Recovery: A Dimensional Approach

Rob Whitley, Ph.D.
Robert E. Drake, M.D., Ph.D.

Various definitions, dimensions, and components of recovery have been posited. Building on existing work, the authors propose five superordinate dimensions of recovery: clinical recovery, experiencing improvements in symptoms; existential recovery, having a sense of hope, empowerment, agency, and spiritual well-being; functional recovery, obtaining and maintaining valued societal roles and responsibilities, including employment, education, and stable housing; physical recovery, pursuing better health and a healthy lifestyle; and social recovery, experiencing enhanced and meaningful relationships and integration with family, friends, and the wider community. The model also identifies lay, professional, and systemic resources that promote each recovery dimension. (*Psychiatric Services* 61:1248–1250, 2010)

The concept of recovery originated in the consumer-survivor movement and is deeply embedded in the community of people who use mental health services (1). Recovery as a goal of mental health services for people with severe mental illness has since been widely endorsed by the federal government, service providers, and mental health services researchers (2).

Yet recovery remains a contested and illusory concept with various definitions; the term has been deployed to describe a diverse variety of processes and outcomes (3–6). Those in the consumer-survivor movement, as well as some progressive researchers in psychiatric rehabilitation, focus definitions of recovery on nonclinical factors that are often difficult to measure, such as empowerment, autonomy, self-esteem, and overcoming marginalization (4,5). Clinicians often use the term in reference to the medical model; recovery to them means a reduction of symptoms and a return to baseline levels of functioning (6). Yet others within and outside of the consumer movement have focused on participation in meaningful (and socially valorized) activities such as employment and education (7). Some researchers see improved physical health as a corollary of recovery, investigating factors such as exercise, diet, weight loss, and smoking cessation among people with mental illness (8).

In this Open Forum we briefly review existing definitions of and approaches to recovery and then describe five superordinate dimensions of a new approach: clinical, existential, functional, physical, and social.

Existing dimensional approaches to recovery

A widely utilized definition of recovery comes from the Substance Abuse and Mental Health Services Administration (SAMHSA) (9): "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." In addition to the above, this definition outlines ten fundamental components of recovery—self-direction, individualized and person-centered, empowerment, holistic, nonlinear, strengths based, peer support, respect, responsibility, and hope.

Another widely cited dimensional exploration of recovery comes from Jacobson and Greenley (3). They proposed a model of "internal and external conditions" in understanding recovery. Internal conditions refer to hope, healing, empowerment, and connection. External conditions refer to human rights, a positive culture of healing, and recovery-oriented services. Another widely cited definition of recovery comes from Davidson and Roe (4), who described two complementary meanings of recovery. The first is clinical improvement over time (a definition grounded in the medical model)—recovery from mental illness. The second refers to a person's right to self-determination and inclusion in community life (a definition grounded in the consumer-survivor movement)—recovery in mental illness.

The above-cited perspectives can be considered responses to calls for more "person-centered care" (10). Person-centered care has been defined as "the experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one person, circumstances and relationships in health care" (11). Person-centered care should be viewed as the opposite of "disease-centered care" or "physician-centered care," terms which often refer to a narrow medical model. Person-centered care attempts to perceive and assist the whole person in his or her social context, working with that person to provide help in a holistic and personally meaningful fashion. Well-known person-centered, recovery-oriented interventions include supported housing, supported employment, peer support, and programs that attempt to harness religion or spirituality (4–7).

Dr. Whitley is affiliated with the Douglas University Mental Health Institute, McGill University, 6875 LaSalle Blvd, Montreal, Quebec, Canada H4H 1R3 (e-mail: robert.whitley@mcgill.ca). Dr. Drake is with the Department of Psychiatry, Dartmouth Psychiatric Research Center, Lebanon, New Hampshire.

A new dimensional approach to recovery

The existing work on recovery tends to delineate its specific dimensions and particular components. In this Open Forum, we propose a rather different approach by proposing a taxonomy of five broad superordinate recovery dimensions: clinical, existential, functional, social, and physical. A summary of our model is presented in Table 1, which also lists lay, professional, and systemic resources that promote each recovery dimension. The proposed dimensions are not meant to be definitive or to replace existing approaches. On the contrary, they are intended to augment current perspectives by creating a broader framework under which more focused recovery components can be considered.

In offering these dimensions, we are cognizant of the fact that recovery must be defined primarily by the individual consumer, in line with the tenets of person-centered care. However, we also note that family members, clinicians, and the wider community can be vital supports in the recovery process. They may benefit from frameworks that allow them to explore and promote recovery among consumers. The proposed model may also be of value to researchers investigating recovery.

Clinical recovery refers to the reduction and control of symptoms so that they do not overwhelm and incapacitate the consumer. In the dimension of clinical recovery, this often comes in the form of psychotropic medication, which can be used in conjunction with appropriate behavioral and talking therapies to reduce symptom severity. This form of recovery may best be managed by psychiatrists, who can delegate appropriate responsibilities to case managers, social workers, or clinical psychologists. For individuals with co-occurring disorders, substance abuse management by addictions counselors can be considered part of clinical recovery. This form of recovery is grounded in the medical model and is referred to in the definition proposed by Davidson and Roe (4). However, much evidence suggests that clinical recovery can be heavily influenced by the other four dimensions described below.

Existential recovery encompasses many of the components posited in the SAMHSA National Consensus Statement (9), such as hope, responsibility, self-direction, and empowerment. These secular psychosocial factors may allow individuals to feel more in control of their lives and less subject to the whim of an uncontrollable illness or a capricious mental health service system. Case managers and peer supports can be instrumental in facilitating these forms of existential recovery. We propose that existential recovery also includes factors such as religion, spirituality, meaning, and values. Many people with severe mental illness may lack hope or may feel abjectly disconnected from the transcendent (5). To make sense of their illness, many seek religious and spiritual guidance from a higher power or from religious leaders. They may come to see their recovery as depending on finding a spiritual path or

Table 1

Dimensions of recovery in context

Dimension	Factors encompassed	Healers involved	Measurable outcomes
Clinical	Symptoms Medical care Psychotropic medication Talking and behavioral therapies	Psychiatrists General practitioners Community nurses Case managers Assertive community treatment teams Clinical psychologists	Rehospitalization Adherence Symptom severity
Existential	Religion and spirituality Agency and self-efficacy Personal empowerment	Religious leaders and congregations A higher power (God) Peers Family and friends Case managers Clinical psychologists	Hope Emotional well-being Spiritual well-being Sense of self-efficacy and autonomy Sense of empowerment
Functional	Employment Education Housing	Supported employment specialists Vocational rehabilitation Housing specialists Case managers Social workers Teachers and educationalists	Obtaining and maintaining employment Beginning and completing educational courses Obtaining and maintaining secure housing
Physical	Diet Exercise Smoking Substance abuse	Nutritionists Physical trainers Addictions counselors	Caloric intake Level of exercise Weight, circumference Substance abuse
Social	Family Friends Peers Community Social activity	Family and friends Case managers Social workers Community leaders Peers Religious leaders	Social support Social capital Social activity Community integration Citizenship Sense of belonging

becoming part of a religious or spiritual community. Mental health services that are sensitive to these existential needs may be more effective.

Functional recovery involves being able to participate effectively and successfully in aspects of everyday life and in society and to accrue secondary gains from this participation in the form of improved morale, self-esteem, and community integration. The most common factors studied as part of functional recovery are employment, housing, and education. People with severe mental illness often lose their jobs, or if they become ill at a young age, they never finish their education or begin working (7). Supported employment and education specialists can help people with severe mental illness to succeed in education and employment. Similarly, people with severe mental illness often live in precarious housing or become homeless. Various supportive housing programs aim to ensure that people with severe mental illness have stable housing and appropriate supports; these services are often delivered by housing specialists in mental health services agencies.

Physical recovery refers to positive improvements in physical health and well-being. People with severe mental illness experience a variety of comorbid and preventable physical conditions. These include obesity, diabetes, respiratory disorders, cardiovascular disease, and hepatic disorders, which contribute to a significantly lower life expectancy (8). These conditions may be a result of lifestyle factors, such as poor diet, smoking, substance abuse, risky sexual behaviors, and lack of exercise. Many of these behaviors are heavily influenced by structural factors. For example, living in a high-crime neighborhood may deter health-promoting physical activity. Physical health is also affected by the metabolic and neurologic side effects associated with long-term use of antipsychotic medications. Physical recovery can be facilitated through an integrated team approach; psychiatrists, physical trainers, nutritionists, addictions counselors, and the like can all be deployed to assist. Existing definitions of recovery have tended to avoid explicit mention of physical recovery, even though many consumers embrace interventions that promote physical health (8).

Social recovery refers to the interpersonal and community arena. Many people with severe mental illness experience social exclusion and ruptured relationships with family, friends, and significant others. They may be socially isolated and may spend large amounts of time alone, leading to loneliness and isolation at best and substance abuse and suicidality at worst. In addition, adults with severe mental illness often have difficult relations with their children, who may be in foster or statutory care. Social recovery involves establishing and maintaining rewarding relations with family, friends, peers, and significant others. Peer support can play a vital role in social recovery. Indeed, it is one of the components of SAMHSA's recovery model. Social recovery also refers to such factors as engaging in rewarding social activity (for example, sports), actual and felt community integration, and active citizenship. Case managers and clinical psychologists often help clients to enhance relationships with family, improve social skills, expand social networks, and reconnect with children. These professionals can employ a range of evidence-based practices that develop social skills and strengthen family relationships. Religious and spiritual leaders and secular community leaders may also support social recovery by involving consumers in existing social networks based on a tradition of hospitality and inclusion. As noted, peers helping peers can have a strong positive influence on social recovery.

Conclusions

The five dimensions have considerable overlap and may have synergistic interactions. For example, employment (functional recovery) may lead to inclusion in positive social networks (social recovery), which might enhance hope and responsibility (existential recovery). These factors may work together to reduce symptoms (clinical recovery). Thus there may be complex and mutually beneficial interrelations between the dimensions; the whole is likely greater than the sum of the parts. At this stage, we can only speculate on the nature of the relationship between the dimensions. Their interrelation is an empirical question that future research can address.

Other empirical questions raised by the dimensional structure include whether progress in one dimension is predicated by progress in another. Are some dimensions more critical than others? Should certain dimensions be addressed first by a clinical team? Of course, if we embrace the notion that recovery is self-defined, it is important for consumers to prioritize dimensions of action, not for professionals to prescribe their preferences. Future research can illuminate common consumer and clinician preferences within and between the five proposed dimensions, which may help in the reconfiguration of mental health services so that they become truly recovery oriented and person centered.

References

1. Anthony WA: Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal 16:11–23, 1993
2. Achieving the Promise: Transforming Mental Health Care in America. Pub no SMA-03-3832. Rockville, Md, Department of Health and Human Services, President's New Freedom Commission on Mental Health, 2003
3. Jacobson N, Greenley D: What is recovery? A conceptual model and explication. Psychiatric Services 52:482–485, 2001
4. Davidson L, Roe D: Recovery from versus recovery in mental illness: one strategy for lessening the confusion plaguing recovery. Journal of Mental Health 16:459–470, 2007
5. Deegan P: Recovery as a journey of the heart. Psychiatric Rehabilitation Journal 19:91–97, 1996
6. Lieberman JA, Drake RE, Sederer LI, et al: Science and recovery in Schizophrenia. Psychiatric Services 59:487–496, 2008
7. Becker D, Drake R: A Working Life for People With Severe Mental Illness. New York, Oxford University Press, 2003
8. Bartels SJ: Caring for the whole person: integrated health care for older adults with severe mental illness and medical comorbidity. Journal of the American Geriatrics Society 52(12 suppl):S249–S57, 2004
9. National Consensus Statement on Mental Health Recovery. Rockville, Md, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2004
10. Mezzich JE: Psychiatry and the person: articulating medicine's science and humanism. World Psychiatry 6:65–67, 2007
11. Berwick DM: What "patient-centered" should mean: confessions of an extremist. Health Affairs 28:w555–w565, 2009