

**RECOVERY IN SERIOUS MENTAL ILLNESS:
PARADIGM SHIFT OR SHIBBOLETH?**

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Abstract

The notion of recovery in serious mental illness has become a dominant force in federal and state mental health policy arenas, as is evident in the Surgeon General's *Report on Mental Illness* and in the more recent President's New Freedom Commission *Final Report*. In both of these potentially influential documents, recovery is stipulated as the overarching goal of mental health care and also as the foundation for policy and programmatic reforms at the state and local levels. These advances have occurred despite the fact that there is much confusion, and little consensus, in the field about the nature of recovery in serious mental illness, the various components of processes that comprise recovery, or the most effective ways in which recovery can be facilitated or promoted. This paper offers a conceptual framework for distinguishing between the various uses of the term recovery in primary medical care, trauma, addiction, and serious mental illness, and then reviews the existing literature on mental health recovery. In recognition of the danger of this notion becoming the latest in a series of shibboleths within mental health, we conclude with a discussion of the implications of mental health recovery for meaningful reforms of policy and practice.

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“The important thing . . . is not to be cured, but to live with one’s ailments”

-- Albert Camus (1955, p. 29).

After residing on the margins of the mental health community for over two decades, the notion of “recovery” has emerged recently as a dominant force among individuals with serious mental illnesses, their loved ones, and the professionals and public officials who serve them. Most recently, it has taken center stage through its prominent role in both the Surgeon General’s *Report on Mental Health* (DHHS, 1999) and the President’s New Freedom Commission on Mental Health’s *Final Report* (2003). In this potentially important report, the Commission recommended “fundamentally reforming how mental health care is delivered in America” in order to be reoriented to the goal of recovery (2003, p. 4). Yet despite, and also perhaps because of, the recent widespread proliferation of the concept, it has been difficult to reach consensus on any one definition, or even on any one list of essential aspects, of the concept (Bullock, Ensing, Alloy & Weddle, 2000; Drake, 2000; Hatfield, 1994; Jacobson, 2001; Jacobson & Greenley, 2001; Sullivan, 1994; Young & Ensing, 1999). In fact, the only thing about which most involved parties seem to be able to agree is that the notion of recovery has become the focus of a considerable amount of confusion, dialogue, and debate between and among various constituencies within the mental health community. For any significant progress to be made in achieving the recovery goals of either the Surgeon General or the New Freedom Commission’s Reports, clarity and consensus must be achieved in relation to this important concept. The following article is one contribution to this process.

Background

There are many possible sources of this confusion. In the first place, two different clinical and political forces have come together around similar, but not identical, approaches to the possibility, nature, and extent of improvement in serious mental illness. Beginning with the World Health Organization's International Pilot Study of Schizophrenia launched in 1967, there have been a series of long-term, longitudinal outcome studies conducted around the world, all of which have produced a consistent picture of a broad heterogeneity in outcome for schizophrenia and other severe psychiatric disorders (Carpenter & Kirkpatrick, 1988). With respect specifically to schizophrenia, this line of research has documented partial to full recovery in between 25-65% of each sample. Recovery in this context has been defined as amelioration of symptoms and other deficits associated with the disorder and a return to a pre-existing healthy state. What these studies suggest is that at least one quarter, and up to two thirds, of people with schizophrenia will achieve this form of recovery from the disorder and its associated effects (e.g., Davidson & McGlashan, 1997; McGlashan, 1988).

A somewhat different use of the term recovery has been introduced by the Mental Health Consumer/Survivor Movement. This sense of recovery does not require remission of symptoms or other deficits, nor does it constitute a return to a pre-existing state of health, but involves viewing psychiatric disorder as only one aspect of a whole person. Unlike in most physical illnesses, people may consider themselves to be "in recovery" according to this view while continuing to have, and be affected by, mental illness. What recovery seems to involve is that people overcome the effects of being a mental patient—including rejection from society, poverty, substandard housing, social isolation, unemployment, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to retain, or resume, some degree

of control over their own lives. As being a mental patient is considered traumatic, advocates in this Movement argue that a return to a pre-illness state is not only impossible, but also would diminish the gains the person has had to make to overcome the disorder (Chamberlain, 1978; if not in original, delete them Deegan, YEAR? ; Frese, YEAR?; Fisher, undated; Jacobson & Greenley, 2001.)

The convergence of these distinct perspectives, along with a variety of other clinical, political, and social factors, has contributed to a situation in which the term recovery is now in danger of becoming merely the latest in a line of shibboleths within mental health (Fink, 1988); that is, words that are used frequently and connote a kind of insider status (being in sync with the latest fad or fashion) without having any meaningful or substantive content. As Jacobson and Greenley noted in their recent review of the recovery movement in state mental health systems, seldom does one word surface so frequently across the separate domains of social policy, outcomes research, services design and provision, system reform and advocacy, and personal narratives in the absence of a uniform or consistent meaning. As they describe:

Recovery is variously described as something that individuals experience, that services promote, and that systems facilitate, yet the specifics of exactly what is to be experienced, promoted, or facilitated—and how—are often not well understood either by the consumers who are expected to recover or by the professionals and policy makers who are expected to help them (2001, p. 482).

The increasingly ubiquitous yet elusive nature of the concept has contributed to a remarkable inconsistency in the degree to which recovery principles are translated into actual clinical practices that can be assessed and that professionals can then be held accountable for delivering. In the face of such ambiguity, it becomes relatively easy for providers to make claims to be

offering “recovery-oriented” care; in many cases, however, simply repackaging old wine in the new bottle of recovery language (Jacobson & Greenley, 2001). As is often the case with ideas that move rapidly from the fringe to the mainstream of service systems, one is then left with the question: “If everybody is doing it, how come nothing is getting done?” (Marrone, 1994).

We believe that this dilemma arises partly due to confusion about what exactly “it” is—in this case, the “it” being recovery. In this paper, we identify some of the sources of the current confusion related to the notion of recovery, offer a conceptual framework to distinguish recovery in mental illness from recovery in other disorders, and delineate several components of the sense of recovery being used at present within the consumer/survivor and psychiatric rehabilitation communities. In closing, we propose a broad understanding of recovery from mental illness that may still be useful in moving the field a step or two beyond current practice and research.

A Conceptual Framework for Recovery

In order to begin to address the ambiguity and uncertainty surrounding notions of recovery in mental health, we turned first to the dictionary. A cursory review of the entry for recovery suggests one potential source of the confusions concerning the term, given that Webster offers the following four different definitions (which we paraphrase for ease of comprehension):

- 1) A return to a normal condition; 2) An act, instance, process, or period of recovering; 3) Something gained or restored in recovering; and 4) The act of obtaining usable substances from unusable sources, as with waste material.

Without forcing square pegs into round holes, we suggest that these four definitions are useful in clarifying the different senses of recovery currently being used within the behavioral health field at large in relation to a range of psychiatric and substance use disorders and across the domains described above. In the following, we examine these definitions of the term and

argue that each term is most appropriate to one category as opposed to others from among the four categories of: 1) acute physical conditions; 2) trauma and its sequelae; 3) substance use disorders; and 4) severe psychiatric disorders. Once differentiated in this way, it becomes obvious that all four variants of recovery may co-exist and/or interact within the context of any given individual's life, encouraging an appreciation of the different ways in which individuals manage to live with, and despite, various combinations of behavioral health conditions.

1) Physical Recovery: Return to a Normal Condition.

This definition of recovery represents by far the most common use of the term, and a use that is perfectly appropriate when referring to the resolution of acute physical conditions such as a cold, the flu, or a broken bone. In all of these cases, recovery is taken to mean that the person has been restored, through whatever means, to the same presumably normal condition she or he had prior to the onset of the illness or the precipitating event that led to the condition (e.g., skiing accident). In all of these cases, there also is an assumption that a healthy state existed prior to the onset of disease and/or dysfunction; i.e., that people are naturally healthy until something happens to deprive them of their health, recovery then being restoration of the person to this prior state (Davidson & Strauss, 1995). Although these assumptions might be questioned, this definition represents a relatively well-accepted use of the term recovery and one that is not a source of contention within physical medicine when applied to acute conditions that leave people in relatively the same state they were in prior to first experiencing the condition.

Recovery takes on a different meaning within physical medicine, however, when applied to chronic conditions such as asthma, diabetes, or cancer. In these cases, the person is not expected to be restored to a previous, pre-morbid, condition of health. To the degree that the term recovery is used at all in relation to these more prolonged conditions (e.g., partial recovery

from a stroke, being in recovery from cancer), it ordinarily is taken to mean a partial return to normal functioning or to incorporate one of the different meanings described below, no longer referring to restoration to a previous condition of health. We suggest that a considerable amount of the controversy within behavioral health in relation to the term recovery stems from a misuse of this meaning of the term to apply to other non-acute conditions such as severe psychiatric and substance use disorders. Were this first definition of restoration to a normal state following an acute illness or episode the only legitimate meaning of recovery, then the term could justifiably be dismissed as inappropriate for many cases of severe psychiatric and substance use disorders; a majority of which are prolonged conditions.

2) Trauma Recovery: An Act or Process of Recovering.

Aside from its common uses in physical medicine in relation to definition #1 above (e.g., as in a 'recovery room' being a place where you recover from the immediate effects of surgery), this second definition of recovery primarily has been commandeered for political and clinical purposes by victims of interpersonal trauma and the people who work with, support, or advocate for, them. As one of several important sources of the distinction between this definition and #1 above, proponents of current trauma models argue that there can be *no* return to a previous or normal condition following trauma. In fact, one of the defining characteristics of trauma is that it leaves the person forever changed as a result, having neither the same sense of personal identity nor of the world at large that existed prior to the event (Herman, 1992; van der Kolk, McFarlane & Weisaeth, 1996). Even if only by accentuating a person's sense of vulnerability and/or the unpredictability of the world, trauma brings about significant alterations in the person's life from which there can be no return. Referred to variously as being "robbed of one's innocence," having one's "world turned upside down," or having the "sky come crashing down," trauma theory

suggests that the person cannot return to a pre-trauma naïveté (Janoff-Bulman, 1992). In what sense, then, can a person who has experienced significant trauma be said to be “in recovery”?

In this case, recovery has come to signify an active *process* of confronting and working through, or integrating, the traumatic events so that their destructive impact on one’s life is minimized as one moves forward into a future, post-trauma, in which oneself and one’s world have changed (Briere, 1996; Herman, 1992; McCann & Pearlman, 1992). Here recovery is viewed as a more constructive alternative either to denial of the trauma or to continued victimization by the trauma. Denial perpetuates post-traumatic stress symptoms such as flashbacks, hypervigilance, and dissociation that continue to cause distress and to disrupt the person’s life, while continuing to view oneself as a victim of the traumatic events (rather than a “survivor”) restricts one’s life to within the confines imposed by the trauma and blocks the person from moving forward. Overcoming this sense of victimization is not to be confused, however, with any form of accepting the trauma *per se*. In cases of sexual abuse and rape—the paradigmatic examples of interpersonal traumatization—it is, according to trauma theory, neither necessary nor recommended for the person to become resigned to such heinous acts in order to be considered “in recovery” (Briere, 1996; Gilfus, 1999).

Being in recovery instead involves being engaged in an active process of making sense of the trauma and incorporating it into one’s life in such a way that its destructive impact decreases over time. Admittedly a gradual process that may not end until the person dies (i.e., being *in recovery* from trauma rather than *recovered*), recovery is a process of moving the trauma and its immediate effects from the forefront of the person’s awareness (the “figure”), where it exerts considerable control over his or her day-to-day life, into less prominent domains on the periphery of the person’s awareness (the “ground”) where it is largely under the person’s control or is at

least no longer considered intrusive.

The dimension of control also is prominent in both of the remaining definitions of recovery, as the path from figure to ground traversed by traumatic events and their impact is similar to the path traversed by both addictions and psychiatric disorders as the person goes from being controlled *by* them to bringing them under some degree of personal control. What may be unique to trauma and to this sense of recovery is the transformation from victim to survivor; a transformation that has more in common with life-threatening illnesses like cancer than with psychiatric or substance use disorders.

3) Addiction Recovery: Something Gained or Restored.

Borrowing from physical medicine, but predating use of the term recovery in referring to the aftermath of trauma, the first use of the term “recovery” in behavioral health can be traced to the self-help movement in the addiction community (White, 1998). Beginning with Alcoholics Anonymous and extending through its several abstinence-based twelve-step derivatives (Cocaine Anonymous, Narcotics Anonymous, etc.), people who are achieving or maintaining abstinence from drug or alcohol use following a period of addiction have been describing themselves as being “in recovery” from their addiction for over half a century (White, 2000). In this tradition, “in recovery” is meant to signify that the person is no longer using substances but, due to the long-term nature of addiction, continues to be vulnerable to “slips” or relapses and therefore has to remain vigilant in protecting his or her sobriety.

Based on this definition, it is possible that many people who have used substances to an extent that would have met criteria for a *DSM-IV* diagnosis of substance use disorder at one point earlier in their lives, but who are no longer actively using or finding it necessary to protect their sobriety, would not consider themselves to be “in recovery.” Similarly, people who have

experienced a traumatic event but who no longer feel that their lives are impacted by the event or its aftereffects might no longer consider themselves to be “in recovery” from the trauma.

Although for some people it may apply to the remainder of their lives, being in recovery from addiction appears to pertain more specifically to the period following the addiction in which the person is aware of the efforts involved in remaining abstinent and in which there continues to be a sense of vulnerability to relapse. In this sense, recovery in addiction is not only hard-won, but it also must be protected and reinforced through persistent vigilance and adherence to the self-help principles which made recovery possible in the first place (e.g., attending 12-step meetings).

In addition to being in recovery from the addiction, this process involves addressing the effects and side effects of the addiction as well. The self-help tradition within the addiction community recognizes that living the life of addiction generates many negative effects on one’s life beyond the addiction *per se*, including detrimental effects on one’s relationships, on one’s ability to learn or work, and on one’s self-esteem, identity, and confidence. Having lost control not only of one’s substance use but also of one’s life as a whole, this sense of being in recovery involves the person’s assuming increasing control over his or her substance use while resuming responsibility for his or her life. In this sense, addiction recovery involves both of the terms used by Webster in the third sense of recovery: gained *and* restored. What is gained is a person’s sobriety, but in the achievement of sobriety and in creating an environment that will protect and reinforce sobriety, the person also has had to restore his or her life as a whole. Being in recovery thus often involves returning to school or work, making amends to others who have been hurt, repairing damaged relationships, and, in general, learning how to live a clean and sober life (Beattie & Longabaugh, 1997; Longabaugh & Wirtz, 1998).

For many people in the self-help community, achieving recovery may be the first time

they have felt like they have known how to live without their addiction, tracing its origins back to their earlier lives even prior to actual substance use. For these people, a clean and sober life is not so much restored by abstinence as it is created for the first time; a gain which they credit to their recovery above and beyond sobriety. It is not unusual in such cases for people in recovery from an addiction to believe they are now a better person for having gone through the addiction and recovery process than if they had never become addicted in the first place. Although it is possible that people suffering from some acute physical conditions, or having experienced a trauma, may believe that they are better off now for having gone through such ordeals, it is a less common occurrence here than in the case of addiction. It is unusual for someone recovering from the flu or rape, for example, to say that she or he has gained something of value in the process. It is not unusual, however, for people in addiction recovery to have done, and to say, so.

4) Mental Health Recovery: Obtaining Usable Substances from Unusable Sources.

As noted in our introduction, long-term longitudinal studies published over the last 30 years have consistently and convincingly documented a heterogeneity in course and outcome for severe psychiatric disorders. Given this heterogeneity, “recovery” has come to mean different things to people experiencing different courses of illness. For those fortunate individuals who experience one episode of major depression or psychosis from which they then return to the healthy state they experienced prior to this episode, our first definition of recovery from physical health conditions is the most appropriate. We can say of these people that they have recovered fully from their psychiatric disorder, having been restored to their previous level of functioning. Although representing a significant proportion of the people experiencing psychiatric disorders at any given time (approximately 30%), such individuals seldom disclose their psychiatric history or define themselves in terms of this isolated episode of dysfunction, preferring to return

(quietly) to the normal lives they led previously. In such cases, the person is unlikely to require long-term mental health care and is unlikely to describe him or herself as being “in recovery” from anything.

The relatively recent notion of being “in recovery” from a serious mental illness appears to apply instead to those individuals who have a prolonged course and for whom the outcome of their disorder is less certain. This meaning of the term recovery was introduced by the Mental Health Consumer/Survivor Movement that emerged in its contemporary form approximately fifty years ago, as former patients of state hospitals began to congregate in urban areas around the country in the early days of deinstitutionalization (Chamberlin, 1978; Gartner & Reissman, 1984). Groups of ex-patients came together both to protest the treatment—from their view, incarceration—they had received in state hospitals and also to develop their own network of support. As the movement began to gather momentum in the 1970’s, ex-patients and other advocates strove for new language to express their emerging, alternative vision of mental illness.

The meaning recovery came to take on within the context of this vision parallels to some degree its use in the addiction field, involving the person’s assuming increasing control over his or her psychiatric condition while reclaiming responsibility for his or her own life; a life that previously had been either subsumed by the disorder and/or taken over by others. In addition to borrowing this meaning of recovery from the addiction community, and being fueled by the fires of the outcome research described above (i.e., demonstrating that many people can and do recover from serious mental illness), another influence on the Consumer/Survivor Movement’s use of the term recovery was the Independent Living Movement established by people with physical disabilities (DeJong, 1979). At the interface of these several diverse streams a somewhat unique use of the term recovery—a use that we suggest corresponds to Webster’s fourth

definition, i.e., the process of obtaining usable substances from unusable sources—has emerged in community mental health.

Despite the overlap described above, there are several ways in which this definition differs from use of the term in the addiction field. Being in recovery from an addiction invariably involves some degree of abstinence; it requires, that is, a change in the person's condition from being controlled by the addiction to the addiction being under at least some degree of control. While a vulnerability to relapse remains a core element of addiction recovery, a person who continues to use actively cannot be considered to be in recovery; i.e., active substance use in the context of a lack of awareness of one's addiction precludes recovery. The same cannot be said, however, for psychosis. In this respect, the mental health community borrows more from the Independent Living Movement in arguing that recovery remains possible even while a person's condition may not change. It is not reasonable to insist that a person with paraplegia, after all, regain his or her mobility in order to be considered in recovery. In the case of mental health, in whatever way recovery is defined it must allow room for the person's continuing to have the disorder in question. If it does not require a change in the person's psychiatric condition *per se*, then what does recovery from serious mental illness represent or entail?

In order to flesh out what such a notion of recovery involves, we conducted a concept analysis of recovery as described in consumer/survivor and psychiatric rehabilitation literatures; those bodies of literature in which this sense of recovery has figured most prominently. The first thing we discover when we turn to this focused domain is that there is little consensus even in this literature about the definition of recovery (Bullock, et al., 2000; Drake, 2000; Hatfield, 1994; Jacobson, 2001; Jacobson & Greenley, 2001; Sullivan, 1994; Young & Ensing, 1999). What recovery involves appears to depend upon whom you ask. Despite the lack of a uniform

conceptualization, most definitions of recovery involve some component of acceptance of illness, having a sense of hope about the future, and finding a renewed sense of self. For example, three of the more often cited definitions of recovery offered in this literature are:

Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability (Anthony, 1993).

Recovery refers to the ... real life experience of persons as they accept and overcome the challenge of the disability (Deegan, 1988, p. 150).

Recovery is a process by which people with psychiatric disabilities rebuild and further develop important personal, social, environmental, and spiritual connections, and confront the devastating effects of discrimination through ... empowerment (Spaniol and Koehler, 1994, p. 1).

Such definitions obviously differ from those employed in clinical research, in which recovery involves alleviation of the symptoms that cause a person distress or ill health and/or a return to his or her premorbid level of functioning (Young & Ensing, 1999). Recovery, from this perspective, is an absence of something undesired, such as illness or symptoms, or the removal of something that was not part of a person's life prior to the illness, such as medications or hospitalization (White, 2000; Whitwell, 2001). While this model also may include more positive, objective indicators of improvement such as employment, housing, and relationships, the focus remains nonetheless on removing obstacles to an otherwise normal or healthy state (Davidson & Strauss, 1995; Jacobson & Curtis, 2000). From the perspective of consumer/survivors and psychiatric rehabilitation practitioners, however, recovery is not understood as a static "end product or result" (Deegan, 1996a). It is neither "synonymous with cure" nor does it simply involve a return to a premorbid state (Deegan, 1993; Jacobson & Greenley, 2001; Walsh, 1996).

Rather, it is a life-long process that involves an indefinite number of incremental steps in various life domains (Deegan, 1988; Frese & Davis, 1997; Hatfield, 1994; Jacobson & Curtis, 2000). As a result, many people view the process of recovery as something that almost defies definition. It is often described as more of an attitude, a way of life, a feeling, a vision, or an experience (Deegan, 1988, 1996a) than a return to health.

One reason that recovery in this sense is not typically viewed as a return to a previous state is that advocates often view the experiences of disability, treatment, hospitalization, stigma, and discrimination associated with their psychiatric disorder as having changed their lives irrevocably. Like trauma survivors who can never simply return to their lives prior to the traumatic event, mental illness in its more severe forms may be experienced as a life-threatening and life-altering condition. For example, Walsh (1996) describes how mental illness had such a profound effect on him that it was impossible for him to return to his life as it was before the illness: "I agree that we can never go back to our 'premorbid' selves. The experience of disability and stigma attached to it, changes us forever." Some people, in addition, would not want to go back to their lives prior to their experiences of illness because that would in effect deny an important part of their existence (Corrigan & Penn, 1998) and/or negate gains they have made in the process of recovery (Davidson & Strauss, 1992).

This last element speaks to the fact that recovery—in contrast to an absence of symptoms, relief from effects of illness, or remediation of difficulties (either due to a reduction in symptoms or improved methods of coping with symptoms and secondary consequences of illness)—often involves growth and an expansion of capacities. It is in this sense that we find Webster's fourth definition of recovery as "obtaining usable substances from unusable sources" to be most relevant. In this case, the unusable sources are psychiatric disorder, stigma, and their

associated effects and side effects, while the usable substances derived from these experiences are the ways in which the person finds her or himself able to rise to the challenge and reclaim a meaningful and gratifying life despite, or beyond the limitations of, the disorder. This form of recovery requires the person to discover and draw upon intrinsic, but often untapped, strengths aside from the disorder, often in the face of what may be unremitting symptoms and other sequelae of the illness. As a result, many people indicate that one of the more essential aspects of their recovery was incorporating the illness as only a minor part of a newly expanded sense of self. This new sense of identity requires expansion of the person's pre-morbid sense of self in order to include all of the skills and strengths the person has had to discover and/or acquire in learning how to live with, and minimize the intrusion of, his or her disorder while still striving to achieve his or her life goals.

Because, from this perspective, the process of recovery may be different for different people, it is difficult to come up with one set of essential ingredients that will be true for all. Our concept analysis of the consumer/survivor and psychiatric rehabilitation literatures did reveal several common aspects of the journey of recovery, however. These are described briefly in Table 1. Each of these areas both assumes and illustrates the basic principle of this form of recovery: a redefinition of one's illness as only one aspect of a multi-dimensional sense of self capable of identifying, choosing, and pursuing personally meaningful goals and aspirations despite continuing to suffer the effects and side effects of mental illness (Davidson & Strauss, 1992; Hatfield, 1994; Pettie & Triolo, 1999; Rigdway, 2001; Young & Ensing, 1999).

Discussion

We have reviewed the various meanings of recovery across different clinical conditions and healthcare contexts—e.g., from physical illness, traumatic experiences, and substance use—

in order to establish a foundation upon which to conceptualize an alternative vision of recovery from serious mental illness. What have we learned from this review and what implications do these lessons hold for psychological practice and research?

From the consumer/survivor and psychiatric rehabilitation literatures we have learned that recovery from serious mental illness does not require remission of symptoms or of other deficits brought about by the disorder. Rather, recovery appears to involve incorporation of one's illness within the context of a sense of hopefulness about one's future, particularly about one's ability to rebuild a positive sense of self and social identity despite remaining mentally ill. This process also appears to involve overcoming the effects of being a mental patient including rejection from family, peers, and society as a whole; poverty, unemployment, and substandard housing; loss of valued social roles and identity; loss of sense of self as an effective social agent and of the sense of purpose and direction associated with it; and loss of control over, and responsibility for, one's major life decisions.

Rather than leading the person back to a pre-existing state of health, the processes by which people with serious mental illness are to achieve these components of recovery are considered to be ongoing or lifelong in nature. Finally, given the traumatic nature of being a mental patient, people should not expect to return to the lives they led prior to onset of their illness. Like other trauma, these experiences change the person's life forever. The best that can be hoped for is a multi-dimensional sense of self and a personally meaningful and rewarding life of which the illness becomes a smaller and smaller part over time. Whether such a view of recovery can be reconciled with the approach of conventional clinical psychology and embraced by the mental health community as a whole remains to be determined.

As useful and important as this notion of recovery may be both personally and politically,

its relevance to processes of improvement may be limited to the extent that it differs substantially from the definition of recovery utilized in outcome research. The consumer/survivor and rehabilitation literatures identified components that people who have had a serious mental illness have found important in reclaiming their lives *despite* continuing to have a disorder. The research that demonstrated a heterogeneity in outcome for people with schizophrenia used a much more narrow definition of recovery that explicitly *included* remission of symptoms and remediation of deficits; both of which are *excluded* from the literature reviewed above. Insofar as we are interested in understanding processes that lead to remission in symptoms and remediation of deficits, this literature will therefore be limited in its applicability. Such issues as stigma and acceptance of illness, for example, would not necessarily be of concern to someone who was no longer ill. Similarly, milder forms of the illness, from which people might recover more rapidly, would most likely not require wholesale redefinitions of self and of one's relation to the world.

If the consumer/survivor and rehabilitation literatures are addressing a phenomenon fundamentally different from that studied by clinical research, is there still reason for clinicians, clinical investigators, and policy makers to be concerned with the various definitions of recovery promoted in these literatures? In closing, we suggest that there are at least two important reasons that these literatures need to be addressed, if not integrated, within psychology. Both of these reasons are based on the fact that the consumer/survivor and rehabilitation vision of recovery has been introduced into, and since permeated, the principles, practices, and daily life of federal and state mental health authorities and many of the people and families they serve, as the New Freedom Commission's Report amply demonstrates. Given this reality, recovery could be taken either to represent an important, and previously unappreciated, dimension of treatment and rehabilitation that moves the field ahead (reason one) or to represent the latest in a series of

shibboleths which, if misused or misunderstood, could actually be detrimental to the field and to the people we serve (reason two).

Is there a way in which adopting the language of “being in recovery” from serious mental illness might move the field as a whole ahead? Based on the lack of consensus even within the consumer/survivor and rehabilitation literatures, arriving at a shared meaning of recovery will require an inclusive approach that necessarily defines the term in a open-ended way that allows room for various combinations of the dimensions reviewed in Table 1. An inclusive definition respects the principle that recovery is a unique process for each individual (Anthony, 1993). In order for this principle to impact practice, however, it will need to be operationalized in a way that goes beyond the simple, but difficult to achieve, notion of individualized treatment planning; a notion already accepted as a standard of care by the Joint Commission on the Accreditation of Healthcare Organizations and other regulatory bodies. What is new about recovery-oriented care cannot simply be its focus on the person as a unique individual, but must include a new vision of the goal and nature of care; i.e., what is to be considered possible for people with serious mental illness and what the person’s role can be in pursuing what is possible, given his or her disorder.

As we noted above, the alternative vision of recovery that emerges is closer to the vision put forth by people involved in the Independent Living Movement. By adopting this vision—in contrast to the stigmatized view of mental illness they inherited unwittingly—people with psychiatric disorders identify themselves as “normal” people who have disabilities as articulated, for example, in the Americans with Disabilities Act of 1990 (Davidson et al., 2001; Deegan, 1993). Having a psychiatric disability should in this way be no different from having any other form of disability, whether a mobility, visual, or auditory impairment. Within this perspective, people with any of these disabilities are still able to strive for a whole, meaningful, and gratifying

life *given* the assumption that their disability is going to be with them for an extended period, if not for the remainder of their lives.

Such a vision of recovery, which could be equally relevant to chronic physical conditions such as diabetes and paraplegia, represents a departure from current practice in at least two ways. First, it stands in contrast to the prevailing goals of treatment over the last half century that have been eradication of symptoms and illness and “maintenance” of the person in the community (Davidson et al., 2001). If one takes as an analogy for schizophrenia an illness like diabetes or a condition like paraplegia, it is easier to see how these goals fall well short of what the person with the illness or condition expects from life. As we noted above, it would not be reasonable to insist that a person with paraplegia regain his or her mobility in order to participate fully in community life. It is for this reason that we have cut curbs in our sidewalks and made public spaces and transportation accessible to wheelchairs. Similarly, we do not demand that adolescents be cured of their diabetes before they can learn to drive a car, or that adults with diabetes no longer need insulin in order to pursue their personal and professional aspirations. Extrapolated to mental illness, the principle becomes: people with psychiatric disabilities need not delay resuming a full life while waiting for their symptoms, deficits, or illness to disappear—while waiting, that is, to be cured. While remaining important, eradicating symptoms and remediating deficits become secondary to the person’s desire to reclaim his or her life in the community, especially when the illness resists all efforts toward eradication.

Second, with acceptance of a disability model of mental illness comes acceptance of the importance of the person’s environment. As disability is the product of person-environment interactions (NIDRR, 2003) strategies to promote recovery need to focus simultaneously on the individual and on his or her environment. Attending solely to the person’s symptom or functional

status in the absence of consideration of environmental influences (whether challenges or supports), for example, would be like teaching a person with a visual impairment to read Braille but then not posting Braille signs on elevators, doors, or other public spaces. While you might demonstrate in the first instance that the person can learn Braille, you would have done little to increase his or her participation in community life. Just as it is not reasonable for researchers to question if people with deafness need *either* to learn sign language *or* to have visual aids in their apartment to notify them when the phone or doorbell rings, it is not reasonable to ask if people with psychiatric disabilities need either treatment *or* environmental modifications. When the aim is not just to reduce or minimize dysfunction but to achieve community inclusion, it is no longer appropriate to continue such an “either or” approach. The most useful and appropriate question rather becomes “what *combination of supports* is required for this person to participate fully in community life?”

We have discovered in our own research that, within the context of persistent symptoms and dysfunction, this sense of recovery can be experienced at the concrete level of enjoying a glass of iced tea on a hot summer day or not having to eat one’s hamburger alone (Davidson et al., 2001a, 2001b). What such experiences offer the person is the sense that life can still be good, worthwhile, enjoyable, and/or meaningful because such experiences prove that there is more to my life than my disability. We suggest that appreciating that this is the perspective of the person in treatment or rehabilitation—regardless of whether or not it is shared by the clinician—does in fact alter care in a significant way. First of all, it introduces the notion that there is more to the person than his or her disorder, and that the person has needs, desires, and aspirations apart from minimizing his or her disability. In fact, from the person’s perspective the purpose of minimizing the disability is not only to decrease suffering but, equally important, it is to allow the person to

pursue his or her goals with as little interference as possible. Thus, when informed by the person's perspective on what she or he would like to be doing despite remaining disabled, the focus of the clinician's efforts shift from the symptoms or disability *per se* to the ways in which these difficulties are getting in the person's way. With the assumption that every person, no matter how disabled, will still find some experiences more worthwhile, enjoyable, or meaningful than others, this vision of recovery becomes universally accessible, with everyone being considered capable, to some extent and in some ways, of having a fuller life.

While belief in the universal potential for this form of recovery is in many ways preferable to the field's traditional pessimistic prognosis of chronicity, it is not without its own limitations. This leads to our second reason for grappling with the recovery literature. For example, if we are to embrace an inclusive definition that implies that all people *can* recover, it is possible that there will be increased social pressure on people that they *must* recover. In moderation, such a position may stimulate individuals, as well as the professionals who support them, to pursue normalized roles and activities. However, when this position is taken to an extreme it lends itself to abuse. People may be prematurely pressured to take up new challenges that are unrealistic in consideration of the limitations imposed by their illness (e.g., maintain competitive employment) or that might be inconsistent with their personal process of recovery (e.g., not everyone wants to assume a more active role in their service planning). An inclusive notion of recovery should not be abused in support of a "get tough" approach to service planning or to the rationing of entitlements. Rather, the concept should be applied in such a way that encourages, but does not mandate, regaining a meaningful sense of belonging in one's community.

In the end, Deegan (1996b) reminds us that our job is not to "judge who will and who will not recover. Our job is to establish strong, supportive relationships with those we work

with” in order to maximize their chances for recovery. At this point, we know that each person has a 50/50 chance of partial to full recovery even as narrowly defined by clinical research, but we cannot yet predict who will and who will not achieve this degree of recovery. Therefore—particularly given the field’s history of overly bleak pronouncements and the detrimental effects these have had on generations of individuals and families—the risk is considered too great *not* to believe in the potential of every person for recovery.

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