the therapeutic encounter. The emergence of "intentional solitude" as a potential therapeutic insight further illustrates the diverse ways individuals seek to mitigate distress and cultivate coherence in their lives.

Familial support emerged as the most influential factor in fostering social inclusion, strengthening identity, and supporting meaning-making. Conversely, loneliness, social exclusion, self-stigma, and public stigma were consistently described as painful barriers that complicated recovery trajectories. Longitudinal studies revealed that reconciliation of trauma, identity disruption, and existential distress is an ongoing, lifelong process. Despite the clear influence of social and material supports, most studies did not explicitly incorporate economic stability or resource access into their research design, even though participants and/or researchers described economic precarity as a barrier to achieving recovery goals. This gap reflects a broader pattern identified in the review: the limited integration of recovery policy and structural determinants of health into empirical research on meaning-making as a standard practice.

Although the studies were conducted in high-income countries with established disability systems, they did not examine in depth or with consistency the limitations embedded in formal recovery-oriented definitions. The absence of policy analysis misses an opportunity to engage with notable critique that recovery discourse has become individualized, responsabilizing, and aligned with neoliberal governance in high income countries and a global phenomenon. Contemporary recovery frameworks often place the burden of change on individuals while minimizing the structural conditions poverty, housing insecurity, disability application processes, discrimination, and trauma that shape distress and constrain recovery. This disconnect between policy and lived experience limits the ability of recovery models to fully support meaning-making transitioning from a thought and intrinsic exercise, particularly for individuals whose economic and social marginalization is chronic and severe, into one of more holistic recovery.

Demoralization, doubt, and despair should not be pathologized but understood as expressions of the healthy part of the person striving to make sense of overwhelming experiences. This framing reinforces the need for recovery-oriented systems to treat meaning-making not as a symptom or risk factor but as a core human process deserving clinical attention, time, and relational support. It also suggests that recovery frameworks must expand beyond symptom reduction to include mourning, demoralization, identity reconstruction, and existential inquiry as legitimate therapeutic goals and frameworks.

Taken together, the findings of this review point to several implications for policy and practice. First, recovery-oriented systems must integrate meaning-making as a foundational component of care, not an optional or secondary element. This includes expanding access to therapeutic modalities that center narrative identity, existential reflection, and relational dialogue to acknowledge personhood. Second, recovery research must more consistently incorporate economic stability, material resources, and quality-of-life parity as essential extrinsic pillars of recovery. Ignoring the depressed and compromised personal economies of those with SMI risks constraining what individuals perceive as possible in their recovery journeys. Third, policymakers should revisit recovery definitions and frameworks to ensure they reflect both the structural determinants of distress and the existential dimensions of healing. Recovery cannot be fully understood or supported without acknowledging what individuals are recovering *from*, including social harm, economic marginalization, and systemic inequities. Finally, this review affirms that recovery is not merely the reduction of symptoms but a dynamic, *lifelong* process of rebuilding agency, dignity, and meaning. We must ask ourselves what does our social contract with those who identify as disabled mean in terms of parity for a life well lived? Given the shortened life expectancy of many SMI conditions, this question becomes even more pressing.

Recognizing these truths requires a shift in both clinical practice and public policy toward systems that honor the full humanity of individuals with SMI, support their material needs, and create environments where meaning-making is a widely discussed act that informs dignity and identity as a whole and as an act of solidarity among disabled and non-disabled populations and does not wait for the alleviation of social stigma for individuals and communities with SMI to plug into society as a whole, but gives them the means to live and thrive in alternative and selective spaces if required.

Limitations

Several limitations of this review should be acknowledged. First, the selection criteria may have limited the breadth of perspectives captured in the analysis. Although the review focused on meaning-making and recovery in schizophrenia, it did not comprehensively include studies examining the influence of age-related identities, or the contributions of music, artistic expression, and spiritual or religious practices. I recognize these factors as important mechanisms through which individuals reconstruct identity, develop purpose, strengthen social connections, and foster recovery. As a result, potentially relevant pathways to meaning-making and recovery may not have been fully represented in the findings.

Second, the studies included in this review were predominantly drawn from higher-income countries, which may limit the transferability of findings across diverse socioeconomic and cultural contexts. I recognize mean-making and recovery are shaped by factors such as cultural values, social norms, family structures, access to healthcare, and economic opportunities. Consequently, the experiences reflected in the reviewed literature may not adequately represent those of individuals living in low- and middle-income countries, where resources and support systems may differ substantially.

Third, the search strategy may have restricted the scope of the literature identified. The use of terms focused primarily on “schizophrenia and meaning-making” may have excluded studies that examined similar concepts under broader diagnostic categories, such as serious mental illness (SMI), or within the context of economic determinants of health. As a result, literature addressing the role of poverty and other structural challenges in shaping recovery and meaning-making may have been underrepresented. This limitation may have constrained the review's ability to fully examine the interplay between intrinsic resources, such as hope, personal agency, and coping strategies, and extrinsic resources, including social support, community engagement, and access to services.

Future Research

Future research should expand the scope of inquiry to include studies exploring age-related identities and the role of music, art, spirituality, and religious practices in recovery and meaning-making. These areas may provide deeper insight into how individuals with schizophrenia and other SMI construct meaning, maintain hope, and develop a sense of identity beyond their diagnosis. A broader examination of creative, cultural, and spiritual resources may also reveal additional recovery-oriented strategies and interventions.

Future reviews should also incorporate research conducted in low- and middle-income countries to better understand how cultural, economic, and social contexts influence recovery processes. Comparative analyses across settings may help identify both universal and context-specific factors that support meaning-making, while highlighting diverse forms of intrinsic and extrinsic resources used by individuals living with serious mental illness.

Additionally, future studies should employ broader search strategies that include terms such as “SMI and meaning-making”, “recovery and social determinants of health”, “meaning-making and poverty”, and “meaning-making in schizophrenia or SMI”. Expanding the search

terminology in this way may capture a wider body of literature and provide a more comprehensive understanding of how personal, social, and structural factors intersect to influence recovery outcomes.

Finally, greater attention should be given to individuals with SMI who experience poverty. Examining how socioeconomic disadvantage shapes meaning-making and recovery trajectories may help identify protective factors, unmet needs, and effective interventions. Such research has the potential to advance a more holistic understanding of recovery that recognizes the interconnected influence of psychological, social, economic, and environmental determinants of well-being.

Reference

- Field, A. [@andrewfield48]. (2026, June 21). What is suffering? Does it have meaning? [Cartoon]. Instagram. https://www.instagram.com/p/DZ3tQkMEbvS/?img_index=1
- About Recovery*. (2024, November 25). <https://www.samhsa.gov/substance-use/recovery/about>
- Åsbø, G., Haavind, H., Kruse, S. H., Wold, K. F., Hegelstad, W. T. V., Romm, K. L., Slade, M., Ueland, T., Melle, I., & Simonsen, C. (2025). “Why shouldn’t I expect a lot from life?” – a qualitative study of what facilitates long-term recovery in first-episode psychosis. *BMC Psychiatry*, 25(1), 423. <https://doi.org/10.1186/s12888-025-06681-y>
- Ayano, G., Tesfaw, G., & Shumet, S. (2019). The prevalence of schizophrenia and other psychotic disorders among homeless people: A systematic review and meta-analysis. *BMC Psychiatry*, 19, 370. <https://doi.org/10.1186/s12888-019-2361-7>
- Beres, D. (2025, May 4). Maga’s era of ‘soft eugenics’: Let the weak get sick, help the clever breed. *The Guardian*. <https://www.theguardian.com/us-news/ng-interactive/2025/may/04/maga-soft-eugenics>
- Bergström, T., Seikkula, J., Holma, J., Mäki, P., Köngäs-Saviaro, P., & Alakare, B. (2019). How do people talk decades later about their crisis that we call psychosis? A qualitative study of the personal meaning-making process. *Psychosis*, 11(2), 105–115. <https://doi.org/10.1080/17522439.2019.1603320>
- Beumont, P. J. V. (1992a). Phenomenology and the History of Psychiatry. *Australian & New Zealand Journal of Psychiatry*, 26(4), 532–545. <https://doi.org/10.3109/00048679209072085>
- Beumont, P. J. V. (1992b). Phenomenology and the History of Psychiatry. *Australian & New Zealand Journal of Psychiatry*, 26(4), 532–545. <https://doi.org/10.3109/00048679209072085>
- Bradshaw, W., Armour, M. P., & Roseborough, D. (2007). Finding A Place in the World: The Experience of Recovery from Severe Mental Illness. *Qualitative Social Work*, 6(1), 27–47. <https://doi.org/10.1177/1473325007074164>
- Braslow, J. T. (2013). The Manufacture of Recovery. *Annual Review of Clinical Psychology*, 9(1), 781–809. <https://doi.org/10.1146/annurev-clinpsy-050212-185642>
- Buonocore, M., Bosia, M., Baraldi, M. A., Bechi, M., Spangaro, M., Cocchi, F., Bianchi, L., Guglielmino, C., Mastromatteo, A. R., & Cavallaro, R. (2018). Achieving recovery in patients with schizophrenia through psychosocial interventions: A retrospective study. *Psychiatry and Clinical Neurosciences*, 72(1), 28–34. <https://doi.org/10.1111/pcn.12605>
- Burgy, M. (2008). The Concept of Psychosis: Historical and Phenomenological Aspects. *Schizophrenia Bulletin*, 34(6), 1200–1210. <https://doi.org/10.1093/schbul/sbm136>

- Cecil, D. P., & Žiaučyna, K. (2023). A Theoretical, Historical, and Socio-Economic Case for Saving Lives through Strategic Improvement of Mental Health Systems around the World. *Mental Health: Global Challenges*, 6(1), 16–28. <https://doi.org/10.56508/mhgcj.v6i1.145>
- Chiu, M. Y. L., Ho, W. W. N., Lo, W. T. L., & Yiu, M. G. C. (2010). Operationalization of the SAMHSA model of recovery: A quality of life perspective. *Quality of Life Research*, 19(1), 1–13. <https://doi.org/10.1007/s11136-009-9555-2>
- Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., Lehman, A., Tenhula, W. N., Calmes, C., Pasillas, R. M., Peer, J., & Kreyenbuhl, J. (2010). The 2009 Schizophrenia PORT Psychosocial Treatment Recommendations and Summary Statements. *Schizophrenia Bulletin*, 36(1), 48–70. <https://doi.org/10.1093/schbul/sbp115>
- Drake, R. E., Deegan, P. E., & Rapp, C. (2010). The Promise of Shared Decision Making in Mental Health. *Psychiatric Rehabilitation Journal*, 34(1), 7–13. <https://doi.org/10.2975/34.1.2010.7.13>
- Drake, R. E., & Whitley, R. (2014). Recovery and Severe Mental Illness: Description and Analysis. *The Canadian Journal of Psychiatry*, 59(5), 236–242. <https://doi.org/10.1177/070674371405900502>
- Ellison, M. L., Belanger, L. K., Niles, B. L., Evans, L. C., & Bauer, M. S. (2018). Explication and Definition of Mental Health Recovery: A Systematic Review. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(1), 91–102. <https://doi.org/10.1007/s10488-016-0767-9>
- Eneman, M., Vanhee, L., Liessens, D., Luyten, P., Sabbe, B., & Corveleyn, J. (2019). Humanistic Psychiatry and Psychotherapy: Listening to Patients as Persons in Search of Meaning. The Case of Schizophrenia. *Journal of Humanistic Psychology*, 59(2), 148–169. <https://doi.org/10.1177/0022167816637291>
- Erickson, B. (2021). Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963. *American Journal of Psychiatry Residents' Journal*, 16(4), 6–7. <https://doi.org/10.1176/appi.ajp-rj.2021.160404>
- Fond, G. B., Yon, D. K., Tran, B., Mallet, J., Urbach, M., Leignier, S., Rey, R., Misdrahi, D., Llorca, P.-M., Schürhoff, F., Berna, F., & Boyer, L. (2023). Poverty and inequality in real-world schizophrenia: A national study. *Frontiers in Public Health*, 11, 1182441. <https://doi.org/10.3389/fpubh.2023.1182441>
- Frank, R. G., & Glied, S. A. (2023). America's Continuing Struggle with Mental Illnesses: Economic Considerations. *Journal of Economic Perspectives*, 37(2), 153–178. <https://doi.org/10.1257/jep.37.2.153>

- Gonzales, L., Kois, L. E., Chen, C., López-Aybar, L., McCullough, B., & McLaughlin, K. J. (2022). Reliability of the Term “Serious Mental Illness”: A Systematic Review. *Psychiatric Services*, 73(11), 1255–1262. <https://doi.org/10.1176/appi.ps.202100661>
- Grassi, L., Nanni, M. G., Caruso, R., Ounalli, H., Chochinov, H. M., Biancosino, B., Testoni, I., Murri, M. B., Bertelli, T., Palagini, L., De Padova, S., & Tiberto, E. (2022). A comparison of Dignity Therapy narratives among people with severe mental illness and people with cancer. *Psycho-Oncology*, 31(4), 676–679. <https://doi.org/10.1002/pon.5913>
- Green, B., & García-Mieres, H. (2022). Construing journeys to recovery from psychosis: A qualitative analysis of first-person accounts. *Psychology and Psychotherapy: Theory, Research and Practice*, 95(4), 888–904. <https://doi.org/10.1111/papt.12408>
- Grodin, M. A., Miller, E. L., & Kelly, J. I. (2018). The Nazi Physicians as Leaders in Eugenics and “Euthanasia”: Lessons for Today. *American Journal of Public Health*, 108(1), 53–57. <https://doi.org/10.2105/AJPH.2017.304120>
- Group Guidelines and Principles of Support—NAMI Treasure Valley*. (2020, October 20). <https://namitreasurevalley.org/support-groups/guidelines/>
- Grunfeld, G., Park, S., & Fulford, D. (2026). Loneliness and psychosis: An integrative review. *Current Opinion in Psychiatry*, 39(3), 201–208. <https://doi.org/10.1097/YCO.0000000000001058>
- Hamm, J. A., Rutherford, S., Wiesepepe, C. N., & Lysaker, P. N. (2020). Community Mental Health Practice in the United States: Past, Present and Future. *Consortium Psychiatricum (English Ed. Online)*, 1(2), 7–13. <https://doi.org/10.17650/2712-7672-2020-1-2-7-13>
- Harper, D. (2012). Uncovering Recovery: The Resistible Rise of Recovery and Resilience. *Studies in Social Justice*, 6(1).
- Hay, C., Lloyd-Evans, B., & Conneely, M. (2026). Personal and Social Identity in Serious Mental Illness Recovery: What Do Mental Health Practitioners Think? *Counselling and Psychotherapy Research*, 26(3), e70184. <https://doi.org/10.1002/capr.70184>
- Hogg Foundation for Mental Health (Director). (2014, September 24). *Pat Deegan: Personal Medicine, Power Statements, and Other Disruptive Innovations* [Video recording]. <https://www.youtube.com/watch?v=hz7rv4s8ZTI>
- Howell, A., & Voronka, J. (2012). Introduction: The Politics of Resilience and Recovery in Mental Health Care. *Studies in Social Justice*, 6(1).
- Jeppsson, S. (2023). A Wide-Enough Range of ‘Test Environments’ for Psychiatric Disabilities. *Royal Institute of Philosophy Supplement*, 94, 39–53. <https://doi.org/10.1017/S1358246123000206>

- Jordan, G., Malla, A., & Iyer, S. N. (2020). Perceived facilitators and predictors of positive change and posttraumatic growth following a first episode of psychosis: A mixed methods study using a convergent design. *BMC Psychiatry*, 20(1), 289. <https://doi.org/10.1186/s12888-020-02693-y>
- Kreyenbuhl, J., Buchanan, R. W., Dickerson, F. B., & Dixon, L. B. (2010). The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2009. *Schizophrenia Bulletin*, 36(1), 94–103. <https://doi.org/10.1093/schbul/sbp130>
- Landolt, K., Rössler, W., Burns, T., Ajdacic-Gross, V., Galderisi, S., Libiger, J., Naber, D., Derks, E. M., Kahn, R. S., & Fleischhacker, W. W. (2012). Unmet needs in patients with first-episode schizophrenia: A longitudinal perspective. *Psychological Medicine*, 42(7), 1461–1473. <https://doi.org/10.1017/S0033291711002406>
- Lehman, A. F. (1999). Quality Of Care In Mental Health: The Case Of Schizophrenia. *Health Affairs*, 18(5), 52–65.
- Lim, C., Barrio, C., Hernandez, M., Barragán, A., & Brekke, J. S. (2017). Recovery From Schizophrenia in Community-Based Psychosocial Rehabilitation Settings: Rates and Predictors. *Research on Social Work Practice*, 27(5), 538–551. <https://doi.org/10.1177/1049731515588597>
- Linehan, M. M., & Wilks, C. R. (2015). The Course and Evolution of Dialectical Behavior Therapy. *American Journal of Psychotherapy*, 69(2), 97–110. <https://doi.org/10.1176/appi.psychotherapy.2015.69.2.97>
- Lomax, S., & Magid, K. (2024). Echoes from the past: How America’s major moments shaped mental health policies through a young adult lens. *The American Journal of Orthopsychiatry*, 94(4), 412–421. <https://doi.org/10.1037/ort0000751>
- Lost Patients*. (2024, September 24). NPR. <https://www.npr.org/podcasts/510377/lost-patients>
- Mak, W. W. S., Chan, R. C. H., & Yau, S. S. W. (2019). Brief Psychoeducation Program to Enhance Recovery Knowledge and Attitudes of Mental Health Service Providers and Users: Randomized Controlled Trials. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(2), 200–208. <https://doi.org/10.1007/s10488-018-0905-7>
- Managing Life with Serious Mental Illness*. (2023a, April 24). <https://www.samhsa.gov/mental-health/serious-mental-illness/managing-life>
- Managing Life with Serious Mental Illness*. (2023b, April 24). <https://www.samhsa.gov/mental-health/serious-mental-illness/managing-life>
- Mazor, Y., Gelkopf, M., & Roe, D. (2018). Posttraumatic growth among people with serious mental illness, psychosis and posttraumatic stress symptoms. *Comprehensive Psychiatry*, 81, 1–9. <https://doi.org/10.1016/j.comppsy.2017.10.009>

- Miranda-Ruche, X. (2025). The Reconstruction of Identity in the Context of Severe Mental Illness: A Qualitative Study of the Recovery Process. *Health & Social Care in the Community*, 2025(1), 4721343. <https://doi.org/10.1155/hsc/4721343>
- Moreno-Küstner, B., Martín, C., & Pastor, L. (2018). Prevalence of psychotic disorders and its association with methodological issues. A systematic review and meta-analyses. *PLoS ONE*, 13(4), e0195687. <https://doi.org/10.1371/journal.pone.0195687>
- Morgan, V. A., Waterreus, A., Carr, V., Castle, D., Cohen, M., Harvey, C., Galletly, C., Mackinnon, A., McGorry, P., McGrath, J. J., Neil, A. L., Saw, S., Badcock, J. C., Foley, D. L., Waghorn, G., Coker, S., & Jablensky, A. (2017). Responding to challenges for people with psychotic illness: Updated evidence from the Survey of High Impact Psychosis. *Australian & New Zealand Journal of Psychiatry*, 51(2), 124–140. <https://doi.org/10.1177/0004867416679738>
- Noordsy, D., Torrey, W., Mueser, K., Mead, S., O’Keefe, C., & Fox, L. (2002). Recovery from severe mental illness: An intrapersonal and functional outcome definition. *International Review of Psychiatry*, 14(4), 318–326. <https://doi.org/10.1080/0954026021000016969>
- Nugent, C. (n.d.). *SAMHSA’s Working Definition of Recovery*.
- O’Keeffe, D., Sheridan, A., Kelly, A., Doyle, R., Madigan, K., Lawlor, E., & Clarke, M. (2018). ‘Recovery’ in the Real World: Service User Experiences of Mental Health Service Use and Recommendations for Change 20 Years on from a First Episode Psychosis. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(4), 635–648. <https://doi.org/10.1007/s10488-018-0851-4>
- O’Keeffe, D., Sheridan, A., Kelly, A., Doyle, R., Madigan, K., Lawlor, E., & Clarke, M. (2022). A qualitative study exploring personal recovery meaning and the potential influence of clinical recovery status on this meaning 20 years after a first-episode psychosis. *Social Psychiatry and Psychiatric Epidemiology*, 57(3), 473–483. <https://doi.org/10.1007/s00127-021-02121-w>
- Saavedra, J., Arias-Sánchez, S., Matías-García, J. A., & Brzeska, J. (2022). “I don’t believe I’m going to recover from anything.” Understanding recovery amongst people with severe mental illness attending community health services in Spain. *Disability and Rehabilitation*, 44(20), 5974–5982. <https://doi.org/10.1080/09638288.2021.1954246>
- Segeren, M., Lauriks, S., Kikkert, M., Heering, J., Lommerse, N., Husen, G. van, & Verhoeff, A. (2022). Deinstitutionalization from the perspective of community-dwelling adults with a severe mental illness in Amsterdam: A cohort study protocol. *BMC Public Health*, 22, 1–14. <https://doi.org/10.1186/s12889-022-13291-w>
- Shern, D. L., Beronio, K. K., Minniear, C.-C. I., & Steverman, S. M. (2010). Comparative Effectiveness Research In Mental Health: An Advocate’s Perspective. *Health Affairs*, 29(10), 1857–1862.

SPIRIT Center at the University of Washington | Supporting Psychosis Innovation through Research, Implementation, & Training. (n.d.). Retrieved April 14, 2025, from <https://uwspiritcenter.org/>

Standfill, P. (2025, February 17). King County program offers early intervention and support for first-episode psychosis. *Valley Cities Behavioral Health Care*. <https://valleycities.org/king-county-program-offers-early-intervention-and-support-for-first-episode-psychosis/>

Tepavicharov, N. K., Christensen, J. R., Møller, T., Eplov, L. F., & Bjørkedal, S. T. B. (2022). “Moving on to an Open World”: A Study of Participants’ Experience in Meaningful Activities and Recovery (MA&R). *Occupational Therapy International*, 2022, 1–12. <https://doi.org/10.1155/2022/7418667>

Thai, H., Sharif, N., Patrick, K., Meldrum, C., Gamble, T., Robertson, C., Wright, N., Fogl, T., Webb, A., Tutino, J., Bahl, N., O’Brien, B., & Team, T. P. C.-D. (2021). A Participatory Action Research (PAR) exploratory initiative for psychosis recovery and resilience. *Psychosis*, 13(2), 143–153. <https://doi.org/10.1080/17522439.2020.1853202>

Topor, A., Boe, T. D., & Larsen, I. B. (2022). The Lost Social Context of Recovery Psychiatrization of a Social Process. *Frontiers in Sociology*, 7, 832201. <https://doi.org/10.3389/fsoc.2022.832201>

Topor, A., Borg, M., Di Girolamo, S., & Davidson, L. (2011). Not Just an Individual Journey: Social Aspects of Recovery. *International Journal of Social Psychiatry*, 57(1), 90–99. <https://doi.org/10.1177/0020764009345062>

Topor, A., Ljungqvist, I., & Strandberg, E. L. (2016). Living in poverty with severe mental illness coping with double trouble. *Nordic Social Work Research*, 6(3), 201–210. <https://doi.org/10.1080/2156857X.2015.1134629>

Turner, P. R. (2024). The Evolution of Self-Determination for People with Psychotic Disorders. *Ethics and Social Welfare*, 18(1), 71–87. <https://doi.org/10.1080/17496535.2023.2200256>

Van Sambeek, N., Franssen, G., Van Geelen, S., & Scheepers, F. (2023). Making meaning of trauma in psychosis. *Frontiers in Psychiatry*, 14, 1272683. <https://doi.org/10.3389/fpsy.2023.1272683>

Windell, D., & Norman, R. M. (2013). A qualitative analysis of influences on recovery following a first episode of psychosis. *International Journal of Social Psychiatry*, 59(5), 493–500. <https://doi.org/10.1177/0020764012443751>

/x/ poster (Director). (2023, August 24). *Bethel—Community and Schizophrenia in Northern Japan (2010)* [Video recording]. <https://www.youtube.com/watch?v=tLhYTWVA160>

Yadav, G., Ashraf, S., Saad, M., Mian, N., Naveed, M. A., Ali, A., Husain, K., Mansuri, Z., & Jain, S. (2025). Trends and disparities in schizophrenia related mortality in the United States: An

analysis of CDC WONDER database, 1999–2020. *Asian Journal of Psychiatry*, 108, 104496. <https://doi.org/10.1016/j.ajp.2025.104496>

Zahavi, D., & Loidolt, S. (2022). Critical phenomenology and psychiatry. *Continental Philosophy Review*, 55(1), 55–75. <https://doi.org/10.1007/s11007-021-09553-w>