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"All that I've been through has made me who I am": youth conceptualisations of personal recovery in mental health

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Background: Youth is a transitional period from 15 to 24 years involving developmental milestones that may be adversely affected by mental health (MH) concerns. Clinical interventions tend to focus on the reduction or cure of illness-based psychiatric symptoms. However, national and international mental policy focuses on promoting well-being and self-management through personal recovery. The leading framework of personal recovery in adults is CHIME, an acronym used to denote five key processes – Connectedness, Hope, Identity, Meaning and Empowerment. The extent to which CHIME reflects the experience of personal recovery in youth is under-researched, yet the framework often underpins youth mental health services. **Method:** The present study uses a qualitative methodology to analyse interviews with 16 youth referred for treatment. Interviews focused on the lived experiences of youth recovery and its alignment with the CHIME processes and were analysed using a hybrid inductive and deductive reflexive thematic analysis. **Results:** The CHIME framework was relevant to youth recovery in two ways: restoring what was perceived to be lost (restorative processes) and encouraging resilience (resilience processes). Adaptations to the CHIME framework for youth included an increased emphasis on the role of family and friends, support for grieving processes and support for identity formation during the recovery journey. **Conclusion:** An adapted CHIME framework for youth can underpin targeted recovery-oriented care to support youth in moving towards emerging adulthood successfully while managing mental health concerns.

Key Practitioner Message

What is currently known?

- Youth mental health is an increasing issue requiring management specific to this cohort.
- Most models of youth mental health, including the CHIME framework, draw on adult frameworks, which may not be suitable for this cohort.

What has been shown?

- Through analysing the voices of youth in recovery, the major factors present in the CHIME framework appear appropriate for youth recovery.
- Adaptations to the CHIME framework may better serve the needs of youth in recovery.

What is the significance of this for clinical practice?

- Clinical implications include increasing the emphasis on the role of family and friends throughout the youth recovery journey, supporting youth as they grieve losses throughout their journey and supporting identity formation during the recovery journey.

Keywords: Youth mental health; youth recovery; CHIME; recovery-oriented care

Introduction

In Australia nearly 40% of youth aged 15–24 years were diagnosed with a mental health (MH) disorder in 2020 (Australian Bureau of Statistics, 2022). MH disorders include a range of conditions that affect thoughts, feelings, behaviours and moods; MH disorders can vary from mild to severe (American Psychiatric Association, 2013). Early intervention reduces the risks and burdens of youth MH issues (McGorry & Mei, 2018). However, youth have lower access rates to MH care than any other age group (Beyond Blue, 2022). Rates of help-seeking in youth may be low due to MH stigma (Brennan et al., 2021; Roe, Joseph, & Middleton, 2010) or the lack of available or affordable services as youth transition from child to adult MH care services at 18 years of age in most states around Australia (Lu et al., 2022; McGorry et al., 2013). In some cases, youth can access MH care up to 25 years of age in Queensland, where this study is situated (headspace National Youth Mental Health Foundation Ltd., 2024; Mater Misericordiae Ltd, 2024; State of Queensland (Queensland Health), 2024).

The challenges to youth engagement and increasing concerns regarding youth MH have led to the exploration of more novel approaches to youth MH care. Typically, clinical interventions focus on the reduction of psychiatric symptoms or the curing of mental illness and often place the professionals as clinical experts (Slade, 2009). This clinical model can disempower help seekers and establish a passive approach to treatment. However, contemporary views of personal recovery involve the promotion of well-being and self-efficacy as people become empowered to live well with symptoms of MH (Anthony, 1993). Personal recovery offers an active approach to MH care from the patient experience (Anthony, 1993). Personal recovery places the professional in the role of advocate and involves discourses around shared expertise, focusing on the ecological validity of treatments (Slade, 2009). This approach incorporates aspects of the disability and diversity models of MH by encouraging social inclusion, disrupting social stigma and discouraging discrimination and victimhood. While personal recovery (hereafter referred to as recovery) promotes self-efficacy, its reflection of the disability model may lead to risk-averse, overprotective care of people with MH concerns. It is essential for youth to explore and take risks for normative development, so there are some aspects of the disability model that must be challenged for youth to thrive (Sapiro & Quiroz, 2022).

Recovery is an established concept among adults with MH concerns, with services around the globe using recovery-oriented frameworks to guide adult recovery (Anthony, 1993; de Wet & Pretorius, 2021; Slade, 2009). The most widely implemented and researched recovery framework is CHIME (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Some researchers posit that the CHIME framework inadequately captures the experience of youth recovery (Dallinger, Krishnamoorthy, du Plessis, et al., 2022; Law et al., 2020; Rayner, Thielking, & Lough, 2018). Although similarities between adult and youth conceptualisations of recovery have emerged, the full extent of the differences between youth and adult recovery remains unknown (Law et al., 2020; Naughton, Maybery, Sutton, Basu, & Carroll, 2020). While the work of Law et al. (2020) used the voices of young people living in the United Kingdom to locate these differences, the current study seeks to analyse the voices of Australian youth to build on this narrative and make a specific case for adjusting the CHIME framework to suit young people, if warranted.

A secondary aim of this study is to address the concerns of critics who reason that limited references within the CHIME framework to inherent challenges or difficulties involved in recovery continue to stigmatise MH and reduce help-seeking (Connell, O'Cathain, & Brazier, 2014; Kelly & Coughlan, 2019; Law et al., 2020; Nakanishi et al., 2021; Simonds, Pons, Stone, Warren, & John, 2014; Stuart, Tansey, & Quayle, 2017). For the required paradigmatic shift to occur, recovery frameworks such as CHIME must acknowledge and destigmatise the challenges associated with MH symptoms (Lindow et al., 2020).

The current study uses a critical realist ontology to determine youth conceptualisations of recovery through a hybrid inductive and deductive reflexive TA (Braun & Clarke, 2021). This analytical approach, which privileges the lived experience of youth, is consistent with the theoretical views informing recovery (Anthony, 1993; Dallinger, Krishnamoorthy, Burton, et al., 2022; Roe et al., 2010; Slade, 2009). This study aims to determine whether conceptualisations of recovery drawn from adult experiences are relevant to youth recovery experiences. Further, it seeks to identify the relevance of the CHIME processes to youth recovery. This study explores the following questions:

1 How does the concept of recovery relate to youth MH?

2 How does the CHIME framework relate to the recovery processes experienced by youth?

Method

Participants

Sixteen youth were recruited and interviewed by the chief researcher as a component of a more extensive study. Both current and recent service users were contacted by professional staff at participating community MH services. Participants and their parents indicated interest in participating verbally with professional staff. This was later corroborated by written consent and followed up by the research team. Participants were selected based on their interest and stage of well-being; no measure of recovery was used to determine suitability for participation. The general ethnicity of the young people was not collected, and no participants identified as Aboriginal or Torres Strait Islander. Participation was voluntary and consent/assent was obtained according to age. Participants were offered remuneration for their participation.

Data collection

All interviews were conducted and recorded by a trained psychologist. Where youth were interviewed via phone, those under the age of 18 years were interviewed under the supervision of a parent or guardian to align with consent provisions. Semi-structured interviews were used to allow for the complexity of the youth experience of recovery and to explore unique views of youth recovery. Questions were broad and did not include the word 'recovery' to permit novel themes to emerge. This mode of data collection for youth and caregivers was

selected to support anonymity, confidentiality and authenticity of experiences and thought processes in a confidential environment. Topics covered include notions of recovery, helpful/unhelpful experiences, advice for future service development and challenges experienced during recovery. The sample size was deemed sufficient as interview data reached saturation.

Data analysis

This study is underpinned by a critical realist theoretical framework, which enables both objective realities and subjective experiences of the young people to be considered when exploring the deeper underlying mechanisms that help or hinder their recovery (Sims-Schouten, Maynard, & Pound, 2022). That is, the words of the young people are not taken at face value. Rather, the data set was analysed using reflexive thematic analysis (TA), which brings social and symbolic interactions to the fore and provides an opportunity to question subjective meanings both provided and drawn from the data. The role of the researcher in both their interactions with the young people and their view of the data is considered when interpretations are constructed from the data.

In this study, a hybrid approach involved inductive analyses taken from the youths' voices and deductive analyses drawing connections between the youth voice and the CHIME framework (Braun & Clarke, 2021). Interviews were transcribed using Panopto software and listened to several times, during which themes were induced from the data. A deductive analysis of the data was completed after this, laying the CHIME framework over the interview data as a lens through which to analyse the youth voice. A deep re-engagement with the themes using an iterative approach involving the primary author and two co-authors led to the central organising concepts being identified.

Researcher positionality and reflexivity

The researchers acknowledge pre-existing apprehensions for youth managing MH concerns and, in some cases, their own lived experience of youth MH issues. They were aware of the possibility of influencing participants to report on elements relevant to the existing recovery framework CHIME, and as such, consulted on the structure of questions to avoid mention of these key processes. The researchers engaged in supervision and reflection throughout the data collection process to reduce any bias or data contamination. This data was collected as part of a PhD programme of research.

Results

Young people shared their insights into recovery to address the question, 'How do recovery and the CHIME framework relate to youth mental health?' Two overarching themes were identified in narratives of personal recovery (see Figure 1). First, personal recovery in youth involves a restorative process of understanding and making sense of the past. Secondly, personal recovery involves resilience processes, emphasising a move towards a more promising future. Approaching youth voices through an inductive analysis led to this distinction between restorative and resilience processes.

Theme 1: Restorative processes

The concept of restoration derives from Attention Restoration Theory and refers to periods of rest and reflection following difficult experiences, usually leading to the replenishment of depleted resources (Kaplan, 1995; Lazarus, Kanner, & Folkman, 1980). Youth in the current study reported engaging in restorative processes as they took time to process and reflect on difficult periods of symptomatology experienced in the past. In particular, the inductive analysis of participants' responses indicated they spent time reconnecting with others, identifying and grieving developmental differences and accepting the journey following episodes of poor MH. These restorative processes were moments of sense-making, where participants worked to reconstruct continuity in their disrupted developmental trajectories. Rather than aiming to 'return' to a previous state, young people appeared to be searching for coherence between their past struggles and emerging sense of self.

Reconnecting with family and friends. Participants in the current study identified that ruptures in their relationships with family and friends were key barriers to recovery.

> My recovery journey was hard for me because my friendships and relationships with family were very broken, so it wasn't always easy just going and talking to them. (Debbie, 18)

The youth interviewed identified that some of the most influential moments in their recovery occurred when they restored relationships with their family and friends.

> Spending more time with family and communicating with them about how I'm feeling rather than isolating myself helped my recovery. To reconnect with them was good. (Rebecca, 15)

They also spoke about the importance of repairing relationships and reconnecting with others within their circle and beyond as vital for recovery. Reconnection was described as gradual and effortful. Youth spoke about trust, safety and testing boundaries in relationships.

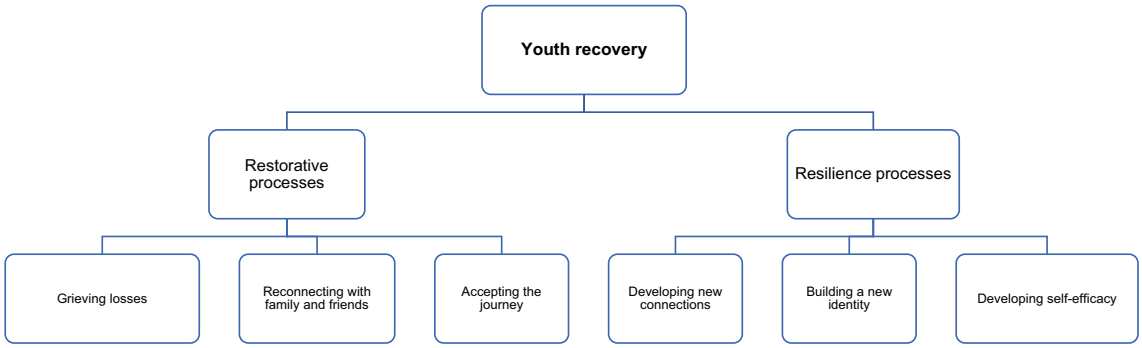

Figure 1. Thematic map of the current study

> I realised my relationships were not broken. There's always something you can do to fix the relationship. (Debbie, 18)

> When I was really struggling, I would go to family, and then my mum started setting me up with people at school that I could talk to. (Breanna, 15)

The connections between young people and others were noted as valuable whether they occurred in person or through online platforms.

Identifying and grieving differences. Youth interviewed in this study identified differences between their experiences and those of typical or expected adolescent development through their recovery journey. This included young people identifying differences in relationship patterns, such as cutting off from family, losing friends and avoiding social settings, which are contrary to the typical or expected developmental tasks of adolescence.

> Having a bad relationship with my family was where it all went wrong. (Rebecca, 15)

> I've been having really bad depressive episodes lately, and I've just been pushing everyone away. I've lost the majority of my friends because I thought I was just being a toxic <person>. I've pushed them away. (Sarah, 16)

Similarly, the youth interviewed for this study identified schooling or educational attainment differences when compared with their peers.

> There are parts of me that aren't looking forward to the future because of how my education levels are. (Breanna, 15)

> I was a truant. I never, ever felt like the teachers were on my side in the school. I had a few outbursts – nobody understood that. No one else in my grade had experiences like that. (Morgan, 21)

Entry into the recovery-oriented care facility allowed the young people interviewed in this study the opportunity to rest and reflect, and thereby to make sense of their experience, often in conjunction with new peers with a similar lived experience, and who acknowledged and validated their own experience of difference. Grieving these differences and making meaning from them was a crucial part of the recovery journey as the young people came to terms with this deviation from their expected trajectory, as set by themselves, their families or society. By grieving their divergence from expected milestones, participants reclaimed agency over how their stories were told. The act of naming difference appeared to be a precursor to reframing it – transforming personal shame into self-understanding.

Accepting the journey. In the current study, acceptance emerged as a sub-theme through participants discussing their nonlinear and unique recovery journeys.

> There will be times when my symptoms are a bit more extreme than other times. Symptoms are still going to happen every now and then, but I'm still getting better, and it happens a little bit less often. (Cameron, 16)

Participants also noted that recovery is an ongoing and changeable journey.

> It's definitely a really long journey with a lot of ups and downs. (Debbie, 18)

Participants articulated complex, sometimes contradictory, understandings of recovery. They expected setbacks and worked to manage them. They used metaphors such as 'ups and downs' to describe progress. Setbacks were integrated into their narratives, rather than denied or resisted. This layered understanding of acceptance was striking, particularly as it countered the assumption that youth might expect quick or total change.

Theme 2: Resilience processes

Psychosocial resilience involves recovery from stressors, protection against future stressors and the development of additional resources required to thrive (Kaplan, Turner, Norman, & Stillson, 1996; Lepore & Revenson, 2009). In the current study, resilience processes were identified as protective for youth experiencing MH concerns as they seek to build new connections and identities and develop self-efficacy through their recovery.

Developing new connections. Youth identified the new connections they made through their recovery journey as central to their recovery. They described the ways that meeting other youth at an inpatient MH service provided camaraderie and an opportunity to destigmatise MH concerns:

> When I went to the psychiatric ward, it was the first time I had a full-on conversation with somebody about MH. It was this subtle realisation in my mind that they were actually other people in the world <experiencing MH concerns >, it wasn't just me. (Morgan, 21)

In the current study, whether these new connections with peers were made in person or via other media, they were resilience-building, worked to disrupt self-directed, peer and societal stigma and built a sense of belonging.

> I like reading about other people who have recovered. Because when you are having a bad day, hearing stories of people who have gone through it, saying, 'it's not easy, but keep trying', reminds you of why you're doing it. (Fiona, 17)

> Hearing other people's stories about how they went through it and what they experienced <helped>. How they dealt with other people and themselves. (Breanna, 15)

The power of connecting with others with a lived and living experience of MH was a transformational realisation for some.

> Whoa! Someone's been in the same boat as me! (Sarah, 16)

Building a new identity. Youth reported that to be in recovery was to explore and seek new opportunities, be willing to try new things, fail and recover from stressors as they worked to build a new identity.

> It's okay to try new things, and if it doesn't work, then it's okay. (Debbie, 18)

They listed new hobbies and activities they had engaged in despite their initial fear of failure.

> Gardening, cooking, kayaking and bushwalking <help> (Eric, 16)

Through these activities and newly recognised skills, some young people found a sense of identity through group affiliation or new career goals.

> It has really got me a whole lot better with talking to people. It's one of the ways I've found to connect to people. (Sarah, 16)

> It has helped me realise what I'm meant to do in life. What I'm going to be doing in 10 years, which is a really big thing for me. I want to be a makeup artist. (Pia, 18)

Some of the young people, particularly those further into their recovery journey, reported subsuming this journey into their identity, rather than focusing on it as a barrier to well-being.

> No matter what happened, it all made me who I am. You know, this strong, independent girl that I am today. I've come to realise that all that I've been through has made me who I am. (Pia, 18)

The youth interviewed reported multiple iterations of identity formation during their recovery journey.

> I've had a lot of identity crises over the years. A lot of that revolved around guilt, past experiences and trying to disconnect from the past. Once you get rid of that, you start letting go. You can move on and then start discovering. (Morgan, 21)

These narratives highlight identity formation as both fragile and generative – reflecting how developmental challenges were shaped by the demands of their MH concerns. In this way, identity development in recovery was not framed solely as liberation from illness but as a renegotiation of value and belonging.

Developing self-efficacy. Youth in the current study identified improved self-efficacy through their capacity to plan for and manage symptom recurrence through various skills and strategies. Youth in the current study provided rich and detailed accounts of the toolkits they have developed to support themselves during relapses.

> Usually, when I wake up, I force myself to be in a positive mood and force myself to get out of bed. I don't know everything, but I know a lot of stuff already that helps … deep breathing, going for a walk, a positive mindset, getting out of bed, sleep hygiene. And being active. (Eric, 16)

> If I'm having urges to engage in negative behaviours, I try to look at the good coping strategies and replace them. Cutting myself, throwing up, not eating, and blocking all my friends and everyone that I love. I replace them with better behaviours. (Peta, 16)

Youth in the current study further developed a sense of self-efficacy through their involvement in collaborative decision-making regarding their treatment across the recovery journey. Youth in the current study identified a loss of empowerment when they were ordered to take medication against their wishes through treatment authorities; in contrast, they felt a sense of self-efficacy when they could collaboratively reduce or remove their medications.

> I felt like I was always being told what to do and told what medication I had to take… I felt like I didn't have any power. Then I got to start weaning off my medication. I feel hopeful that I'm able to make my own decisions about my medication. (Debbie, 18)

> I ended up having a conversation with my therapist about how I could wean off medication slowly. I started taking lower and lower doses and eventually I went off it. It made me realise that I could do more for my own treatment. (Morgan, 21)

Participants described using strategies like deep breathing or getting out of bed with mixed feelings – satisfaction, ambivalence and frustration. They tested, adapted and sometimes rejected these strategies. Agency was negotiated with adults, especially in decisions about medication. Some felt empowered when involved; others felt controlled. Participants felt most empowered when adults – both parents and professionals – recognised their developmental needs and involved them in decision-making, even in situations where adults needed to take the lead. Empowerment emerged not from full control, but from being heard and considered within appropriate boundaries.

Discussion

The aims of the current study were to determine if the CHIME framework is suitable for use with young people and inclusive of the realities they may face throughout their recovery journeys. Initial inductive analyses of the data indicated two main processes that young people move through during their personal recovery journeys: restorative processes through which they take stock of their experience and reflect on the changes to their expected development or imagined future, and resilience processes through which they develop the skills to continue their development following recovery. This initial distinction recognises the challenges faced by young people and the strategies they adopt as they traverse important developmental milestones in parallel with the recovery journey.

In order to illustrate the differences in youth recovery identified in the study, Figure 2 displays how the study findings relate to the concepts of the CHIME framework (see Figure 2). When viewed in this way, while youth narratives involved the conceptualisation of recovery through the CHIME framework, specific nuances stood out as particularly relevant to the youth experience. Table 1 depicts the study findings as they relate to adult conceptualisations of CHIME (Leamy et al., 2011). The table shows concepts not strongly linked to the youth experience via struck-out text. Additional or renamed elements unique to the youth experience are identified in bold font.

Connectedness

Youth develop through relationships with others, a factor that differs from the adult experience (Ballesteros-Urpi

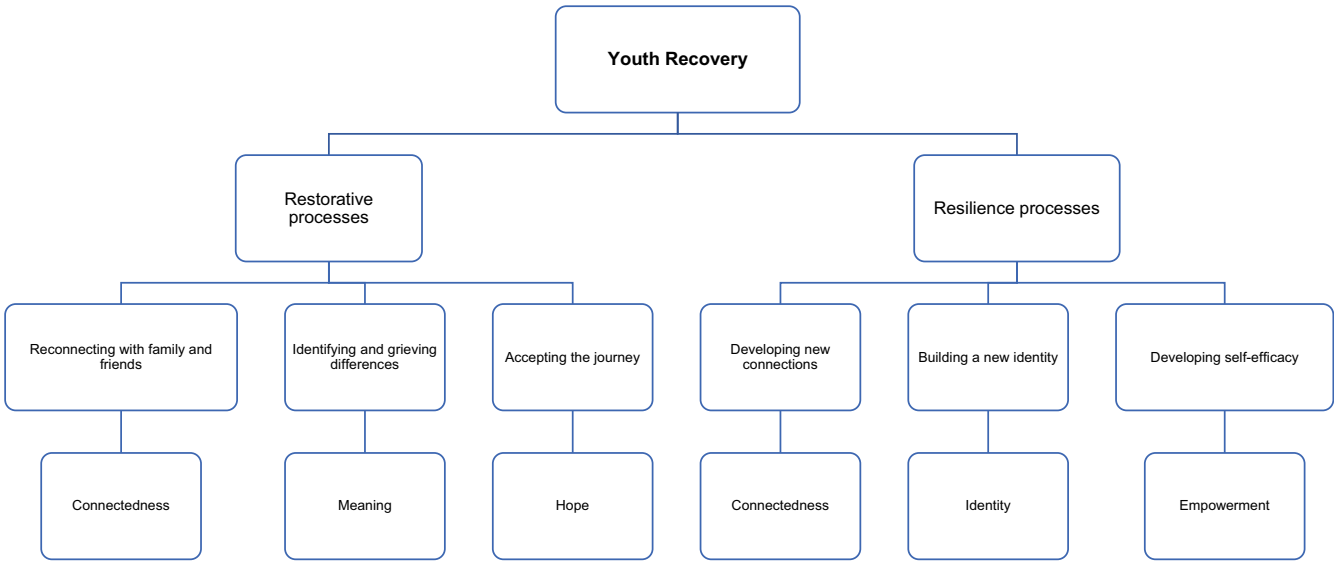

Figure 2. Thematic map of the current study aligned to CHIME framework

Table 1. Proposed adaptations to the CHIME framework for youth

Connectedness	Hope/Optimism	Identity	Meaning in life	Empowerment
Peer support and support groups (in-person and virtual)	Belief in the possibility of recovery	Dimensions of identity	Meaning of mental illness experiences	Self-efficacy
Relationships with friends and family	Motivation and skills to change	Developing a positive sense of identity	Identifying and grieving differences	Collaborative or shared decision-making
Support from others (peers and trusted adults)	Hope-inspiring relationships	Overcoming stigma and shame	Quality of life	Focusing upon strengths
Being part of the community	Positive thinking and valuing success	Supported risk-taking	Meaningful life and social roles	
	Having dreams and aspirations		Spirituality	

et al., 2019). It is common for youth to experience strained relationships, family conflict and disrupted attachment with close family throughout their MH recovery journey (Baumann, 2022; Hartnett, Carr, & Sexton, 2016; Stern, King, & Diamond, 2023). While normative development typically sees youth individuate away from the family unit, family relationships persist longer for youth in recovery (Braehler & Schwannauer, 2012). Naughton et al. (2020) found that the gradual release of responsibility to youth often does not apply to youth experiencing MH concerns. Instead, recovery usually involves the family stepping in to support the youth to a greater extent. For this reason, connectedness – or, where relevant, reconnection – with family and close friends in treatment can be restorative in supporting youth recovery and should be identified as a core component of a CHIME framework targeting youth (Edwards, Rudaizky, Toner, & Chen, 2021).

Connecting with others can occur formally through counselling or therapy, informally through close others participating in the recovery journey, as well as coincidentally through community connections (Rayner et al., 2018; Stern et al., 2023). Like Barnett and Lapsley (2006), who gathered data from 40 youth who had received support for MH concerns and found that connections with warm and approachable staff helped their recovery, youth in the present study particularly identified the role of connecting with support services and trusted adults in their recovery.

The role of peers was pronounced throughout the narratives of the youth interviewed, a salient point that is different from the adult framework. Youth cite new connections with peers who also have a lived experience of MH concerns as a key source of support (Barnett & Lapsley, 2006; Kanehara et al., 2022; Piat, Seida, & Sabetti, 2017; Schneidtinger & Haslinger-Baumann, 2019). According to relational-cultural theory, peers with similar lived experiences are an essential source of camaraderie who can help to destigmatise experiences of MH concerns (Kranke, Floersch, Townsend, & Munson, 2010; Sapiro & Quiroz, 2022). In the current study, the local narratives of peers were resilience-building and worked to disrupt self-directed, peer and societal stigma and to build a sense of belonging that had been lost during an earlier period of MH concern. Youth may not typically encounter these peers or counter-cultural narratives outside of recovery-oriented care facilities and, as such, youth-focused recovery spaces (online and in-person) are required for these narratives to be shared (Barnett & Lapsley, 2006; Rayner et al., 2018). Youth establish themselves through connectedness with a range of others, a factor that

differs from the adult experience (Ballesteros-Urpi et al., 2019), and which is crucial to MH recovery for this demographic.

Hope

Youth in the current study provided rich and detailed accounts of the toolkits they developed to support themselves during relapses. The construction of these specific means of self-support is underpinned by a positive vision of the future and the young person's belief in and hope for a recovered self in that future. Hope is a common trope of recovery narratives for adults (Schrank & Slade, 2007). For instance, Andresen, Oades, and Caputi (2003) found that 'finding and maintaining hope' was an attribute of psychiatric rehabilitation for people living with schizophrenia, while Jacobson and Greenley (2001) identified hope within the personal recovery conditions necessary for recovering from mental illness. However, some previous research has indicated that hope is less likely to be present in young people experiencing MH recovery (Simonds et al., 2014), despite the fact that some research indicates that the presence of hope is necessary for recovery in children and adolescents (Berry et al., 2022; Khoury, 2020).

Rayner et al. (2018) identified further nuance in young people's vision of the future, suggesting that young adults (in this case, 18–23 years) hold concurrent and conflicting views of the future, simultaneously remaining optimistic about their recovery and the opportunities that may open up, even as they recognise the difficulties that their mental illness may present. In line with Rayner et al. (2018), the present study found that hope for the future was present in youth articulating the story of their recovery journey, and that importantly, they accepted the nonlinear path this may take. Just as Berry et al. (2022) observe, the hope the youth in the present study expressed was therefore realistic, meaningful, personal and goal-oriented, rather than naive, and indicated the youth's understanding of their MH concerns and their acceptance of the work needed to continue the recovery journey throughout their life. Furthermore, connectedness to peers with similar lived experiences has been found to support the development of hope and motivation for the future in youth recovery journeys (Barton & Henderson, 2016). Thus, the formation of hope in the youth of the present study is linked to the resilience process of connectedness to new peers, who may model the positive behaviours desired by those at an earlier stage of the recovery journey and reinforce these as realistic and meaningful.

Identity

Recovery can occur through youth exploring and seeking new opportunities, trying new things and failing and recovering from stressors as they build a new identity (Lepore & Revenson, 2009; Rayner et al., 2018; Simonds et al., 2014). Creating a new identity through engaging in new activities and taking risks may prevent an overidentification with the illness narrative that can accompany MH challenges (Kranke et al., 2010; Lindow et al., 2020). Clinical treatments focused on youth experiencing MH concerns can be experienced as paternalistic and risk-averse. Caregivers and youth may avoid exploration to reduce risks (Dean, Stratton, & Yarhouse, 2021; Kranke et al., 2010; Lindow et al., 2020). When youth become less risk-averse, and the people around them exhibit less fear of risks, they can engage in the critical developmental tasks of exploration in service of identity formation (Dean et al., 2021). This concept differs from adult conceptions of recovery that primarily focus on rebuilding or redefining an existing identity.

Youth in the current study listed new hobbies and activities they had engaged with despite their initial fear of failure. Identity formation is vital for youth development, even more so during the recovery journey (Schneidtinger & Haslinger-Baumann, 2019; Simonds et al., 2014). In some cases, self-directed, peer and societal stigma must be overcome for identity development to occur (Kranke et al., 2010; Lindow et al., 2020; Naughton et al., 2020). When stigma is overcome, youth can work through feelings of shame and isolation, locating a sense of belonging and identity (Clement et al., 2015; Naughton, Maybery, & Sutton, 2018). While adults in recovery often report seeking to return to a former identity, youth explore and develop a new identity through recovery (Rayner et al., 2018; Simonds et al., 2014).

Meaning

Participants identified their experiences of developmental differences during their recovery journey, including differences in relationships, schooling or educational attainment, belonging, control, feeling understood or empowered or an imagined future (Grief, 1989). Youth in this study recognised that grieving these differences was an important step in making meaning of their recovery journey. This differs from the adult experience of recovery, whereby developmental norms are less pronounced or impactful.

For some youth in this study, their differences were not acknowledged or validated, let alone witnessed or grieved (Grief, 1989). This led to the generation of stigma that can cause youth to believe their behaviours are their fault and that any resulting isolation or struggle is deserved. This can cause youth to limit social interactions by employing strategies of disconnection, which can be detrimental to normative development and hinder help-seeking efforts (Kranke et al., 2010; Sapiro & Quiroz, 2022). Rayner et al. (2018) found a similar response when they interviewed 15 youth and noted that youth recognised times they had pushed their friends away and how that had negatively affected their recovery. The grieving of differences in youth narratives in this study is dissimilar to adult conceptualisations of recovery, which tend to be overly optimistic (de Wet & Pretorius, 2021; Piat et al., 2017; Stuart et al., 2017). Acknowledging these differences and supporting youth with their grief may be an important aspect of recovery-oriented care (Baumann, 2022; St. Clair, 2013).

Empowerment

Empowerment in youth MH relies on youth having a belief in their capacity to recover from symptoms and manage their MH concerns (Davidson, 2005; Kelly & Greene, 2014). Youth in the current study identified empowerment through their capacity to plan for and manage symptom recurrence through various tools. There is empowerment in stories of youth who show self-efficacy when recognising and replacing less helpful coping strategies and behaviours (Law et al., 2020; Rayner

et al., 2018; Schneidtinger & Haslinger-Baumann, 2019). Feeling confident about managing symptoms involves youth developing various strategies and techniques to mitigate symptoms of MH concerns (Davidson, 2005; Kelly & Greene, 2014). Youth in the current study provided rich and detailed accounts of the toolkits they have developed to support themselves during relapses. An increased focus on self-efficacy and equipping youth with tools for managing their MH concerns is important (Davidson, 2005; Kelly & Greene, 2014).

Through their recovery journey, youth in the current study developed a sense of agency or control over their treatment, which disrupts dominant discourses of helplessness through MH concerns (Davidson, 2005). Unlike adults, it is not a case of personal responsibility at this stage of life. Shared decision-making is recognised as a vital part of youth recovery. When youth in this study shared their experience of collaborative decision-making, especially when considering medication use, they reported an increased sense of empowerment. While researchers express concerns about the capacity of youth to manage their symptoms, clinical practitioners can implement collaborative decision-making with all youth, considering each case as unique when determining the extent to which youth (and their families) play a role in their treatment.

Strengths and limitations

Strengths of the current study include diverse youth voices and deep listening to their voices as experts who have traversed the recovery journey. The honesty with which the young people shared their thoughts with the research team speaks to the safety established during treatment and/or interviews. A limitation of this study was the lack of diversity in the age of participants and the lack of information regarding their stage of recovery. While it was valuable to hear the narratives of youth at different developmental and recovery stages, stratified sampling by age and recovery stage could be used to consider trends across recovery.

Summary

The current study aimed to identify the relevance of the CHIME framework to youth recovery in MH. The voice of youth was examined in depth, with the results suggesting adaptations to the CHIME framework, which was developed for adults. The changes, made by adding or emphasising recovery processes unique to the youth experience and deemphasising or removing those that are relevant to adult consumers, could shape recovery efforts with youth. Implications for clinical practitioners may include a clearer understanding of their role in encouraging young people to reconnect with others and/or develop supportive relationships, providing young people with strategies to support their desired changes, supporting youth to identify and grieve developmental differences, formulating treatment goals collaboratively and supporting young people as they take risks and develop. By providing young people with recovery-oriented care suited to their developmental stage, they may successfully shed the stigma and shame associated with MH concerns and continue on their developmental journey equipped to thrive.

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Conflict of interest statement

The authors have declared that they have no competing or potential conflicts of interest.

Ethical considerations

Ethics approval was obtained through the University of Southern Queensland Human Research Ethics Committee (H20REA100; 18/06/2020) as part of a larger programme of research. Informed consent was appropriately obtained from all individual participants included in the study. Written informed consent was obtained from the parents or guardians of participants under 18 years of age. All participants signed informed consent regarding publishing their data.

Data availability statement

The data analysed during the current study is not publicly available due to client confidentiality, but is available from the corresponding author on reasonable request, although restrictions apply to the availability of these data.

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