What Is Recovery? A Conceptual Model and Explication

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This paper describes a conceptual model of recovery from mental illness developed to aid the state of Wisconsin in moving toward its goal of developing a "recovery-oriented" mental health system. In the model, recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment, and connection—and external conditions that facilitate recovery—implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services. The aim of the model is to link the abstract concepts that define recovery with specific strategies that systems, agencies, and individuals can use to facilitate it. (*Psychiatric Services* 52:482–485, 2001)

The current notion of recovery from mental illness dates back to the 1980s, with the publication of a major study that demonstrated that the course of severe mental illness was not an inevitable deterioration (1) and of several first-person accounts by consumers who described their experiences with a diagnosed mental illness and how they had managed to emerge intact or recover (2–4). Mental health professionals drew on such accounts to formulate theoretical and practical models of recovery that could be adapted for use in psychosocial rehabilitation and other mental health services (5–9). In the 1990s, as states were faced with the challenge of reconfiguring their publicly funded mental health services according to the principles of managed care (10), recovery became a tool for guiding system reform in both policy and practice (11).

The use of the term "recovery" in these different arenas—outcomes research, personal narrative, services design and provision, and system reform—has led to confusion. 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.

The conceptual model of recovery described in this paper was designed for the purposes of education and self-assessment (12). It was developed by the first author under the aegis of the State of Wisconsin's recovery implementation task force, an advisory body composed of consumers, providers, advocates, and policy makers that has been charged with moving the state toward its goal of developing a "recovery-oriented" mental health system (13). The model aims to link the abstract concepts that define recovery with the specific strategies that systems, agencies, and individuals can use to facilitate it.

The model

In our model, the word recovery refers both to internal conditions—the attitudes, experiences, and processes of change of individuals who are recovering—and external conditions—the circumstances, events, policies, and practices that may facilitate recovery. Together, internal and external conditions produce the process called recovery. These conditions have a reciprocal effect, and the process of recovery, once realized, can itself become a factor that further transforms both internal and external conditions.

Internal conditions

An analysis of numerous accounts by consumers of mental health services who describe themselves as "being in recovery" or "on a journey of recovery" suggests that the key conditions in this process are hope, healing, empowerment, and connection.

Hope. The hope that leads to recovery is, at its most basic level, the individual's belief that recovery is possible. The attitudinal components of hope are recognizing and accepting that there is a problem, committing to change, focusing on strengths rather than on weaknesses or the possibility of failure, looking forward rather than ruminating on the past, celebrating small steps rather than expecting seismic shifts in a short time, reordering priorities, and cultivating optimism. Gaining hope has about it something of the transcendent. "A tiny, fragile spark of hope appeared and promised that there could be something more than all of this darkness. . . . This is

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the mystery. This is the grace. . . . All of the polemic and technology of psychiatry, psychology, social work, and science cannot account for this phenomenon of hope. But those of us who have recovered know that this grace is real. We lived it. It is our shared secret" (3).

The source of this grace is different for each individual. For one it will be the entity he or she knows as God. For another, it might be a spiritual connection with nature. Individuals not drawn to spirituality may find their grace in other sources, such as making art or contemplating philosophical issues. Hope sustains, even during periods of relapse. It creates its own possibilities. Hope is a frame of mind that colors every perception. By expanding the realm of the possible, hope lays the groundwork for healing to begin.

Healing. Consumers and professionals who accept the dictionary definition of recovery—to regain normal health, poise, or status—may resist the very possibility of recovery because they see it as an unrealistic expectation. However, it is important to remember that recovery is not synonymous with cure. Recovery is distinguished both by its endpoint—which is not necessarily a return to "normal" health and functioning—and by its emphasis on the individual's active participation in self-help activities. The concept of recovery is better captured by the notion of healing, a process that has two main components: defining a self apart from illness, and control.

As Estroff (14) has noted, people who have psychiatric disabilities often find that they lose their "selves" inside mental illness. Recovery is in part the process of "recovering" the self by reconceptualizing illness as only a part of the self, not as a definition of the whole. As consumers reconnect with their selves, they begin to experience a sense of self-esteem and self-respect that allows them to confront and overcome the stigma against persons with mental illness that they may have internalized, thus allowing further connection with the self.

The second healing process is control—that is, finding ways to relieve the symptoms of the illness or reduce the social and psychological effects of stress. For some consumers, medication is a successful strategy for effecting control. Another strategy is learning to reduce the occurrence and severity of symptoms and the effects of stress through self-care practices, such as adopting a wellness lifestyle or using symptom monitoring and response techniques (15,16)

The word "control" has a double meaning. In one sense it refers to the outcome of managing symptoms or stress. The second meaning, however, refers to the locus of control, or who

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has control. In recovery it is the consumer who has taken control, who has become an active agent in his or her own life. Control is an important factor in the next internal condition, empowerment.

Empowerment. In its simplest sense, empowerment may be understood as a corrective for the lack of control, sense of helplessness, and dependency that many consumers develop after long-term interactions with the mental health system. A sense of empowerment emerges from inside one's self—although it may be facilitated by external conditions—and it has three components. The first is autonomy, or the ability to act as an independent agent. The tools needed to act autonomously include knowledge, self-confidence, and the availability of meaningful choices. The second is courage—a willingness to take risks, to speak in one's own voice, and to step outside of safe routines. The third is responsibility, a concept that speaks to the consumer's obligations.

In the recovery model, the aim is to have consumers assume more and more responsibility for themselves. Their particular responsibilities include developing goals, working with providers and others—for example, family and friends—to make plans for reaching these goals, taking on decision-making tasks, and engaging in self-care. In addition, responsibility is a factor in making choices and taking risks; full empowerment requires that consumers live with the consequences of their choices.

Connection. Recovery is a profoundly social process. As consumers' accounts make clear, much of what is being recovered is a way of being in the company of others. The internal condition called connection captures the aspect of recovery that has to do with rejoining the social world—what some have called "getting a life." The ability to forge connections with others is both a result of hope, healing, and empowerment and a way to make these internal conditions possible.

To connect is to find roles to play in the world. These roles may involve activities, relationship status, or occupation. Many consumers report that the most powerful form of connection is helping others who are also living with mental illness. For some consumers, this means becoming a mental health provider or advocate; for others, it means bearing witness, or telling their own stories in public arenas. In all of these capacities, consumers increase the general understanding of what it is like to live with a mental illness. They find ways to validate and reconcile their own experiences, and by standing as living exemplars of the possibility of recovery, they serve as role models for others.

In yet another sense, connection is the bridge between internal and external conditions, allowing reciprocal action between the two.

External conditions

The external conditions that define recovery are human rights, "a positive culture of healing" (17), and recovery-oriented services. On the surface, these three conditions seem quite different. Human rights denotes a broad, societal condition; a positive culture of healing refers to the cultural milieu in which services are offered; and recovery-oriented services are the actual services provided. It is important to recognize, however, that these three conditions are simply different foci viewed through the same lens. That is, implementation of the principles of human rights in an organization results in a positive culture of healing, and recovery-oriented services are services that emerge from such a culture.

Human rights. In its broadest sense, a human rights agenda lays out a vision of a society in which power and resources are distributed equitably. When applied to mental illness, human rights emphasizes reducing and then eliminating stigma and discrimination against persons with psychiatric disabilities; promoting and protecting the rights of persons in the service system; providing equal opportunities for consumers in education, employment, and housing; and ensuring that consumers have access to needed resources, including those necessary for sustaining life (adequate food and shelter) as well as the social and health services that can aid recovery (physical, dental, and mental health services; job training; supported housing; and employment programs).

This human rights agenda allows for different perspectives and different types of activism. It can be used to advocate for the reduction and ultimately the elimination of involuntary commitment and other forced treatment, which many view as violations of human rights, or it can be used to campaign for parity legislation and universal health coverage. In this formulation, equal opportunity is promoted through expanded access to care and services that might otherwise be restricted by poverty, stigma, or the law itself.

A positive culture of healing. Fisher (17) has written of the need to "build a coherent social faith and order" as a way to promote recovery. He described this new order as "a positive culture of healing . . . a culture of inclusion, caring, cooperation, dreaming, humility, empowerment, hope, humor, dignity, respect, trust, and love." When applied to the culture of a human services organization, this vision of a positive culture of healing begins with an environment characterized by tolerance, listening, empathy, compassion, respect, safety, trust, diversity, and cultural competence. A healing culture is oriented toward hu-

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man rights for all individuals and groups. Consumers' rights are incorporated into all decisions, and informed consent is part of the bedrock of daily practice.

In a positive culture of healing, professionals as well as consumers are empowered and engaged. For providers, empowerment means first believing that they can make a difference and then making a commitment to changing the way they conceptualize the course of mental illness and the way they practice. Providers must embrace the belief that every consumer can achieve hope, healing, empowerment, and connection, no matter what his or her current status. This belief must lead them to focus on the person, not the illness, and on his or her strengths and goals.

A key component of a positive culture of healing is the development of collaborative relationships between consumers and providers. In contrast to a hierarchical model of service provision, the collaborative model allows consumers and providers to work together to plan, negotiate, and make decisions about the services and activities the consumer will use to support his or her recovery. Collaboration implies that the consumer is an active participant, that he or she is presented with a range of options and given the opportunity to choose from among them, and that providers allow the consumer to take some risks with these choices. Consumers have the opportunity to make choices other than those the provider might have made for them.

Finally, a true collaborative relationship is one in which both consumer and provider come to see each other as human beings. For providers, this means learning to see beyond the diagnostic—or racial, ethnic, and socioeconomic—categories they have been trained to use and rethinking "boundary issues" so they can allow themselves to relate to consumers on a human level.

Recovery-oriented services. The Boston University Center for Psychiatric Rehabilitation has developed a model for designing recovery-oriented services (5,7). The model delineates four major consequences of severe mental illness—impairment, dysfunction, disability, and disadvantage. Recovery-oriented services address the range of these features and include services directed at symptom relief, crisis intervention, case management, rehabilitation, enrichment, rights protection, basic support, and self-help.

A second model, developed by the Ohio Department of Mental Health (18), describes the best practices to be implemented by consumers, clinicians, and community supports at four different stages of the mental health recovery process. The practices encompass clinical care, peer and family support, work, power and

control, stigma, community involvement, access to resources, and education. A third model (19) offers practice guidance within "a framework for designing, implementing, and evaluating behavior healthcare services that facilitate individual recovery and personal outcomes." Using the overarching metaphor of "a healing culture," this model addresses such issues as language, dignity and respect, empowerment and personal responsibility, consumer and family involvement, challenging stigma and discrimination, reflective practice and continuous improvement, cultural sensitivity and safety, and spirituality and personal meaning.

Each of these models integrates services provided by professionals, services provided by consumers, and services provided in collaboration. Services provided by professionals include medication, psychiatric rehabilitation, and traditional support services such as therapy and case management. The recovery orientation in these services lies in the attitudes of the professionals who provide them. For example, decisions about medication are worked out in a partnership between the provider and the consumer, rather than being dictated by the provider.

Consumer-run services are planned, implemented, and provided by consumers for consumers. Examples include advocacy, peer support programs, hospitalization alternatives, hotlines or "warm lines," and programming that provides opportunities for role modeling and mentoring.

Collaborative services are provided by and for both consumers and professionals as well as family members, friends, and members of the larger community and emphasize their diverse but complementary strengths. Examples include recovery education and training, clubhouse organizations, crisis planning, the development of recovery and treatment plans, community integration, and consumer rights education.

Although many of these services may sound similar to services currently being offered in many mental health systems, it is important to recognize that no service is recovery-oriented unless it incorporates the atti-

tude that recovery is possible and has the goal of promoting hope, healing, empowerment, and connection.

Conclusions

The reciprocal relationship between the internal and the external conditions of recovery has been implicit in the presentation of this model. For example, reducing social stigma will help reduce the internalized stigma that restricts the ability of some consumers to define a self apart from their diagnosis. Access to appropriate mental health services, including education, will provide consumers with the knowledge, skills, and strategies that can help them relieve symptoms and control the effects of stress. Collaborative relationships between providers and consumers will empower both parties, allowing meaningful power sharing and a more mutual assumption of responsibility. Peer support provides opportunities for bearing witness, a practice that allows the speaker and the listeners to establish new connections and validates the idea that recovery is possible.

Similarly, as more consumers recover, and as recovery becomes more firmly entrenched in policy and practice, internal and external conditions will be transformed. More consumers in recovery will provide more models of what hope, healing, empowerment, and connection might look like. More experience with and evaluation of recovery-oriented services will determine which of these services has the greatest influence on recovery. ♦

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