Recovery Constructs and the Continued Debate That Limits Consumer Recovery

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It is generally agreed that the concept of recovery is the result of two primary influences: longitudinal studies and the work, writing, perspectives, and advocacy of the consumer-survivor movement. To clarify what is actually meant by recovery, investigators have compared and contrasted the constructs being conveyed through each primary influence. This process has resulted in the proposal of two main taxonomies—"recovery from" as opposed to "recovery in" and "recovery as an outcome" as opposed to "recovery as a process." The author draws on her experience as a consumer to examine the efficacy of distinguishing the recovery constructs in each of these ways, concluding that both taxonomies limit the consumer recovery paradigm in a way that is neither valid nor helpful. It is essential to the progress of recovery-based services that the mental health field avoid the trap of a dualistic, either-or approach to recovery that was once so prevalent. (*Psychiatric Services* 64:270–271, 2013; doi: 10.1176/appi.ps.001612012)

Recovery-focused services are now the goal of many national mental health plans (1). However, debate continues on the concept of recovery itself, and this debate can derail efforts to introduce recovery services. The concept of recovery is generally recognized to have two origins–one in longitudinal studies of people with experience of mental illness and the other from the personal experience of consumers, as expressed through the consumer-survivor movement. These lead to different conceptualizations of recovery, which have been compared and contrasted to provide greater clarity in understanding the concept (2–5).

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"Recovery from" or "recovery in"?

Davidson and others (2,3) argued that longitudinal studies have led to the concept of "recovery from," in which clinical symptoms remit or are extinguished, whereas the consumer movement has embraced the concept of "recovery in," in which consumers work to retain, or resume, some degree of control over their lives notwithstanding that symptoms are still present. They explicated that by definition, "recovery in" is relevant only for individuals who have not "recovered from," given that it would make no sense to engage in the process of attempting to live fully despite having a psychotic disorder if, in fact, the psychosis had resolved.

A preoccupation with the elimination of symptoms fails to acknowledge that the distress caused by mental illness is actually far greater than just the symptoms themselves; what is most distressing are the consequences of symptoms in terms of a person's ability to live his or her life. What's more, the distress is resolved not simply as an automatic effect of symptom remission. If only it was that easy to recover relationships, work, security, time, and resources! These, and the support to achieve them, are the essential elements of retaining or resuming some degree of control over life, whether or not symptoms persist. By maintaining the focus essentially on the persistence of symptoms, Davidson and colleagues (2,3) promulgate a model of recovery that will continue to fail persons lucky enough to experience symptom remission.

My own most recent inpatient experience illustrates the point well. Two months into a seven-month stay, I asked my psychiatrist to allow me to be discharged. I felt that this request was quite reasonable, given that my immediate acute mental illness symptoms had been addressed. The psychiatrist refused to entertain any notion of immediate discharge, however, reasoning that I seemed to have no relationship with anyone or anything. You see, the psychiatrist argued, relating to people is absolutely fundamental to living well. So, that is what I did—during the next five months on the unit, I worked on relearning and practicing relationships with myself, my family, my friends, and my community (6).

Irrespective of whether the inpatient setting was necessary to support this aspect of my recovery, I now believe that the later, longer period of my hospitalization was crucial in terms of enabling me to resume active engagement in my roles as a mother and a wife capable of working, dancing, writing, vacationing, and shopping.

Recovery—outcome or process?

An alternative model of differentiating between these two constructs is to conceptualize recovery as an outcome (arising from the longitudinal study influence) compared with recovery as a process (arising from the influence of the consumer-survivor movement) (2,4,5). An exclusive focus on process implies that we are condemned to an unending journey—indeed, the very

"chronicity" that removed hope from so many people with mental illness in the past. Such a perspective risks the promulgation of mental health services that deliver optimal support of the recovery process but fail to support the pursuit or realization of any actual aspirations.

Although consumer recovery proponents often claim to reject the notion of outcome, in fact their descriptions generally embrace notions of both process and outcome. For example, Deegan (7) described needing to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability (process) in order to be able to live, work, and love in a community in which one makes a significant contribution (outcome). Similarly, Anthony (8) expressed a belief that recovery is about changing one's attitudes, values, feelings, goals, and skills or roles; developing new meaning and purpose in life; and growing beyond the catastrophic effects of mental illness (process); by doing so, one may lead a satisfying, hopeful, and contributing life (outcome). The consensus statement by the Substance Abuse and Mental Health Services Administration stated that recovery is a journey of healing and transformation (process) that enables a person with a mental health disability to live a meaningful life in communities of his or her choice while striving to achieve full human potential or "personhood" (outcome) (9).

As these examples attest, the notion of outcome per se is not antithetical from a consumer recovery perspective, but the conceptualization of what outcome actually entails may differ from traditional measures. For example, the Health of the Nation Outcome Scales (HoNOS) (10) are central to outcome evaluation in several countries. However, this measure, with its predominant focus on symptoms, is incapable of reflecting the concepts of outcome highlighted above in the descriptions of consumer recovery. Hence it is not surprising that consumers express concerns about the ability of this and similar measures to capture their experiences (11). Certainly the HoNOS is unable to reflect the extent and significance of the outcomes of my relearning and practicing being in relationship—resuming active engagement in my roles and life generally—yet in the four years since my discharge I have made no further use of specialist mental health services, despite five admissions in the two years prior to my last hospitalization.

Limiting consumer recovery to a process construct does not support the current focus of outcomes to be challenged. Many recovery-focused outcome measures are now available (12,13). Unfortunately, they are not being adopted and applied by researchers and leading clinicians in academia, the pharmaceutical industry, and rehabilitation and occupational therapy, even when the goal is to assess everyday, real-world outcomes (14). This is especially perilous given that outcome measures often drive the types of service provided. Broader concepts of outcome, including all those domains considered by consumers to be relevant to their recovery, have the potential to unite process and outcome into a single construct within which symptoms play, appropriately, a minor part.

Conclusions

Not surprisingly, efforts to clarify the concepts of recovery have emphasized points of difference. This has limited the consumer recovery construct in a manner that is neither valid nor helpful from a consumer perspective. More specifically, the taxonomy of "recovery from" as opposed to "recovery in" fails those of us who experience symptom remission. The alternative—"recovery as an outcome" as opposed to "recovery as a process"—implies that persons with a mental disorder are condemned to a hopeless, unending journey, potentially inspiring apathetic services, that continues to be assessed and driven by symptom-focused outcome measures.

I have attempted to present a broader construct of recovery that emphasizes the importance of the impact of symptoms rather than their mere occurrence and integrates process and outcome concepts. This construct, and related broader evaluation measures that reflect consumer concerns, has the potential to drive real development of recovery services that are applicable to the full range of consumer experiences and needs.

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