Dimensions and Predictors of Personal Recovery in Major Depression

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13.1 Introduction

Symptomatic remission has long been the only treatment goal of severe mental disorders (SMD) [1]. It can be defined as "a period during which an improvement of sufficient magnitude is observed that the individual is asymptomatic (i.e. no longer meets syndrome criteria for the disorder and has no more than minimal symptoms)" [2]. However, current treatment guidelines suggest that symptomatic remission cannot be considered any longer the only goal of treatment, but rather the first step towards the more challenging goal of recovery. In fact, in the last decades treatment outcome in SMD has evolved from the symptomatic remission to the broader concept of recovery [3].

Recovery has been defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles" and "a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness" [4]. The first definition of recovery was used in the thirteenth century and referred to the act of "regaining consciousness" [5]. In the early fourteenth

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century, the term recovery was used with the meaning of "regaining health or strength", and more recently of "returning to a normal or healthy status", referring mainly to physical illnesses rather than to mental disorders. In the past, recovery was traditionally understood as a sustained remission, or as the absence of symptoms and signs, accompanied by functional improvement (e.g. cognitive, social, and vocational functioning); this concept underlined the idea that recovery could be considered as the return to a former state of health [6]. This definition refers to "clinical recovery", usually defined by a set of criteria to be met and mainly assessed by mental health professionals. Various definitions of clinical recovery have been provided. One of the most adopted and recognized definitions of clinical recovery includes full remission of symptoms, full or part-time engagement in work activities or education, independent living and the presence of friends with whom sharing pleasant activities, all sustained for a period of 2 years [7]. Clinical recovery is conceptualized as a dichotomous objective outcome (in recovery versus not in recovery) that can be rated by an expert clinician with standardized assessment instruments. The definition of clinical recovery does not vary among individuals with a given diagnosis, as the concept emerged from professional-led research and practice [8].

Despite clinical recovery can be defined as an initial attempt to assess the outcome of mental disorders beyond treatment response and remission from psychopathological symptoms, it has to be considered only a part of the process of recovery. In fact, also based on suggestions coming from individuals who have had personal experience of a severe mental illness, the term "personal recovery" came up. This definition implies that recovery can be achieved despite the presence of symptoms of a given mental disorder. The concept of personal recovery is of particular importance since it involves the process by which a person attempts to develop new goals and meaning in life, beyond the catastrophic event of having a mental illness [9]. Individuals' skills to cope with symptoms are one of the most important elements of personal recovery. They refer to the ability of an individual to overcome the negative personal and social consequences of mental disorder and regain a self-determined and meaningful life. Thus, personal recovery is not simply the acquisition of a healthy status as it was before the onset of the mental disorder, but rather the growth beyond the premorbid status [10].

Contrary to the concept of "clinical recovery", then, personal recovery is considered as a process or a continuum, and not as an outcome, founded on the concept of an individual's journey of growth and personal development [11]. It is subjectively defined by the persons with a mental disorder, and individually rated by themselves [12]. Moreover, personal recovery is a heterogeneous concept, which assumes different meanings for different people, although many aspects are shared among individuals [8, 13].

However, a widely accepted definition of personal recovery has not been achieved yet. Law et al. [14] carried out a study involving 381 patients with psychosis, in order to find a common definition of personal recovery. The highest number of participants agreed that "recovery is the achievement of a personally acceptable quality of life" and that "recovery is feeling better about yourself".

Patients' clinical and personal recovery has been extensively assessed in people with lived experience of severe mental illnesses such as schizophrenia spectrum disorders or bipolar disorders, while little is known about the process of personal recovery in patients with other severe mental disorders, including major depressive disorders (MDD) [3, 15].

The focus on recovery from depression comes from recent studies on the efficacy of antidepressants, when it became apparent that standard treatments were not sufficient for achieving clinical recovery in many patients with MDD [10]. Indeed, several clinical features associated with the naturalistic course of MDD, such as its chronicity, the associated high relapse rates, the increasing probability of recurrences with every new episode [16–18], the frequent persistence and deleterious impact of residual symptoms [19–21], and the high comorbidity with physical illnesses, with long-term damaging effects on health and well-being greater than those associated with angina, arthritis, asthma or diabetes [22], justify the recent interest in applying the concept of personal recovery to MDD. Moreover, the lack of synchronicity between symptomatic and functional improvement often seen in recovering from MDD adds interest to the study of personal recovery in mood disorders [23]. Another clinical issue that stresses the importance of considering personal recovery in MDD is the evidence that the quality of remission is different according to the number of previous episodes; past depressive episodes seem to have a negative cumulative impact on psychomotor retardation, for example [24], or on other dimensions of cognitive functioning (e.g. memory) [25], supporting the scar effect hypothesis. Living well despite the illness or the long-term negative and persistent consequences of the disorder becomes an essential goal of the treatment of MDD.

The aim of the present overview is to provide readers with a description of the components of personal recovery and report available data on personal recovery in MDD.

13.2 From *Response* to *Full Functional Recovery* in MDD: History of Outcome Definitions in the Treatment for MDD

MDD is a common mental condition ranked by the World Health Organization among one of the leading causes of health-related disability worldwide. Globally, MDD affects more than 300 million people of all ages representing one of the major contributors to the overall global burden of disease. Moreover, depression causes not only relevant economic costs due to disability, healthcare system utilization and absenteeism, but is also associated with premature loss of life, especially by suicide [26]. MDD has a high lifetime prevalence (16.2%), and two thirds of cases have an episodic recurrent course [27, 28]. More than 50% of MDD patients report not satisfying outcomes from available treatments, with a high relapse rate after 2 years from the onset of the disorder [29–31].

The magnitude of this public health problem has led researchers and clinicians on one hand to look for better treatments for this condition and, on the other, to define

more specific treatment goals such as *response*, *remission* and *recovery*. These terms, in fact, have evolved as the study of novel therapeutic treatment strategies [32]. Lacking a reliable physical marker of depression, clinicians must judge wellness based on levels of symptoms and functional impairment, with the outcomes of such assessment driving the choice of therapeutic interventions [33]. Since the 1950s, after the introduction of antidepressant pharmacotherapy, the most common outcome criterion used for evaluating MDD treatment was simply symptoms improvement, and until the early 1990s, outcome terms, definitions and criteria showed inconsistencies in the literature. The introduction of standardized rating scales such as the Hamilton Rating Scale for Depression (HAM-D) or the Montgomery-Asberg Depression Rating Scale (MADRS) for evaluating treatment outcomes in the early 1980s led to some consistency in the definition of response (i.e. percentage change from baseline or reduction to a predefined cut-off score) [33]. In 1991, Frank and colleagues [2] proposed a uniform terminology for treatment outcomes aiming at allowing consistent comparisons of different clinical trials.

Response was defined as a ≥50% decrease from baseline in the total score on a standardized symptom scale (e.g. HAM-D, MADRS) and maybe represents the most consistently defined term, widely used as the acute treatment goal. How a ≥50%, instead of 40 or 60%, decrease from baseline measurements became the standard definition of symptoms improvement remains unclear [34]. In the Sequential Treatment Alternative to Relieve Depression (STAR-D), *response* rates were reported to range between 39 and 56.6% [35]. *Response* has proven useful in research settings but it is of less utility to the clinical practice. This definition does not consider symptoms severity at the end of the treatment period so that subjects in the *response* group might still have clinically significant depression at the end of the protocol. Treatment responders might, in fact, still meet MDD diagnostic criteria and paradoxically even meet inclusion criteria for the clinical trial in which they had just participated. Moreover, in clinical practice, responding to antidepressant therapy but failing to achieve symptomatic *remission* implies a negative prognosis. Residual depressive symptoms, in fact, predispose to relapse/recurrence, chronicity, and suicidality in depressed patients [19–21, 36].

Remission is considered a more rigorous definition of a positive endpoint, identified since the end of the 1990s as the treatment goal for MDD [37–39]. In clinical trials, a score reduction under a specific cut-off score on rating scales represents *remission* and operationalized criteria have been proposed depending on the specific rating scales adopted (e.g. HAM-D score ≤7; MADRS score ≤10). As compared to *response*, achieving *remission* provides a greater opportunity for improving long-term prognosis and preventing relapses and recurrences. Unfortunately, only 30–40% of individuals with MDD reach symptomatic *remission* after an adequate treatment with first-line antidepressants. Furthermore, since the definition published by Frank et al. [2], alternative thresholds continue to be utilized determining difficulties in comparing different results [40–42]. This definition of *remission* is, in fact, theoretical vague and directly depends on the psychometric characteristics of the instrument used [43, 44]: a HAM-D score of 7 cannot be considered a priori a sign of true *remission*, and, for example, a lower score (<5) appears to be in some

studies a more objective cut-off point [45]. Another controversial issue is the duration threshold for remission and recovery [46]; in the original proposal of operational criteria by Frank and colleagues [2], full remission required ≥2 weeks and less than 6 months asymptomatic, while recovery ≥6 months asymptomatic. Other authors considered a threshold of ≥8 weeks to define symptomatic remission [33, 47]. These duration thresholds have been found not to be empirically supported [48], so that the duration criteria for declaring remission and recovery seem unnecessary to date.

Moreover, results showing that a significant proportion of patients do not reach full psychosocial *recovery* even when they reach symptomatic "affective" *remission* indicate how non-affective symptoms are relevant for functional outcome [10, 49, 50].

Considering that cognitive dysfunctions (i.e. impairments in psychomotor speed, attention, verbal memory, executive functions) are among the most frequently encountered residual symptoms [51, 52], constitute a substantial risk for relapse in depression [53] and are strongly related to impaired psychosocial functioning, some authors have proposed the term *cognitive remission* as a new main objective in the treatment of MDD [54–56]. Cognitive dysfunctions may constitute a different dimension of major depressive symptomatology, responding differently (to different strategies) and in a non-synchronous way with respect to affective symptoms [56, 57]; thus, evaluating cognitive remission may be of clinical utility. Although different instruments have been proposed for evaluating cognitive dysfunctions in MDD and proved to be sensitive to changes during treatment (e.g. Digit Symbol Substitution Test—DSST; Trails Making Test B—TMT-B; or the THINC-it tool, a freely available, patient-administered, computerized screening tool integrating subjective and objective measures of cognitive function in adults with major depressive disorder) [58–60], no operationalized criteria for cognitive remission have been proposed.

Other authors pointed out that remission from depression as it is currently conceptualized (and defined with the HAM-D or MADRS cut-offs) is probably adequate for remitting negative mood, but not good enough for recovering positive mood, hedonic tone, functioning, or meaningfulness of life [61]; the focus is too much on the decrease of negative affect (i.e. depressive and anxiety symptoms) instead of on restoring positive affect or hedonic tone, despite the fact that loss of interest and pleasure is a core criterion for the diagnosis of MDD.

In this regard, *remission* is substantially different from *recovery*, also considering that even subthreshold depressive symptoms may be associated with substantial psychosocial impairment and that the number of residual symptoms correlates to the likelihood of subsequent relapse [47, 62]. Depressed individuals experience not only mood symptoms, but impairments in physical, occupational, and social functioning too [63, 64]. It is also worth mentioning that impaired functioning is a predictor of subsequent relapse of MDD; moreover, although measures of psychosocial functioning generally move in parallel with depressive symptoms (as depressive symptoms increase in severity, psychosocial disability worsen), improvements in affective symptoms and functionality

do not always resolve in tandem [23]. In light of this, some authors have proposed *functional recovery* as a more adequate endpoint/outcome for the MDD treatment [10]. Research shows, in fact, that the prioritized therapeutic objective in MDD is the return to premorbid functioning, positive mental health, over the extinction of depressive symptomatology. Several functional outcome assessment tools have been proposed, such as the Global Assessment of Functioning (GAF) scale, the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q), the Sheehan Disability Scale (SDS), the Social Adjustment Scale-Self Report (SAS-SR), the WHO Disability Assessment Schedule (DAS 2.0), the Work and Social Adjustment Scale (WSAS), among others. Most of these instruments represent patient-reported outcomes that measure subjective perception of functioning, quality of life enjoyment and satisfaction, adjustment. Functional capacity is a more objective outcome; it may be measured with the University of California San Diego Performance-based Skills Assessment (UPSA), which assesses the capacity of an individual to perform specific skills required for independent living in a controlled situation. *Functional remission or recovery* in MDD has been proposed to be operationalized as having a GAF disability score ≥61, or a Sheehan Disability Scale score <5 on the three subscales, or as having an improvement on the University of California San Diego Performance-based Skills Assessment (UPSA) ≥7 or ≥9 points [65, 66].

Ongoing functional impairment may negatively impact on return back into daily life and in turn delay *full functional recovery*. *Full functional recovery* can be defined as a condition in which the patient starts to enjoy his/her usual activities again, returns to work and is able to take care of him/herself [3, 58]. Although full functional recovery has not been operationalized, it may be conceptualized as made of both clinical/symptomatic remission and functional remission/recovery.

Despite the evidence-based effective treatments available to date for MDD (both pharmacological and psychosocial), the achievement of full symptomatic and functional *recovery* persists to be an open challenge in psychiatry. The return to previous functioning levels may also have a slower trajectory with respect to symptomatic *response* or *remission* [67–70]. Among several clinical trials, rates of *remission* are low for any antidepressant drug (approximately 33%) [71, 72] and may be worse in clinical practice [73, 74]. Even more challenging is the achievement of both symptoms *remission* and *functional recovery* after a trial of an antidepressant treatment [75]; moreover, *functional remission* does not always move in tandem with *symptoms remission* and it may take longer to reach *functional recovery* [23]. In a pooled analysis of three randomized, double blind, short-term (8-weeks) treatment studies in MDD Sheehan et al. [76] reported that only 23% of subjects achieved combined symptomatic *remission* and *functional recovery*. *Full functional recovery* (symptomatic remission + functional recovery) remains a difficult-to-reach target of the long-term treatment of MDD: post hoc analysis from a 24-week prospective, observational study that involved 1549 MDD patients found that *clinical* and *functional remission* was achieved in 70.6% and 56.1% of the MDD patients, respectively, but only 52.1% of them reached *full functional recovery* at the end of the 6-month trial [77].

This historical shift from symptomatic remission to full functional recovery as the treatment target in clinical trials is reflected by a similar trend in identifying more holistic objectives of mood disorders management by recent practice guidelines for mood disorders. The CANMAT 2016 clinical guidelines for the management of the adults with MDD, for example, state that the goals of the acute treatment (8–12 weeks) are the remission of symptoms and the restoration of functioning, while the goals of the maintenance phase (6–24 months) are the return to full functioning and quality of life and the prevention of recurrence [78]. The more recent 2020 Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders [79] explicitly recommend that "the aims of mood disorder treatment should go beyond symptom relief to include resilience and improve well-being"; this is particularly recommended in the context of chronic and relapsing mood disorders, where an episode of care is viewed also as an opportunity to develop the patient's resilience against the future illness. Resilience is here defined as the "ability to adapt to, and recover from, stress; not simply the absence of vulnerability". Guidelines identify *personal recovery* as the ultimate goal of treatment, as the "process of adaptation to serious mental illness", and encourage clinicians to have a more active engagement with patients [79]. The development of resilience "focuses on instituting new strategies, embedding new resources and addressing vulnerabilities".

As one can see, the term personal recovery appears for the first time as the goal of treatment in MDD.

13.3 Dimensions of Personal Recovery in Severe Mental Disorders

Different definitions of personal recovery in SMD have been proposed and several determinants of personal recovery identified. However, all definitions of personal recovery include components such as accepting mental illness, finding hope for the future, re-establishing a positive identity, developing meaning in life, taking control of one's life through individual responsibility, spirituality, empowerment, overcoming stigma, and having supportive relationships [6]. Probably, a higher consensus definition of personal recovery has not been achieved yet due to the complexity of the recovery construct. The complexity is increased by the evidence that there are at least five stages of recovery [12]: (1) moratorium (i.e. denial, confusion, hopelessness, identity confusion and self-protective withdrawal); (2) awareness (i.e. the initial appraisal that recovery is possible, with the possibility of a better life, including the development of the awareness of a possible self, other than that of being a patient with a SMD); (3) preparation (i.e. person start to working on recovery, by learning about mental illness and available services, by becoming involved in groups, and connecting with others who are in other stage of recovery); (4) rebuilding (the hardest phase of the recovery process, which involves a change to a more positive identity, by reassessing old values and moving towards a new way of living, taking responsibility for managing illness and for control of life, and showing

tenacity by takings risks and suffering setbacks); (5) growth (i.e. gaining new skills on how to manage symptoms and disabilities).

One of the most comprehensive definitions of personal recovery has been provided by Leamy et al. [80], who developed a framework to understand the concept of personal recovery, through a systematic review and narrative synthesis: the CHIME Framework. It consists of three interlinked superordinate categories of recovery, including the characteristics of recovery journey, the recovery processes and recovery stages. The acronym CHIME derives from the recovery process identified by the framework: Connectedness (i.e. peer support and support from social groups, good social relationships, supports from others, being part of the community), Hope and optimism (i.e. belief in the possibility to recover, motivation to change, hope-inspiring relationships, positive thinking and valuing success, having dreams and aspirations), Identity (i.e. dimensions of identity, ability to rebuild or redefining a positive sense of identity and to overcome stigma), Meaning in life (i.e. meaning of mental illness experiences, spirituality, quality of life, meaningful life and social roles and goals, ability to rebuilding life), Empowerment (i.e. personal responsibility, control over life, focusing upon strengths). In particular, empowerment is a core concept of the World Health Organization vision of mental health promotion [81] and it plays a key role in the concept of personal recovery. Empowerment is the core component of the UK movement "no decision about me without me", a user-led movement which aimed to transform the English National Health System to a recovery-oriented service system [82]. Empowerment refers to people's ability to become stronger and more confident, particularly in controlling their own life and claiming for their rights. Empowerment helps to adopt autonomy and self-determination and to influence the decision-making process, thus impacting self-esteem and self-efficacy [83].

The process of personal recovery is defined by three main dimensions: the inner experience, the contribution from others and the participation in social activities [5]. The first category refers to patients' inner experiences of the disease and to their ability to accept themselves as persons rather than as patients, and to identify themselves as responsible to build up an independent life. In this sense, recovery refers to the ability to accept the disability. Acceptance, which should not be considered a synonym of giving up and surrendering to symptoms, is the most difficult stage of the whole recovery process, but also the most essential [84]. Acceptance includes hope, spirituality, empowerment, connection, purpose, self-identity, symptom management and stigma [85].

The second category refers to the support from relevant others in the recovery process, including professionals, family members and other caregivers, friends, other patients. As regards the professional support, several therapeutic approaches have shown to be effective in fostering the process of personal recovery, including cognitive remediation, psychoeducational interventions, and cognitive-behavioural approaches [86]. Independently from the therapeutic approach, a key element of professional support, strongly linked with personal recovery, is the provision of a guide to patients through symptoms, and of instruments to help them to overcome the crises. Mental health professionals' characteristics associated with a better

personal recovery are empathy and respect, being active and carefully listening and showing interest to patients' problems [5, 87]. The role of mental health professionals and of the organization of mental health services has become a key topic in the promotion of personal recovery in the last years. In fact, many countries have adopted national mental health policies shifting towards recovery-oriented mental health services and interventions [88]. The recovery-oriented approaches offer a transformative conceptual framework for practice, culture and service delivery in mental health service provision [89]. Several studies have highlighted that spirituality is a relevant factor in the personal recovery, since religion can motivate and inspire patients to live their lives with greater acceptance [90]. Moreover, being part of a faith community and having a religious affiliation is seen as an important component of an individual's recovery [80].

The third component of personal recovery includes patients' participation in social activities. Being active on a daily basis and staying in contact with the real world allows patients to avoid isolation and reduces detachment from reality [91]. Moreover, having a stable employment helps keeping the feeling of being able to give something back to the society, feeling competent and appreciated by colleagues [87], while reducing at the same time the stigma and building a sense of independence from others. Moreover, the participation in leisure activities is a major contributing factor to the recovery process. Participating in leisure activities allows people to being distracted from mental health problems, to meet new people and to create social networks, thus enriching their social life [5].

An integrated dimensional model of recovery has been proposed by Whitley and Drake [92]. It defines recovery on the basis of five dimensions: (1) clinical—reduction in symptoms; (2) existential—better sense of hope, empowerment, and spiritual well-being; (3) functional—recovering meaningful role; (4) physical—promoting physical health; and (5) social—consolidating relationships with others and feeling that one is part of society. One of the advantages of this framework is to provide an integrated approach with both a focus on clinical and personal aspects of recovery (including a focus on physical health—and thus strategies implementing physical health) and may provide clinicians with a useful framework for identifying and promoting strategies to foster recovery.

13.4 Personal Recovery in Major Depression

The recovery process from MDD is still understudied. In fact, recovery has been mainly investigated in patients with schizophrenia, other psychoses and/or bipolar disorders. Patients with major depression are underrepresented in the consumers' movements, where the concept of personal recovery has been developed and conceptualized [10, 15]. Despite personal recovery is conceptualized as a process which can occur independently from patients' symptoms, several studies have highlighted that the type and the severity of psychiatric symptoms can have a different impact on personal recovery [93]. In fact, the core symptoms of schizophrenia, such as delusions and hallucinations, have a reduced influence on patient's experience of

recovery, while affective symptoms are considered a barrier in the process of recovery of patients with schizophrenia [94]. In particular, authors reported that personal recovery was predicted mainly by affective symptoms, while the negative and positive ones were not associated with personal recovery in a sample of 105 patients with schizophrenia and bipolar disorder. Moreover, the severity of affective symptoms was more strongly related to personal recovery in patients with non-psychotic disorders than in those with schizophrenia.

Only a few studies have assessed personal recovery in major depression. Available evidence suggests that the recovery journey in MDD can be considered a complex, personalized and multifaceted process. Complexity arises from the fact that several social, clinical and contextual factors are potentially implicated in the process of recovery [15].

Social support, measured as the size of social network, subjective feeling to be supported by relatives or friends and the number of close relationships and satisfaction with received support, is one of the most influential factors that can impede or foster the process of recovery in MDD [95, 96]. In particular, Gladstone et al. [97] reported that more than 50% of patients with MDD feel that recovery is made difficult by lack of perceived social support. Interventions targeting the development and maintenance of supportive relationships may then prove to be effective approaches to foster personal recovery. The relationship between perceived poor social support and depression, leading to a delay in the recovery process is, however, complex: it is possible that the depressive state is associated with a negative perception of social support while this is not true, but also that chronicity of depression or multiple recurrences of depression trigger erosion of social support networks over time (a sort of social scar of recurrent or chronic MDD).

It is then essential to carefully assess this dimension in the real life of the patient. This also implies that clinicians should promptly recognize, diagnose and appropriately treat MDD since its onset; an early personalized and optimized treatment is essential in terms of a) pharmacologic compound or psychotherapeutic intervention, b) appropriate dose (drug) or frequency (psychotherapeutic intervention), c) right choice of the specific intervention according to the clinical subtype/predominant symptom dimension of MDD, and d) quick adoption of alternative strategies when at least a partial response is not evident within the first weeks of treatment [3, 98]. The duration of untreated illness and the lack of an early improvement in depressive symptoms (e.g. $\geq$20% decrease in HAM-D score after 2 weeks) have been consistently found to be associated with non-remission and/or relapses/recurrences, thus interfering with the personal recovery journey [99–101].

It is also imperative, in order to promote recovery from depression, to aggressively treat the full spectrum of symptoms accompanying the episode, including residual symptoms and dysfunctions eventually associated with drug side effects (e.g. sexual dysfunctions). Integrating multiple treatment approaches (sequentially) may prove to be the optimal way of fostering personal recovery.

If we refer to the integrated model of recovery proposed by Whitley and Drake [92], these may be conceptualized as strategies fostering clinical recovery and

contributing, at a later time, to personal recovery. Other strategies that patients themselves can implement together with healthcare providers include, for example, analysing and changing dysfunctional beliefs (cognitive-behavioural treatments) and/or learning how to pay attention to mood changes (e.g. regularly taking notes on mood changes) in order to recognize early signs of a relapse and thus implement appropriate strategies as soon as they became aware that symptoms are becoming more intense [102].

As regards contextual factors, it should be noted that patients and clinicians hold different perspectives regarding what constitutes recovery from major depression and what they consider important for recovery from MDD [103–105]. In fact, most physicians consider the reduction of the number and severity of depressive symptoms, as well as the improvement of patients' functioning, the focus of their treatment goals, while patients focus mainly on restoration of positive affect, including having a meaningful life, satisfaction with personal relationships, improving their ability to concentrate and their personal strengths [106]. Moreover, perceptions of MDD symptoms and the associations between these symptoms and functioning differ significantly between patients and healthcare providers across all phases of the disorder (acute, post-acute and remission) [107]. The findings of this latter study highlight the need for improved communication between patients and healthcare providers in order to set appropriate treatment goals. Different priorities in treatment outcomes between patients and clinicians can lead clinicians to systematically ignore all the components of personal recovery as an outcome to be achieved, thus reducing the possibility that patients will recover.

An interesting study found that discordance between what patients and physicians consider important in the definition of cure from depression significantly influences clinical outcomes at 6 months: the subgroup with a poor physician–patient agreement on expectations had a worse clinical outcome than the subgroup with an excellent physician–patient agreement, with differences in response rate between these groups ranging from 9 to 27% [108].

Again, the clinical complexity and heterogeneity of MDD in terms of predominant symptom dimensions, perceived different relevance of each symptom dimension according to patients and healthcare providers perspectives, subtype, chronicity, etc. highlights the need of a personalized, individually tailored approach to the person living with MDD [109].

MDD patients consider four elements as the main factors that can impede their recovery journey; the first one is the lack of consensus on the nature of depression: having no personalized treatment, receiving insufficient information about proposed treatments and lack of discussion concerning medications (e.g. mechanisms of action, potential side effects, time to response) are reported as major impeding elements in the patient-clinician relationship [30]. In this regard, psychoeducational consensus checklists may be used by practitioners in order to promote a better relationship and improve shared decision-making in MDD [110]. Other elements that are seen by patients with MDD as potentially interfering with the recovery journey are: (1) a precarious relationship with the clinician, including lack of trust in

clinicians' abilities to treat depression, lack of continuity in treatment due to frequent changes in treating clinicians, inappropriate professional attitudes, and lack of professional guidance; (2) the unavailability of mental healthcare when needed, particularly in case of emergencies (long waiting lists, unavailability of treating clinician and lack of care after symptom resolution are the most relevant factors in this category), and (3) insufficient involvement of significant others, preventing full use of support networks [30].

In order to promote recovery from depression, several approaches have been proposed in the last few years [111]. One of the most promising is the self-management approach, which increases individualism, empowerment, and participation in social activities [102]. Self-management includes both professional- and user-led strategies. Among the former, booklets, books and e-health programmes have been proposed [112, 113]. Promising suggestions come from patients' perspectives on how they recovered from depression; an interesting study [102] explored strategies used by people recovering from depressive and anxiety disorders, classifying them according to the model proposed by Whitley and Drake [92]: these strategies may be implemented in clinical practice to foster recovery. Having a proactive role towards depression and its treatments (e.g. seeking information from mental health professionals about depressive symptoms and gaining insight into illness, taking your medication), managing daily symptoms (e.g. analysing and changing your thoughts/emotions and behaviours) and remaining vigilant to signs and symptoms of potential relapses are among the self-management strategies used to foster *clinical recovery*. Among strategies fostering *existential recovery,* patients reported having a positive outlook, e.g. taking inspiration from someone who has previously recovered—well-known public personalities with the same disorder, or people in a support groups, having spiritual beliefs, using humour, developing a balanced sense of self (e.g. distinguishing the illness from your personality), finding meaning (e.g. finding a project, a goal, a dream), among others. Self-managed strategies fostering *functional recovery* included creating a routine (e.g. following a schedule, having and respecting regular rhythms—going to bed at a regular time) and proactively taking activities (e.g. engaging in pleasant activities and engaging in activities in which you can feel competent); again, the usefulness of this approach is that psychosocial interventions (led by healthcare providers but also led by peers) may be implemented in order to train patients to adopt these strategies. Regaining and promoting physical health is another important dimension of recovery; strategies fostering *physical recovery* include engaging in sport activities, adopting sleep hygiene, eating at regular times and well, reducing consumption of alcohol, smoking and other substances. In this regard, it has to be borne in mind that physical health is compromised in mood disorders because of different contributors, some of them not modifiable such as genetic predisposition, other modifiable such as dysregulations in social rhythms, substance abuse, poor sleep hygiene, or side-effects of medications. Both individuals living with the disorder and their healthcare providers can intervene to prevent physical complications and

foster physical recovery. Lastly but not least, self-management strategies fostering *social recovery* reported by patients with depressive disorders consisted of surrounding myself with people who make me feel better and avoiding negative people, and taking care of others such as family members or friends [102].

13.5 The Way Forward

Despite the recent interest of the scientific community, much work has still to be done in order to define a clear and internationally recognized conceptualization of personal recovery for individuals living with major depression and its dimensions. There are still too many unanswered questions, such as whether the process of personal recovery from depression is similar or distinct from that of personal recovery from other severe mental disorders. The methodology adopted in the different studies is very heterogeneous, and different instruments have been used to assess personal recovery, hindering cross-studies' comparisons. Differently from what happened in studies on personal recovery of patients with schizophrenia or bipolar disorders, the paucity of data does not allow to identify which aspects should be considered as the most important in recovery from major depression. This information is essential in order to provide clinicians with useful information to guide patients in their "journey to recovery". It is not a case that one of the most important factors slowing the process of recovery is the lack of professional support perceived by patients. Patients with major depression often perceive the clinician as an authority who makes decisions about treatments on their behalf with a low level of encouragement to obtain autonomy, motivation and self-management [30]. Several authors have highlighted that the way in which decisions are made during the clinical encounter affect patients' recovery, and that the identification of treatment priorities should be always shared with patients, according to the shared decision-making model, which is associated with better outcomes in terms of symptom reduction and improvement of psychosocial functioning, empowerment and satisfaction with received care [83, 114].

Different views have been reported between clinicians and patients about dimensions of personal recovery for patients with major depression, but only a few studies exploring the impact of these differences have been carried out [103–106].

Lastly, available studies on recovery from depression, and from other severe mental disorders, show that a shift in the provision of psychiatric care is needed [115]. In fact, there is the need to move away from a "treat-and-recover" approach, in which priority is given to the provision of treatments with the aim to make people re-engage with their life [116]. For decades, mental health services have been organized around a clinical version of recovery, where professionals diagnose and treat patients, with the aim of reducing their symptoms, and where they do not consider the possibility to recover from severe mental disorders beyond symptoms' reduction [117]. Many interventions are now available to promote users' personal recovery, including the "Wellness Recovery Action Planning (WRAP)" [118], the "Illness

Management and Recovery Program (IMR)" [119], and the "REFOCUS" intervention [120]. All these approaches have shown their efficacy in promoting personal recovery in patients with severe mental disorders in randomized controlled trials.

13.6 Conclusions

Over the course of recent years, the focus of interest of clinicians and individuals living with MDD shifted from just achieving symptomatic remission to clinical recovery, functional recovery and ultimately personal recovery. Personal recovery is an idiographic process, that is each persons' recovery is unique. Personal recovery is not a dichotomous outcome of interventions but rather a journey, a dynamic process, that requires a shared decision-making approach. Living well despite depressive residual symptoms and despite the scars of an often chronic, recurrent, long-lasting condition such as MDD (e.g. cognitive scars, social scars, physical scars) is not only possible, but should become the main objective of the management of MDD, as recently acknowledged by international clinical guidelines [79].

The journey towards personal recovery in MDD may be viewed as a sequential, multi-dimensional route where several individuals contribute to the final outcome; it starts with strategies aimed at fostering clinical recovery in order to quickly move at implementing strategies to promote existential, functional, physical and social recovery. Healthcare providers, individuals living with the condition, peers and family members/caregivers can contribute each in its own way to this final outcome.

Personal recovery in MDD is still understudied as compared to personal recovery as an outcome in other severe mental disorders; it is necessary and urgent that future studies can be funded and performed in order to achieve a better understanding of dimensions and predictors of clinical and personal recovery in MDD.

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