

**SPECIAL ARTICLE**

# The vision of recovery today: what it is and what it means for services

**MARIANNE FARKAS**

Center for Psychiatric Rehabilitation, Sargent College of Rehabilitation Sciences, Boston University, 940 Commonwealth Ave. West, Boston, MA 02214, USA

*In the past, practice in mental health was guided by the belief that individuals with serious mental illnesses do not recover. The course of their illness was either seen pessimistically, as deteriorative, or optimistically, as a maintenance course. Research over the past thirty to forty years has indicted that belief and shown that a vision of recovery can be achieved for many individuals. People with serious mental illnesses have themselves published accounts of their own recovery as well as advocated for the development of recovery promoting services. In North America and other regions, policies have been developed to make recovery the guiding vision of services. Today, particularly in the United States, much effort is going into the transformation of services and systems to achieve recovery outcomes. Despite these trends, the idea of recovery remains controversial and, some say, even illusory. This article clarifies the meaning of the term "recovery", reviews the research and first person accounts providing a rationale for recovery, and sets out implications for developing recovery oriented services.*

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For many years, the conventional wisdom in the field of mental health has been that severe mental illnesses, particularly schizophrenia, inevitably result in progressive deterioration. Professional practice has then understandably focused on managing psychopathology and its symptoms. Research efforts in the 1960s, 1970s and 1980s documented the heterogeneity of outcomes, particularly for individuals with schizophrenia (1-3), including often regaining functioning over the long term, developing friendships and reporting satisfying lives (4-7). The practice field, however, continued to be organized to fend off relapse and deterioration (8,9).

It is unfortunate but not surprising that it has taken the practice field so long to adopt this forty year old understanding of the possibility of recovery. The large gap between research findings and adoption in practice has been often cited as a major barrier to innovation in mental health (10-13). In fact, recent analyses of the state of mental health systems in the United States have concluded that mental health care in America fails a wide variety of individuals, but particularly fails those with serious mental illnesses (14), because it is "not oriented to the single most important goal of the people it serves, that of recovery" (15). Furthermore, the U.S. President's New Freedom Commission report strongly urged the adoption of the notion of recovery as possible for all and as the guiding vision for the system. Bringing the vision of recovery into the practice field requires an understanding of what is meant by recovery, the research findings that provide a rationale for recovery and the implications of these findings for the delivery of services (15).

**WHAT IS RECOVERY?**

Even though there is no explicit consensus about the meaning of the term, the notion of recovery is guiding policies and practices in many American state mental health

systems as well as those of other countries, such as Canada and New Zealand (16-21). Consumer researchers have examined how systems can facilitate or hinder recovery and identified systems performance indicators (22). Recovery is also listed as a performance indicator to monitor and improve the outcome of individuals served by American state mental health systems (23).

Recovery has been the subject of debate among advocates, providers, family members and other stakeholder groups over the past few decades. Some who view mental illnesses as primarily biological in etiology have questioned whether recovery is even possible and have argued that using the term will give false hope both to those diagnosed and those who care about them (24). On the other side of the debate, former patients and other critics of biological approaches have questioned whether mental illnesses even exist as medical entities and prefer to think of life crises as normal parts of human existence (25). From this viewpoint, there can be no "recovery" because there has been no illness. In addition to such controversy, most stakeholders agree that the term itself can be confusing and seem illusory. For example, words such as "recovery", "rehabilitation", and "reintegration" have often been confused one for the other (26). "Rehabilitation" is a field or a service designed to facilitate success and satisfaction in a specific valued role chosen by the individual (27). "Reintegration" into society is an outcome which can be achieved using mental health treatment services, such as community psychiatry and rehabilitation among others, as well as political action and community organizing to promote solidarity and openness to individuals with serious mental illnesses. "Recovery", on the other hand, is neither a service nor a unitary outcome of services. Researchers, providers and, most importantly, individuals with serious mental illnesses themselves have contributed to the meaning of the term as it has evolved over the past few decades.

Some clinical research groups have identified recovery as the alleviation of symptoms and a return to premorbid functioning (28). Working definitions by several groups (6,29) have operationalized variables such as symptom remission, vocational functioning, independent living, and peer relationships. Consumer and psychiatric rehabilitation literature, however, does not hold the view that either symptom remission or a return to premorbid functioning is necessary for recovery to occur (8,30).

Individuals with mental illnesses have long written about their experiences of recovery (31-33). Approximately fifty years ago, the ex-patient movement identified the language of recovery to help to make sense of their own experiences and to develop an alternative vision of mental illnesses (34). The ideas of the Independent Living Movement (i.e., centers established and managed by people with physical disabilities) (35) heavily influenced mental health consumers' views that recovery remains possible, even if a person's functional limitations may not change. In the area of physical disabilities, consumers and rehabilitation specialists have long known that it is possible to regain employment, go back to school, or regain a valued position in society despite never having regained the use of one's limbs or senses (8,36,37). As Anthony and colleagues (8,38) point out, the experience of recovery from mental illnesses includes not only regaining a valued role, but also recovering from the effects of having been diagnosed with a mental illness (e.g., discrimination, disempowerment, negative side effects of unemployment, crushed dreams) as much as from the effects of the illness itself. Like trauma survivors, individuals with serious mental illnesses may experience these effects as having changed their lives irrevocably (39) and thus feel simply unable to return to their lives prior to the onset of illness, but endeavor rather to incorporate the illness experience into a new identity. Deegan (30) eloquently makes this point when she says: "The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human". First-person accounts and consumer advocate descriptions of recovery then underscore the fact that recovery was the personal journey of an individual in taking back control of his or her life, or the lifelong process of "becoming more fully human", even with functional limitations and deep traumas.

The Center for Psychiatric Rehabilitation at Boston University has developed a working definition of recovery, derived from an analysis of first-person narratives and the views expressed by members of the consumer/psychiatric survivor movement. Recovery from mental illnesses has therefore been defined as "the deeply personal process of changing one's attitudes, feelings, perceptions, beliefs, roles, and goals in life". It was further conceptualized as "the development of new meaning and purpose in one's life, beyond the impact of mental illness" (8,38,40). This definition includes and/or implies some of the most common elements of many other definitions that have emerged

over the past fifteen years: the importance of renewing hope and meaning (7,18,30,41,42); overcoming stigma and other sources of trauma associated with serious mental illnesses (7,30,43) and assuming control over one's life (28, 41,44-47). Empowerment which closely accompanies the element of assuming control over one's life and, by extension, the notion of regaining citizenship are additional elements which are, perhaps, more implied than stated in Anthony and colleagues' definition, but have certainly been identified as a critical factor by the Center for Psychiatric Rehabilitation and others (7,8,41,47,48).

## RECOVERY RESEARCH

As pointed out by Rogers et al (49), it is somewhat difficult to classify the research that has a direct bearing on recovery, given the historical lack of clarity about the term. Traditionally, this research includes longitudinal studies of individuals with schizophrenia, qualitative studies, and first-person accounts of individuals with major mental illnesses. In addition to these traditional sources, developments in other fields of study, such as positive psychology and behavioral science research, have also begun to be seen as contributors to knowledge about recovery.

Recovery research is somewhat unusual in the field of mental health in that it has placed a high value on researchers who are themselves exemplars of recovery (i.e., researchers who are also ex-patients). This focus has contributed to broadening the kinds of questions under study. For example, it was consumers themselves who first recommended the investigation of issues related to success by individuals who had achieved meaningful lives rather than focusing only on issues related to relapse and deterioration, a shift in focus which contributed to the momentum of the recovery vision (8).

### Longitudinal studies

Studies designed to examine the long-term outcome of individuals with schizophrenia have been recently summarized by Harding (50). These include studies from Switzerland (51,52), Germany (53), Japan (54) and the United States (1,2,55). Moreover, the World Health Organization recently conducted a multinational study in which outcomes among diverse cultural groups were examined (56). The follow-up period in all of these studies ranged from 22 to 37 years, with sample sizes ranging from 186 to 269 individuals, mainly those hospitalized with a diagnosis of schizophrenia. In the aggregate, one half to two thirds of the subjects were reported as recovered or significantly improved. The outcome indicators for recovery in these studies included: no further symptoms, no use of psychotropic drugs, living independently in the community, working, and relating well to others with no behaviors displayed that others

considered unusual. The designation of “significantly improved” was given when all recovery outcome indicators but one were present (50). These findings have largely held up over time. Despite variations across studies, it is clear that, when viewed through the lens of several decades, significant improvement has been reported for a substantial number of individuals with major mental illnesses.

### Qualitative studies

The richness of the experience of recovery has been captured in several qualitative studies and analyses of first-person accounts. They have shown that individuals with serious mental illnesses have achieved recovery both using mental health services and without professional intervention. While it is clear that some do achieve a meaningful life (57,58) without professional intervention, we currently do not have sufficient data to explain or understand which individuals recover on their own or how this occurs.

Several authors (59-62) conducted qualitative studies to describe elements in the course of the recovery journey. In their in-depth interviews of small numbers of individuals over time, they were able to describe common challenges in the recovery process, including elements such as coping with a sense of loss, a loss of power and valued roles (such as parent, worker), a loss of hope, struggles to prevent relapse and to redefine oneself and one's social identity. In addition, they identified processes that appeared to be important to the experiences described, such as discovering a more active sense of self, for example, taking stock of strengths and weaknesses and fostering empowerment.

A number of researchers recently conducted meta-analyses of first-person accounts and narratives of the process of recovery (7,50,63,64), which have provided information on the explanatory frameworks used by individuals to understand the cause of their mental illnesses. For example, some individuals view their condition as the result of a spiritual crisis, others see it as biological, others as environmental or political, while others view it as the result of specific trauma.

Researchers have also examined the processes, coping factors and tasks identified as important to accomplish for recovery to occur (63,65). Examples of categories of the recovery process include those identified by Jacobson (63): recognizing the problem, transforming the self, reconciling the system, reaching out to others. Recovery experiences have also been categorized as being overwhelmed by the disability, struggling with the disability, living with the disability and living beyond the disability (58). Coping factors suggested by Ralph (64) include personal factors (e.g., insight), external factors (social supports), self-managed care (e.g., participating in one's own health care) and empowerment (e.g., sense of self efficacy). Tasks or themes to accomplish recovery suggested by Ridgway (7) include reawakening of hope, achieving understanding of disability, engagement in life, active coping, reclaiming a positive sense of self and re-

gaining a sense of meaning and purpose. The power of a person who believes in the individual, even when the individual cannot believe in him or herself, has been cited, almost universally, as critical to recovery (8,31,50).

### Contributions of positive psychology and behavioral science

The fields of positive psychology and behavioral science have begun to contribute to our emerging understanding of the factors associated with recovery. Positive psychology argues that psychology and psychiatry, in general, have focused, to their detriment, almost exclusively on the identification and alleviation of disorder (66). Positive psychology, while focused on individuals without disabilities, emphasizes growth, personal accomplishments and success in valued roles (67), which are also identified as recovery outcomes. Rogers et al (49) argue that the dimensions and processes proposed by positive psychology are equally important for individuals with serious mental illnesses. In addition, behavioral and social science research conducted with the general population in the areas of self-esteem, self-regulation, self-judgment and subjective well-being is all pertinent to the process and outcome indicators of recovery. For example, Diener's work (68) on the individual, cultural, and situational effects on subjective well-being furthers our understanding of individual processes for recovery. Moreover, this research is useful to the investigation of other questions, such as whether or not, as people progress toward recovery, their motivation shifts from preventing losses to promoting gains (69), or how to understand the perceived risks of pursuing self-esteem goals (70).

In summary, recovery research has shown that recovery: is possible over time; represents a multidimensional, highly individualized non-linear process that can be described; may be achieved with or without professional intervention; has multiple objective and subjective outcome indicators that reach beyond symptom reduction.

### IMPLICATIONS FOR SERVICES

Recovery has been suggested as the critical overarching goal or mission that can serve to integrate the efforts of all services in mental health, including self-help services, basic support, rights protection as well as treatment and rehabilitation services (71).

While recovery is not an intervention that providers can make, all services can contribute (or not) to the outcomes and experience of recovery (e.g., well-being, self-esteem, valued roles, symptom reduction, empowerment, etc.). Intervention research has suggested that, while the picture is not totally clear cut, we are currently able to facilitate or promote some indicators of recovery outcomes.

Psychiatric rehabilitation has been described as a public health strategy in which all stakeholders, including con-

sumers, families, policy makers, researchers and clinicians play an important role (72), including community psychiatrists (73). Rehabilitation has been identified as effective in helping individuals to gain or regain valued roles in domains such as residential/community, vocational or employment and educational or schooling (74-78), outcomes recently reconfirmed as beyond those achieved by medication alone (79). Farkas (27) notes that these outcomes can promote recovery by increasing an individual's social capital, resources, empowerment and full citizenship in society.

In the field of treatment, effective interventions that promote at least one of the recovery outcomes include, among others, cognitive behavior interventions (80), medication management (81,82), integrated mental health and substance abuse treatment, and family psychoeducation (83). Qualitative studies (58) have also reported that support from others, effective medication and symptom management strategies, access to medical and psychiatric services, and basic resources like shelter, are recognized by consumers themselves as making a difference in an individual's recovery.

Based on the present state of our knowledge about what constitutes recovery, its process and its outcomes, it is possible to identify some key ingredients of a recovery oriented program, regardless of which specific practice is used. When evidence-based practices are developed, described and replicated (84), possible important philosophical elements of a practice may be omitted, because they may not as yet be empirically linked to the traditional outcomes reported. Yet these features may be important, because they can significantly alter the consumer's personal experience of the program and thus his/her unique process of recovery (85,86). Similar recognition has emerged in general medicine of the importance of value based practice in providing not only effective evidence based interventions, but also those interventions which are perceived to be meaningful to the patient (87).

While there are many values that may be associated with recovery-oriented services, there are at least four key values that support the recovery process and that appear to be commonly reflected in the consumer and recovery literature. These values are: person orientation, person involvement, self-determination/choice and growth potential (88). Farkas et al (89) have detailed an initial comprehensive set of recovery standards for program missions, policies, procedures, documentation and staffing, based on these core recovery oriented values. Regardless of the type of services delivered within the programs (i.e., treatment, case management, rehabilitation, crisis intervention, etc.), these values can guide recovery promoting service delivery.

### **Person orientation**

First-person narratives convey that people with psychiatric disabilities appreciate when mental health professionals express interest in them as a person and in roles

other than as "patient" (90,91). They may feel damaged by professionals who refuse to connect in a more holistic way (92). Consequently, recovery oriented services encourage the assessment and development of talents and strengths rather than narrowly focusing on deficits. "Person orientation" also guides services to promote access to resources and environments outside the mental health system where meaningful, socially valued roles can be attained, rather than limiting individuals to ghettos created by mental health service programs.

### **Person involvement**

Research data suggest that outcomes are better for people who have an opportunity for meaningful involvement in the planning and delivery of their services (93). Consumer involvement in designing and delivering mental health services (e.g., program planning, implementation and evaluation) is seen as a critical component of a quality management system for any mental health service (94), as well as critical to the development of a sense of empowerment (95) and a shift in self-identity. Actively promoting the hiring of individuals with serious mental illnesses as peer providers and support personnel, as well as in the role of helping professionals and administrators, is becoming an important element in the development of a recovery oriented service or system (8,22,48). The consumer movement's slogan "Nothing about us without us" sums up its expectations of partnership and involvement in a recovery oriented service.

### **Self-determination/choice**

Self-determination and self-choice is the cornerstone of a recovery process. The opportunity to choose one's long-term goals, the methods to be used to get to those goals and the individuals or providers who will assist in the process, are all components of a service acknowledging this value. Several mental health program models, such as psychiatric rehabilitation (78,96), supported housing (97), psychosocial clubhouses (98) and some case management programs (99), articulate the values of choice and partnership.

Davidson and Strauss (100) note, based on their qualitative research, that coercion has the effect of diminishing, rather than strengthening the self. Compliance does not promote the development of meaning and purpose in life and hence is a barrier to recovery. Placing a person in facility, job, school program or prescribing medications without exploring the person's preferences may achieve the outcome of reducing symptoms or gaining a role in society, without promoting the individual's sense of self, empowerment, well being or recovery. Helping an individual take back a meaningful life requires supporting self-determination and, if necessary, actively creating opportunities and providing assistance to develop more experience in making

informed choices. If a person cannot choose a specific type of role because he/she has not, for example, worked in many decades, a recovery oriented service would organize a variety of work experiences to help the individual figure out what his/her preferences might be. A recovery oriented service based on choice also provides individuals with sufficient education about medications, their intended outcomes and side effects to permit the individual to make choices from a menu of possibilities about which medications, if any, he/she wishes to use to support his/her recovery process.

## Hope

Hope for the future is an essential ingredient in all recovery oriented services. A commitment to creating and maintaining hopefulness in both service participants and their practitioners is critical to selecting, training and supervising staff as well as developing program activities in recovery oriented services. While research shows that professionals do no better than random chance in predicting success (8), some staff may believe it is unrealistic to expect their patients to recover because they are "too sick" or "too disabled". Because such staff lack hope themselves, they cannot promote a recovery orientation. Services that promote activities focused on simple maintenance or the prevention of relapse, without opportunities and support to move beyond maintenance, are not recovery oriented. For example, services need to be able to support the aspirations of those who wish to go to or return to university or community colleges, as well as those who wish to complete grade school or high school. Services need to be able to facilitate the goals of those who wish to get married, have families, and start their own businesses, as well as those who wish to live in some type of supported residence and work in a more sheltered employment situation.

Hopefulness does not mean using the promise of recovery as a new tool to label or devalue the individual. The impulse to label someone as "unmotivated" should not now be replaced by the label of "recovery failure" because recovery goals are not met in the moment. Hope means remembering, as research has shown, that recovery can be a long-term process with many setbacks and plateaus along the way.

## CONCLUSION

While the field is still developing its understanding of the process and meaning of recovery, it is clear that recovery is a reality that is possible to promote. Services should use practices with some evidence base that are reflective of, at a minimum, the four core recovery values (person orientation, person involvement, self-determination/choice and growth potential) in order to remain relevant as well as effective in the lives of the people they serve. Services fo-

cus on people or the full human experience, not "cases", partnership not compliance, choice not coercion, and a commitment to hopefulness, not helplessness hold the promise of more than just survival or maintenance. Such services promote recovery or the realization of a meaningful life for individuals with serious mental illnesses.

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