Recovery in Mental Illness: The Roots, Meanings, and Implementations of a "New" Services Movement

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The history of the care and treatment of the mentally ill in America for almost four centuries offers a sobering example of a cyclical pattern that has alternated between enthusiastic optimism and fatalistic pessimism. (Gerald Grob, 1997, *The Mad Among Us*, pp. 309)

INTRODUCTION

Moral treatment, moral hygiene, asylums, psycho-pharmaceuticals, community mental health, and community support: all have been heralded as positive new directions for the treatment of severe and chronic mental illness. But the reality of all of these models has fallen short of providing a permanent solution or even the ideal support for treatment. Some have come to be seen in the long run as actually harmful with people with serious mental illness. It was against this backdrop of unsatisfactory, incremental, and unintentional consequences — what Frank and Glied (2006) called “better but not well” in the US context — that the movement of “recovery” has taken root modern mental health services.
"Recovery" for in the field of mental health services is actually a complex of ideas—but I propose it can be understood most simply as hope that someone, particularly someone in the throes of suffering acutely from a serious and persistent mental health problem, can reclaim their life or create a newly meaningful one. "Recovery-oriented" systems of care, then, are those that help rather than hinder that individual in their "recovery." But admittedly, that broad brush fails to captures what the range of meanings that "recovery" in the context of mental illness means and has meant to different actors—individuals with mental illness, family members, service providers, and policy makers—over time. Hopper offers another start: "If a provisional consensus may be hazarded, it would read something like this: recovery is difficult, idiosyncratic, and requires faith—but it is possible" (2007: 870, emphasis added).

But how do concepts such as "hope" and "faith" fare in a mental health service system? How do these concepts become embodied in the interaction between provider and individual? How do these concepts become institutionalized and embedded in a system of care marked with disappointment, lack of resources, disorganization, and invisibility? What happens if these terms and movements are co-opted or fail to take root? And what if Grob’s historical view of the pendulum swings from enthusiastic optimism to fatalistic pessimism proves prophetic—and this is just the moment before the plunge?

The impact of major reform movements in mental health services, such as deinstitutionalization (Brown, 1985; Jones, 1993), community care in Britain (Rogers and Pilgrim, 2001) and the even the serendipitous origins of psychopharmacology (Healy, 2002) reveal that shifts in treatment can have profound effects at individual, family, institutional, and state levels. The movement toward "recovery" and "recovery-oriented services" has already had some impact on the direction of recent mental health policy in the United States (Department of Health and Human Services, 2003) and England (Department of Health, 2001, 2004) and research (Lieberman et al., 2008). The challenge this concept "recovery" presents to individuals to understand serious mental illness differently is one important matter, but so too is the challenge the idea’s promotion has had on individual and organizational practices and structures of care in a changing fiscal, policy, and scientific environment.

The focus of this chapter is on the organizational field of mental health services. The purpose is not to define "recovery"—as many have attempted this already and the definition continues to change and be debated (Bellack, 2006; Davidson and Roe, 2007; Hopper, 2007; Jacobson and Greenley, 2001; National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation, 2004; Noordsy et al., 2002; Onken et al., 2007). Instead, it is to argue that recovery is a concept and movement in modern mental health services. To that end, this chapter will present a brief history of the concept in the mental health services field, including a set of key (but not uncontested) definitions for recovery. It will also highlight the critiques, largely from within the movement and offer a brief description of the diffusion of
recovery-oriented services and some of the most relevant social science research on recovery.

Whether recovery is truly the “guiding vision” (Anthony, 1993), the “heart and soul of treatment” (Townsend and Glasser, 2003), “old wine in new bottles” (Davidson et al., 2005; Pilgrim, 2008), or it is just another pendulum swing up to the “enthusiastic optimism” that Grob (1997) warned about, the concept’s diffusion throughout the field marks an important moment in modern mental health services. This movement has different implications for the different cultural and material environments it enters. While this chapter focuses on the US context, it will also briefly discuss how the concept of recovery has been received in several other contexts, such as the United Kingdom and Australia.

A BRIEF HISTORY OF "RECOVERY" IN THE MENTAL HEALTH SERVICES FIELD

There is nothing new about the term “recovery” for people with mental illness. The term has been used for many years to refer to a remission or reduction of symptoms. In 1937, Abraham Low, a psychiatrist working in state mental hospitals in Illinois founded a group called “Recovery, Inc.” devoted to structured self-help groups to provide “after-care” for recently discharged hospital patients. Recovery, Inc. focused on reducing “relapses” through social coping skills, goal-setting, and increasing self-confidence. While Low’s original organization failed to gain acceptance in the larger research and treatment community and was dissolved, it was reborn as a peer-led group model (Low, [1991] 1943) that still exists today.

However, the roots of a concept of recovery – if not the term – have been traced back to over 200 years ago to Philippe Pinel and his traitement moral in Paris asylums (Davidson et al., 2010). And certainly the concept of recovery is familiar from the field of addictions treatment (Davidson and White, 2007). Yet, at some points in recent history, recovery was, for some seen as impossible. In the case of schizophrenia, even the clinical definition asserted a declining course and a permanent state of illness – such as in Emil Kraepelin criteria for “dementia praecox.” Remission or recovery was seen as prima fascia evidence that the illness had not been dementia praecox. Eugen Bleuler, who challenged this diagnosis and renamed this condition “schizophrenia” in part to remove the connotation with dementia, also challenged the chronicity of the problems, recognizing that people diagnosed with it could get better.

This early dispute is often cited in the literature about recovery (Bellack, 2006; Corrigan et al., 1999; Jacobson, 2004; Lieberman et al., 2008). In addition, several longitudinal studies of the outcomes of individuals who had been institutionalized or diagnosed with schizophrenia suggested that a large percentage, perhaps a large majority, of individuals were improved after a period of time, particularly in the area of remission of symptoms (Bleuler, 1974; Harding et al., 1987;
The concept of recovery in mental health services is often less concrete and posits a more expansive view of the possibilities for individuals than the outcomes investigated in these studies (e.g., symptom reduction, decreased medication usage, living independently, working, etc.). However, as studies showed evidence that improved quality of life in some key life domains was possible, they provided an "evidence base" of recovery and had a particular meaning to researchers who sought to promote the ideological concept (Jacobson, 2004).

In one of the first and most cited articles about recovery, clinical psychologist, and advocate Patricia Deegan (1988) wrote a first person account of her illness and recovery experience and argued that recovery is different from psychosocial (or psychiatric) rehabilitation. Rehabilitation, she argued, is about services and technologies, but "recovery refers to the lived or real experiences of persons as they accept and overcome the challenge of the disability" (1988: 7). Early first person accounts had a strong influence on the direction researchers went with their recovery writing and pushed beyond the traditional concepts of symptom reduction, independent living, treatment utilization, and employment that were hallmarks of psychiatric outcomes work.

Themes that emerge from Deegan's work, and that three other notable first person accounts of recovery from mental illness – Marcia Lovejoy (1982), Esso Leete (1989), and Rae Unzicker (1989) – include hope, acceptance, engagement in social life, active coping, and reclaiming a positive sense of self (Ridgway, 2001). First person accounts such as these became the basis for establishing a definition of recovery, and even now comprise a large basis of research for recovery researchers and for seeing recovery as a unique "journey" into finding purpose in one's life (Davidson, 2003; Deegan, 2003; Mead and Copeland, 2000; Ridgway, 2001; Roe and Lachman, 2005; Wisdom et al., 2008).

It would not be long before researchers and providers were also promoting the concept of recovery. After publishing a short piece addressing the topic in 1991, William Anthony, a psychologist and director of the Boston University Center for Psychiatric Rehabilitation, returned to the topic wrote the recovery "call to arms" in the mental health services literature (1993). In this he outlined both the "vision" of recovery that would guide services in the years to come and what a recovery-oriented system would look like. Recovery is:

> a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (1993: 527)

Anthony asserts that "(r)ecovery is what people with disabilities do ... Recovery is a truly unifying human experience" (1993: 527–528). Recovery, according to Anthony, is multi-dimensional, defying simplistic measurement. However, he laid out a set of assumptions to which providers in a recovery-oriented system of care should adhere: recovery happens with or without treatment; it requires social
support; it is independent of etiological beliefs about illness; and it can continue even if symptoms re-occur (i.e., recovery being a “non-linear process”). For Anthony, recovery is unique to each person, requires that the person have choices about their situation, and must also take place in a social context in which recovery from the consequences of the illness (such as stigma) can be harder to overcome than the mental health problem. Recovery-oriented services would not just rely on more traditional activities such as treatment, crisis intervention, case management, and rehabilitation, but would also seek to enrich lives, protect rights, and enable basic support and self-help.

Anthony’s work is still highly cited, even though the effort to find a commonly accepted definition of recovery has so far been elusive, even by those quite motivated to promote and carry it out in services (e.g., Clay et al., 2005; Davidson et al., 2005). Several comprehensive reviews and proposed reformulations have been attempted (Bellack, 2006; Corrigan and Ralph, 2005; Jacobson, 2001; Jacobson and Greenley, 2001; Lunt, 2002; Noordsy et al., 2002; Onken et al., 2007; Ralph, 2000; Roe et al., 2007). But there is broad agreement among those who study recovery is that the notion is subject to much “confusion, dialogue, and debate” (Davidson et al., 2006: 6) and that “(l)ike mental illness itself, the notion of recovery represents a multidimensional set of phenomena which may share nothing more than a Wittgensteinian sense of ‘family resemblance’” (Davidson and Roe, 2007: 460).

Two often cited distinctions that appear in the literature are “recovery in” vs. “recovery from” (Davidson and Roe, 2007) or to internal vs. external processes in recovery (Jacobson and Greenley, 2001). Davidson and Roe distinguish between the meaning of recovery “from” mental illness as a more symptom-based remission type of return to function, whereas recovery “in” mental illness can refer to moving ahead with life even as symptoms persist and functions are not returned. Jacobson and Greenley (2001) refer to the “internal” components of recovery, such as hope, attitudes, experiences and processes of individual change, whereas “external” conditions – such as material circumstances, services, policies, practices, can aid or hinder the process. These themes are echoed again and again as researchers attempt to clarify the meaning of recovery.

Recovery in the United States

In the United States, the banner of recovery was seen as an opportunity for common ground for individuals with mental illness and providers (Frese, 1998). It was lauded as a goal for individuals and for systems in the 1999 Surgeon General’s Report (Department of Health and Human Services, 1999). Two of the more influential recent definitions came from high profile public reports on the “transformation” of the mental health systems, one from President George W. Bush’s New Freedom Commission on Mental Health (New Freedom Commission on Mental Health, 2003) and the other from the Substance Abuse and Mental Health Services Administration (SAMHSA)’s National Consensus
Statement (2004). In the New Freedom Commission report, recovery was a central organizing concept:

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual’s recovery. (2003: 5)

Shortly after, the US Substance Abuse and Mental Health Services Administration (SAMHSA) produced a “consensus statement” that defined recovery as “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.” The consensus was reached after a series of reports and paper on topics surrounding recovery was commissioned and over 100 stakeholders in mental health service providers – individuals with mental illness, family members, academic researchers, providers, government officials, etc. – worked to find agreement on the meaning. The consensus statement also identifies ten “dimensions” of recovery: self-direction, individualized and person-centred, empowerment, holism, non-linearity, strengths-based, peer support, respect, responsibility, and finally, hope (National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation, 2004).

Critiquing the concept of recovery

Even among supporters for the concept of “recovery” in the mental health services field, some have pointed out that studying recovery is a problem for scientists because it can become overly broad and meaningless (Roe et al., 2007). While arguing for understanding that would draw from economist and philosopher Amartya Sen’s capabilities approach, Hopper described the current state of affairs of the concept of recovery a “co-opted, near-toothless gospel of hope” (2007: 877). He noted the lack of contentiousness about the varied meanings reflect “working misunderstandings” of the meanings and values attached to the concept (2008: 307). Pilgrim (2008, 2009) makes a similar argument about the “polyvalent concept” of recovery and argues that ethnographic study of the concept is needed to untangle meanings and enactments lest these misunderstandings continue. Others have argued recovery could be in some instances a veiled attempt to further cut services or to leave behind those in most need in the name of reaching an elusive goal (Dickerson, 2006; Johnson, 2005). Peyser (2001) warned that it could actually harm individuals by interfering with treatment goals of symptom reduction. As the call for recovery-oriented services was (and still is) happening alongside managed care reforms and calls for the “transformation” of US mental health services, Jacobson and Curtis (2000) note that recovery could be co-opted as a concept and left without content.

The moving target of the definition, coupled with the difficulty of pinning down concepts as “hope” and “unique processes,” have led to frustration and
scepticism and some suggestion that recovery ought to be rooted in “objectively measureable” functional criteria focused on symptom reduction and remission (Bellack, 2006; Liberman et al., 2002; Roe et al., 2007). This is a direct challenge to the view that recovery is not about symptoms or functional improvement. However, the focus on functional remission may serve as a de facto answer for researchers frustrated with concepts too difficult to operationalize. Liberman and Kopelowicz (2005), for instance distinguishes between the “process” and “outcome” of recovery. A recent special issue of Schizophrenia Bulletin (see Essock and Sederer, 2009) published a series of seven reports on measurement of “functional recovery.” The focus of this “functional recovery” that it is focused more on an individual’s ability to be able to perform daily activities (such as self-care and work) and be integrated into social life.

Leiberman et al. (2008) suggests that in order for it to be a useful heuristic, recovery should be qualified with the domain of life in which it is achieved – such as “recovery of vocational function” or “recovery of cognitive function.” This account of a way to pull together neuroscience and psychiatry with the recovery movement allows the focus to stay on more traditional issues of symptomatology and “acknowledges” but does not address the other issues of living so close to the recovery movement: “civil rights, stigma, housing, vocational opportunities, and other community issues” (Leiberman et al., 2008: 488). Some within the movement have also argued that recovery as a term suggests going or looking back to a previous, perhaps mythical “state of health,” whereas the true goal should be moving forward. Advocate Kathleen Crowley has termed this idea “Procovery” (Crowley, 2000) and has developed a set of trainings for providers and individuals and “Procovery Circles” that function like peer-led support groups.

But the component parts of recovery remain difficult to measure. An effort by European researchers to review the literature for the use of the concept of “hope” found 49 different definitions and 32 different measurement tools (Schrank et al., 2008). In an era of increased interest and demand for evidence-based practices in mental health services, some have questioned (Browne, 2006) whether recovery can be be appropriately tied to outcomes, while others have said that it can and should be done (Anthony et al., 2003; Frese et al., 2001). Tanenbaum (2006) identifies the tensions between the tenets of evidence-base practice (EBP), so heavily dependent on randomized control trials and experimental methods and aggregate results, and the tenets of recovery, so focused on individualized and self-determining recovery goals. In short, she argues that recovery demands a new standard for EBP studies, one that involves individuals with mental illness in the meaning making of research framing and interpretation.

It is important to note where in the mental health services literature rigorous discussion has been taking place. Discussion and disagreements about the meaning of recovery in the psychiatric/psychosocial rehabilitation and community mental health journals have been answered with a more muted critique – even silence – from the larger clinical psychiatric and psychological community. For instance, a recent working group of prominent psychiatrists and neuroscientists
considered criteria for remission of schizophrenia and came up with some significant changes, but explicitly avoided engaging the criteria for recovery, as the concept is underspecified and reflects "ongoing multidisciplinary efforts seeking to incorporate the viewpoints of patients, caregivers, and clinicians, as well as an evolving appreciation for the relationship between improvements in symptoms, cognition, and functionality" (Andreasen et al., 2005: 442). The relatively supportive language about the potential for recovery as a concept—if only it can be more clearly specified—belie a larger silence by some of the most prominent journals in the fields of clinical psychiatry (such as the Archives of General Psychiatry, Journal of Clinical Psychiatry, and the American Journal of Psychiatry) or clinical psychology (such as Psychological Medicine, or the influential Annual Review of Psychology or Annual Review of Clinical Psychology) about anything other than a functional recovery outcome measure (far more akin to a remission paradigm). One exception to this is the British Journal of Psychiatry, which has published a number of pieces taking the issue head-on (Dickens, 2009; Dinniss, 2006; Lester and Gask, 2006), perhaps reflecting a different national response to the concept (discussed more below). In the United States, academic discussion has been largely relegated to journals that are focused on services research (Psychiatric Services, Journal of Psychiatric Rehabilitation, and Community Mental Health Journal) and the more narrowly focused journal, Schizophrenia Bulletin (which, not coincidentally, published some of those early first-person accounts (Leete, 1989; Lovejoy, 1982) that came to influence the concept's development.

As George Bernard Shaw wrote, "Silence is the most perfect expression of scorn" and this quiet could portend a larger battle for this community of service researchers to have the idea of recovery, with its messy multiple constituencies, recognized in larger academic circles. This silence in the broader community, after a 20-year history of writing high profile policy involvement, and the emergence of new treatment models, speaks volumes of the "fractiousness that has yet to face the fact" (Hopper, 2007: 307). Sociologists would do well to pay attention to these cleavages—as they reflect long-standing divisions in the treatment and research of mental illness within psychology and psychiatry—between medical and social understandings of illness.

MARCHING AHEAD: "RECOVERY-ORIENTED SERVICES"
IN AN AGE OF "EVIDENCE-BASED PRACTICES"

As recovery has gained currency, so have efforts to tie specific models of treatment to it. Davidson defined recovery-oriented services as those that emphasize the shared decision making of individual and provider (Davidson et al., 2009). Psychosocial, or psychiatric, rehabilitation models, which emphasize goal setting, skill-building and community integration were a welcome home for recovery principles (Lamb, 1994; Stromwall and Hurdle, 2003; Taylor and
Yuen, 2008). One of the field's leading journals, *Psychiatric Rehabilitation Journal*, (founded and edited by Anthony), has become central for publications on recovery. The connection between the field of rehabilitation and recovery is an early one with Anthony's involvement and Deegan's warning in 1988 that rehabilitation was not synonymous with a recovery-oriented approach. The United States Psychiatric Rehabilitation Association, the field's professional certification organization, has adopted recovery language in its mission statement and recovery-oriented services as a center point in its training efforts.

The concept of recovery has focused on new individual service models, practices, types of actors, and the interaction between care providers and those they work with. Simultaneously, there has been an interest in developing and implementing evidence-based practices (analogous to the evidence-based medicine movement in general health research). How to square the goals of evidence-based practices with the more subjective terms of recovery has been the subject of much discussion (Anthony et al., 2003; Bellack, 2006; Farkas et al., 2005; Fisher and Ahern, 2002; O'Connor and Delaney, 2007; Tanenbaum, 2006). Frese et al. (2001) suggests that recovery-based models of treatment (those that emphasize more choice, empowerment, and regaining control of one's life) would be more appropriate when the individual is experiencing less severe symptoms of illness and is not as highly impaired in their decision-making ability. A more evidence-based medical model approach could be appropriate when individuals are more impaired. Frese et al. points out that among activists, support for "recovery-oriented services" vs. "evidence-based practices" varies along a continuum of severity of illness for which the activists advocate. This illustrates a tension between functional remission (recovery "from") and personal journeys of recovery (recovery "in").

One identified evidence-based practice that is explicitly tied to recovery movement and stresses empowerment of individuals is "Illness Management and Recovery" (Mueser et al., 2002; Roe et al., 2009). Illness Management and Recovery is a structured program for providers that encourages them to work in concert with individual consumers/users to plan for and pursue individual goals. It stresses educating individuals about mental illness, about the "stress vulnerability model" and how to reduce their chances of stressful circumstances that could lead to relapse. Individuals are also walked through steps to build their own social support networks, counselled about their medication use, and to navigate the mental health system.

Deegan, in attempting to address some of the problems that individuals face when they talk to their providers about their medication use, has introduced "CommonGround" (Deegan et al., 2008). This model offers a web-based software package to help individuals talk more openly about their psychotropic (and other) medication usage with their doctors. An individual would use CommonGround, which asks questions about usage, side effects, and other issues involving medication, before seeing their provider. They would also be prompted to share information with their doctor about their "personal medicine,"
(Deegan, 2005) or non-pharmaceutical techniques, like walking or gardening, they use to gain relief from their problems. This intervention, still in the pilot stage, is one of many efforts to foster collaboration between individuals and their providers and to provide a more “recovery-oriented” approach to care.

But the recovery movement has also advanced the creation of a new category of professional caregivers – that offered by peers who also have mental illness who then are trained to work with others (Clay et al., 2005; Corrigan et al., 2005). Peer support is nothing particularly new – recall Low’s reliance on peers in the late 1930s for his Recovery, Inc. and the emphasis on peer-run support programs such as clubhouses and advocacy organizations (Clay et al., 2005). But, the new emphasis on training and certifying peers (“Peer Recovery Support Specialists”) to provide mental health services to other individuals, has added a new professional category for individuals with mental illness (or their family members). Special certification programs (at the Institute for Recovery and Community Integration, for instance), special billing codes for services, and a national professional organization (the National Association of Peer Specialists, Inc.) have developed. Certification as a peer specialist depends on an individual’s identity as someone diagnosed with a mental illness, but other identity-based professional statuses are available. In Florida, for instance, certification is available as a “peer,” as a “family peer” and as both.

One of the motivations behind peer support as recovery-oriented services hearkens back to advocate demands for more involvement in the treatment system by individuals affected with mental illness. But there is also Deegan’s concept of the contagiousness of hope (1988) – that by modeling recovery, peers can provide inspiration to others to pursue their own goals.

**CONCORDANCE AND CONTRASTS: RECOVERY IN NON-US CONTEXTS**

The discussion above is not to suggest that recovery is a conceptual product or discovery of the United States (indeed, international scholars are engaged in discussions with US scholars cited above). The concept of recovery has a much longer history, crossing many eras and national borders (Davidson et al., 2010). It is perhaps more appropriate to talk about the “rediscovery” of recovery (Ramon et al., 2007). But as others have noted (Allott and Loganathan 2002; Ramon et al., 2007), the influence of some US (and New Zealand) researchers and policy makers has been felt in the United Kingdom, particularly through policy documents, such as those from the Ohio Department of Mental Health, and through specific recovery approaches, such as the Wellness Action Recovery Plan (Copeland, 1997[2002]).

However, the modern recovery movement met a somewhat different set of circumstances when it began to be recognized and written about in the UK. It meshed with the political agenda of “social inclusion” in welfare policies since
New Labour came to power in 1997 (Ramon et al., 2007) and with a more general focus on lay-lead self-management of chronic physical and mental conditions (Davidson et al., 2005). The meaning of that social inclusion rhetoric has been questioned by some (Pilgrim, 2008; Rogers and Pilgrim, 2001), as they note the concurrent fascination with “risk management” of individuals with mental illness. While social inclusion is a clearly stated goal of many US policy documents, it is clearly not a central focus of most recovery work – which is far more focused on individuals. Appealing to Amartya Sen, some US researchers (Hopper, 2007; Ware et al., 2008) have called for a reconceptualization of recovery from a capabilities approach and social model of disabilities approach – yet another example of the border-crossing of ideas.

Similar to the “transformation” effort of the United States, mental health services in the UK have also been the subject of a decade of concerted transformation efforts begun in 1999 called the National Services Framework. This framework, while ambitious and underfunded, has been focused largely on deinstitutionalization and a community support model (Department of Health, 2001; Sainsbury Center for Mental Health, 2003). Ramon et al. (2007) declare it a largely unimplemented process, with few clear guidelines for seeing it through. Throughout Britain and Ireland there are varying degrees of implementation. Ireland, for instance, has only recently begun to address recovery in policy documents (Kartalova-O’Doherty and Doherty, 2010), whereas Scotland has already developed and begun implementing its own recovery indicator tool – based on one developed in New York State – and has made a concerted effort to train peer recovery specialists (Scottish Recovery Network, 2005; Slade, 2009).

Australia, as Ramon et al. (2007) points out, might not have been using the term “recovery” in policy documents until 2003, when it was addressed as a core concept in the National Mental Health Service Plan. But as early as 1989, language that echoed central tenets in most recovery definitions – optimism for improvement and the importance of involving people with mental illness in their own treatment planning process – were central to Australian national policy. There, recovery oriented work is being pushed largely by consumer/service user groups, and is largely housed in a somewhat separate psychosocial rehabilitation system heavily influenced by consumers/service users. This stands outside the more “clinical” approach of most public mental health clinics (Ramon et al., 2007).

While Anglophone researchers and writers of recovery often refer and even import work from other national contexts, the conceptual flexibility can mean important differences are lost. This international diffusion of ideas and practices deserves attention.

**CONSIDERING RECOVERY IN THE SOCIAL SCIENCES**

Some sociologists have already begun addressing recovery and recovery-oriented services and the impact they could have on individuals and mental health systems.
Nora Jacobson’s articles (Jacobson, 2001, 2003; Jacobson and Greenley, 2001) and book length treatment on recovery efforts in the state of Wisconsin (2004) is expansive in its scope and places recovery in the US federalist context. In an effort to understand the definition, process, and consequences of recovery in mental health services, she (2004) deconstructs the various usages of the term recovery and identifies five key meanings: evidence, experience, ideology, policy, and politics. These “recovery-as” meanings each operate at different levels and convey different meanings about what recovery is.

Jacobson parses the various definitions of recovery that mental health stakeholder draw upon. “Recovery-as-evidence” refers particularly to the growing understanding by mental health service researchers that individuals with serious mental illness could, and did, in fact get better over time and see a remission of symptoms. “Recovery-as-experience” drew meaning from the lived experiences and narratives of those with mental illness, and drew more from a political and social-disabilities based understanding of the individual embedded within a social context. “Recovery-as-ideology” drew from the two previous wells of meaning and crafted a new stream of research and writing about how providers and services ought to be organized to support recovery. “Recovery-as-policy” developed as policy-setting bodies (like state governments) tried to make sense of this new emphasis to translate it into policy and practice. “Recovery-as-politics” is the ongoing process of how to deal with the consequences of the movement in light of other realities, such as constricted finances, more calls for evidence-based practices, and peer involvement in the provision of treatment.

Jacobson (2004) poses seminal questions about the consequences of recovery: what will a recovery-oriented system looks like, who benefits, how it will be compatible with other system changes, and how its success or failure will be evaluated? Further, who will have the right to evaluate success? As she noted earlier (Jacobson and Curtis, 2000), the questions start as questions of epistemology and end with questions of policies and values.

Others find different sets of meanings and interest groups. Pilgrim (2008, 2009) cautions that recovery is a “polyvalent concept,” and using Britain as a case study, finds it to have at least three distinct and sometimes contradictory meanings. In one, it refers to a notion that biomedical psychiatric biological recovery from illness is possible – a direct contradiction to the Kraepelin pessimism of a declining course. A second meaning, held by those providers offering a social skills or rehabilitation approach, takes another optimistic view of the course of illness from a different philosophy of treatment. A third, what Pilgrim refers to as the “dissenting service user” approach is a more social model of recovery, focused on empowerment and autonomy, sometimes in opposition to the oppressiveness of treatment regimes. These three meanings, all operating under the same banner of recovery, can be used simultaneously or individually, but can mask critical ontological positions and make meaningful policy consensus precarious or impossible.
Other sociologists have taken interest in recovery – particularly as an outcome. For instance, one group of researchers (Link et al., 2001) have taken a sociological approach to understanding how stigma can impede recovery and found that experienced stigma impacts later self-esteem measures. Relatedly, Markovitz (2001) has approached recovery from the outcomes perspective, and has proposed a recovery model that incorporates symptoms, self-concept, and life satisfaction as all reciprocally related to one another in the lives of individuals with mental illness. Finding support in his work for both a social stress/social support argument that social circumstances contribute to illness and to medical/psychiatric view of symptoms causing social distress, Markovitz concludes that that treatment that incorporates both symptom management and social and vocation skills training are key to being “recovery-oriented.”

Echoing (but not drawing from) Jacobson and Greenley’s (2001) distinctions of “internal” vs. “external” conditions for recovery, Yanos et al. (2007) argue that sociologists understanding of both structure and agency can be enhanced by paying attention to the ways in which individual choices and constraints and collective action can reconfigure social structures and enhance or inhibit recovery for individuals. Individual actions, such as coping and goal-setting coupled with structural transformation through collective political action, can increase individuals’ abilities to recover. Both social structure and individual agency become critical considerations when considering recovery, a task made no easier when outcomes for individuals are often considered outside a structure/agency framework, and rather a function of biology and of symptomatology.

With an explicitly political economic take on recovery, Warner (1994) argues provocatively that recovery from schizophrenia is tied to socioeconomic conditions. Oppressive economic conditions create stressors for people who then suffer disproportionately when economic conditions keep them from resuming meaningful adult social roles (such as employment) or from enjoying basic necessities (such as secure housing and food). Furthermore, systems of care that do not ameliorate stress on caregivers and families leave individuals adrift and socially isolated, stressed further.

All of these arguments about the nature of recovery, particularly as they impact the individual are important. However, there is a further set of questions about what recovery suggests for the future of the mental health service system, and how it is organized that are only now beginning to be answerable. What, for instance, does it mean when the meaningful and unique personal journey of recovery is a valued concept by researchers and providers, but remains so illusive in definition and measurement? What does this portend for policy choices? What happens when “recovery” meets a policy environment interested in enacting performance-based standards and “transformation” (in the United States). The literature on engaging recovery and evidence-based practices begins to suggest that there is no simple answer.
CONCLUSION: AGENDA FOR THE SOCIOLOGICAL STUDY OF RECOVERY

Brand new technologies and revolutionary ideas can rapidly displace old ways. But the history of mental health treatments reveals that many elements of care for people with serious mental illness – such as moral treatment, moral hygiene, asylums, psycho-pharmaceuticals, community mental health, and community support – do not simply appear or disappear, but rather wax and wane in importance, and get reinvented and rediscovered over time. Perhaps the concept of recovery will be something similar. While it has increased in prominence in rhetoric, policy, and services over the last two decades, the concept has a long history.

While it is clear that the rhetoric of recovery has permeated at least one corner of the modern mental health services field, that of rehabilitation, this material impact of this “guiding vision” is still unfolding. Certainly services have been challenged, efforts to change attitudes and outlooks are underway, and the diffusion of this idea and language has crossed many borders.

For a field that has been so active and fruitful in discussing the social construction of mental illness, few sociologists of mental health have taken on the flip: the social construction of recovery. It is time and we are well-equipped. For instance, sociology can and should explore further the provocative political economic research of Warner (1994) and the questions it raised. Sociologists of mental health have done excellent work in understanding how mental illness and stress is stratified, but paid less attention to how recovery from that same problem is also stratified. If we are to believe Warner, understanding this could point us to clear ways in which systems can be strengthened for the most vulnerable.

In addition, drawing the concept of recovery from the stories of the successful can draw on a rich history of the sociology of mental illness of identity research. In addition to the obvious contributions we can offer to understanding the lived experiences of people with serious mental illness who are recovering or are recovered, sociologists of mental health should attend to this social movement both inside and outside of research circles as it develops or withers. Who will win in this nascent dispute over whether outcome or process should come to represent recovery in the academic literature? Will recovery become another fad of the mental health services literature and fade away, or will it have staying power as it is ingratiated into treatment models and policy statements? What impact does this recovery have on traditional social pressures such as stigma? And finally, who “recovers,” and who does not?

REFERENCES


