Recovery as the New Medical Model for Psychiatry

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Treatment grounded in recovery principles is often viewed as not being based on the "medical model." In this Open Forum the author asserts that recovery from mental illness is entirely compatible with concepts of recovery from medical illness and with new approaches to medical treatment. Three ways of conceptualizing recovery are defined: clinical recovery, illness management, and personal recovery. Basing treatment on recovery principles is supported by research that has shown significant remission rates over time among persons with schizophrenia. The author uses examples of public figures and of one family with physical disabilities to illustrate the progress society has made toward accepting and including people with physical illness and disability. Recovery-oriented mental health treatment parallels the move in other medical specialties toward person-centered care. A clinical approach to promote recovery is discussed. (*Psychiatric Services* 63:277–279, 2012; doi: 10.1176/appi.ps.201100248)

Recovery has been at the forefront of discussions of mental health for several years (1,2). The impetus for such discussions has been traced to the psychiatric rehabilitation movement and other social movements (3). From this perspective, recovery is not generally regarded as being grounded in the field of medicine; in fact, the recovery framework is frequently contrasted with the "medical model." However, this is a false dichotomy, because a recovery approach in mental health mirrors changes that have occurred in the wider field of medicine and in societal attitudes toward illness.

Recovery can be thought of as the new medical model for psychiatry. This Open Forum traces the roots of this new medical model in medicine, psychiatry, and in changes in societal attitudes toward illness and disability.

Recovery definitions follow models for other illnesses

Many ways of conceptualizing recovery from mental illness have been proposed. One framework includes three types of recovery from serious mental illness, corresponding with concepts of recovery applied to other chronic illnesses and disabilities.

The first type of recovery is cure, or remission of the illness, which has been called clinical recovery (4). The person is free of symptoms, can function well in work and relationships, and does not need medication or other treatment. Standardized remission criteria for schizophrenia have been proposed (5), as they have for other illnesses.

The second type of recovery, known as illness management (6), involves symptom control and long-term monitoring of the illness by both doctor and patient. This type of recovery is what physicians generally strive for in chronic illnesses such as hypertension, diabetes, and HIV disease. If the person takes medications faithfully, recognizes early signs of illness, and follows a treatment program, he or she can minimize exacerbations of the illness.

The third type of recovery, personal recovery (4), involves functioning at one's best despite ongoing symptoms of illness. This philosophy has been embraced by the disability rights movement, by cancer survivors, and by people with mental illness (7,8). Neither denying their illness nor defining themselves by it, people strive to get the most out of life in the face of continued symptoms. Anthony (9) described recovery in this sense as "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."

These three types of recovery are not mutually exclusive. When a person is in remission (clinical recovery) from any severe illness, he or she still needs to work on personal recovery, returning to work and other previous activities, and perhaps even relearning some activities if the illness was prolonged. Personal recovery is also important in illness management to help the person stay on track with treatment and focus on activities unrelated to taking medication that maintain mental health. Deegan (10) has termed these activities, which may include work, talking with friends, exercise, and other pursuits, as "personal medicine."

Recovery is grounded in research findings

Ten long-term follow-up studies of schizophrenia published between 1972 and 1995 indicated that people with this illness achieve significant clinical recovery over time (11). In

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these studies, people with schizophrenia were followed from ten to more than 30 years, and as many as a third were found to achieve remission of illness symptoms with no further need for medication. Roughly another third of participants in these studies achieved partial remission of symptoms and the ability to function in the community. Two more recent studies had similar findings (12,13). They showed that a subset of patients with schizophrenia does not appear to need lifelong medication treatment.

The populations in these long-term studies are different from samples in clinical research trials or clinical caseloads of patients seeking treatment. Findings from such studies paint a fuller picture of how people with schizophrenia fare over time because the studies follow people whether or not they are in treatment.

Recovery parallels changes in society

Miraculous cures tend to strengthen our belief in medicine and science. However, amazing stories of personal recovery from an illness help us believe in people's abilities. Examples of personal recovery from outside the mental health field show how far we have come as a society toward accepting and integrating people with physical illnesses and disabilities.

Helen Keller's childhood breakthrough in learning how to use sign language is well known. Keller later graduated from Radcliffe, wrote several books, and became an antipoverty activist and an advocate for women's suffrage. When Franklin Delano Roosevelt became paralyzed at age 39, it seemed that his political career was over and that he would face a life of dependence. Roosevelt defied these expectations, becoming the longest-serving U.S. president. Yet he was able to do so only by hiding his inability to walk and stand unassisted, often through great personal effort. Keller remained blind and deaf and Roosevelt remained paralyzed, but both transcended their disabilities to achieve great things. They did not reach clinical recovery, but their stories provide excellent examples of personal recovery from physical disability.

One family's case further illustrates generational attitudes about physical illness. Alice, who is now 70 years old, grew up in a Southeastern city. When her Uncle Bobby was eight, he was hit in the head by a baseball, causing permanent weakness in his right foot and hand. Bobby's parents kept him hidden in the house after his accident. They schooled him at home and kept him isolated from his former friends. Alice recalls that when her family visited Uncle Bobby's parents, Bobby, who was by then a young adult, hid from visitors and refused to step out of the house. When Bobby's parents died, he spent the rest of his life in a nursing home.

Alice's brother Daniel was born with cerebral palsy. Through newly created programs, he received speech and physical therapies from an early age. He was bright, and he attended public school with accommodations for his mobility challenges. After high school, Daniel went to college but could not major in science as he wished, because the laboratory was not wheelchair accessible. When Daniel graduated with an English degree, no one would hire him. In his 30s, unemployed and still living with his mother, Daniel became despondent and killed himself.

Alice witnessed attitude shifts between her uncle's generation and her brother's. Happily, we have progressed since Daniel's generation. The cosmologist Stephen Hawking developed amyotrophic lateral sclerosis before he earned his doctoral degree. Despite being unable to walk or talk without assistance, he has built a prolific career. The contrast between Roosevelt's need to hide his paralysis, Bobby's institutionalization, and Hawking's ability to thrive despite physical limitations is great. Examining the growth in our thinking about physical disability gives us a window into how attitudes can change—and need to change—toward people with serious mental illness.

Recovery as the new medical model

Radical changes have occurred in other areas of medicine, most notably in obstetrics and cancer care (14). In a generation, we have gone from a system of care in which childbirth occurred under general anesthesia with the spouse in the waiting room to one in which women and their partners have enormous control and choice about aspects of pregnancy and birth. We have gone from treating cancer as the dreaded "C word," sometimes not even disclosing the diagnosis to the patient and certainly not offering more than one treatment option, to today's model of cancer care in which patients are encouraged to educate themselves about their illness and be active participants in their treatment.

Elements of person-centered care include information sharing (15) and shared decision making (16). Rather than distancing themselves from patients, physicians who use this approach regard patients and their families as valuable partners in successful treatment (17).

Promoting recovery

Becoming recovery focused does not mean abandoning our medical knowledge. On the contrary, longitudinal data on schizophrenia bolster the case for promoting all three types of recovery. Traditionally, a psychiatrist told a patient with a new diagnosis of schizophrenia, "You will have to take medication for the rest of your life," comparing the illness to diabetes. Using our knowledge of current research findings, we could give a more hopeful prognosis: "You will have to take medication for several years and may need to be hospitalized at times. But over time, you have an excellent chance of recovery and of needing less or even no treatment."

When physicians consider the real possibility of remission as a long-term outcome, elements of recovery-focused care naturally follow. If the person has a good chance of recovery, we don't want to make clinic visits and medication adherence the end goals. Instead, we want to use medication and clinic visits as one part of helping the person build on the skills and strengths that he or she had before becoming ill. We want to encourage the person to undertake roles and missions in life other than being a patient—relationships, work, school, parenthood, hobbies, and so forth (18)—so that he or she will

have a life to continue when symptoms abate.

Even when symptoms remain active, working on life skills and activities can be helpful. Mental health professionals traditionally cautioned patients against the "stress" of work when they were symptomatic. However, for people with mental illness—as for anyone —work, volunteering, and other activities restore focus and purpose and help diminish negative thoughts, worries, and even psychotic symptoms (10).

Physicians can learn to accept that patients who are not at high risk of harm to self or others may want breaks from treatment. Treating these breaks as "graduations" rather than as "dropouts" and planning for them will be more satisfying for both patient and doctor. If the person reenters treatment after a break, we need not consider it a failure but a sign of the patient's strength in seeking needed help. If patients leave treatment on good terms and go on to achieve clinical recovery, they may be willing to return and report their success. Then the doctor would get to see what clinicians rarely see—a former patient recovered.

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