Introduction

Recovery and rehabilitation in mental health: Historical perspectives

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Abstract

Recovery and rehabilitation are highly charged terms in contemporary mental health, with their meanings and implications contested by professionals and survivors alike. A loose 'recovery movement' with radical reformist aims, which emerged across Britain and the United States in the later decades of the twentieth century has, some argue, been co-opted by 'neoliberal' poltical and clinical interests. Most of these narratives begin with the emergence of the recovery movement as a result of service-user/peer activism in the 1970s: few consider the longer history of ideas and practices of recovery and rehabilitation. In turn, recovery and rehabilitation have been strangely marginal in the works of historians of psychiatry, madness and mental health. This article traces some of the key literatures and concepts in relation to recovery and rehabilitation, and introduces this special issue of History of the Human Sciences, with

contributions on Britain and the United States from the late nineteenth century to the turn of the twenty-first century.

Keywords

history of Britain, history of psychiatry, history of the United States, psychiatric rehabilitation, recovery in mental health

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Since 2015 a group of British mental health survivors in Britain have maintained a website and associated social media channels entitled Recovery in the Bin, which mixes satire and serious critique. They are 'fed up', they argue, 'with the way co-opted 'recovery' is being used to discipline and control those who are trying to find a place in the world, to live as they wish, trying to deal with the very real mental distress they encounter on a daily basis'. Recovery in the Bin challenge the teleological framing of mental health interventions such as Cognitive Behavioural Therapy and Recovery Colleges, and how welfare reform has shifted mental health care to prioritise the restoration of individuals to be able to participate as economically active workers (and spenders), regardless of their actual state of health or wellbeing. In turn, what they see as the real root causes of madness - socio-economic and environmental factors including racism, discrimination and material and structural inequities – are ignored by each

successive government. As a challenge to this pressurized coercion towards a false state of recovery they state that:

> …[we] consider 'Unrecovered' is as valid and legitimate as "Recovered", and we accept and respect the political and social difference. So some of us have accepted a new word / signifier 'Unrecovered'. However, this doesn't mean we want to stay 'unwell' or 'ill' (whatever that means), but that we reject this new neoliberal intrusion on the word 'recovery' that has been redefined, and taken over by marketisation, language, techniques and outcomes.
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> We recognise that the growing development of MH 'Recovery' in UK/US, during the past decade or so has been corrupted by neoliberalism and capitalism is the crisis! Some of us will never feel "Recovered" living under these intolerable and inhumane social pressures. (Recovery In The Bin, 2016)

Recovery, then, is a highly charged word in the contemporary field of mental health studies. As Angela Woods, Akiko Hart and Hel Spandler discuss, the meaning of 'recovery' has been appropriated and distorted from its earlier usage among the survivor movements of the 1970s and '80s in the anglophone Global North, with the range of possible 'endings' to recovery narratives becoming ever-more narrow in current clinical practice. This, in turn, has been an exclusionary shift, particularly when it cancels out the existence of neurodivergent identities, and denies the lived reality of chronic ill-health (Woods, Hart, and Spandler, 2022).

In the American context, recovery and rehabilitation have also animated public debate and scholarship in the first decades of the twentieth century. The popular website and radio programme *Mad In America*, which brings together broad stakeholders in mental health with a

reformist agenda, frequently posts stories and interviews on recovery themes. In amongst those who critique the 'whitewashing' of the idea of recovery for clinical interests (Watts, 2016 https://www.madinamerica.com/2016/02/recovery-compromise-or-liberation/) are articles of celebratory remembrance, reminding readers of the work of key early figures in rehabilitation psychiatry and the 'recovery movement'. One such is an article by psychiatrist Mark Ragins celebrating the work of William Anthony, who founded of the Centre for Psychiatric Rehabilitation at Boston University in 1979 and was editor of the *Psychosocial Rehabilitation Journal* (Ragins, 2020; Anthony, 1978). Ragin revisits the original principles of the recovery movement as an 'outsider' reformist coalition, loosely comprising the following:

- People with mental illnesses – "consumers" – fighting for themselves and helping each other
- People with experience with the 12 step-recovery movement, wanting to integrate mental health and substance abuse recovery
- Psychosocial rehabilitation and psychiatric rehabilitation programs
- Civil rights advocates
- People who don't like following the rules and are naturally pragmatic rebels
- People who prioritize trauma over illnesses and want to focus on trauma recovery
- Staff who came to mental health for personal reasons who are "abnormal in a certain, special way so our hearts go out to people normal people would avoid," who want to connect to their clients authentically and reciprocally rather than reduce them to cases
- People who heavily value cultural contexts, understandings, and services
- People who are "doing God's work" and find spirituality to be forcibly excluded from our current system

(https://www.madinamerica.com/2020/08/recovery-jedi-master-bill-anthony/ Ragins, 2020)

This eclectic set of solidarities and overlapping agendas didn't in itself constitute a movement, but, as Jeanette Copperman and Sarah Chaney point out, it did signal a coalescence of actors broadly looking for alternatives to a pharmaceutical-driven biomedical model of mental illness, one which was important on both sides of the Atlantic (Chaney and Copperman, 2024; Thornton and Lucas, 2011). Recovery has also animated anthropological scholarship, with Neely Meyer's landmark 2015 ethnography of the Horizons mental health clinic, a facility partly run by peers with lived experience themselves, Neely Meyers reported that the lofty hopes communicated through recovery rhetoric were rarely achieved in practice. While the focus on autonomy and individual moral agency appealed to many within the programme, the social and economic contexts of peoples' lives – and the stigma and discrimination faced by people with mental ill-health - made the ideal of recovery difficult to reach (Myers, 2015). While peer-support seemed to offer positive opportunities, the definition of 'recovery' as re-entry into the community and the world of work, and proving themselves 'worthy of intimate connections with others' was almost impossible without the pre-existence of solid social relationships. This definition, according to Myers, 'foreclosed' individuals' outcomes, echoing Woods, Hart and Spandler's critique of the British clinical 'recovery model' (Myers, 2015: 156).

It is clear that recovery or rehabilitation – terms that remain ill-defined and hard to measure – have become the centre of contemporary mental health services in the UK and US in particular, with long-term institutional care abandoned for the vast majority of people with lived experience of mental health difficulty or addiction. In turn, recovery is still a motivating concept for alternative and radical approaches to care, despite it having been 'co-opted' for

clinical and political purposes by governments from George W. Bush to David Cameron as a means to justify limiting funds for mental health care. But what of the twentieth century and earlier? These contentious current debates lack a historical dimension, with little discussion of recovery prior to the service-user movements of the 1970s (Myers, 2015; Woods, Hart, and Spandler, 2022). Joel Braslow challenges this presentist assumption, arguing that recovery notions precede the 'recovery movement' by decades and that the values of early-to-mid twentieth century psychiatric practice in relation to rehabilitation made possible the era of deinstitionalization and pharmaceutical innovation (Braslow, 2013).

Braslow is also not unique in emphasising that the imperatives towards economic productivity and gainful employment in the delivery of mental healthcare since the 1980s have been an artefact of neoliberalism (Braslow, 2013; Woods, Hart, and Spandler, 2022). By drawing together historical research on the late nineteenth and early twentieth century, this special issue argues that these economic concerns have been a core facet of clinical intervention in formal and informal services long before the periods of Reagan and Thatcher (figures considered exemplary in the consolidation of neoliberalism), and their enduring effects into the twenty-first century are not simply a medium-term manifestation of late-twentieth century free market ideology. From philanthropic asylum after-care in turn-of-the-twentieth-century Britain to inter-war adolescent rehabilitation to war-time industrial psychology, and later in 1970s American drug addiction practices, we see these same priorities resurface as a primary motivating force and justification for interventions across varied contexts, and within different types of service (see Blythe, Whorrall-Campbell, Jones and Fees, Koch). Teleological care and individualized responsibility in the interests of economic (as well as, sometimes, political) citizenship are nothing new in the world of Anglo-American clinical practice. It would be somewhat crass to make sweeping generalisations about a transatlantic Protestant work ethic to account for this oft-repeating leitmotif in the archival material, drawing on Max Weber's

view that Protestant attitudes towards work transcended religious confession and became secularised as a mode of identity and behaviour within capitalist societies that had previously been dominated by Protestantism (Weber, 1904). Nevertheless, recent scholarship in the sociology of wellbeing, which revisits the question of the existence of a Protestant ethic, points out that the 'psychic cost' of unemployment on the individual 'hurts more' in historically Protestant societies – regardless of the religious orientation of the individual (van Hoorn and Maseland, 2013). Whether or not it can be accounted for by Weberian frameworks, worklessness as a site of clinical intervention, and the imperative towards productivity, is one of the most historically stable features of Anglo-American mental health intervention since the nineteenth century.

With this 'long view' in sight, the co-opting of recovery for these imperatives is, if anything, a restoration or continuation of long-standing clinical and societal norms, even as the meaning and character of work, and indeed recovery, deserves further specification within different political-economic configurations. The late twentieth century brought with it new technologies of measurement to quantify recovery and decide on 'end points' in care, as we see in Rachael Rosner's article on metrics and outcome inventories for depression, enabling the possibility of rating treatment success and the certification of recovery at the end of therapy. What is worth remarking upon and accounting for, however, is the brief success of grassroots survivor movements in reappropriating the language of recovery for a more inclusive and progressive end from the 1970s to the 1990s: in this spirit, Jeanette Coppermann and Sarah Chaney offer us a case study of feminist user-led support from late twentieth century Britain in relation to self-harm (Copperman and Chaney, 2024).

The historiography of psychiatry, madness, and mental health for entirely worthy reasons, has tended (at least until recently) to focus on institutions, 'heroic' physical therapies and their abuses, the rise of psychopharmaceuticals, psychoanalysis and, subsequently, on the

history of psychotherapies. Questions of how recovery and rehabilitation were conceptualised and practised over time have not often been at the centre of analyses, although one can draw together rich implicit threads hidden within wider histories of e.g. social psychiatry, radical- and anti-psychiatry, deinstitutionalisation, mental health and criminal justice, and emerging histories of the survivor movement. A key exception has been Ralph Höger and Max Gawlich's 2021 special issue of *Medizinhistorisches Journal* on 'recovery' and 'cure' in psychiatry (Höger and Gawlich, 2021). This focuses on European cases, and reminds us of the fate of patients deemed 'incurable' in Nazi euthanasia programmes, as well as what has been at stake in construing individuals as capable or incapable of recovery or rehabilitation. Our work here builds on the ground laid by Höger and Gawlich, with a focus on Britain and the United States as states whose psychiatric and psychological professions are professionally and intellectually intertwined, in spite of radically different healthcare systems. This introductory article examines the adjacent scholarly literatures on recovery, begins to map out changes in conceptual definitions of recovery and rehabilitation, and introduces the contributions of our authors to this special issue.

Recovery and rehabilitation's more marginal status in the history of madness and psychiatry is perhaps due to the long-lasting (if now waning) dominance of asylum studies in the field, sparked by Foucault's Great Confinement narrative (1967).[1] What happened inside asylums has been of enduring interest to historians, and has continued to produce studies steeped in archival detail (Golding, 2021; Hide, 2014; Hilton, 2021). The asylum declined over the second half of the twentieth century and the deinstitutionalisation of psychiatric system in Britain and America was largely completed in the 1990s. Attendant scholarship emerged (Cummins, 2020; Grob, 1991; Kritsotaki, Long, and Smith, 2016). Some works take a longer perspective, covering institutionalisation and deinstitutionalisation (Crammer, 1990; Jones, 1993). These histories predominantly do not address the recovery and release of patients from

asylums: they instead ask how policymakers decided that the community was now the place to deliver treatment and care.

The idea of asylums as inescapable receptacles for everyone ever deemed mad pervaded early histories, and some writers have continued to emphasise custodialism despite mounting evidence that it was far from the whole story (Appignanesi, 2008; Clark, 1993; Scull, 1980, 2015). Eastoe (2020) has more recently investigated Caterham Asylum, Surrey, for patients diagnosed as incurable – designated 'idiots', 'imbeciles' and 'weak-minded' and chronically insane. Eastoe's history of confinement highlights how a conceptual division between curability and incurability has long influenced psychiatric treatment. Custodialism is an important aspect of the history of psychiatry, but exclusive focus on this theme misrepresents the past and precludes a myriad of important avenues of research. Indeed, during the 1990s, some scholars looked for evidence of whether and how patients left Victorian asylums. Busfield (1994) uses records of death, recovery and discharge of male and female inmates to undermine Showalter's (1987) depiction of madness as 'the female malady'.

Wright (1999: 93-112) called for historians to make discharge an object of investigation. His statistical and legal analysis of release and recovery from Buckingham County Asylum established that 'discharge… was an important social phenomenon',and issues a call for research into the lives of individuals after leaving the institution. Melling and Forsythe (2006: 99-124) and Rehling and Moncrieff (2021) have since deepened our knowledge of patients' movements in and out of asylums. The impact of curability on therapeutic regimes within institutions has been covered more tacitly. Numerous historians of Victorian asylum psychiatry have remarked that one of these stated institutions' purposes was to return inmates to their positions as citizens in the community (Melling, 199: 1-30; Scull, 1993: 93). Scull (1991: 155) maintains a focus on custodialism by arguing that moral treatment was asylum psychiatry's failed method of 'return[ing] the dependent to the ranks of productive citizenry'.

Chaney (2016: 277-97) has produced more nuanced commentary than Scull's narrative, confirming his observation that asylum practitioners were interested in creating 'useful members of society', but looking beyond productivity. This attention to 'social' usefulness and citizenship in addition to gainful employment is also a theme that resurfaces often across the special issue.

Concepts across time

With the exception of Höger and Gawlich (2021), the themes of recovery and rehabilitation have rarely been put at the forefront of historical work on madness and mental health, while considerable attention has been paid to the prevention, onset and treatment of mental illness in its acute phase. How are we to understand fully the implications of past treatments, diagnoses, professional activities, service-user activism and subjective phenomena without reflection upon what it meant to get better from psychological illness and suffering? How can we assess treatments without interrogating what it was that practitioners, patients, and observers were striving for? Recovery and rehabilitation also exist in relation to non-recovery, chronicity and relapse, meaning that historical investigation into the desire to regain mental wellness reveals much about chronic conditions and the reasons for custodialism. Taking a historical perspective also offers a new frame for contemporary debates about recovery and rehabilitation in the Anglo-American context, reminding us that the current meaning of these terms is not static, and that interventions towards recovery and rehabilitation have varied in their approaches, and in how they conceive of individual subjectivity.

Recovery and rehabilitation encapsulate a wide range of notions of what it has meant and means to experience a cessation, or at least abatement, of psychological suffering or unwanted behaviours. These words have been used over the last century and a half to refer in varying ways to the alleviation of symptoms of mental illness, and to the relinquishment or

diminution of actions deemed pathological. Recovery, as Hannah Blythe's article notes, has been used in British psychiatry since the late nineteenth century to describe relief from symptoms such as hallucinations and delusions, and the ability to rejoin society has been used as an external signifier of these mental shifts. Recovery has also been employed throughout the history of the Western psychiatric profession to indicate a general cessation of symptoms, in much the same way as the term has been used in the broader world of medicine. Indeed, Rachael Rosner looks at how Aaron T. Beck, founder of cognitive therapy, and sometimes referred as father of Cognitive Behavioural Therapy (CBT), used the general concept of recovery as an overarching description for the alleviation of negative psychological experiences associated with depression to develop his Depression Inventory, published in the USA in 1961 (2025: Page). However, as Jeanette Copperman and Sarah Chaney observe in their study of self-harm and women's mental health activism in late-twentieth-century Britain, 'recovery' has taken on a more specific meaning in certain contexts. They note that, 'today, the "recovery model" generally refers to the idea that recovery may not mean a cessation in symptoms but can be a relative concept, associated with quality of life' (Chaney and Copperman, 2025: 2).

The phrase 'rehabilitation' has been used throughout the twentieth-century in the British and American mental health field in relation to a range of psychological challenges. There has been no unified definition of the word, but it has often been harnessed by practitioners, policymakers and in popular lexicon in relation to conditions depicted as adjacent to, but not necessarily conceived of as, mental illness. 'Rehabilitation' in these instances described the process and end point of assuming or returning to one's place as a healthy and responsible member of a given society. Indeed, in this special issue, Grace Whorrall-Campbell identifies attempts to rehabilitate workers suffering from 'industrial neurosis' to their place in the work-a-day world in mid-twentieth-century Britain. Ulrich Koch contemplates how

attempts to ‘rehabilitate’ people living with opioid addiction in the USA in the 1960s assumed a narrow focus on restoring people to employment. David Jones and Craig Fees illuminate the application of the concept of rehabilitation in approaches to shaping the behaviour and wellbeing of ‘troubled young men considered at risk of delinquency’ (2025: page) in interwar Britain. The language of rehabilitation has then, broadly, articulated a greater degree of concern with the social aspects of psychological wellbeing.

Interestingly, these examples contrast with the ideas of rehabilitation outlined by Neely Myers in her ethnography of an American ‘recovery movement’ clinic in the 2010s. By this point in the US, rehabilitation held a more distinct meaning to recovery. While still social in its meaning, it was associated with a more paternalistic and even therapeutically nihilist position, in contrast to the optimistic model of full recovery based on principles of self-determination and striving through peer support. Rehabilitation, for Myers, still held on to the idea that many individuals with psychosis may not be able to fully achieve wellbeing, with a focus instead on manageability and compliance. In a rehabilitation model the clinician (and the State) retained more control over the individual who was afforded less autonomy as a subject. On the other hand, the fact that full recovery was never truly seen as a goal meant an acknowledgment of an ongoing relationship between the individual and clinical services (Myers, 2015). Ulrich Koch’s article in this special issue shows how some of these transformations in the concept of recovery had already been arrived at in relation to substance abuse management in 1970s America, catalysed by the introduction of Methadone Maintenance Treatment for opioid use, and the concurrent rise of therapeutic communities as a competing model (Koch, 2025).

A good deal of the cases in Myers’ book also discuss the complex relationship between mental health and addiction. Indeed, historians of addiction have paid possibly the greatest attention to recovery and rehabilitation in mental health and psychiatry contexts. Trysh Travis

(2010: 1-10) endeavours to 'establish recovery as a legitimate subject for scholarly analysis' with a history of the Alcoholics Anonymous (AA) movement in the USA. She charts the history of the AA from its foundation in 1935, embedding it in the United States' political history and print culture, and evaluating the influence of mysticism, religious, gender the marketplace on definitions and practices of recovery. Koch's article highlights a contrasting approach to opiates addiction in the USA, charting how earlier approaches focused on rehabilitation into *society*, and a more individualised approach to recovery emerged in the 1970s with a heavier focus on work (Koch, 2025). Historian Claire Clark's work *The Recovery Revolution* also resonates with this shift in narrative from a 1960s ethic of 'radical communitarianism' to 'moralizing conservatism' (Clark, 2017).

The varyingly defined and loose concepts of recovery and rehabilitation have operated in relation to a myriad of notions regarding the health of the self. 'Cure' has been applied in ways that subtly differ from recovery, often conveying a greater optimism that the root cause of the mental illness had been eradicated. Cure, or the German equivalent *Heilung* was at the very centre of Freud's original psychoanalytic 'talking cure', after all (Breuer and Freud, 1895), even as the purpose of psychoanalytic treatment has been intensely contested since its conception. Later behaviourist approaches to psychotherapy still aimed for a cure, but disputed the 'root cause' of distress as a product of unconscious conflicts which needed to be prised apart with the help of a psychoanalyst. In the words of the infamous Hans Eysenck, one of the key proselytizers for behaviour therapy in the 1950s and '60s for phobias, obsessions and compulsions, 'get rid of the symptom and you have eliminated the neurosis' (Eysenck, 1959: 65; Marks, 2015). In 2012, Psychiatrist and philsopher Abraham Rudnick claimed that his edited book was 'the first published collection of contributions that focus primarily on philosophical aspects of recovery of people with mental illness' (Rudnick, 2012: 3) As part of this volume, Paul Lysaker and John Lysaker explicate apparently recent shifts amongst

psychiatric commentary from conceptualising recovery as the alleviation of symptoms to understanding recovery as regaining capacities that make it possible to exert agency in one's own life even if the challenges of mental illness remain (Lysaker and Lysaker, date). Our authors show this to be a longer and more complex process than this argument conveys, and we acknowledge that this is only a small drop in the ocean compared to the breadth of research still required in order to build wider philosophy of the matter - one which clearly requires a historical approach.

Moreover, the histories of recovery and rehabilitation have implications for comprehending the wider groups of ideas that have been, and continue to be, used to describe the transient and dynamic nature of mental health. We cannot have relapse without prior rehabilitation or recovery. The expectation or apprehension of a return of receded symptoms or disorder raises the notion of remission. Convalescence has been, and is, evoked to express the process of emerging from a period of acute illness. All of these descriptions of getting better and getting worse operate in relation to descriptions of mental and/or psychological health, mental wellbeing and 'normality'. Here, as Blythe demonstrates, we must think about how past experiences of non-wellbeing can influence a subsequent state of wellbeing. Putting the emphasis on recovery and rehabilitation shifts the temporal emphasis, generating new research questions about how we conceive of therapeutic efficacy (or even the very definition of treatment goals) past and present. In turn, this prompts the question of how success, or effect, is assessed in the course of someone's life course in the days, months or years after treatment.

Recovery, rehabilitation, cure, remission, relapse, convalescence and life-after-recovery all convey a sense that psychological subjectivities are dynamic, commonly moving between varying degrees of equanimity, tolerability and pain. A more static notion that operates in connection to these is 'normality'. Nikolas Rose has famously written on the history of psychological 'normality', arguing that psy-disciplines have been instrumental in the

government of human subjects through the development of new 'technologies of the self' (1985: 1–11; 1990: ix). In turn, this has impacted on ideas of psychological citizenship (Rose, 1985: 1–10; 1990: 1–32) Rose charted what he saw as the 'formation of the modern psychological enterprise' in England between 1869 and 1939, using this narrative to claim that 'psychological knowledge of the individual was constituted around the pole of abnormality' (1985: 3-5). Yet, the research in this special issue reveals numerous attempts to offer positive definitions of mental health, and cater for the idea that the human mind shifts between states. Furthermore, as Chaney and Copperman's work demonstrates, recovery has not always been assumed to be the same for everyone.

Our discussion of recovery and rehabilitation in mental health is of course shaped by the geographical and chronological parameters of research upon which its articles draw. Our papers span from the late-nineteenth century to the beginning of the twenty-first century. They cover Britain and the United States of America, with the hope of prompting a new field of research by collating and comparing findings from an expansive set of contexts within the modern history of Western mental health practice. We call for further studies from a wider geographical and temporal reach to build on the foundations we offer. Our articles study actors operating in a range of roles, including psychiatrists, psychologists, psychiatric social workers, charity employees and volunteers, patients, service-users and survivor groups, interrogating how individuals and groups negotiated and contested the meanings of recovery and rehabilitation from a variety of positions and perspectives.

A word must be said on the ethical implications of publishing on mental recovery. Of course, there are certainly optimistic elements of histories of recovery. The desire and hope for the alleviation of symptoms are familiar and important to many of us who experience mental illness, madness, addiction or psychological suffering. It is important to acknowledge and explore that alleviation. Yet, a full history of recovery and rehabilitation includes those for

whom that cessation of symptoms did not happen, and those who contested whether 'rehabilitation' took place, even if symptoms may have lessened. It also takes seriously those experiences of recovery that were followed by relapse. A comprehensive history of recovery and rehabilitation also incorporates resistance: we learn how those undergoing treatment have not always agreed with practitioners or policymakers what 'recovery' or 'rehabilitation' should look like, or have questioned narrow stipulations of what recovery means. It highlights where activists reshaped concepts of and aims for recovery and rehabilitation in ways that reflected and suited their own experience, priorities and needs. A history of recovery and rehabilitation also notes that treatment deemed 'successful' have often demanded difficult and gruelling treatments that might also have inflicted certain kinds of harm.

Articles in this special issue

Blythe's article, the first in our special issue, turns to the question of how patients left British asylums at the turn of the nineteenth century. It examines the birth of Britain's first national level community-based psycho-medical charity, the Mental After-Care Association (MACA), illuminating the challenges faced by those who were discharged recovered from English and Welsh lunatic asylums between 1879 and 1928. It shows how medical notions of recovery in terms of symptom alleviation were linked to political ideas of what it meant to operate as successful member of society.

This article also presents a case study of how legislation has influenced experiences of psychomedical treatment. Throughout the period, certification of insanity for institutional treatment stripped patients of the status and rights of citizenship. Discharge from an asylum on account of recovery restored a patient's legal access to citizenship, yet suspicions about their right and ability to participate in society lingered. The MACA's leaders designed after-care to facilitate restoration to full citizenship. The charity was a product of the active citizenship

movement, according to which, one's right to identify as a citizen depended on the performance of certain duties to the community. These duties varied according to socio-economic position and sex, meaning that each individual was prescribed a gendered personal citizenship role. MACA personnel saw their endeavours as part of their own citizenship roles, and designed their treatments accordingly. Patients' social capabilities were used as a proxy indication of restored psychological soundness, using a patient's assumption of a citizenship role to indicate recovery, and believing that supporting the performance of that role had mentally healing effects for patients who had been discharged recovered. MACA workers thus imbued the psychiatric innovation of after-care with the liberal political and social values of active citizenship.

Blythe's article reveals the importance of charities as a mode of medical and social negotiation of the meaning of mental illness and health. It highlights how the philanthropic world operated as a nexus in which medical professionals, voluntary social organisers, paid administrative staff and religious actors negotiated what it meant to return to mental health, and how the challenge of returning to social functioning ought to be managed and supported. We see a reciprocity of lay, medical and church expertise. Blythe's work can be read alongside the literature on AA to demonstrate how medical, religious and social forces have in many contexts and times been entwined in the generation of interventions designed to elicit psychological recovery.

Our next article brings out attention to the 1930s and 1940s. Jones and Fees offer a psychosocial studies examination of the actors and ideas that fashioned an 'experimental rehabilitative intervention for troubled young men considered at risk of delinquency between 1936 and 1941' and shows how this intervention went on to shape post-war developments in 'therapeutic childcare and work with adults' (p. 1). Their article charts the development of the Q Committee's creation of a psychosocial intervention for kind of psychological pathology that

was observed and interacted with in the generation of the concepts of antisocial and borderline personality disorders. Jones and Fees trace a group that included psychoanalysts and early psychiatric social workers called the Q Committee, whose primary project was Hawkspur Camp for young men (Jones and Fees, 2023). A historical analysis of this initiative highlights the innovative theories and practices from the 1930s that - despite being under-recognized today - significantly influenced post-war developments in theory and practice. The Q Committee's project exemplifies some of these developments. It offered an alternative to traditional institutional detention for young men (and by extension young women), and also challenged the conventional understanding of mental disorder by proposing that pathology existed in a psychosocial space formed at the intersection of individuals and their social environments, and that treatment therefore needed to address this intermediate space.

Jones and Fees's work points to intersections between psychoanalysis, the burgeoning profession of psychiatric social work, criminology Quakerism and spiritualism. The focus on delinquency highlights how concepts of rehabilitation have at times simultaneously drawn on criminological understandings and penal activity as well as attitudes towards the behavioural signs of psycho-pathology. Here, the young people towards whom the interventions discussed were targeted were deemed to have the capacity and potential to be rehabilitated into society according to the social norms and legal standards supported by the projects' practitioners. Jones's and Fees work can be placed in conversation with later psychosocial studies literature about the contentious concept of personality disorder as a later correlate of 'delinquency' in criminal justice settings. Martyn Pickersgill (2012) has demonstrated how in legal and criminological implications of the 2007 Mental Health Act of England and Wales spurred a shifting of personality disorder from a 'obdurate' to a 'plastic' and treatable condition. By contrast, a recent article in this journal by Becka Hudson has tracked the reversal of this trend in the UK Prison system, where risk management technologies have re-inscribed the past

trauma experienced by some people with personality disorder diagnoses as rendering them too high-risk to release from prison. Trauma in these instances, she argues, becomes in-effect 'sedimented' as though untreatable, and the individuals become excluded from rehabilitation, returning personality disorder to its former 'obdurate' status prior to the 2007 Mental Health Act (Hudson, 2025; Pickersgill, 2007). These examples highlight how definitions of recovery and rehabilitation can become more complex when mental health interventions are also shaped by criminal justice imperatives, with the bar for potential 'rehabilitation' having become higher as risk management processes intervene.

Grace Whorrall-Campbell's article takes the case study of the Roffey Park rehabilitation facility that was established to treat 'industrial neurosis' in the post-Second World War period, inspired by the wartime disability rehabilitation facilities. A 'distinctly mid-century effort to strengthen democracy and national prosperity through healing the bonds that connected workers to the social fabric' (Whorrall-Campbell, 2025: p.?), Roffey Park's explicit mission was to return workers to the workplace following a residential stay of 6-8 weeks, during which time they would receive psychotherapeutic support and an array of occupational therapy approaches from handicrafts to woodwork, physical exercise and a dietician-controlled diet (which patients would cook themselves with vegetables harvested from their own communal garden). Roffey Park had strong parallels to long-standing Moral Treatment practices originating from the York Retreat at the end of the eighteenth century (Digby, 1987), reframed for a postwar industrialised social democracy. It also aimed to reverse the alienating effect of modern industry by reconnecting individuals to purposeful labour. Working women were also patients, and it was acknowledged that their load was 'double', although little was done to challenge gender inequality.

Roffey Park blended a range of expertise, from psychiatry to organization and management theory, and trade union practice such as modelling 'principles of joint

consultation' in staff-patient committees as a means of training individuals for the workplace, providing them with skills to negotiate challenges at work, and as a means of boosting group morale. Whorrall-Campbel describes this as 'Industrial democratic therapy', one which was ultimately about modelling good citizenship within the small community as a preparation for rehabilitation to the larger outside world (mirroring the object lessons of Jones and Fees' description of Hawkspur). For Whorrall-Campbell this focus on economic productivity constituted a kind of 'latent neoliberalism'. Placed in juxtaposition with Blythe's article on the practices of asylum after-care, which also had a focus on restoration of economic citizenship and which pre-dated Roffey Park by several decades, we might ask whether seeing earlier interventions in teleological relation to the 1980s neoliberal moment is the right point of analysis. Instead, it invites us to ask what was really new about 'neoliberalism', given that the psychiatric tools it deployed were common to social democracy four decades previously, and an emerging British liberal democracy decades before that.

Moving across the Atlantic, Rachel Rosner's contribution is simultaneously a story about the rise of CBT through Beck's skillful use of metrics, but also shines light on a little-known aspect of the history of American psychoanalysis in the mid-twentieth century, most notably the appropriation of quantitative methods by Leon Saul, a member of the Chicago School, to validate psychoanalysis. While histories of CBT have made much of the technique's amenability to measurement in accounting for its success (Marks, 2015), Rosner's research shows that this was not the radical break from psychoanalysis that it is often portrayed to be, but is in fact an adaptation of a certain set of psychoanalytic imperatives in the 1950s. The emergence of rating scales in psychoanalysis and psychotherapy this period does signal an epistemic rupture in the psychological disciplines more broadly, we argue, as self-reported subjective ratings came to have a value of their own, potentially exceeding that of clinician-reported judgment. The subjective experience of recovery and treatment effectiveness, even if

only caught in an ephemeral snapshot on a simplistic numerical scale, was a new and important type of data for the psy-sciences. The ongoing persistence of these rating scales into the twenty-first century demonstrates how transformative this shift was, but also perhaps shows us how little these technologies of measuring the subjective sense of recovery have changed over six decades.

Beyond innovations in measurement and treatment evaluation, Rosner argues that, for Beck, this was not simply a question of medical recovery as defined by a resolution of symptoms. Instead, 'lowered scores post-CBT on its own meant something else entirely… something Saulian: not just symptoms reduced but skills mastered, self-inoculation achieved, active citizenship restored' (Rosner, 2025: page) The principles of CBT were a set of skills enabling increased personal freedom, and a new-found ability for the individual to manage their emotional responses and adapt better to their environment and social relationships. While the techniques and assumptions may have been quite different to our previous British examples, a similar notion of rehabilitation resonates here – one that is also linked with citizenship.

Remaining in the USA, Ulrich Koch charts the shifting concepts around which policymakers and treatment providers organised the aims of addiction treatment in the mid-century. He highlights how actors from a range of spheres, including medical professionals, peer support workers, a myriad of 'helping professions', and the judiciary, developed a shared focus on rehabilitation in the post-war decades. The concept of rehabilitation came with a strong focus on stable employment, economic productivity and integration into the labour force. He highlights the decline in faith in rehabilitation by the late 1970s due to a range of social, political and medical factors, including falling optimism in the ability to encourage people being treated for addiction into the workforce and rising ethical questions about the infringement of rehabilitation goals on individual freedoms. He notes how these processes were entwined with the introduction of methadone maintenance treatment (MMT), which was seen

as a biomedical treatment for the individual patient. These factors led to a reduction in the prominence of rehabilitation as an organising principle for addiction treatment which, in turn made space for its replacement with recovery by the coming of the new millennium.

Recovery, Koch observes, was a more individualised notion, which allowed actors to see treatment as a personal project, while also questioning the social barriers that prevented reintegration into economic and social society. Koch's article shows comprehensively that 'addiction treatments always involve aims that extend beyond reducing someone's illicit drug use' (Koch, 2025: 21), illustrating how ideas about the virtuous citizen have been woven into thoughts about how to achieve this fundamental aim.

Our final article, by Copperman and Chaney, illustrates how recovery has often held different meanings for clinicians, service-users and survivors. They present a history of a peer listening service called Bristol Crisis Service for Women (BCSW) between 1986 and 2002 to show how these differences have been particularly marked regarding self-injury. They illustrate the development of the 'survivor-led model of self harm recovery' (Copperman and Chaney, 2024: 2), positioning it as a precursor to twenty-first century models in which recovery has become less tied to the cessation of symptoms. Proponents see recovery as something more relative, tied to the individual's perception and evaluation of their own quality of life. While Koch's article traces the rise of an increasingly individualised notion of recovery, Chaney and Copperman's research shows how BCSW's service users and survivors pushed against the individualised medical model for its failure to take account of the structural and real-world factors affecting women. They foreground the experiences, voices and actions of service users and survivors. This approach in turn situates the survivor-led model of self-injury and the BCSW's approach to recovery within second wave feminism and the rise of grassroots mental health groups. Here, self-injury was seen as an understandable reaction to the poverty,

discrimination, abuse and distress experienced by the survivors, and a more complicated, nuanced and collective attitude towards recovery was established.

Conclusion

As Neely Myers notes in her study of twenty-first century recovery clinics in the US, the aims of experimental treatment programmes can be idealistic and ambitious, but the messy reality of subjects' engagement with services and their outcomes is often much more complex, with many of the individuals that she spent time with struggling to find a safe place in the world, often affected by poverty or homelessness for the long-term (Myers, 2015:). While the political contexts can be wildly different, our case studies highlight the tension between intended goals, partial successes, frequent failures and feelings of ambivalence from service-users. Grace Whorrall-Campbell recounts that although some patients at the Roffey Park industrial neurosis rehabilitation centre of the 1940s recalled it as somewhere they 'missed' after their recovery and discharge, they also remembered the lives of their fellow patients lost to suicide. Recovery and rehabilitation could not be taken for granted, in spite of the significant material resource, as well conceptual investment, put into services.

A notable change in tone from the mid-to-late twentieth century emerges from a new interest in the self-reported experiences of the subject. As Rachael Rosner's article shows, by the 1950s and '60s both psychoanalysis and the emerging practice of cognitive therapy acknowledged the need to understand the patient or client's self-understanding of their recovery status, with quantification and rating scales offering a two-way judgment on the success of a therapeutic process. While rating scales certainly offered new data for the clinical gaze, they also implicitly allowed the subject to invert the gaze back onto the therapy (or therapist) and pass numerical judgment on its success or failure. Subjective expression in these scales was limited to a pre-assigned set measures, yet we shouldn't underestimate the radical

shift that this represented in terms of the clinician-client dynamic. This was also not long before the emergence of the figure of the 'peer' in addiction services as a therapeutic ally, as detailed in Koch's article. The interior world of the subject began to attain a higher status in the second half of the twentieth century: whether operationalised as a way of enhancing psychotherapies' claims to scientificity, or through acknowledging the limitations of clinicians' ability to fully appreciate the perspective of the client or patient if they themselves have not been through a similar experience themselves. The rise of the peer-support role as a distinct therapeutic agent reflects this moment, as does the emergence of user-led grass-roots services built on collective experiences as alternatives to the clinical mainstream.

The subject's own sense of wellbeing became more important to defining the recovery process as the twentieth century unfolded. Yet, taken together, the overwhelming theme to emerge from our articles over different times and spaces in the US and Britain is the extent to which recovery and rehabilitation have been hitched on to notions of morality, productivity and sociability. The imperative to work is a recurring theme from the 19th century through to the present, and historical interrogation shows us that the imbrication of a concepts of mental 'health' with productive economic activity (as well as a focus on the responsibility of the individual to achieve that capacity) is by no means an invention of a neoliberal 1980s moment. Clinical attention to work itself as a site for generating mental distress may have diminished during the course of the twentieth century, however, with Roffey Park a striking outlier as a facility designed to address just that, even if its mode of addressing it was by encouraging patients to accept their place in the hierarchy and return to productivity (Whorrall-Campbell, 2025). It is perhaps apt that the activists in our final article by Copperman and Chaney are a late case study of resistance to the idea of recovery-as-productivity, instead shining a light on the socio-economic contexts of distress – a theme that endures in service-user and activist critique through to the present (Copperman and Chaney, 2024).

Even more striking as a point of continuity is the iteration of the term 'citizenship' across articles dealing with quite different political moments from the 19th century to the 1970s on both sides of the Atlantic. From post-asylum befriending to industrial occupational therapy and adolescent 'Q camps', through the formulation of rating scales in mid-century psychotherapies to 1970s addiction management, recovery and rehabilitation were indicated by a wide range of what we might call 'virtues' that were predominantly about the individual's relationship to society rather than their own sense of health and wellbeing. These ranged from a capacity to abide by the law, the completion of education, the ability to form meaningful intimate relationships, a sense of being able to fulfil 'duties' to society, participation in democracy, to Beck's commitment to the individual as someone who had 'self-agency' and the ability to plan. As Marcel Gauchet and Gladys Swain argue in relation to the emergence of moral treatment in France, it is in the transition to democratic modernity that psychiatry (and its associated professions) come into their own. Previously, under absolutism, 'the state made the insane the objects of its own but no-one regarded them as enough like others that they could be cured and returned to normal life. Only democracy would institute these more radical assertions, first the equal inclusion of all people in the body of citizens…and the assumed rationality of all these citizens'. As such, mental illness becomes a democratic society's mirror (Gauchet and Swain, 1980: xvi). By researching recovery and rehabilitation our authors tell us as much about modernity and the values of British and US society at different moments across the last 150 years as they do about the psy-professions.

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Note

1. Over the years, historians pursued archival research to consider with evidence the questions Foucault promoted. Publications asking why asylums became widespread, who was admitted, and why, proliferated. These studies also often asked what happened inside the asylum, exploring treatments, living conditions for inmates, and the work environments of psychiatrists, asylum attendants and nurses (Scull, 1979; 1993; Digby 1983; 1985; Crammer, 1990; MacKenzie, 1992; Smith, 1999; 2007; Melling and Turner, 1999; Melling and Forsythe, 1999).

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