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Recovery and practice-based evidence: reconnecting the diverging discourses in mental health

Introduction

Mental health professionals and those that use mental health services commonly begin from a similar position. Both parties seek the alleviation of mental health distress and believe that receiving support from others can be important in achieving this. From this point onward, however, mental health professionals have diverged from service users in (a) their ways of understanding distress, (b) their ways of seeking solutions for mental distress and consequently (c) in the type of solutions they promote.

Mental Health Professional Discourse

Causes of mental distress

Given the diversity of professional disciplines and specialisms within mental health it is understandable that a range of views exist about the key agents involved in the origin of mental distress. Nevertheless, across many disciplines the most dominant paradigm remains that of the “stress-diathesis” approach whereby constitutional or genetic predispositions to mental diseases are ‘triggered’ or exacerbated by environmental factors (Zuckerman, 1999).

Understandings of mental distress and Recovery

Deriving from traditional empirical and medical paradigms, professional conceptualisations have sought to discover the one ‘true’ nature of particular ‘illnesses’ and thereby develop effective ‘treatments’ for them. As a methodology this has been remarkably successful in many areas of medicine with medical interventions advancing in their efficacy at a significant rate (Coleman et al., 2011). Given Psychiatry’s identity as a medical profession and their professional power as the dominant discipline within the mental health system (Pilgrim and Rogers, 2009), it is unsurprising that this also became the dominant methodology in attempts to alleviate mental distress. This approach was also adopted to a large degree by other mental health disciplines engaged in researching mental health difficulties. Such an approach has been described by Collins (2016) in the following terms:

“Once upon a time, the task of mental health professionals and academic researchers seemed relatively straight-forward. Classify and categorise the different varieties of mental distress out there, establish threshold boundaries between being ill and being well, and then empirically test out what makes people better.”

(Collins, 2016 pg. 25).

Similarly Slade and Longden (2015) have outlined seven traditional attitudes to mental health embedded in the professional discourse within the mental health system (while also producing empirical evidence to contest each of these):

“recovery is best judged by experts or using standardised assessment; few people with mental health problems recover; if a person no longer meets criteria for a mental illness, they are in remission; diagnosis is a robust basis for characterising groups and predicting need; treatment and other supports are important factors for improving outcome; the barriers to receiving effective treatment are availability, financing and client awareness; and the impact of mental illness, in particular schizophrenia, is entirely negative”

Slade and Longden (2015 pg. 1)

While paradigms such as that of the ‘biopsychosocial’ approach to understanding mental distress have become more popular in recent decades, the use of diagnostic classification systems (e.g. DSM-V and ICD-10) in treatment, and to justify research, is ubiquitous. The philosophy that severe mental distress is best understood as deriving from a disease process that requires accurate diagnosis and treatment, resulting in symptom reduction or elimination, remains the dominant professional paradigm within which mental health services work (Cohen et al., 2004; Glasby and Beresford, 2006).

Sources of Recovery (and their limitations)

In professional terms, the dominant paradigm translated to an expectation that all mental health professionals would closely follow developments within the research field and continuously evolve their practice to deliver those interventions for which there was best evidence. The main arbitrators of what constituted best evidence (e.g. the National Institute for Clinical Excellence: NICE) outline a clear hierarchy of evidence where meta-analyses of RCTs constitute the ‘gold standard’. In practical terms, this resulted in the active promotion of particular medications and psychological therapies (predominately individual-based), as these tended to be the ‘treatments’ with the greatest level of associated research.

The attraction of such an ‘evidence-based’ approach was manifold. It aligned mental health professionals with well-respected disciplines in other areas of healthcare. It seemed to

provide clarity, consistency and a pathway to ever-improving interventions. There was initial evidence of success, with particular medications and psychological interventions appearing to perform vastly superior to placebos (Lambert 2005; Seligman 1995). It also fit with standard conceptualisations within a western culture of what healthcare professionals should be doing. Finally, it allowed professional guilds to emerge which could claim exclusive knowledge and skills justifying their employment and remuneration (Pilgrim, 2003).

In many respects had this paradigm produced ever-improving results similar to certain areas of medicine (e.g. cancer care - Coleman et al. 2011) then less questioning of its appropriateness may have arisen. The unfortunate reality, however, was that this approach, even in the rarefied conditions of controlled trials, has failed in recent times to produce results significantly superior to those being produced when RCTs were first utilised in the 1970s and 1980s. The best psychiatric medications have “numbers-needed-to-treat” of 3 to 10 (Arroll, et al., 2009, Hodgson et al., 2011; Ketter et al., 2011), that is to say that, at best, only 1 out of every 3 individuals treated with the medication demonstrated a clinically significant improvement. Psychological interventions similarly, when drop-outs were included, showed NNTs of 3 (Westen and Bradley, 2005) in the most effective trials. In essence, the majority of people were not getting better exclusively as a result of the work of mental health professionals.

This matched clinicians’ experience on the front-line. Although within the professional community responses included suspicion about ‘medication compliance/concordance’, which then spawned psychological interventions aimed at compliance with medication regimes – ‘concordance therapy’ (Morris and Schulz, 1992). It also led to research where the blame for the ineffectiveness of interventions was implicitly placed at the door of service users i.e. they had a ‘treatment-resistant disorder’ (Sackeim, 2001) or, in relation to psychological therapies, they lacked motivation (DiClemente et al., 2008) or hadn’t had positive enough expectations about the therapy (Meyer et al., 2002).

Within the mental health disciplines it was also, however, increasingly questioned whether rigidly applying interventions developed in atypical circumstances (i.e. those of RCTs) was appropriate (Williams and Garner, 2002). In particular, clinicians queried whether service users with multiple difficulties (‘co-morbidities’) in very challenging social circumstances would be best helped by interventions developed through work with individuals with specific

difficulties ('unimorbid') without the challenging circumstances typical of many presentations.

In addition, the longitudinal evidence was showing that despite the limitations of the interventions being offered, service users were recovering and at levels vastly in excess of what had previously been believed. Longitudinal research (e.g. Marneros et al., 1989; Harrison et al, 2001) was increasingly showing that even with those conditions most felt to be chronic and enduring (e.g. Schizophrenia) the majority of service users were clinically recovering if followed for a period of 20+ years. This seems to justify a re-examination of what exactly was facilitating recovery and in particular a renewed interest in the service users own perspective of 'what works for whom'.

Service User Discourse

Causes of mental distress

An examination of the literature in this area reveals that service users tend to have quite different perspectives on mental distress, and its alleviation, from that of mental health professionals, researchers and service providers (see Davidson and Roe, 2007). A tolerance for multiple different narratives about ill-health and its causes exists – rather than an insistence on associating emotional distress with specific medical disorders. There is also a strong sense from this literature that illness and wellness are best judged by the person living with the experience, rather than by professionals using standardised tools, and that recovery can take place through various idiosyncratic routes (Whitley and Drake, 2010).

Service users often report being given a range of different diagnoses during their engagement with services (Cooke et al., 2014). Many others believe that they do not suffer from any 'disorder' and that their 'symptoms' are part of their personality, or that they can be a positive and beneficial experience in some way (Curtis et al., 2000). This may link with the fact that diagnostic criteria for these disorders are regularly being changed and adapted due to low reliability (Slade and Longden, 2015), with the very existence of many disorders currently being called into question (Maddux, 2008). Others highlight the influence of social factors, such as poverty and support networks (Clark, 2014), and life events, such as trauma (Cooke et al., 2014), on the so-called 'abnormal' experiences of individuals.

Understandings of mental distress and Recovery

Traditionally, recovery from mental distress was seen as reduced symptomatology and a return to previous levels of functioning (Lieberman et al., 2008). Known as ‘clinical recovery’, this is seen as one pole in a dichotomous category (between ‘recovered’ and ‘not recovered’), which can be objectively measured and rated by professionals, and does not vary between individuals (Slade, 2009). This understanding of recovery, however, has been contested in recent decades, particularly by the service user movement. Service users report understanding recovery as a process or continuum, which is subjectively defined and can differ between individuals (Ralph, 2000); this understanding has led to the use of the term ‘personal recovery’ to differentiate it from traditional definitions. Personal recovery is understood as being much more than the clinical remission of symptoms, and focuses instead on attaining a personally acceptable standard of living (Law and Morrison, 2014). One well known definition of personal recovery provided by Anthony identifies it as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles... a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness” (Anthony, 1993 pg. 17).

In 2011, Leamy, Bird, Le Boutillier, Williams and Slade conducted a quantitative systematic review and a qualitative synthesis of the research on service users’ first-person accounts of recovery. From this, they identified that the recovery journey could be characterised by five processes: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment, giving the acronym CHIME.

Sources of Recovery

Along a similar vein, the Scottish Recovery Network (SRN, 2007) launched a Narrative Research Project in which they interviewed 67 individuals who were recovered, or in recovery from, long-term mental health issues. The resulting booklet “Routes to Recovery” highlights that the path to recovery is an individual process, where clinical treatment often only represents one aspect of an individual’s recovery journey. For some people recovery is about regaining a life similar to the one they had before the onset of their illness. For others, however, it is about discovering a new way of living a fulfilling life despite the enduring effects of their condition (Roe, Chopra & Rudnick, 2004). Many service-users see recovery as an active process – that is, something that they have to participate in and engage with, and not something that can be done to them.

“It is – it’s a personal thing. You can’t say to someone do this, do that, and do the next thing and you’ll be fine... you have to take ownership” (SRN, 2007).

The differences in this discourse, from that of the traditional professional-centred discourse on mental health, potentially highlight one of the sources of tension in the relationship between service providers and receivers. These differences along with the evidence highlighting the limitations of traditional diagnosis and treatment of mental illness, would suggest that it may be helpful to examine an alternative, more ‘service user-informed’ approach to the alleviation of mental distress.

Practice-Based Evidence

Fortunately attempts already exist, to bring together in a live, ongoing fashion, the experience of service users as well as the expertise of mental health professionals. The use of ‘Practice-based evidence’ seeks to utilise the rigour of empiricism (“checking out whether this actually works”) but at an individual, rather than a population or diagnostic level. In essence, this involves clinicians measuring on a contact-by-contact basis whether their input is giving rise to positive results. Furthermore, many advocates of ‘practice-based evidence’ utilise measures that explicitly seek to elicit the service user experience of the therapy and their perspective on whether it is meeting the service user’s goals for such work (see the ‘Outcome Rating Scale’ and ‘Session Rating Scale’; Miller et al., 2003; Duncan et al., 2003). This contrasts with a symptom-checklist method which privileges professional-centred views of mental distress and the purpose of therapy (i.e. the reduction of symptoms).

Such an approach does not reject the value of traditional evidence but seeks rather to utilise it in a particularly bespoke and responsive fashion. For example, someone who attends a service seeking help for low mood might be initially offered ‘CBT for depression’ if the alleviation of low mood is the service user’s primary goal. However, the progress of such work in achieving such an aim would be monitored not only by symptom checklists (e.g. BDI at beginning, middle and end of contact) but potentially more importantly by session by session rating on whether this way of working was a good ‘fit’ and was giving rise to improvements of value to the service user. Furthermore, if this work didn’t appear to be helping the practitioner would actively explore alternative approaches to be of help. Such an exploration might examine other ‘evidence-based’ approaches (e.g. anti-depressants, IPT,

behavioural couples work, psychodynamic) but also seek to learn from the service user's own feedback on what has helped in the past (e.g. reconnecting with particular people, finding a meaningful role, seeking out experience which restore a sense of agency or empowerment) and actively incorporate that as part of any further support. Such latter elements could be deeply idiosyncratic (e.g. getting a hamster, listening to folk music, building garden fences) but would again be guided by the evidence from the past and ongoing monitoring of whether it was working this time round for this service user. Figures 1 and 2 help outline this approach, where the progress towards a common goal (either personal or symptom specific) is monitored on a session-by-session basis and adapted in light of the information obtained, until the goal is achieved. In effect such close monitoring of outcomes would constitute true 'empiricism in action'.

The importance of the therapeutic approach being fundamentally responsive to the needs and wishes of the service user is not a new idea. The longstanding research on the importance of the therapeutic alliance in predicting outcome (Lambert and Ogles, 2004; Luborsky, 1994) would seem to support the importance of adapting an approach to meet the service user individual preferences. Indeed from the 1940s/50s Carl Rogers had found that it was not exclusively the technical expertise of the clinician that service users found helpful, but rather the process of being listened to, taken seriously, offered choices and treated with dignity and respect (Rogers, 1942). Most recently, this is what one participant in the SRN 'Routes to Recovery' document stated was most helpful for them:

"Their approach was just amazingly different. They were actually offering it (CBT) to you... (They were) putting things in front of you and saying, "we think this could be beneficial, what do you think?", and that made a big difference. They gave you a bit of choice". (SRN, 2007)

Using an approach that is bespoke to the service user is also very much in keeping with the broader Recovery ethos in mental health services. Henderson and colleagues (2009) and Ashcroft and Anthony (2008) suggest that considering service user preferences and suggestions when choosing an intervention, including crisis planning and risk management, promotes empowerment and self-management, two crucial Recovery concepts. Further research suggests that services would be improved through the development of meaningful relationships with service-users where they are included in the decision making process in

relation to their treatment options (Bracken et al., 2012). If clinical services are serious about operating from a Recovery-based model, then a treatment process which actively includes the service user's feedback on the apparent success and failure of different treatment options, in the way that practice-based evidence would, could certainly help to achieve this.

This approach also mirrors contemporary views exploring the development of mental health difficulties as an idiosyncratic process, with an epigenetic basis (see Nolte et al., 2011). This approach sees the intertwining of environmental and genetic influences on later development as inherently unique to the individual even if its manifestations can be similar across individuals. However, there being such an idiosyncratic genesis to such difficulties would appear to support the concept that one should similarly seek idiosyncratic solutions.

Figure 1 : Reconnecting Diverging Discourses of Mental Health Professionals and Service Users Using Practice-Based Evidence

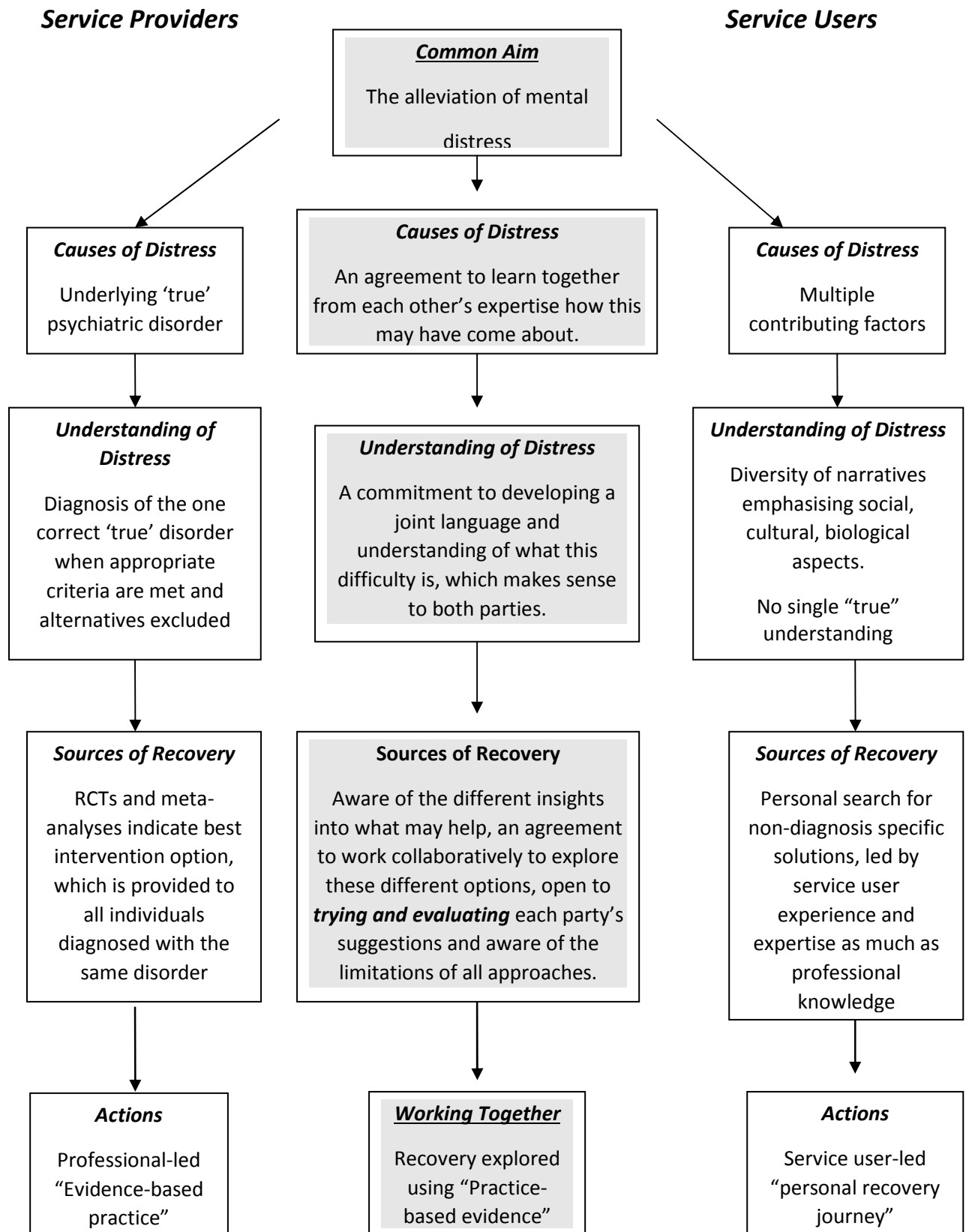
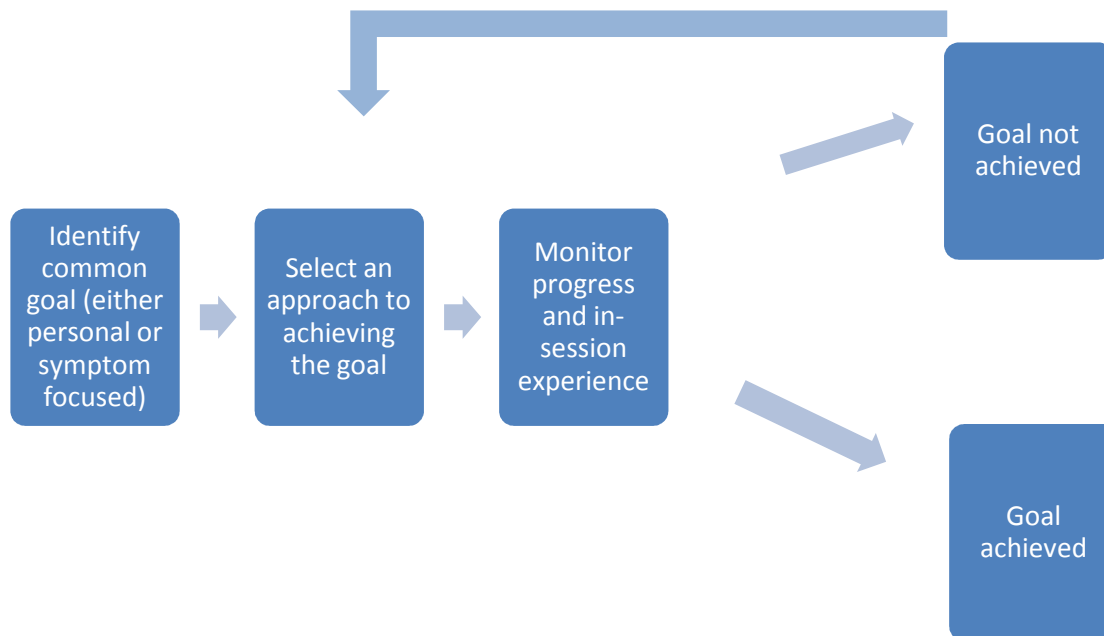


Figure 2: Steps towards using Practice-Based Evidence to Facilitate Recovery-Orientated Collaborative Clinical Work



Conclusion

It is evident that the discourse which exists around the cause and treatment of mental distress differs greatly between service users and service providers. The perspectives of service users include a diversity of individual narratives about ill-health and its causes, as well as regarding the most effective actions towards achieving recovery. This differs markedly from the professional desire to match particular treatments to specific diagnoses based on the best available evidence. As such, it may be helpful to examine an alternative, ‘service user-informed’ approach to the alleviation of mental distress, while still incorporating the benefits of an empirical approach. This would involve an ongoing review of the service user’s experience of any intervention, as well as a measure of how effective this approach was to meeting the collaboratively agreed goals. ‘Practice-based evidence’ could help to achieve this in a way ‘evidence-based practice’ does not, by providing an informed ‘trial and error’ process which includes engaging with client and utilising their expertise, rather than imposing an approach upon them based on professional-centred frameworks. In this way practice-based evidence provides a practical and pragmatic approach to true collaborative

working, and a means of helping services remain true both to their traditional commitment to scientific empiricism and their stated desire to truly be “recovery-oriented”.

References

- Anthony, W.A. (1993), “Recovery from mental illness: The guiding vision of the mental health service system in the 1990s”, *Psychosocial rehabilitation journal*, Vol. 16 No. 4, pp. 11-23.
- Arroll, B., Elley, C.R., Fishman, T., Goodyear-Smith, F.A., Kenealy, T., Blashki, G., Kerse, N. and MacGillivray, S. (2009), “Antidepressants versus placebo for depression in primary care”, *Cochrane Database of Systematic Reviews*, Issue 3. Art. No.: CD007954. DOI: 10.1002/14651858.CD007954.
- Ashcraft, L., & Anthony, W. (2008). Eliminating seclusion and restraint in recovery-oriented crisis services. *Psychiatric Services*, 59(10), 1198.
- Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., Bhunnoo, S., Browne, I., Chhina, N., Double, D. and Downer, S. (2012), “Psychiatry beyond the current paradigm”, *The British Journal of Psychiatry*, Vol. 201 No. 6, pp. 430-434.
- Clark, T. and Heath, A. (2014), *Hard Times: The Divisive Toll of the Economic Slump*, Yale University Press, London, U.K.
- Cohen, A.M., Stavri, P.Z. and Hersh, W. R. (2004), “A categorisation and analysis of the criticism of evidence-based medicine”, *International Journal of Medical Informatics*, Vol. 73, pp. 35–43.
- Coleman MP, Forman D, Bryant H, Butler J, Rachet B, Maringe C, Nur U, Tracey E, Coory M, Hatcher J, McGahan CE. (2011) Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data. *The Lancet*. Jan 14;377(9760):127-38.
- Collins, P. (Ed.) (2016) “Recovery: a journey for all disciplines”, National Office for Advancing Recovery in Ireland. HSE: Mental Health Division, Dublin, Ireland.

- Cooke A, Basset T, Bentall R, Boyle M, Cupitt C, Dillon J, Freeman D, Garety P, Harper D, Johnstone L, Kinderman P. (2014) *Understanding psychosis and schizophrenia*. London: British Psychological Society.
- Curtis, T., Dellar, R., Leslie, E. (2000), *Mad Pride: A Celebration of Mad Culture*, Chipmunka publishing, London, U.K.
- Davidson, L. and Roe, D. (2007), "Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery", *Journal of Mental Health*, Vol. 16 No. 4, pp. 459-470.
- DiClemente, C. C., Nidecker, M., & Bellack, A. S. (2008), "Motivation and the stages of change among individuals with severe mental illness and substance abuse disorders", *Journal of Substance Abuse Treatment*, Vol. 34 No. 1, pp. 25-35.
- Duncan, B.L., Miller, S.D., Sparks, J.A., Claud, D.A., Reynolds, L.R., Brown, J. and Johnson, L.D. (2003), "The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure", *Journal of Brief Therapy*, Vol. 3 No. 1, pp. 3-12.
- Glasby, J. and Beresford, P. (2006), "Who knows best? Evidence-based practice and the service user contribution, commentary and issues", *Critical Social Policy*, Vol. 26 No. 1, pp. 268–284.
- Harrison G, Hopper KI, Craig T, Laska E, Siegel C, Wanderling J, Dube KC, Ganev K, Giel R, Der Heiden WA, Holmberg SK. Recovery from psychotic illness: a 15-and 25-year international follow-up study. *The British journal of Psychiatry*. 2001 June 1;178(6):506-17.
- Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmukler, G. (2009). Views of service users and providers on joint crisis plans. *Social psychiatry and psychiatric epidemiology*, 44(5), 369-376.
- Hodgson, R., Cookson, J. and Taylor, M. (2011), "Numbers-needed-to-treat analysis: an explanation using antipsychotic trials in schizophrenia", *Advances in Psychiatric Treatment*, Vol. 17 No. 1, pp.63-71.

- Ketter, T.A., Citrome, L., Wang, P.W., Culver, J.L. and Srivastava, S. (2011), "Treatments for bipolar disorder: can number needed to treat/harm help inform clinical decisions?", *Acta Psychiatrica Scandinavica*, Vol. 123 No. 3, pp. 175-189.
- Lambert, M. J. & Ogles, B. M. (2004), "The efficacy and effectiveness of psychotherapy", in Lambert, M. (Ed.), *Handbook of Psychotherapy and Behavior Change*, Wiley, New York, N.Y., pp. 139-193.
- Lambert, M. J. (2005), "Early response in psychotherapy: Further evidence for the importance of common factors rather than "placebo effects"", *Journal of Clinical Psychology*, Vol. 61 No 7, pp.855-869.
- Law, H. and Morrison, A.P. (2014), "Recovery in Psychosis: A Delphi study with experts by experience", *Schizophrenia Bulletin*, Vol. 40 No. 6, pp. 1347-.1355.
- Lieberman, J.A., Drake, R.E., Sederer, L.I., Belger, A., Keefe, R., Perkins, D. and Stroup, S. (2008), "Science and recovery in schizophrenia", *Psychiatric Services*, Vol. 55 No. 5, pp. 487-496.
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J. and Slade, M. (2011), "Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis", *The British Journal of Psychiatry*, Vol. 199 No. 6, pp. 445-452.
- Longden, E. (2014), *Learning from the voices in my head (e-book)*, TED Books, New York, N.Y.
- Luborsky, L. (1994), "Therapeutic alliances predictors of psychotherapy outcomes: Factors explaining the predictive success--New directions", in Horvath, A. and Greenberg, L. (Eds.), *The Working Alliance: Theory, Research and Practice*, Wiley, New York, NY, pp. 38-50.
- Marneros A, Deister A, Rohde A, Steinmeyer EM, Jünemann H. Long-term outcome of schizoaffective and schizophrenic disorders: A comparative study. *European archives of psychiatry and neurological sciences*. 1989 Mar 1;238(3):118-25.
- Meyer, B., Pilkonis, P. A., Krupnick, J. L., Egan, M. K., Simmens, S. J., & Sotsky, S. M. (2002), "Treatment experiences, patient alliance and outcome: Further analyses from the National Institute of Mental Health Treatment of Depression Collaborative

- Research Programme”, *Journal of Consulting and Clinical Psychology*, Vol. 70 No. 4, 1051-1055.
- Miller, S.D., Duncan, B.L., Brown, J., Sparks, J.A. and Claud, D.A. (2003), “The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure”, *Journal of Brief Therapy*, Vol. 2 No. 2, pp.91-100.
- Morris, L.S. and Schulz, R.M. (1992), “Patient compliance—an overview”, *Journal of Clinical Pharmacy and Therapeutics*, Vol. 17 No. 5, pp. 283-295.
- Maddux, J.E. (2008), “Positive Psychology and the Illness Ideology: Toward a Positive Clinical Psychology”, *Journal of Applied Psychology*, Vol 57, pp. 54–70.
- Nolte T, Guiney J, Fonagy P, Mayes LC, Luyten P. (2011), “Interpersonal stress regulation and the development of anxiety disorders: an attachment-based developmental framework”, *Frontiers in Behavioral Neuroscience*, Vol 5 No 55, pp. 1-21.
- Pilgrim, D. & Rogers, A. (2009), “Survival and its discontents: the case of British psychiatry”, *Sociology of Health & Illness*, Vol. 31 No. 7, pp. 947-961.
- Pilgrim, D. (2003), “Six threats to the sustainability of clinical psychology”, *Clinical Psychology*, Vol. 28, pp. 6-8.
- Ralph, R. O. (2000). Recovery. *Psychiatric Rehabilitation Skills*, 4(3), 480-517.
- Roe, D., Chopra, M., & Rudnick, A. (2004), “Coping with mental illness: People as active agents interacting with the disorder”, *The Journal of Psychiatric Rehabilitation*, Vol. 28, pp. 122 – 128.
- Rogers, C. R. (1942), *Counseling and Psychotherapy; Newer Concepts in Practice*, Houghton Mifflin, Boston, MA.
- Sackeim, H. A. (2001), “The definition and meaning of treatment resistant-depression”, *Journal of Clinical Psychiatry*, Vol. 62, pp. 10-17.
- Scottish Recovery Network (2007), “Routes to Recovery. Collected Wisdom from the SRN Narrative Research Project”, Scottish Recovery Network, Glasgow, U.K.
- Seligman, M.E. (1995), “The effectiveness of psychotherapy: The Consumer Reports study”, *American Psychologist*, Vol. 50 No. 12, pp. 965-974.

- Slade, M. (2009), "Personal Recovery and Mental Illness: a guide for mental health professionals", Cambridge University Press, Cambridge, UK.
- Slade, M. and Longden, E. (2015), "Empirical evidence about recovery and mental health", *BioMed Central Psychiatry*, Vol. 15 No. 1, pp. 1-14.
- Slade, M., Amering, M. and Oades, L. (2008), "Recovery: An international perspective", *Epidemiologia e Psichiatria Sociale*, Vol. 17 No. 2, pp. 128-137.
- Westen, D. and Bradley, R. (2005), "Empirically supported complexity rethinking evidence-based practice in psychotherapy", *Current Directions in Psychological Science*, Vol. 14 No. 5, pp. 266-271.
- Whitley, R. and Drake, R.E. (2010), "Recovery: a dimensional approach", *Psychiatric Services*, Vol. 61 No. 12, 1248-1250.
- Williams, D., and Garner, J. (2002), "The case against 'the evidence': a different perspective on evidence-based medicine", *The British Journal of Psychiatry*, Vol. 180 No. 1, pp. 8-12.
- Zuckerman, M., (1999), *Vulnerability to Psychopathology: A Biosocial Mode*, American Psychological Association, Washington, DC.