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Conceptual Paper

Recovery and Mental Health: Exploring the Basic Characteristics of Living Well with Mental Illness

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Abstract

A considerable body of literature exists to substantiate the contention that individuals can live well with mental illness. The purpose of this paper is to provide a broad introduction to recovery for individuals living with mental illness and/or struggling with mental health. Recovery is defined in this paper as a process of self-development that involves change in a number of areas related to well-being. In particular, this paper examines six key characteristics of recovery: acceptance, hope, identity, pleasurable life events, agency/autonomy, and social connections/engagement. Finally, these characteristics are linked to leisure and to therapeutic recreation practice through the lens of the Leisure and Well-Being Model, providing implications for practice for therapeutic recreation professionals.

Keywords

Leisure, mental health, recovery, therapeutic recreation, well-being

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Mental illness is a costly condition affecting many people globally and which has lasting impacts on individuals, families, communities, and societies. In North America, one in five people will experience a mental illness in their lifetime, with one in two having previous experience with or currently experiencing symptoms consistent with mental illness by the time they reach age 40 (National Institute of Mental Health, n.d.; Smetanin et al., 2011; Statistics Canada, 2017). The combined economic burden of mental health in Canada and the United States is estimated to be $243 million annually, including health care costs, lost productivity, and reductions in health-related quality of life (Insel, 2008; Smetanin et al., 2011), nearly 1.5 times higher than all cancers combined (Canadian Institute for Health Information, 2007). It is estimated that 11 Canadians will complete suicide each day, with up to 200 others making an attempt (Statistics Canada, 2017). In the United States, there are more than twice as many suicides as there are homicides each year (Centre for Disease Control and Prevention WISQUARS, 2016). Furthermore, individuals who are of low socioeconomic status are three to four times more likely to report fair to poor mental health than those of high socioeconomic status (Centre for Addictions and Mental Health, 2019) with only one-third of all individuals in need of mental health support services ever actually receiving them (Statistics Canada, 2002).

In spite of the many challenges associated with mental illness, there is much evidence to suggest that people learn to live well with their illness (Andresen, Oades, & Caputi, 2011; Davidson, 2003; Davidson et al., 2006; Jacobson & Greenly, 2001; Ralph & Corrigan, 2005; Slade, 2009; Slade, Oades, & Jarden, 2017; Whitley, Palmer, & Gunn, 2015). The purpose of this paper is to bring the recovery literature to the attention of therapeutic recreation professionals. A full understanding of recovery concepts is necessary for effective work with clients with mental illnesses (McCauley et al., 2015) and this paper will illuminate important links between the literature related to recovery and therapeutic recreation practice. First, the paper will explore the conceptual foundations of recovery with mental illness (also referred to here as living well with mental illness). The paper will then describe in detail a set of characteristics of recovery, followed by a discussion of how each characteristic relates to leisure and therapeutic recreation practice, as framed by the Leisure and Well-Being Model (Carruthers & Hood, 2007; Hood & Carruthers, 2007). The characteristics discussed are acceptance, hope, identity, pleasurable life events, agency/autonomy, and social connections/engagement.

Understanding Mental Illness

Mental illness affects one's thinking, mood, and/or behavior and may be associated with impairment of functioning. There are a number of different diagnoses that fall under the umbrella of mental illness, including mood disorders such as depression and bipolar disorder, and thought disorders such as psychosis and schizophrenia (American Psychiatric Association [APA], 2013; Regehr & Glancy, 2014). The severity and experience of symptoms varies with each individual (APA, 2013; Centre for Mental Health and Addictions, 2009; Davidson, 2003; Shatkin, 2015); mental illness is therefore a very personal and unique experience.

Governments often discuss mental illness in terms of financial expenditure and allocation of resources within budgets. However, there is considerable literature that describes the consequence of mental illness as it extends beyond the health care system

and impacts all aspects of one's life, creating challenges that may include unemployment or underemployment, low social economic status, increased isolation, increased boredom, self-medication, and an overall lack of satisfaction in everyday life (Drake, et al., 2012; Government of Canada, 2006; Health Canada, 2002; National Institute of Mental Health, n.d.). Davidson et al. (2009) concur, emphasizing that the onset of mental illness is associated with a sense of loss of one's self across a variety of domains, with personal and social consequences extending beyond that of many other disease processes.

Understanding Recovery and Mental Health

The literature related to recovery and mental health provides a number of definitions for the terms. Current definitions of recovery describe it as a *process*; it is regarded as a personal journey that involves management of clinical symptoms and engagement in personal development that increases daily functioning (Andresen et al., 2011; Davidson et al., 2009; Ralph & Corrigan, 2005; Wellesley Institute, 2009). Deegan (1988), in her classic work on recovery with mental illness, stated that "recovery is a process, a way of life, an attitude and a way of approaching the day's challenges " (p. 57). Drake and Whitley (2014) report that "people with mental illness frequently state that recovery is a journey, characterized by a growing sense of agency and autonomy, as well as greater participation in normative activities, such as employment, education, and community life" (p. 236). This is the notion of recovery, also referred to here as living well with mental illness, that will be further discussed in this paper.

It is important to note that recovery should not be understood as a return to symptom-free state, but rather as a highly individualized process of learning to live well with mental illness and its symptoms (Clark, Oades, & Crowe, 2012). Recovery supports the development of a purposeful life that includes enhanced traits and practices that are specifically intended to maintain one's level of satisfaction in everyday life, while supporting the management of recurring symptoms and/or changes in current life circumstances (Andresen et al., 2011; Deegan, 1988; Iwasaki et al., 2014; McCormick, 1999; McCormick & Iwasaki, 2008; McCormick et al., 2012; Whitley et al., 2015).

Mental health is defined as "a state of well-being in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (World Health Organization, 2014). It affects how one thinks, feels, and acts. It is a predictor of one's ability to handle stress, relate to others, and make positive choices (Anthony, 1993; Shatkin, 2015). Mental health encompasses physical, mental, and social well-being and is not merely the absence of disease or infirmity (Andresen et al., 2011; Anthony, 1993; WHO, 2014).

It is important to note that mental illness is but one specific component of mental health and that it is possible to have poor mental health without the presence of formal illness, and it is also possible to have good mental health while living with a mental illness. Both mental health and mental illness exist on continuum that range from psychological dysfunction to flourishing (Keyes, 2002; 2005; Lyubomirsky, 2007; Lyubomirsky & Layous, 2013).

Using the Leisure and Well-Being Model as a Framework for Living Well

Therapeutic recreation (TR) services are ideally suited to support the recovery process for individuals who are struggling with mental health challenges. The central core of the profession is to support well-being through the use and/or enhancement of leisure/free time engagements (Carruthers & Hood, 2007; Hood & Carruthers, 2007; Robertson & Long, 2019). Therapeutic recreation interventions involve both purposeful psychoeducational interventions and opportunities for meaningful engagement in leisure experiences (Hood & Carruthers, 2007, 2016a). Psychoeducation interventions are designed to assist clients to develop resources needed for living well and to maximize the benefits of leisure engagement. The provision of experiential opportunities for leisure engagement allows clients to reap the benefits of well-chosen free time engagements (Hood & Carruthers, 2016a).

The Leisure and Well-Being Model (LWM) of therapeutic recreation (Carruthers & Hood, 2007; Hood & Carruthers, 2007, 2016a) provides a useful framework for examining concepts of recovery or living well with illness. The LWM identifies well-being as the desired outcome of therapeutic recreation service and it extends positive psychology and strengths-based therapy perspectives to provide a model for TR service delivery. Well-being is defined by Carruthers and Hood (2007) as a "state of successful, satisfying, and productive engagement with one's life and the realization of one's full physical, cognitive, and socio-emotional potential" (p. 280). The LWM suggests that, while there are many components of well-being, the two components that are particularly relevant for TR practice are 1) positive emotion and experience on a daily basis, and 2) the cultivation and expression of one's full potential (Carruthers & Hood, 2007; Hood & Carruthers, 2007). As with the definition of recovery, a remediation or elimination of illness, disability, and/or symptoms is not required in order to experience well-being.

The model further identifies two broad areas for TR intervention: Enhancing Leisure and Developing Resources. Enhancing Leisure is defined as increasing both the quality and quantity of leisure engagements and the model "delineates five ways to cultivate and enhance leisure experiences as an avenue through which to support well-being" (Hood & Carruthers, 2007, p. 310). These five components of Enhancing Leisure are 1) Savouring Leisure, 2) Authentic Leisure, 3) Leisure Gratifications, 4) Mindful Leisure, and 5) Virtuous Leisure (see Hood & Carruthers, 2007, 2016a for a more detailed description of these components).

Developing Resources is defined in the LWM as supporting the acquisition, development, and refinement of those characteristics, qualities, and external attributes that support well-being. The LWM identified resources in five broad categories: psychological resources such as hope and optimism, autonomy, and competence; cognitive resources such as concentration, memory, and goal setting; social resources such as communication skills and social confidence; physical resources such as health, mobility, and fitness; and environmental resources such as social connectedness and networks and community engagement/empowerment (Hood & Carruthers, 2007). These resources may be developed "through the use of leisure, psychoeducational interventions, the therapeutic relationship, and advocacy" (Hood & Carruthers, 2007, p. 300). Many of the resources identified in the LWM align with many of the components of

recovery, including hope and optimism, autonomy and self-determination, capacity for happiness, emotion regulation, self-awareness and identity development, sense of meaning and purpose, and connection to others and to community (Hood & Carruthers, 2007).

Characteristics of Recovery

In a recent examination of the literature related to recovery conducted by the authors, a variety of characteristics emerged that represent living well with mental illness and that are related to leisure and therapeutic recreation. These characteristics included a) illness acceptance, b) hope, c) positive identity, d) pleasurable life events, e) agency/autonomy, and f) social connections/engagement. Each of these characteristics will be examined in turn, and the discussion will provide a definition of the characteristic coupled with a description of how it contributes to living well and how it is affected by mental illness. The discussion will end with an exploration of the role of TR related to each characteristic.

Illness Acceptance

Acceptance in recovery refers to one's ability to assent to the reality of illness without attempting to change or fight it. Acceptance is not about submission to the challenges of mental illness but rather a purposeful choice to embrace that which cannot be changed as a means of creating space to envision and move toward one's desired life (Hayes, Strosahl, & Wilson, 1999; Harris, 2009).

> Acceptance … refers to the ability to allow unwanted private events or behaviour (thoughts, feelings, physical sensations, memories, urges, and so on), to simply let them be present until they pass rather than trying to push them away, push them down, or avoid doing things that bring them up. (Turrell, Bell, & Wilson, 2016, p. 33)

Central to a life well lived is one's ability to accept the challenges associated with the acquisition of illness and/or disability and central to acceptance is letting go of the innate desire to "get rid of the things we can't get rid of" (Turrell et al., 2016, p.13). Hayes, Pistorello and Levin (2012) suggest that regardless of the origin of dysfunction, acceptance is central to moving toward one's desired goal (a better life).

Illness Acceptance, Mental Illness, and Recovery

The nature of mental illness and the stigma associated with it creates particular challenges to the process of acceptance (Angermeyer, Matscinger, & Schomerus, 2013). Stigma, and in particular self-stigma, contributes to the belief that people with mental illnesses are broken and to be feared, thus making it a difficult condition to accept (Corrigan & Kosyluk, 2014; Kravitz, Faust, & David, 2000). The diagnosis, coupled with the ever-changing symptoms of mental illness, often feel all-encompassing to individuals and thus make the notion of accepting the illness as merely a part of the broader self particularly challenging (Yanos, Roe, & Lysaker, 2010).

The acceptance of illness creates a foundation for the recovery process and may be one of the prerequisites to overcoming difficulties associated with mental illness (Deegan, 1988; Mizock & Russinova, 2016). Acceptance may create the opportunity to foster hope and optimism, to explore and establish a positive identity, to develop a

sense of agency, to experience pleasure, and to establish meaningful social connections (Leamy et al., 2011). Although recovery is seen as an ongoing process that involves a purposeful, evolving exploration of self and self in society, Hayes and colleagues (1999) suggest that acceptance of self and illness is one of the primary catalysts to this development.

Illness Acceptance and Therapeutic Recreation Practice

Although not identified explicitly in the LWM, therapeutic recreation has a role to play in supporting acceptance of illness. Therapeutic recreation specialists may foster acceptance by working with clients to demonstrate that there are still meaningful and positive engagements possible (leisure). Through the mirroring of strengths and capacities, an anti-stigma perspective (Corrigan & Kosyluk, 2014), TR professionals may show clients that their sense of self is not solely defined by a disease or disorder and that a good life is possible even when symptoms and challenges exist. Finally, the focus on the holistic aspect of the therapeutic alliance that is common in TR sets the stage for viewing clients through a lens of wholeness rather than through a lens of disability (Anderson & Heyne, 2012; Jones-Smith, 2012).

Hope

Central to the recovery process, and mediated by acceptance, is hope. Hope, most simply defined, is the ability to imagine a desired future (Larsen et al., 2015). Lynch (1965) defined hope as "the fundamental knowledge and feeling that there is a way out of difficulty, that things can work out, that we as human persons can somehow handle and manage internal and external reality" (p. 32). Larsen and Stege (2012) expand these definitions by suggesting that hope is an emotional disposition engaging the hoper in action toward a personally meaningful future, most often in the face of difficulty or uncertainty.

Hope has been viewed as both a trait and a quality that can be learned and developed. Jacobson and Greenly (2001) suggest hope is an internal process that supports one's sustainability in the face of challenge. Snyder (2002) suggests that hope is not an emotion, but rather a thinking process that influences how a person feels. He suggests that hope is developed by setting attainable goals and developing the sense of competence necessary to pursue those goals. A number of scholars suggest that hope can be cultivated and developed through life experiences as well as through direct interventions (Edey et al., 2016; Larsen et al., 2015; Seligman, 2002) and is central to living well (Seligman, 2002).

Hope, Mental Illness, and Recovery

Loss of hope is central to the experiences of mental illness (Yanos et al., 2010) and, in fact, hopelessness is identified as a defining symptom of several mental illnesses (APA, 2013). Conversely, the cultivation of hope is central to the process of recovery (Andresen et al., 2011; Slade, 2009). In a recent qualitative study that examined the experiences of six people who self-reported as living well with mental illness (Cripps, 2014), in addition to identifying leisure as central to living well, participants spoke of hope, optimism, and the anticipation of a better life as processes that are often thwarted by the onset of illness. One of the participants spoke about feelings of despair being more comfortable than feelings of hope and therefore recognizing their resistance to hope as being a turning point in learning to live well. Another participant talked about

fears of being hopeful, as disappointment and failure became the common expectation, leading to years of amotivation and psychological dysfunction.

Hope and Therapeutic Recreation Practice

Hope is identified in the LWM as a psychological resource that is important for individuals with disabilities and illnesses as they move toward living well. Hope, as noted above, is often a key starting point for the recovery process. Without hope, clients will be less likely to engage in experiences that are future-oriented or require action taken toward future goals and aspirations (Snyder, 2002). Hope has been connected to leisure in several ways.

The expectation of a positive experience, so often a defining quality of leisure, may be considered a form of hope. Interestingly, Miceli and Castelfranchi (2010), while not studying leisure specifically, identify expectation and anticipation as specific factors associated with a more generalized mentality of hope. In addition, there is some literature that directly links hope with leisure; for example, Oliver, Tomaz, and Montoro-Rodriguez (2017) found that leisure engagement was significantly correlated with measures of hope in older adults. These findings, among many others, suggest that the anticipation of the positive aspects of experiences sets the stage for a more generalized sense of hope. As such, leisure, with its emphasis on freely chosen, pleasurable engagements may then play a role in supporting and sustaining hope.

In addition to using leisure engagement as a means to increase hope, TR professionals can develop hope-based psychoeducational interventions (see Hood & Carruthers, 2016a for one example). Schrank et al. (2012) reviewed the literature related to hope and recovery and found several psychoeducational strategies that were helpful for people with mental illnesses, including "(i) collaborative strategies for illness management, (ii) fostering relationships, (iii) peer support, (iv) helping clients to assume control and to formulate and pursue realistic goals, and (v) specific interventions to support multiple positive factors such as self-esteem, self-efficacy, spirituality and well-being" (p. 554). Most of these strategies fall within the purview of therapeutic recreation practice and could form the basis of TR psychoeducational interventions.

Positive Identity

Identity refers to how people define themselves individually and within a social group. Sharma and Sharma (2010) state that "identity is an umbrella term used throughout the social sciences to describe an individual's comprehension of him or herself as a discrete, separate entity" (p. 119). Identity is generally conceptualized in terms of a personal identity (me vs. not me) and a social identity (us vs. them) (Hine, Maybery, & Goodyear, 2018). These two types of identities interact and influence the other (Forrester-Jones & Barnes, 2008). Personal identity can be defined as "distinctive combination of personality characteristics and social style by which one defines oneself and by which one is recognized by others" (Grotevant, 1998, p. 1119). Social identities tend to be influenced by membership in a group, labelling, roles, and culture (Forrester-Jones & Barnes, 2008; Hine et al., 2018; Tsang, Hui, & Law, 2012). Psychologists tend to focus on the awareness of self and the capacity for self-development, while sociologists examine social identity and role behavior.

The development of clear and positive identity/identities involves building self-esteem, facilitating exploration of and commitment to self-definition, reducing self-discrepancies, and fostering role formation and achievement (Tsang et al., 2012). Posi-

tive identities have been associated with living well, flourishing, and overall health (Andresen et al., 2011; Carr, 2011; Renwick, Brown, & Nagler, 1996; Slade, 2009; Slade et al., 2017).

Positive Identity, Mental Illness, and Recovery

Mental illness has a significant impact on one's sense of self (Andresen et al., 2011; Buck et al., 2013; Davidson, 2003; Shahar & Davidson, 2003). Andresen and colleagues (2011) identify that individuals living with mental illness often experience a complete loss of self-identity. Their sense of self becomes subsumed under the diagnosis, label, and/or symptoms of the illness; they no longer know who they are. In addition, individuals who are struggling with mental health issues or experiencing disability often cling to negative schemas and self-constructs as a result of stigma, previous life experiences, or as a recent adaptation to their illness (Andresen et al., 2011). Consequently, individuals living with mental illnesses (or experiencing mental health challenges) often exist in cycles of dysfunction that result in the disruption of psychosocial functioning and have negative impacts on one's social identity in particular. Add to this the negative identity the consequence of stigma and self-stigma, and it is clear that identity (both personal and social) is deeply impacted by mental illness (Corrigan & Kosyluk, 2014; Forrester-Jones & Barnes, 2008; Kravetz, Faust, & David, 2000; Yanos et al., 2010).

Cripps' (2014) participants suggested that the discovery of strengths and capacities was central to living well and was determined through the exploration of abilities in combination with the recognition of limitations. It required accountability and was reliant on honesty with self and others. Participants engaged in the journey of recovery discovered their strengths and areas in need of improvement. The resultant growth in self-esteem and self-efficacy enabled self-awareness to be recognized as essential to living well. Andresen and colleagues (2011) suggest three avenues to reconciling one's self with the illness: i) illness can be accepted as part of the self in a spirit of growth (acceptance), ii) illness can be seen as something that has to be lived with, but is separate from the true self (externalization), iii) illness can facilitate the opportunity to connect to a sense of purpose in life that brings about new meaning (sense of agency). Externalization of mental illness from self involves a self-narrative that depersonalizes mental illness and places the diagnosis outside of the self (Tooth et al., 2003). This strategy can be supported through professional guidance or self-taught practice and is often employed as a coping strategy to aid in the acceptance of illness or disability (Bland & Darlington, 2002). This strategy results in language that names the mental illness as a separate entity from the self and is helpful in creating a positive identity that includes mental illness but is not defined by it.

Knowledge of self that includes self-awareness, acceptance, and congruence are essential elements to the development of resources necessary for recovery (Davidson et al., 2009; Zaff & Hair, 2003). This involves personal acknowledgment of strengths as well as limitations. Without such knowledge, individuals will remain challenged in their ability to engage in authentic leisure, develop goals that reflect personal meaning, or improve on elements of personal limitation (Hood & Carruthers, 2007, 2016b). Within the development of self-awareness, acceptance, and congruence, an individual must be conscious of their personal attributes and capacities, accept their strengths and limitations, and be able to express this identity in a variety of contexts, including

personal, vocational, and leisure-based pursuits (Sheldon & Elliot, 1999; Sheldon & Kasser, 2001).

Positive Identity and Therapeutic Recreation Practice

The LWM identifies that developing a positive identity is central to living well with disability and illness (Hood & Carruthers, 2007, 2016a, 2016b). Self-awareness/self-acceptance/self-congruence are identified as psychological resources in the model. Moreover, the cultivation and expression of one's full potential, identified as a mid-range outcome in the model, implies positive sense of self and identity. Once again, positive identity can be cultivated through psychoeducational interventions (see for example, Hood & Carruthers, 2016b) and through the experience of leisure.

In terms of the experience of leisure, a recent study (Taylor et al., 2017) demonstrated that participation in a TR camp (consisting of outdoor, expressive, and social leisure activities) for individuals with a mental illness results in increased awareness of self. In the LWM (Hood & Carruthers, 2007), Authentic Leisure speaks to the value of leisure in helping people come to know themselves as well as to express valued aspects of self in meaningful engagements. Authentic leisure can support the development and expression of self as well as creating a context for self-exploration and experimentation. The fact that leisure is freely chosen suggests that individuals will choose to engage in experiences that tap into their strengths and capacities rather than their limitations. These experiences will then generate positive feelings about those experiences and personal strengths.

In addition, TR psychoeducational interventions can be used to support the development of a positive identity. Hood and Carruthers (2016b) described the development and implementation of a TR psycho-educational program entitled "Be Your Best Self" that focused specifically on the development of a strengths-based sense of self. The program incorporated topics such as the role of self-storying in recovery with mental illness, strengths discovery, using strengths in leisure, strengths-based goal setting, posttraumatic growth, and incorporating strengths into the story of self. See Hood (2016b) for a more detailed description of the program.

Pleasure in Everyday Life

Positive emotion is "the combination of positively valanced physiological and/or psychological experiences (positive affect) coupled with some type of positive evaluative appraisal of the experience" (Carruthers & Hood, 2007, p. 284). Lyubomirsky (2001, 2007) used the term happiness interchangeably with well-being to describe the feelings of joy, contentment, positive affect and having a meaning in life, all of which are synonymous with positive emotion.

Happiness (positive emotion) has been an ongoing discussion across the positive psychology literature, with an emphasis placed on the role of intentional, purposeful activities in the cultivation of positive emotion (Lyubomirsky, 2001, 2007; Lyubomirsky & Layous, 2013). Fredrickson (1998, 2001, 2009, 2013) presented the Broaden and Build theory, suggesting that through the ongoing daily experience of positive emotion, individuals build up a protective barrier against adverse life events. Within this framework, Fredrickson (1998, 2001, 2009, 2013) suggested that positive emotions broaden individuals' perspectives and sense of options available. The broadened sense of possibility leads to willingness to undertake challenge, which in turn creates an upward

spiral of development that could inspire and support individuals to embrace change and the possibility of a better life.

Pleasure in Everyday Life, Mental Illness, and Recovery

Mental illness creates specific challenges to the experience of positive emotion. Anhedonia (the inability to experience pleasure) is a dimension of many mental illness diagnostic categories (APA, 2013) and is a side effect of many medications used to treat mental illness (Regehr & Glancy, 2014). The inability to experience pleasure coupled with lethargy and amotivation (also associated with mental illness and its treatment) (Luther et al., 2017) make the intentional activities identified by Lyubomirsky (2001, 2007) particularly difficult. Thus, not only do individuals with mental illness struggle with feeling positive emotion, they also struggle to take the actions that might generate more positivity. Conversely, the experience of positive emotion and happiness are seen as central to the recovery process and to living well with mental illness (Davidson, 2003; Davidson et al., 2006; Fitzpatrick & Stalikas, 2008; Lyubomirsky & Layous, 2013; McCormick & Iwasaki, 2008; McCormick et al., 2012). Gruber and colleagues (2009) examined the impact of positive emotions on individuals with mental illness, highlighting the importance of positive emotion as a means of reducing one's functional impairments and morbidity associated with such disease. That said, positive emotion has been regarded for more than its contribution in reducing impairment, but rather as central to living well (Lyubomirsky, 2007).

Davidson and colleagues (2006) suggest that positive life events produce protective effects on individuals and assist them in dealing with the daily challenges associated with mental illness. Cripps' (2014) participants concurred, suggesting that the experience of positive emotion was foundational to their recovery. They also noted that their ability to connect to pleasure was often challenged by mental illness and therefore was an experience that grew over time and was an indication of overall improvement.

It is important to note that the experience of positive emotion can vary in both quality and quantity. Furthermore, positive emotion can be experienced as past, present or future events (Carruthers & Hood, 2007; Hood & Carruthers; 2007). Thus, even if the current circumstances lack opportunity for positive emotion, there are strategies that can be used to insert positivity into daily life events.

Lyubomirsky (2007) suggested that active engagement in intentional activities is the simplest way to increase happiness as it provides opportunities for individuals to connect to positive emotions. She suggested that as individuals learn to create opportunities for and acknowledge multiple pleasant events on a daily basis, their capacity for happiness will increase. In addition, savouring such experiences through anticipation and reminiscence along with active engagement in meaningful activities will also increase one's potential for happiness. Finally, Lyubomirsky (2007) found that intentional activities can create a cascade of positive experiences associated with recovery, including expressions of gratitude, cultivation of optimism, avoidance of social comparisons, the practice of kindness, nurturing of social relationships, development of coping strategies, and opportunities to experience flow.

Pleasure in Everyday Life and Therapeutic Recreation Practice

Therapeutic recreation, with its focus on leisure engagement, encourages experiences of pleasure, satisfaction, contentment, achievement, and absorption. By definition, leisure features positive emotion, either in recollection, in the actual experience

or in anticipation of the experience (Hood & Carruthers, 2012). Thus, engaging clients in experiences that create the possibility of positive emotion—leisure—can be an important strategy for recovery. Therapeutic recreation professionals can also develop and implement psychoeducational interventions that increase pleasure and positive emotion. For example, the Savouring Leisure component of the LWM (Hood & Carruthers, 2007), with the focus on increasing attention to positive aspects of experience, provides guidance for supporting the development of skills related to paying attention to, maximizing, and appreciating the positive aspects of leisure experience (See Hood & Carruthers, 2016a for an example of a Savouring Leisure program outline). Savouring Leisure also incorporates a focus on increasing the quantity of positive experiences in daily life, thus supporting recovery by increasing both the quality and quantity of positive emotion-generating experiences in daily life. Finally, Hood and Carruthers (2016a) provide an overview of a TR psychoeducational program called "Happy Habits" that combined information about positive emotion (Fredrickson's Broaden and Build Model and Lyubomirksy's intentional activities) with elements of Savoring Leisure (gratitude and appreciation), Virtuous Leisure (being of service to others), social connectedness, and hope and optimism. This program is currently being used in outpatient mental health services.

Agency/Autonomy

Autonomy is a concept that is based on one's perception of the degree of control they exercise with regard to choices (Deci & Ryan, 2000). Bolton and Banner (2012) defined psychological autonomy as "the condition under which a person's desires, beliefs, reasons and action can be considered as originating or belonging to the self, as authentic…" (p. 80). Within the context of health, autonomy can be augmented or diminished by one's ability and/or opportunity to participate in the goal-setting process. Ryan and Deci (2000, 2001) identified both autonomy and competence as essential human needs through which behaviour is motivated.

Agency/Autonomy, Mental Illness, and Recovery

Mental illness presents direct challenges to psychological autonomy. In mental illness, the mind is often considered "unable" to make reasoned decisions and take purposeful action (Bolton & Banner, 2012). Bolton and Banner (2012) suggest that autonomous action is based on the interplay between a variety of factors, all of which are potentially impacted by mental illness. Perceptions of reality may be distorted or mistaken, beliefs may be unreasonable or false, emotions may be volatile and unprovoked, and action (which follows from perceptions, beliefs, and emotions) may be missing or unreasonable. Moreover, typical characteristics of mental illness such as lethargy, disinterest in life activities, fatigue, pain, and others all contribute to a lack of sense of autonomy and action. Finally, a sense of being victimized by mental illness, of having one's sense of self and ability to influence events taken away by the illness, also contributes to a loss of sense of autonomy (Corrigan & Watson, 2002; Kravetz et al., 2000).

In the context of recovery, if individuals are unable to connect to their sense of autonomy and competence, they are less likely to engage in positive behaviour that will assist them in living well. If fact, they will be less likely to engage with the process of change in any way at all. Davidson and colleagues (2006) proposed that positive life experiences (leisure) promote resilience and adaptation and through play and pleasure individuals with mental illness build up their restorative power, self-efficacy, and social

agency (all related to autonomy) that contribute directly to an overall sense of well-being.

Agency/Autonomy and Therapeutic Recreation Practice

Like hope, agency and autonomy are also identified in the LWM as psychological resources. Agency and autonomy are often developed by engaging in experiences that offer opportunities to exercise choice and self-direction (Taylor et al., 2017). Leisure, by definition, is an experience that is chosen in relative freedom (thus is both agentic and autonomous) and there is evidence that these opportunities to experience autonomy can generalize to create a more autonomous and agentic sense of self (Deci & Ryan, 2000). Cripps' (2014) research participants suggested that meaningful free-time activities (leisure) supported their development of autonomy and motivation, and served as an effective coping mechanism for stress.

There have been a number of autonomy-supportive psychoeducation interventions developed in the nursing, education, and psychology fields (see for example, Cheon et al., 2018; Hodge, Danish, & Martin, 2012; Kayser, Cossette, & Alderson, 2013) that can inform TR services. Many of these studies focus on leadership or instructional styles that support the development of autonomy. For example, a study by Taylor and colleagues (2017) showed that participation in a TR camp that was autonomy supportive resulted in increased perceptions of choice for clients with mental health challenges.

Social Connections/Engagement

Close friends and relationships are an important source of health and well-being across the lifespan (Antonucci et al., 2010). In fact, social connections have been identified as fundamental human need that motivates much human behavior (Carr, 2011; Ryan & Deci, 2000, 2001). As noted by Hood and Carruthers (2007), "quality relationships are associated with positive emotion (Watson, 2002) resiliency and coping (Frydenberg, 2002; Mikulincer & Florian, 1998), and one's willingness to take the risks necessary for personal growth (Ornish, 1998)" (p. 306). Meaningful relationships with family, friends, and partners involve the establishment and maintenance of connections that are a key factor in one's biological, psychological, and emotional health (Leamy et al., 2011; Slade et al., 2017).

Social Connections/Engagements, Mental Illness and Recovery

Mental illness creates a number of barriers to social engagement and participation. First, the symptoms of mental illness itself (cognitive distortions, emotional dysregulation, poverty of speech, lethargy, etc.) may make social interactions, conversations, and relationships with other people particularly difficult (Perese & Wolf, 2005). Second, many people with mental illnesses do not have access to social opportunities due to financial constraints, lack of awareness of opportunities, and lack of potential social partners for engagement (McCorkle et al., 2009; Perese & Wolf, 2005; Topor, Ljungqvist, & Strandberg, 2016). Finally, stigma and self-stigma create significant barriers to social interaction for people with mental illnesses (Corrigan & Kosyluk, 2014; Corrigan & Watson, 2002). Self-stigma in particular plays a major role in social isolation as people with the mental illnesses often hold on to a devalued, illness-based identity and as such do not feel worthy or capable of social connections or of divulging this part of their identity (Corrigan & Rao, 2012; Yanos et al., 2010).

Social connections are considered to be an essential part of life and living well for all people (Public Health Agency of Canada, 2016; Rath & Harter, 2010; Renwick et al., 1996). Renwick and colleagues (1996) identify "belonging" as one of the three pillars of quality of life in their model and suggest that belonging encompasses belonging to community and neighborhood; belonging with important others; and belonging to the broader society, including access to important social and leisure resources. Furthermore, much of the literature on recovery also identifies social and civic engagement as a key ingredient to living well (Andresen et al., 2011; Hopper, 2007; Slade, 2009; Wong, Stanton, & Sands, 2014). In fact, Wong and colleagues (2014) stated that capacities related to "establishing reciprocal social relationships and taking responsibility as citizens and community members" (p. 685) are essential for quality of life and living well.

Cripps (2014) supported the importance of reciprocal relationships with others in the development of a meaningful life. Within the study, the participants iterated the importance of valued social roles through engagement in volunteer-based positions. As a result, meaningful relationships with family, friends, and partners and giving back to community may be of equal importance in the creation of a meaningful life regardless of the life stage.

Social Connections/Engagements and Therapeutic Recreation Practice

In the LWM, Social Resources are identified as a key set of resources that support well-being. Most therapeutic recreation practitioners recognize the value of social capacities in building a life of meaning and as a result, support the development of skills and abilities related to social connections and facilitate opportunities for social engagement in the community (Anderson & Heyne, 2012).

Therapeutic recreation practitioners recognize that shared leisure experiences provide a common starting place for the development of meaningful social relationships. For example, Kerstetter et al. (2008), while not examining people with mental illnesses specifically, found that leisure-based shared activities were related to a number of positive outcomes, some of which were developing and maintaining friendships, creating new opportunities to meet people that one might otherwise not meet, and increasing enjoyment in shared experiences. Thus, shared leisure activities may confer significant benefits to people with mental illnesses who often struggle with isolation and boredom.

Supported socialization is another important potential area of intervention for TR practice in mental health services. Davidson and colleagues (2004) first reported on a process where individuals with mental illnesses were paired with a community volunteer, and then subsequently instructed and supported financially to engage in "natural social and recreational activities within their local community" (Sheridan et al., 2015, p. 242). Supported socialization studies have shown many positive outcomes, including improved social functioning (Sheridan et al., 2015), increased engagement in community recreation activities beyond the program expectations (Sheridan et al., 2015), friendship development with the volunteers (McCorkle et al., 2009), increased self-esteem and confidence (McCorkle et al., 2009), and increased reciprocity and interdependence of relationships (Wong, Matejkowski, & Lee, 2011), to name a few. Supported socialization programs are clearly within the purview of therapeutic recreation practice as TR professionals are ideally situated to match volunteers with clients and help them find meaningful activities within which to engage.

Finally, psychoeducational interventions designed to enhance communication skills, conversational skills and /or relationship skills may help clients with mental ill-

nesses to enact socially normative behaviors in their pursuit of social connections and these social connections are instrumental in reducing stigma and self-stigma (Corrigan & Kosyluk, 2014; Corrigan & Rao, 2012). See Hood and Carruthers (2016a) for an example of a TR psychoeducational program designed to support social engagement called "Getting Out and Getting Involved."

Conclusion

The purpose of this paper was to discuss the intersection between recovery in mental illness and therapeutic recreation services. Many of the key dimensions of recovery can be linked to leisure engagement and therapeutic recreation practice as discussed above. Leisure engagement in and of itself can set the stage for the development of needed capacities related to recovery and therapeutic recreation psychoeducational interventions can be used to support the development of specific skills and capacities related to recovery.

Therapeutic recreation services can play a seminal role in the creation of meaningful experiences and an overall sense of enjoyment in life, which are both essential elements for living well with mental illness. Beyond this, TR services can support clients to develop an acceptance of their illness while creating hope for a meaningful future. Therapeutic recreation services can use leisure to support the development of a sense of autonomy and competence. Finally, leisure engagement sets the stage for the ongoing development of a strengths-based positive identity and the development of meaningful social connections.

In terms of next steps, the authors encourage TR professionals and researchers working in mental health services to directly connect TR interventions to the characteristics of recovery. This connection can be demonstrated by articulating the connections between leisure and recovery clearly, by developing new programs and/or framing existing programs within the recovery approach, and finally by conducting evaluation research that demonstrates the value of TR services in facilitating recovery and well-being. Demonstrating that TR services contribute to achieving the valued goals of clients and agencies is instrumental for creating effective interventions and supporting clients to live as well as possible with mental illnesses.

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