

“Recovery is fearful to me...”: Conceptualizations, concerns and hopes about personal recovery in adults who are chronically homeless

Dimitar Karadzhov PhD 

Centre for Health Policy, School of Social Work and Social Policy, University of Strathclyde, Glasgow, UK

ABSTRACT

This qualitative investigation explored how 18 chronically homeless adults with serious mental illness residing in emergency and temporary supportive housing facilities in Glasgow, Scotland, and New York City conceptualized personal recovery. Thirty-six interviews were conducted and analyzed using interpretative phenomenological analysis. The analysis produced four superordinate themes revealing how participants engaged with, envisioned, or disidentified with, the recovery idea, in the context of chronic life adversity, co-occurring conditions, a precarious present and an uncertain future. Health and social care providers should be responsive to clients' diverse ideas about recovery and facilitate their exploration of authentic pathways to a “good life.”

KEYWORDS

Personal recovery; homelessness; qualitative; serious mental illness; mental health; social work; chronic illness

Introduction

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA, 2022a) has recognized that personal recovery in people with mental conditions “[. . .] is characterized by continual growth and improvement in one's health and wellness and managing setbacks.”. While symptom remission may be part of personal recovery, personal recovery (or simply “recovery” hereafter) encompasses a broader range of outcomes such as gains in both physical and socio-emotional well-being, as well as the attainment of a stable home and a meaningful contribution to society (Davidson et al., 2008; SAMHSA, 2022a; Topor, Fredwall, Hodoel, & Larsen, 2021). The rebuilding of a sense of control, hope and purpose has been shown to be central to recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Clinical recovery, in contrast, is synonymous with the reduction in clinical symptomatology and improvements in general functioning and productivity (Slade, Amering, & Oades, 2008). Clinical recovery is believed to be objectively measurable, largely universal in nature, and induced by clinical interventions (Slade et al., 2008) – a premise that has been critiqued for de-contextualizing suffering and

CONTACT Dimitar Karadzhov  karadzhov.d@gmail.com  University of Strathclyde, McCance Building, 16 Richmond Street, Glasgow G1 1XQ

© 2022 The Author(s). Published with license by Taylor & Francis Group, LLC.

This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

neglecting individuals' unique strengths, values and social ecologies (Bonney & Stickley, 2008). Rather, as Slade and colleagues (2008, p. 130) argue, “[r]ecovery is not a step-by-step process but one based on continual growth with occasional setbacks.” The recovery journey has been described as an exploration entailing both risks and rewards (Liggins, 2018).

Diverse conceptualizations of recovery

Research has emphasized the need to give primacy to individuals' own definitions of recovery and support them in their reflective engagement with this process (Gwinner, Knox, & Brough, 2013). However, research capturing divergent views such as the disidentification with, or rejection of, the recovery paradigm has been relatively rare, especially among socio-economically, demographically and ethnically diverse groups (Leamy et al., 2011; O’Keeffe et al., 2022; Rose, 2014). As Gwinner and colleagues (2013) incisively observe, individuals' negotiation of the meaning of recovery “[...] is largely avoided and indeed remains problematic for many” (p. 102). In one such rare example, Saavedra et al.'s (2021) qualitative study with 51 community health service-users in Spain aimed to gather “a wider range of conceptualisations” (p. 2) of personal recovery. It found that participants' understandings often did not neatly fit within popular models of personal recovery and encompassed biomedical conceptualizations, conceptualizations of recovery as a process of resistance pervaded by setbacks, and skepticism toward the possibility of recovery. Notably, their participants often held diverse definitions of recovery simultaneously, illustrating the complex and evolving nature of individuals' relationship with it. Furthermore, O’Keeffe and colleagues' (2022) thematic analysis of meanings of personal recovery in 20 individuals with long-term psychosis, half of whom were evaluated as “clinically recovered”, and the other half – as “not clinically recovered”, underscores the ambivalence and contradictoriness of the personal recovery process. Some of the main themes pertain to participants' apprehension arising from navigating multiple definitions of recovery, each of which placed different expectations upon participants, and some participants' explicit disidentification with the recovery idea.

Homelessness and serious mental illness: impediments to recovery

Safe and stable housing is a fundamental condition for sustained treatment engagement, citizenship and long-term recovery (SAMHSA, 2022a). Homelessness has been persistently linked to a higher incidence of co-occurring serious mental illness and problem substance use compared to the general population (Scottish Public Health Observatory, 2021). Epidemiological estimates among different homeless subpopulations in the U.S. have indicated prevalence rates of co-occurring disorders of 26–37%

(SAMHSA, 2020). In Scotland, 27% of homelessness applicants in 2019/20 reported having a mental health problem (Scottish Public Health Observatory, 2021). This multimorbidity is exacerbated by the poorer access to appropriate, well-integrated health and social services faced by this population (Omerov, Craftman, Mattsson, & Klarare, 2020; SAMHSA, 2021; Scottish Government, 2018).

Across both the U.S. and Scotland, due to the inadequate housing availability and the slow roll-out and underfunding of innovative permanent supportive housing programmes such as Housing First, many homeless individuals continue to face extended stays in temporary housing facilities such as night shelters, hostels and interim housing – posing further barriers to housing stability, mental health treatment engagement, community integration and citizenship (Coalition for the Homeless, 2020; Watts, Littlewood, Blenkinsopp, & Jackson, 2018). Clients' experiences in those living arrangements are often characterized by delays, precarity, a lack of choice, frustrations, and the exposure to violence and other anti-therapeutic environmental triggers, which all impede their mental well-being and recovery (Irving, 2021; Zerger et al., 2014).

Transitioning from homelessness

The modest number of studies examining individuals' experiences of temporary housing and transitioning from homelessness have yielded conflicting findings regarding those individuals' preparedness to engage in recovery and envision a meaningful life post-rehousing. To demonstrate, while some of Macnaughton and colleagues' (2016) Canadian housing services (including Housing First) participants discussed regaining freedom, autonomy and better self-management, and shifting their orientation from the present (i.e. being in a "*survival mode*") to the future, others grappled with feeling "stuck," devising feasible plans and forging paths back to the community. As the authors theorize, those transitions are ultimately about "*becoming future oriented*" and envisioning "*possible selves*" and "*reclaiming personhood beyond illness*" (p. 152).

While some studies have highlighted residents' hopefulness and optimism, "*vision for recovery*" and "*clear visualisation*" of the role of housing in recovery (Kirst, Zerger, Harris, Plenert, & Stergiopoulos, 2014, p. 6; Henwood et al., 2013), others have demonstrated residents' barriers to envisioning a desired future (Irving, 2021; Zerger et al., 2014). For instance, Irving's (2021) study found variations in the ability to envision a "good life" among hostel residents in England, as a result of the adverse contextual conditions and the short-termism fueled by chronic drug use. Last but not least, Zerger et al.'s (2014) study with interim housing clients in Canada found that clients' non-housing recovery goals tended to be neglected, with providers' housing-related

workload often displacing attention to clients' holistic needs. The authors argue that this may impede long-term recovery and engagement with services.

Study rationale and aims

Few qualitative studies have explored how individuals who are currently homeless and reside in temporary accommodation conceptualize personal recovery. Drawing from a larger investigation of the barriers to, and facilitators of, personal recovery in chronically homeless adults in Scotland and New York City (NYC), this study explores individuals' attitudes toward, and experience of, personal recovery. In contrast to extant studies with participants considered "*recovered*" or having "*markers of mental health recovery*" (Henwood, Padgett, Smith, & Tiderington, 2012, p. 239; Topor et al., 2021; Fullagar & O'Brien, 2014), the present study purposefully imposed no such eligibility criteria so as to capture a broader range of lived experience and views of the possibility and/or acceptability of recovery.

Methods

Settings and sampling

This qualitative study was conducted in several homeless services in NYC, U.S., and Glasgow, Scotland, between February and September 2018. Gathering the perspectives of diverse individuals in different settings allows for a richer, more sophisticated understanding, especially of underresearched phenomena (Robinson, 2014). Specifically, it was anticipated that the transatlantic data collection would yield insights from groups historically underrepresented in the recovery scholarship, particularly ethnoracial minorities (Leamy et al., 2011).

Intensity sampling, a purposive sampling technique for maximizing theoretical insights by including "*information-rich case[s] that manifest the phenomenon intensely*" (Robinson, 2014, p. 35), was applied to identify appropriate geographical settings, service types and participant profiles. Scotland and the U.S. were selected as they have had persistently high rates of income inequality and homelessness – higher than most other developed countries – posing significant challenges to realizing the recovery ideal (Shinn, 2010). Chronic homelessness (defined as "*an individual with a disability who has been continuously homeless for one year or more or has experienced at least four episodes of homelessness in the last three years where the combined length of time homeless in those occasions is at least 12 months.*" (U.S. Department of Housing and Urban Development, 2017, p. 2) was focused on as an "*intense*" manifestation of health inequalities and social exclusion. Accordingly, service providers offering support to homeless clients with complex needs, including

chronic homelessness, were targeted. The drop-in center and two of the temporary housing facilities were located in NYC; those were low-threshold residential facilities for homeless clients with complex needs (“safe havens”) – characterized by the less strict curfew and sobriety policies, and the lack of limits on the allowed length of stay (Coalition for the Homeless, 2020). The other two facilities were located in Glasgow (Scotland) – a temporary accommodation (assessment center) facility for homeless men, and an emergency residential facility for women.

Finally, to understand the experience of recovery amidst significant mental health-related disability, individuals with a history of an SMI diagnosis were recruited. SMI refers to “*a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities*” (SAMHSA, 2022b). At each site, service providers assisted with recruitment by identifying and referring clients who met the eligibility criteria: being 18 years of age or older and having the decisional capacity to provide informed consent, and having a history of SMI diagnosis and chronic homelessness.

Data collection

The study consisted of two semi-structured life story interviews, which focused on participants’ housing history, most significant life events or “chapters,” critical/transition points, sources of strength and hardship, and hopes for the future (Stott & Priest, 2018). The life story interviews served to contextualize participants’ perceptions of, and attitudes toward, recovery as embedded within their social contexts and biographies. Participants were also asked about their present-day life, values, hopes and priorities, and ideas about well-being, recovery and the “good life” (Nott & Vuchinich, 2016). In the latter stages of the interviews, participants were encouraged to define recovery in their own words (e.g. “*I wonder if you have heard about the term ‘recovery’ as applied to your mental health or substance use. If yes, what does ‘recovery’ mean to you?*”; “*Do you consider yourself to be in recovery? Why/why not?*”; See “Appendix”). Where helpful, their understanding of the concept was also elicited by offering a broad definition of recovery as “[l]iving a satisfying, hopeful, and contributing life, even when there are on-going limitations” (Mental Health Commission of Canada, 2012, p. 15), and asking participants to comment on it. This definition was chosen due to its lack of academic jargon and openness to interpretation. The interview guide was applied flexibly as the interview was “*led by the participant’s priorities and concerns*” and the researcher remained responsive to any unanticipated and unprompted insights shared (Smith, Flowers, & Larkin, 2022, p. 55). The interviews lasted between 20 and 90 minutes, and were held in a private room at the accommodation provider during office hours. Participants were offered a shopping

voucher worth £15/\$20 per interview. All interviews were audio-recorded and transcribed verbatim by the researcher.

Ethics

Ethics approval was granted by the University of Strathclyde Ethics Committee. Participation was contingent upon written informed consent. The providers ensured no client asked to participate was experiencing acute mental health or other life crises at the time of the study, and were available to assist should any participant become distressed. During transcription, all names of people and services were omitted or replaced with pseudonyms to protect participants' identities.

Data analysis

An interpretative phenomenological analysis (IPA) was completed to capture the complexities and idiosyncrasies of how a relatively small number of individuals made sense of experiences and phenomena that may be difficult to comprehend or express (Smith, Flowers, & Larkin, 2009). The analytic procedure followed Smith et al. (2009). First, each participant's interview transcripts were read and re-read, making initial exploratory comments and engaging empathetically with the data to understand participants' viewpoints ("immersion"; Eatough & Smith, 2008). Second, the transcripts were imported into NVivo 12 (QSR International, 2015; <https://qsrinternational.com>), where the content most relevant to participants' ideas and experiences of recovery was coded line by line by assigning descriptive codes for manifest (surface-level) content; linguistic codes for particularities in participants' verbal and non-verbal communication (for instance, metaphoric language, use of colloquialisms, repetition and pauses); and conceptual codes for latent, more abstract meanings (Smith et al., 2009). Third, after a long list of codes was generated for each participant, provisional clusters of codes were created on NVivo based on conceptual "closeness," and organized into emergent (provisional) themes capturing the "*psychological essence*" of the phenomenon (Smith et al., 2009, p. 92). Minor themes, or subthemes, were merged into a smaller set of more abstract, superordinate themes. The analysis gradually moved from primarily descriptive and empathetic toward more interrogative and critical so as to capture "hidden" aspects of the phenomenon that participants might not be fully aware of or able to articulate clearly (Eatough & Smith, 2008). Because the study aimed to identify common ways individuals with a history of chronic homelessness conceptualized recovery shared across two countries characterized by high rates of health inequalities and housing shortages, the findings were not disaggregated by country.

The researcher remained reflexive about how his own preconceptions, identities and life experiences might be inadvertently influencing the analysis (Smith et al., 2009). The researcher, a Caucasian male, had an academic background in mental health, and no professional social work or clinical experience. The researcher's "outsider" status helped minimize professional biases and facilitated humility and a willingness to learn from the participants. Reflexivity was aided by keeping analytic memos, in addition to engaging with a community of practice, whereby the researcher regularly discussed emerging interpretations, participated in discussions with supervisors and critical peers, and sought to identify any "*blind spots*" (Rossman & Rallis, 2017; Smith et al., 2009).

Results

Participant characteristics

Eighteen participants (14 male and four female) were recruited – ten in NYC and eight in Glasgow. They had a mean age of 48 years and self-identified as White/Caucasian (nine), African-American (four), Hispanic (three) and Asian (two). All Scottish participants identified as White/Caucasian. Thirteen participants disclosed one or multiple mental health diagnoses: depression (eight); anxiety (seven); schizophrenia/psychosis (four); bipolar disorder (one); undisclosed (five). Twelve (67%) also had a history of problem substance use. The participants' mean total length of time homeless in their lifetime was 11 years (with a median of six years) and ranged between two and 30 years. Six had first experienced homelessness before the age of 18, while seven – after the age of 30. The participants had been clients of their current accommodation provider for between three years and two weeks, with a mean of nine months. At the time of the study, most (15) occupied single or dormitory-style rooms at the service provider. The remaining three NYC participants attended a 24-hour drop-in center.

This paper is based on 36 interviews exploring participants' life stories, hopes for the future and ideas about recovery and "the good life." Two participants dropped out after the first interview due to a relocation and to loss of contact with the researcher, respectively. Two other participants each completed three life story interviews (compared to the usual two) because they preferred shorter interviews. The remaining 14 participants took part in two interviews.

IPA findings

The analysis produced four superordinate themes: (a) Recovery as something unfamiliar and ambiguous; (b) Recovery as elusive and out of reach; and (c)

Recovery as a chance for “*a quote-unquote somewhat normal life*”; and (d) “*It’s all interlinked with each other*”: dual recovery. Those themes reveal how participants engaged with, envisioned, or disidentified with, the recovery idea, in the context of chronic life adversity, co-occurring conditions, a precarious present and an uncertain future. Nine participants’ conceptions of recovery could be categorized under one superordinate theme only. In contrast, six participants (Scott, George, Benjamin, Neil, Craig and Conor) seemed to simultaneously hold diverse ideas about recovery belonging to two or more superordinate themes. Finally, three participants’ ideas about recovery could not be ascertained due to the brevity of the encounters and the limited information provided.

Overall, no stark cross-country differences were observed; participants from both countries were represented in each superordinate theme. It should be noted, however, that the “*recovery as elusive and out of reach*” theme was more prevalent among the U.S. participants. This could be due to the fact that all three drop-in center clients, whose living conditions were highly volatile, were in NYC.

Recovery as something unfamiliar and ambiguous

Three participants shared that “mental health recovery” was an unfamiliar and/or ambiguous idea, and often struggled to articulate what it meant to them. Those participants’ relationships with the recovery idea were characterized by uncertainty, ambiguity and even “*fear*.”

(Not having) “my own idea”. One distinctive theme in participants’ reflections about recovery and their desired future pertained to the novelty of those topics and the uncertainty they engendered. For example, while Susan (an Asian woman who had been homeless for six years and was currently attending the NYC drop-in center) showed an implicit understanding that recovery was of “*essential*” importance to her, she could not define it in concrete terms. She explained that this had been the first time she had been receiving the appropriate professional support that would hopefully enable her to embark on her recovery journey. This journey started with “*speaking up about it*” and formulating her “*own idea*” about her recovery:

“But again this is the first time so I don’t know what it’s gonna entail. So I don’t even have my own idea of what the recovery stage is gonna be like.”

Her use of possessive pronouns (“*my own idea*”) seems to underscore her perceived importance of achieving an authentic conception of recovery.

“Recovery is fearful to me”. The future triggered uneasiness in several other participants, particularly when asked about what they looked forward to; how they envisioned recovery; or what they imagined life would be like after

rehousing. Participants tended to justify such feelings by highlighting their chronic life adversity, for example – relationship breakdown, housing instability and addiction struggles, which had deprived them of stability, self-efficacy and a future orientation. One participant, George, a Hispanic safe haven client in his late 60s, who had been homeless for more than 20 years in his lifetime, described his “*fear*” toward recovery:

“... recovery is fearful to me. Because it’s the other side of life that I never experienced.”

He elaborated he felt “*pressure*” regarding giving up drinking, as well as the burden of uncertainty about the route to a meaningful life “in recovery.” He expressed his unwillingness to be part of the “*general population*” – describing his “*weakness*” as a result of the high risk of relapse in the community. George also emphasized the importance of engaging in introspective activities in order to define and design his recovery. He characterized this process of intensive self-searching, self-analysis and “*finding*” himself as ambiguous and frightening and yet as integral to his recovery:

‘It’s [stutters] kinda frightening ... [..] See, right now, I’m analysing myself because I’m trying to figure out the same thing you’re trying to figure out - what is it that I’m searching for. I mean ... Am I searching for gold, am I searching for family, am I searching for happiness? [..] What I mean by ‘find myself’ is figure out exactly what it is that I wanna do and what it is that I am capable of doing ... [..]’

Similarly, Ashton, a Scottish participant in his late 40s, who had been homeless for 27 years in his lifetime, felt “*nervous*” and “*apprehensive*” about his imminent rehousing:

‘I’m nervous and apprehensive. [..] Just because I’ve never had my own house before. I don’t know what to expect. I don’t know how to run a house. So ... it’s just ... unknown.’

Indeed, several participants such as Craig, Simon, Neil and Ashton shared they had never had their own housing. For them, it seems, recovery was less about regaining something lost but rather about confronting and learning to navigate an unexplored terrain of uncertainty and possibility.

Recovery as elusive and out of reach

This superordinate theme applies to seven participants and captures a continuum of experiential states – from feeling a lack of control over one’s well-being and recovery, and feeling “*stuck*” with one’s chronic mental illness, through to the explicit disidentification with the possibility for recovery.

“In and out of” recovery. Overwhelmingly, participants were more inclined to describe their *non-recovery* states rather than define their desired attributes of recovery. In other words, they tended to discuss what recovery *was not*. Those accounts revealed the deeply anti-recovery nature of homelessness and co-

occurring life adversity, which impinged on their abilities to imagine what recovery would be like for them. For example, Kelly, an African-American safe haven client in her late 30s, who had been homeless for five years in her lifetime, described herself as being “*in and out of*” recovery; while Edward, a Hispanic drop-in center client in his late 50s, who had been homeless for five years in his lifetime – as “*just hanging in there.*”

Craig, an assessment center client in Glasgow in his late 40s, who had been homeless for two years in his lifetime, explained his difficulties maintaining a future orientation as a result of his lack of choice and control over his living arrangements, as well as his chronic housing instability – conveyed by the metaphoric expressions “*out of my hands*” and “*hit with*”:

‘Every day while I’ve been here, every day while I’ve been homeless, it’s . . . basically thinking where I am about to go next and . . . I’ve kinda go in my head where I want to go. But then, it’s out of my hands-it’s . . . it’s what available, (it’s) what I am going to get hit with [. . .] I actually feel . . . a lot of paranoia and quite high anxiety at times when thinking about certain things like where I am gonna get put [. . .] I mean, that’s just the housing side. [. . .] I’ve never had my own personal housing [. . .]’

“You never finish recovery.” For three participants, recovery seemed to be associated with ideas about the chronicity and even incurability of mental illness, which triggered apprehension and uncertainty regarding the attainability of recovery. Two participants, including Neil, an assessment center client in Scotland in his late 50s, who had been homeless for six years, seemed to associate recovery with complete symptom remission or illness disappearance, which triggered apprehension because they perceived such outcomes to be unrealistic:

“You say ‘in recovery’ – I’m never gonna get better from it. I know I’ll always have it forever. I know I’ll have it. I’m stuck with it.” (Neil)

The repetition, “*I know I’ll have it (forever)*”, and the metaphoric expression, “*I’m stuck with it.*”, signify Neil’s uneasiness and sense of inevitability regarding his chronic mental illness. When the researcher offered Neil a definition of personal recovery as “*the idea of being in control of one’s life and being able to have a fulfilling life despite the illness,*” he seemed to identify with the notion to a much higher degree, responding with “*That helps.*”. Yet, he admitted he had not encountered “recovery” as defined in such terms. Similarly, when asked to describe recovery, Scott, a Caucasian man in his late 50s living in NYC, tended to emphasize the chronicity of his addiction rather than the distinct components or meaning of recovery:

“Recovery is a lifelong process [. . .] You never finish recovery.”

Similarly, while Benjamin, an African-American safe haven client in his late 50s, who had spent 30 years being homeless in his lifetime, struggled to define the term “mental health recovery”, he explained he was not in recovery, and emphasized the chronicity and incurability of his depression, and yet shared recovery was about an internal change:

“I’ll probably deal with depression for the rest of my life. I don’t think there is cure for it. I think there is but it has to come from within oneself.”

“I don’t hold up any hope for my recovery.” While a number of participants shared they had a recurring sense of anguish and dejection due to their housing and financial insecurity, one participant, Matthew, an Asian safe haven client in his late 50s in NYC, who had been homeless for a total of seven years, explicitly questioned the possibility of recovery. His account conveyed his overwhelming distress and hopelessness, which had rendered the recovery idea distant and unintelligible. His account of his present-day life and well-being was permeated by feelings of loss, isolation and existential suffering. When asked whether he had ever thought about his mental health recovery, after pausing for several seconds, he replied:

‘Honestly, no because nobody has shown it [hope] to me. No one has taken the time to erm . . . give me an inkling of hope. No [stutters] one here. [. . .] I don’t hold (up) any hope for my recovery.’

The repetitive “no one” and the paralinguistic cues (e.g. the stuttering) reveal a limbo-like experiential state, in which Matthew could identify no viable routes to recovery. For Matthew, the “*inkling of hope*” seemed to be the elusive catalyst for recovery. His account seems to indicate that the experience of hope was a relational phenomenon, which had been diminished as a result of not being believed or listened to, which further impaired his ability to fully grasp and convey the complexity of his struggles.

Recovery as a chance for “a quote-unquote somewhat normal life”

Nine participants articulated their conception of recovery and/or the “good life” as attaining normality, and/or as stability, control and self-direction.

A desire for normality. Normality meant something different to each participant. To Craig, it entailed attaining his own housing, own business and social recognition:

‘I want to climb the ladder again . . . I just wanted to have a normal life like everybody else . . . [. . .] I wanna get back to . . . being the ‘average Joe’ that I used to be . . . well-known to everybody [. . .]’

For two other Scottish participants, Claire and Conor, normality was associated with coming off psychiatric medication:

“I don’t wanna be taking tablets for the rest of my life. [...] At the present moment, I try to come off my tablets. I don’t want to be on tablets for the rest of my life. [...] I’m not a tablety person so ... [...]” (Claire)

The colloquialism, “*a tablety person*”, reveals Claire’s, a Scottish woman in her late 30s, who had been homeless for five years in her lifetime, disidentification with the stigmatizing label of the needy and vulnerable medication user. This seemed to threaten her identity as a capable parent.

Moreover, for Scott, recovery was “*a chance (...) for a quote-unquote somewhat normal life*”. Scott highlighted the role of consistent, positive daily behaviors such as engaging with treatment and making rational, reflective choices, as well as coming to terms with being dependent on medication for his recovery.

Recovery as stability, control and self-direction. Participants also envisioned recovery as stability and control, and as being active and self-directed. For Neil, recovery meant “*being in charge of*” his life – enabled by securing housing stability and financial independence. For him, crucial to achieving recovery was restoring his financial autonomy – an antipode to what he described as being “*powerless*” and dependent on the state. He expressed his desire to enter the workforce again as that would give him a sense of normality, purpose and control.

For several participants such as Conor, an assessment center client in Glasgow in his late 20s, who had been homeless for a total of three years, attempting to construct a desired future, however, induced uncertainty and anxiety. While Conor reported an enhanced sense of control and self-direction since entering the assessment center, his anticipation of life post-rehousing induced anxiety regarding his continuing substance use recovery, with the metaphoric verb “*slip*” possibly indicating the fragility of recovery during this transition:

‘Before, I felt that I had no control over my life. [...] Whereas in the last few months, I’ve came along a lot better - now I feel I’m in control of what happens in my life [...] I think I do have a worry (?) like when I move into my tenancy here - like I need to keep sticking to these things because there is a chance it could all slip again.’

Conor did, however, eagerly await the “*empowerment*” and “*confidence*” he would gain with the help of his support workers at the Housing First programme – including rent payment, bills and other aspects of daily living: “

[...] these people, the Housing First, are gonna help you with your letters if there are letters you don’t understand - the council tax, they’ll do that for you. I think it may be better if they teach you how to deal with it rather than doing it for you [...]”

Interestingly, while Benjamin struggled to articulate the meaning of mental health recovery in his own circumstances during the initial interviews, his last interview revealed his understanding of recovery as focusing on the present but also “*moving forward*” and believing he could effect positive change in his future:

‘[...] not holding on to the past, leaving the past behind me. [...] Yesterday is a history, tomorrow is a mystery. So I have to live in today, just today, just for the day. And that helps me, you know, to just deal with, to deal with the ‘the here and now’, with what I’m going through now. I can’t change the past, you know. But I can somewhat shape my future.’

“It’s all interlinked with each other”: conceptualizing dual recovery

This theme captures three participants’ discussion of the interconnectedness of mental health and substance use recovery, and the holistic nature of (dual) recovery – the recovery from co-occurring SMI and problem substance use. Conor, for instance, shared:

“I think they’re all connected. I think it is achieving things that collects all of that because you can have someone that doesn’t take drugs but still has mental health problems. [...] In my case, I think it’s all together – through my past, through my present, do you know what I mean like ... I think it’s all interlinked with each other.”

For George, recovery meant much more than merely the cessation of substance use or the management of mental illness symptoms. Rather, it meant “*envisioning*” a desired self and having a life in which he would be a productive citizen who paid bills:

‘[...] You can stop drinking, or you can stop getting high or both, you know ... [...]. But what happens when you stop? What are you gonna do with yourself? (...) That’s what hope is all about. Envisioning yourself. When you envision yourself — that’s what hope is all about. You know what I mean? And that’s the image you want to bring out, and that’s what recovery does.’

This contrasted with much of his past life, which had included involvement in the drug scene, a nomadic lifestyle and “*falling victim*” to addiction. To George, the rekindling of hope entailed expanding one’s inner boundaries toward a more contemplative and self-directed self. The repetition, “*That’s what hope is all about.*”, reinstates the future-oriented (transcendental) nature of recovery but also possibly highlights the precariousness of the future, in light of his concerns about keeping away from the “*people, places and things*” that triggered his substance use, and about establishing a new identity as a productive citizen (his “*image*”) despite his disability.

Discussion

Collectively, the findings of this transatlantic qualitative study underscore the inherent vicissitudes and ambiguities associated with making sense of, and envisioning, recovery – advancing the understanding of recovery as unpredictable, painful and risky (Davidson et al., 2008; Liggins, 2018), but contextualizing those experiences within the lives of chronically homeless persons with SMI residing in temporary accommodation.

Recovery as elusive, ambiguous and fearful

The findings regarding participants' uncertainty, ambiguity and even “*fear*” toward recovery are relatively novel, and stand in contrast to the bulk of recovery research, which has overemphasized stories of “successful” recovery, to the neglect of those who continue to face severe and complex impediments to recovery (O’Keefe et al., 2022; Rose, 2014; Topor et al., 2021). These findings present an important counterpoint to qualitative studies with similar populations that have found predominantly positive, hopeful and clear expectations about life post-rehousing (e.g. Henwood et al., 2013; Kirst et al., 2014). The present findings about recovery as elusive and out of reach resonate with Irving’s (2021) study illustrating hostel residents’ diminished abilities to envision a desired life post-rehousing. The present findings could be interpreted as evidence of *capability deprivations* as a result of chronic life adversity – impinging upon participants’ control over the environment, affiliation, imagination and practical reason (the latter being often defined as “*having a conception of a ‘good life’ and actively working towards this*” (Irving, 2021, p. 11). The present study, therefore, expands the research on homelessness as capability deprivation (Batterham, 2019) – demonstrating its impact on the abilities to envision and enact recovery.

Several participants’ skepticism about their recovery – ranging from accounts of being overwhelmed and lacking control to having no hope – could also be interpreted as an act of resistance against the unjust, unnavigable and undignifying socio-structural conditions characterizing homelessness (Kerman, Gran-Ruaz, Lawrence, & Sylvestre, 2019). Some participants’ struggles to define recovery in concrete terms and tendencies to discuss what recovery was *not* could also be explained by Borg and Davidson’s (2008, p. 134) assertion that “[r]ather than being the planful, rational, and stepwise process suggested by treatment plans, initiating recovery appears to be experienced as a somewhat desperate effort to break out of a cycle of recurrent problems associated with mental illness [...]”. Relatedly, Gwinner et al. (2013) found that their participants frequently adjusted the meanings attributed to recovery and wellness in response to the shifting practical demands of daily living, and may reject the “recovery” term as being derivative of a clinical discourse of mental illness, which did not resonate with the participants’ experiences. Indeed, several of the

present study's participants seemed to view recovery as the cessation of symptoms, akin to a biomedical conceptualization, which triggered uneasiness and feelings of entrapment. It remains unclear whether this conceptualization had been influenced by prior contact with services. Ultimately, those findings underscore the dynamic, contextualized and political nature of recovery, and indicate the need to ascertain whether and how provider and other dominant, institutionalized views of recovery impede or empower service-users' authentic recovery projects (Fullagar & O'Brien, 2014; Gwinner et al., 2013; O'Keeffe et al., 2022; Saavedra et al., 2021).

The pursuit of normality, control and self-direction amidst chronic life adversity

The theme capturing participants' more concrete and future-oriented ideas about recovery, specifically their pursuits of stability, normality, control and authentic self-direction, expands the relatively scarce research on individuals' recovery-oriented hopes and priorities prior to moving into independent housing (Henwood et al., 2013; Kirst et al., 2014). While restoring normality and control has been shown to promote hope and recovery in several studies (Schrank, Bird, Rudnick, & Slade, 2012), the present study offered insights into the specific dimensions of normality and control the participants, a severely marginalized group, valued the most such as "*being in charge*," having autonomy to make decisions, being medication-free, gaining social recognition and reestablishing productivity. Those personally valued outcomes can inform the delivery of tailored mental health and social care interventions that help clients build bridges (back) to citizenship and belonging (Schrank et al., 2012). Additionally, these findings illustrate that recovery is often constituted and reinstated by ordinary, daily occurrences and transactions, rather than by one-off transformational events (Borg & Davidson, 2008). Research on individuals' everyday narratives should continue to unravel the significance of the "insignificant" – of the routine and taken-for-granted aspects of living – for individuals' capacities for recovery, across a range of settings (Borg & Davidson, 2008).

Dual recovery and homelessness

The present study also attempted to redress the gap in the understanding of "*how persons with dual diagnosis experience the influence of having (a lack of) resources on their recovery process*" (De Ruysscher, Vandeveld, Vanderplasschen, De Maeyer, & Vanheule, 2017, p. 275–276), and of how such persons conceptualize dual recovery amidst homelessness. The present findings resonate with Hipolito et al.'s (2011) findings of self-knowledge, the meaningful exploration of the past and the aspiration for personal transformation as core aspects of dual recovery, as well as with De Ruysscher et al.'s (2017) systematic review conclusions about the centrality of hope, a positive identity

reestablishment, and self-responsibility for recovery in dually diagnosed persons. However, while the centrality of hope in mental health and substance use recovery has been well established, knowledge gaps persist as to *how* hope is ignited, internalized and sustained in different contexts, including post-rehousing, and should be addressed in future research (Davidson et al., 2008; De Ruyscher et al., 2017; Macnaughton et al., 2016). The evidence that some individuals continue to experience barriers to social inclusion and citizenship post-resettlement warrant further, longer-investigations, and underscore the role of post-rehousing support (Bassi, Sylvestre, & Kerman, 2020).

Study limitations and recommendations for research

The underrepresentation of women and ethnic minorities in the current sample is a significant limitation in light of the evidence that recovery is a gendered (e.g. Fullagar & O'Brien, 2014) and culturally situated phenomenon (e.g. Adeponle, Whitley, & Kirmayer, 2012). Ethnic minority groups' experiences of recovery, including culturally specific notions of mental health, have been historically neglected in the recovery scholarship (Leamy et al., 2011). For instance, the relationship between recovery and cultural norms and values such as spirituality, interdependence and collective responsibility warrants further investigation (Jones, Hardiman, & Carpenter, 2007). Relatedly, the present analysis focuses predominantly on participants' inner worlds to the potential neglect of the role of culture and other contextual factors shaping the lived experience – a common criticism of IPA (Brueckner, Green, & Sagers, 2011). Future comparative cross-cultural investigations hold promise for unraveling the relationship between socio-cultural and socio-economic context and recovery attitudes and experiences. Furthermore, the study attrition and variation in the responsiveness to the questions about mental well-being and recovery among participants affected the completeness of the data. Also, while the repeat interviewing enhanced data richness, longitudinal qualitative investigations following participants after resettlement can expand the understanding of individuals' dynamic relationship with recovery.

Implications for practice

The present findings indicate that health and social care providers should demonstrate a sensitivity to the diverse and often subtle ways in which individuals contemplate, make sense of, and relate to recovery. As argued by Bonney and Stickley (2008), “[r]ecovery does not stand still but is an ongoing process of personal discovery [...]” (p. 149). Providers should create the psychological and emotional space for clients to articulate their concerns, aspirations and priorities, while also allowing for ambiguity, openness to

change, experimentation and self-definition (Macnaughton et al., 2016; Peters, Hobson, & Samuel, 2022; Sælør, Ness, Borg, & Biong, 2015).

Service providers should also be prepared to respond with empathy and understanding to some clients' reluctance or inability to articulate recovery in definitive, positive and future-oriented terms. As noted by O'Keeffe and colleagues (2022, p. 479), "[s]ervice users reporting that 'recovery' is neither meaningful in, nor applicable to, their lives [...]" should be offered the resources to explore alternative conceptions of, and pathways to, a better life, some of which may fall outside of the personal recovery paradigm. Moreover, homeless individuals should be offered prompt and adequate access to counseling services, as well as to peer support and community-based mental health services such as self-help groups (Barker & Maguire, 2017; Kerman et al., 2019; SAMHSA, 2020; Schrank et al., 2012).

The findings pertaining to some participants' hopelessness and anxieties regarding recovery and life post-rehousing highlight the importance of providers' instilling hope as a daily practice (Kirst et al., 2014). Efforts to maintain hope-inspiring practices, however, are often thwarted by systems rife with bureaucracy, stigma, inadequate support structures and overwhelmed staff, amidst other structural barriers, which can amount to providers' *contextual helplessness* (Peters et al., 2022). In this sense, providers' own resilience, creativity and manoeuvrability could serve as a source of hope and resistance, alongside formal hope-building interventions (Sælør et al., 2015; Schrank et al., 2012).

Increased attention is also warranted toward the identification and realization of clients' recovery-related goals at various points along their housing transition, including adequate post-rehousing support facilitating access to choice-expanding opportunities such as socialization and employment (Macnaughton et al., 2016).

Acknowledgments

I would like to thank Prof. Beth Weaver and Prof. Neil Quinn for their thoughtful supervision and mentorship.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the European Union's Horizon 2020 research and innovation programme under the Marie Skłodowska-Curie Grant 690954.

ORCID

Dimitar Karadzhov PhD  <http://orcid.org/0000-0001-8756-6848>

References

- Adeponle, A. B., Whitley, R., & Kirmayer, L. J. (2012). Cultural contexts and constructions of recovery. In A. Rudnick (Ed.), *Recovery of people with mental illness: Philosophical and related perspectives* (pp. 109–132). Oxford: Oxford University Press.
- Barker, S. L., & Maguire, N. (2017). Experts by experience: Peer support and its use with the homeless. *Community Mental Health Journal*, 53(5), 598–612. doi:10.1007/s10597-017-0102-2
- Bassi, A., Sylvestre, J., & Kerman, N. (2020). Finding home: Community integration experiences of formerly homeless women with problematic substance use in housing first. *Journal of Community Psychology*, 48(7), 2375–2390. doi:10.1002/jcop.22423
- Batterham, D. (2019). Homelessness as capability deprivation: A conceptual model. *Housing, Theory and Society*, 36(3), 274–297. doi:10.1080/14036096.2018.1481142
- Bonney, S., & Stickley, T. (2008). Recovery and mental health: A review of the British literature. *Journal of Psychiatric and Mental Health Nursing*, 15(2), 140–153. doi:10.1111/j.1365-2850.2007.01185.x
- Borg, M., & Davidson, L. (2008). The nature of recovery as lived in everyday experience. *Journal of Mental Health*, 17(2), 129–140. doi:10.1080/09638230701498382
- Brueckner, M., Green, M., & Sagers, S. (2011). The trappings of home: Young homeless people's transitions towards independent living. *Housing Studies*, 26(1), 1–16. doi:10.1080/02673037.2010.512751
- Coalition for the Homeless. (2020). *State of the homeless 2020*. Retrieved from <https://www.coalitionforthehomeless.org/state-of-the-homeless-2020/#:~:text=State%20of%20the%20Homeless%202020%20analyzes%20the%20institutional%20forces%20that,the%20true%20scope%20of%20family>
- Davidson, L., Andres-Hyman, R., Bedregal, L., Tondora, J., Frey, J., & Kirk, T. A., Jr. (2008). From “double trouble” to “dual recovery”: Integrating models of recovery in addiction and mental health. *Journal of Dual Diagnosis*, 4(3), 273–290. doi:10.1080/15504260802072396
- De Ruyscher, C., Vandevelde, S., Vanderplasschen, W., De Maeyer, J., & Vanheule, S. (2017). The concept of recovery as experienced by persons with dual diagnosis: A systematic review of qualitative research from a first-person perspective. *Journal of Dual Diagnosis*, 13(4), 264–279. doi:10.1080/15504263.2017.1349977
- Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage Handbook of qualitative research in psychology* (pp. 193–211). Thousand Oaks, California, and London: Sage Publications.
- Fullagar, S., & O'Brien, W. (2014). Social recovery and the move beyond deficit models of depression: A feminist analysis of mid-life women's self-care practices. *Social Science & Medicine*, 117, 116–124. doi:10.1016/j.socscimed.2014.07.041
- Gwinner, K., Knox, M., & Brough, M. (2013). Making sense of mental illness as a full human experience: Perspective of illness and recovery held by people with a mental illness living in the community. *Social Work in Mental Health*, 11(2), 99–117. doi:10.1080/15332985.2012.717063
- Henwood, B. F., Hsu, H. T., Dent, D., Winetrobe, H., Carranza, A., & Wenzel, S. (2013). Transitioning from homelessness: A “fresh-start” event. *Journal of the Society for Social Work and Research*, 4(1), 47–57. doi:10.5243/jsswr.2013.4

- Henwood, B. T., Padgett, D. K., Smith, B. T., & Tiderington, E. (2012). Substance abuse recovery after experiencing homelessness and mental illness: Case studies of change over time. *Journal of Dual Diagnosis*, 8(3), 238–246. doi:10.1080/15504263.2012.697448
- Hipolito, M. M. S., Carpenter-Song, E., & Whitley, R. (2011). Meanings of recovery from the perspective of people with dual diagnosis. *Journal of Dual Diagnosis*, 7(3), 141–149. doi:10.1080/15504263.2011.592392
- Irving, A. (2021). Exploring the relationship between housing conditions and capabilities: A qualitative case study of private hostel residents. *Housing Studies*, 1–21. doi:10.1080/02673037.2021.1928004
- Jones, L. V., Hardiman, E. R., & Carpenter, J. (2007). Mental health recovery: A strengths-based approach to culturally relevant services for African Americans. *Journal of Human Behavior in the Social Environment*, 15(2–3), 251–269. doi:10.1300/J137v15n02_15
- Kerman, N., Gran-Ruaz, S., Lawrence, M., & Sylvestre, J. (2019). Perceptions of service use among currently and formerly homeless adults with mental health problems. *Community Mental Health Journal*, 55(5), 777–783. doi:10.1007/s10597-019-00382-z
- Kirst, M., Zerger, S., Harris, D. W., Plenert, E., & Stergiopoulos, V. (2014). The promise of recovery: Narratives of hope among homeless individuals with mental illness participating in a housing first randomised controlled trial in Toronto, Canada. *BMJ Open*, 4(3), e004379. doi:10.1136/bmjopen-2013-004379
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6), 445–452. doi:10.1192/bjp.bp.110.083733
- Liggins, J. (2018). Healing the heart of recovery. *International Journal of Social Psychiatry*, 64(7), 660–667. doi:10.1177/0020764018796538
- Macnaughton, E., Townley, G., Nelson, G., Caplan, R., Macleod, T., Polvere, L., . . . Goering, P. (2016). How does housing first catalyze recovery?: Qualitative findings from a Canadian multi-site randomized controlled trial. *American Journal of Psychiatric Rehabilitation*, 19(2), 136–159. doi:10.1080/15487768.2016.1162759
- Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Retrieved from https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG_0_1.pdf
- Nott, B. D., & Vuchinich, S. (2016). Homeless adolescents' perceptions of positive development: A comparative study. *Child & Youth Care Forum*, 45(6), 865–886. doi:10.1007/s10566-016-9361-2
- 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. doi:10.1007/s00127-021-02121-w
- Omerov, P., Craftman, Å. G., Mattsson, E., & Klarare, A. (2020). Homeless persons' experiences of health and social care: A systematic integrative review. *Health & Social Care in the Community*, 28(1), 1–11. doi:10.1111/hsc.12857
- Peters, L., Hobson, C. W., & Samuel, V. (2022). A systematic review and meta-synthesis of qualitative studies that investigate the emotional experiences of staff working in homeless settings. *Health & Social Care in the Community*, 30(1), 58–72. doi:10.1111/hsc.13502
- Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology*, 11(1), 25–41. doi:10.1080/14780887.2013.801543
- Rose, D. (2014). The mainstreaming of recovery. *Journal of Mental Health*, 23(5), 217–218. doi:10.3109/09638237.2014.928406

- Rossmann, G. B., & Rallis, S. F. (2017). *An introduction to qualitative research: Learning in the field*. Thousand Oaks, California, and London: Sage Publications.
- Saavedra, J., Arias-Sánchez, S., Matías-García, J. A., & Brzeska, J. (2021). “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*, 1–9.
- Sælør, K. T., Ness, O., Borg, M., & Biong, S. (2015). You never know what’s around the next corner: Exploring practitioners’ hope inspiring practices. *Advances in Dual Diagnosis*, 8(3), 141–152. doi:10.1108/ADD-05-2015-0010
- SAMHSA. (2020). *Substance use disorder treatment for people with co-occurring disorders: Treatment improvement protocol*. Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf
- SAMHSA. (2021). *Behavioral health services for people who are homeless*. Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-04-003.pdf
- SAMHSA. (2022a). *Recovery and recovery support*. Retrieved from <https://www.samhsa.gov/find-help/recovery>
- SAMHSA. (2022b). *Mental health and substance use disorders*. <https://www.samhsa.gov/find-help/disorders>
- Schrank, B., Bird, V., Rudnick, A., & Slade, M. (2012). Determinants, self-management strategies and interventions for hope in people with mental disorders: Systematic search and narrative review. *Social Science & Medicine*, 74(4), 554–564. doi:10.1016/j.socscimed.2011.11.008
- Scottish Government. (2018). *Health and homelessness in Scotland*. Retrieved from <https://www.gov.scot/Publications/2018/06/7974/0>
- Scottish Public Health Observatory. (2021). *Homelessness: Health*. Retrieved from <https://www.scotpho.org.uk/life-circumstances/homelessness/data/health/>
- Shinn, M. (2010). Homelessness, poverty and social exclusion in the United States and Europe. *European Journal of Homelessness*, 4(1), 19–44.
- Slade, M., Amering, M., & Oades, L. (2008). Recovery: An international perspective. *Epidemiology and Psychiatric Sciences*, 17(2), 128–137. doi:10.1017/S1121189X00002827
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London and Thousand Oaks, California: Sage Publications.
- Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd Core new ed.). London and Thousand Oaks, California: Sage Publications.
- Stott, A., & Priest, H. (2018). Narratives of recovery in people with coexisting mental health and alcohol misuse difficulties. *Advances in Dual Diagnosis*, 11(1), 16–29. doi:10.1108/ADD-08-2017-0012
- Topor, A., Fredwall, T. E., Hodoel, E., & Larsen, I. B. (2021). “Before recovery – A blind spot in recovery research? Users’ narratives about the origins and development of their mental health and/or addiction problems. *Journal of Recovery in Mental Health*, 4(2), 29–47.
- U.S. Department of Housing and Urban Development. (2017). *The 2017 Annual Homeless Assessment Report (AHAR) to congress*. Retrieved from <https://www.huduser.gov/portal/sites/default/files/pdf/2017-AHAR-Part-1.pdf>
- Watts, B., Littlewood, M., Blenkinsopp, J., & Jackson, F. (2018). *Temporary accommodation in Scotland: Final report*. Retrieved from <https://researchportal.hw.ac.uk/en/publications/temporary-accommodation-in-scotland-final-report>
- Zerger, S., Francombe Pridham, K., Jeyaratnam, J., Connelly, J., Hwang, S., O’Campo, P., & Stergiopoulos, V. (2014). The role and meaning of interim housing in housing first programs for people experiencing homelessness and mental illness. *American Journal of Orthopsychiatry*, 84(4), 431–437. doi:10.1037/h0099842

Appendix

Sample Interview Questions

Priorities, Hopes and Goals:

What does it mean in general to have a good life? When you think about our future, how far into the future do you usually think about? A year from now? Day-to-day?

What is now ahead of you next? What are the most important things that will happen next week, this month, next month? And what about further into the future? If you have to imagine your life a year from now, what will it be? What are your concerns about the future? What in your life needs to change for you to be better off, do you think?

Personal Recovery:

Have you ever heard of the term "recovery" before? If yes, when? What does recovery mean to you, if anything? Would you say you are in recovery now? Would you like to recover/be in recovery? How would your life be different if you were? (If in recovery) Thinking back, can you pinpoint any time or event that started your recovery? What happened? How easy/difficult was it?

Note: Not all questions were posed to every participant due to the personalized, participant-centered interview strategy.