# Chapter 13
# Recovery: A Complete Mental Health Perspective

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Interventions and research surrounding mental health treatment are oriented toward the alleviation of mental illness symptoms and functional impairments. This approach reflects the pathogenic paradigm in which mental health is conceived of as the absence of psychopathology. Until recently, mental health as something positive (e.g., Jahoda 1958) remained undefined, unmeasured, and therefore largely ignored. In 1999, the US Surgeon General defined good mental health as "a state of successful performance of mental function resulting in productive activities, fulfilling relationships with people, and the ability to adapt to change and to cope with adversity" (U.S. Public Health Service 1999).

This definition coincides with social scientists' views of mental health, which has come to be known as individuals' quality of life in the domain of subjective well-being. Reviews (Keyes 2006b; Ryan and Deci 2001) have acknowledged as many as 13 specific dimensions of subjective well-being that, when factor analyzed, represent the latent structure of emotional well-being and positive functioning in adults (Keyes 2002) and adolescents(Keyes 2005b, 2006a) (see Table 13.1). Whereas emotional well-being refers to positive emotions toward one's own life, such as happiness and life satisfaction, positive functioning is measured as psychological and social well-being, which reflect a sense of engagement and fulfillment in one's private and social life (Keyes 1998; Ryff and Singer 1996).

Positive mental health is a core construct for mental health promotion (Barry 2009) and the salutogenic paradigm (Antonovsky 1979) because it requires the study and implementation of the causes of good health in order to prevent disease and promote recovery. Until recently, positive mental health was defined and

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**Table 13.1** Factors and 13 dimensions reflecting mental health as flourishing

*Hedonia (i.e., emotional well-being)*

1. *Positive affect*: Cheerful, interested in life, in good spirits, happy, calm and peaceful, full of life
2. *Avowed quality of life:* Mostly or highly satisfied with life overall or in domains of life

*Positive psychological functioning (i.e., psychological well-being)*

3. *Self acceptance:* Holds positive attitudes toward self, acknowledges, likes most parts of personality
4. *Personal growth:* Seeks challenge, has insight into own potential, feels a sense of continued development
5. *Purpose in life:* Finds own life has a direction and meaning
6. *Environmental mastery:* Exercises ability to select, manage, and mold personal environs to suit needs
7. *Autonomy:* Is guided by own, socially accepted, internal standards and values
8. *Positive relations with others:* Has, or can form, warm, trusting personal relationships

*Positive social functioning (i.e., social well-being)*

9. *Social acceptance:* Holds positive attitudes toward, acknowledges, and is accepting of human differences
10. *Social actualization:* Believes people, groups, and society have potential and can evolve or grow positively
11. *Social contribution:* Sees own daily activities as useful to and valued by society and others
12. *Social coherence:* Interest in society and social life and finds them meaningful and somewhat intelligible
13. *Social integration:* A sense of belonging to, and comfort and support from, a community

measured piecemeal, with a focus on specific and often only emotional aspects of well-being rather than including positive functioning in life (Zubrick and Kovess-Masfety 2005). There is a growing consensus on the heuristic value of hedonic and eudaimonic well-being for further developing knowledge about positive aspects of mental health (Barry 2009). Here, the *mental health continuum long* (Keyes 2002) and *short* (Keyes 2006a) *forms* are used not only as a guide to build new instruments for—but also as a measure of—positive mental health, such as the Warwick-Edinburgh Mental Well-being Scale (Tennant et al. 2007).

Another important distinction between mental health promotion and mental illness treatment concerns the complete state model of mental health (Keyes 2005a, 2007). Such a distinction has been represented in the scientific literature for more than half a century (Jahoda 1958; World Health Organization 1948) and posits that mental health is not only the absence of mental illness but also the presence of subjective well-being. More recently, the availability of a research methodology for assessing states of complete mental health has provided specific criteria for combining indicators of mental illness and positive mental health (i.e., subjective well-being). This was developed and used to study the model of complete mental health, which is also called the two (or the *dual*) continua model (Keyes 2005a, 2007).

Since the mid-1980s, persons with psychiatric disabilities have highlighted that it was possible to recover from mental illness, here corresponding to the achievement

of a full and meaningful life in spite of enduring psychiatric symptoms or impairments. Consistent with this view, phenomenological and other qualitative approaches (Silverstein and Bellack 2008), and numerous personal accounts (e.g., Ridgway 2001; Spaniol and Koehler 1994), have provided a better understanding of personal and environmental factors that hinder or facilitate recovery, as well as valuable insight about key dimensions (e.g., hope, empowerment, positive sense of identity) and phases underlying this experience (Onken et al. 2007). The voices of persons with psychiatric disabilities are thus viewed as the *royal road* to advance knowledge on recovery, and the acquisition and use of experiential knowledge (e.g., critical analysis of personal experiences) is especially targeted in peer support interventions (Mead et al. 2001).

A large number of researchers and clinicians have endorsed consumers' viewpoints on recovery. Provencher (2002), for instance, has defined recovery as the transcendence of symptoms, functional limitations, and social handicaps attached to mental illness, from which emerges a new sense of existence, the performance of meaningful roles in society, and a better sense of well-being and quality of life. However, consumers' definition of recovery has challenged a more traditional view of this phenomenon that is still largely represented in the scientific community, which conceives of recovery through the lens of the disease and focuses on the extent, or the level, of remission from mental illness (Silverstein and Bellack 2008). In this vein, several long-term follow-up studies have reported significant improvement in psychiatric symptoms and deficits—or even complete recovery—from schizophrenia over time, in contrast to the deteriorating course that is typically assumed for this disorder (Calabrese and Corrigan 2005).

Distinct conceptions of recovery may be viewed as desirable and as providing enriching perspectives and stimulating multidisciplinary work in order to better understand this phenomenon. However, such diversity remains problematic until theoretical approaches are developed to clearly address how they can complement each other. Potential attempts to resolve this issue may reduce ongoing tensions, encourage a dialogue, and foster collaboration among proponents, whereas neglect of this issue may perpetuate the confusion that prevails about recovery and may possibly carry the risk of decreased interest in the delivery of recovery-oriented services over the long run. What has been overlooked so far has been the fact that those proposed conceptions of recovery rely on distinct approaches of mental health: the search and engagement in a pleasant and fulfilling life in alignment with the salutogenic vision and the alleviation of mental illness outcomes with the pathogenic vision. This stresses the relevance of theoretical approaches that bring together mental illness and positive mental health.

This chapter proposes that the study and process of recovery from mental illness can be augmented by adopting the model of complete mental health. The first part presents a brief overview of Keyes' model. Current definitions of recovery are then reexamined based on their underlying conceptions of mental health. Third, recovery is redefined as a complete mental health experience, relying on two complementary processes and outcomes, restoration from mental illness, and optimization of positive mental health. An emphasis is placed on outcomes, which are viewed as pathways

to complete mental health over the recovery process. Finally, some concluding remarks are made about how the complete view of mental health recovery extends previous conceptions, and some future directions for research in order to advance knowledge in this area are proposed.

## Complete Mental Health

Positive mental health, like mental illness, is a syndrome of symptoms that consist of an individual's subjective well-being. Previous research on subjective well-being (Keyes 2005b; Ryan and Deci 2001) yielded latent factors that are the converse of the cluster of symptoms used in the DSM-IV-TR (American Psychiatric Association 2000) to diagnose major depressive episode (MDE). Depression requires symptoms of *an*hedonia, and positive mental health consists of symptoms of hedonia, or emotional well-being; depression consists of symptoms of *mal*functioning, and positive mental health consists of symptoms of eudaimonia, or positive functioning.

Table 13.1 presents clusters of symptoms of positive mental health, and the diagnosis of states of positive mental health is modeled after the DSM-III-R approach to diagnosing MDE. In order to be diagnosed as *flourishing* in life, individuals must exhibit high levels (*every day* or *almost every day* during the past 2 weeks) on at least one measure of hedonic well-being and high levels on at least six measures of positive functioning. Individuals who exhibit low levels (*never* or *once or twice* during the past 2 weeks) on at least one measure of hedonic well-being and low levels on at least six measures of positive functioning are diagnosed as *languishing* in life. Adults who are *moderately mentally healthy* do not fit the criteria for either flourishing or languishing in life. A continuous assessment sums up all measures of positive mental health, and conclusions have not varied between the categorical and the continuous assessment of positive mental health.

The following findings come from papers using the 1995 Midlife in the United States (MIDUS) survey, a random-digit-dialing sample of noninstitutionalized English-speaking adults between the ages of 25 and 74 living in the 48 contiguous states. The MIDUS used DSM-IV-TR (APA 2000) criteria to diagnose four mental disorders (i.e., major depressive episode, panic, generalized anxiety, and alcohol dependence) using the Composite International Diagnostic Interview Short Form (CIDI-SF) scales. Four separate summary measures served as indicators of mental illness, operationalized as the number of symptoms of major depressive episode, generalized anxiety, panic disorder, and alcohol dependence. Three scales served as indicators of positive mental health: the summed scale of emotional well-being (i.e., single item of satisfaction with life + a six-item scale of positive affect), the summed scale of psychological well-being (i.e., Ryff's six scales summed together), and the summed scale of social well-being (i.e., Keyes' five scales summed together).

Confirmatory factor analysis was used to test the complete state model of mental health. The single factor model hypothesizes that the measures of mental health and mental illness reflect a single latent factor, support for which would indicate that the

absence of mental illness implies the presence of mental health. The two-factor model hypothesizes that the measures of mental illness represent the latent factor of mental health that is distinct from, but correlated with, the latent factor of mental illness that is represented by the measures of mental illness. The data strongly supported the two-factor model (Keyes 2005a), and the two continua model has been recently confirmed in US adolescents (Keyes 2009b).

Across studies, the latent factor of mental illness correlates with the latent factor of mental health ($r = -.55$). Although level of good mental health tends to increase as mental illness symptoms decrease, the association is moderate. Data support the argument that the absence of mental illness does not imply the presence of mental health; too, the presence of mental illness does not imply the absence of some level of mental health. Complete mental health is a state in which individuals are free of mental illness and are flourishing. Of course, flourishing may sometimes occur with an episode of mental illness, and moderate mental health and languishing can occur both with and without a mental illness.

With regard to states of positive mental health, languishing adults reported the highest prevalence of any of the four mental disorders, as well as the highest prevalence of two or more mental disorders during the past year. In contrast, flourishing individuals reported the lowest prevalence of any of the four 12-month mental disorders or their comorbidity. Compared with languishing or flourishing, moderately mentally healthy adults were at intermediate risk of any of the mental disorders, or two or more mental disorders, during the past year. The modest correlation between the latent continua reflects the tendency for the risk of mental illness to increase as mental health decreases. For example, the 12-month risk of major depressive episode was over five times greater for languishing than flourishing adults.

In addition, previous findings on Keyes' model revealed that level of mental health differentiated the level of functioning for those with, and for those free of, a mental disorder. Of the 77% MIDUS adults free of any of the four mental disorders, the 16.6% who were flourishing functioned better than the 50.6% with moderate mental health: those who were flourishing reported the fewest workdays missed, the fewest workdays cutback by one-half, the lowest rate of cardiovascular disease, the lowest level of health limitations of activities of daily living, the fewest chronic physical conditions at all ages, the lowest healthcare use (medical visits, hospitalizations, and medications), and the highest levels of psychosocial functioning. In terms of psychosocial functioning, this meant that completely mentally healthy adults reported the lowest level of perceived helplessness, the highest level of knowing what they want from life, the highest level of self-reported resilience (e.g., that they try to learn from adversities), and the highest level of intimacy (e.g., that they have very close relationships with family and friends). Using the same criterion measures, the 9.8% who were languishing and free of mental disorder functioned worse than adults with moderate mental health (Keyes 2007). Of the 23% MIDUS adults with at least one of the four mental disorders, the 1.5% who were flourishing functioned better than the 14.5% who had moderate mental health and who, in turn, functioned better than the 7.0% who were languishing. In other words, level of mental health differentiates levels of impairment and disability, even among adults

who have had a mental illness in the past year; just over two-thirds of adults with a mental disorder in the past year had at least moderate or flourishing mental health. In short, previous research on Keyes' model has provided evidence that anything less than complete mental health results in increased impairment and disability (Keyes 2007).

## Recovery from Mental Illness

Over the last two decades, recovery has become the overarching aim of mental health services systems in many countries: Australia, New Zealand, England, Scotland, and the United States, to name a few (Slade et al. 2008). Current definitions of recovery, as a process and as an outcome, are now revisited in light of their underlying conceptions of mental health.

### *A Pathogenic View of Recovery*

As mentioned before, the vision of recovery as an outcome corresponds to the traditional or clinical view of this phenomenon and falls under the umbrella of *scientific-oriented definitions* (Silverstein and Bellack 2008). Outcomes of recovery here are defined from a pathogenic perspective which views mental health as improvements in typical indicators of mental illness, such as psychiatric symptoms and impairments in cognitive, role, and social functioning. However, there is still an ongoing debate about the requirements for declaring someone recovered. Some authors (Andreasen et al. 2005) have proposed that the full remission of symptoms and the return to premorbid levels of function are necessary, whereas others (Liberman and Kopelowicz 2005; Torgalsboen 2005) have suggested that partial remission of symptoms and role restoration that are sustained over two consecutive years are sufficient.

The pathogenic view of recovery is also represented in the literature that focuses on key dimensions, or process elements, that are involved in the minimization of mental illness and that have been particularly documented in *consumer-oriented definitions* (Silverstein and Bellack 2008). More specifically, this side of the recovery experience targets the building of protective factors against relapse, functional deterioration, and handicap, which has been traditionally addressed in the field psychiatric rehabilitation (Anthony et al. 2002). Those protective elements refer to personal and environmental resources that contribute to the reduction of mental illness and its negative social consequences (e.g., stigma, discrimination). At the individual level, they involve the restoration of skills that had been altered by the illness and the learning of illness management strategies, such as strategies for preventing relapse or coping with enduring symptoms, as well as advocacy skills for getting needed services (Mueser et al. 2006; Salyers et al. 2009). At the environmental

level, they include the provision of accommodations for supporting the performance of social roles, such as parents, students, or workers (e.g., later start times or flexible break times as work adjustments). They also rely on the use of community interventions for restoring civil rights and reducing barriers to social exclusion, such as educating potential employers and other members of the community about mental illness (Corrigan et al. 2008). In addition, several subjective changes take place throughout this process, such as the development of a positive identity based on restored abilities (Brown and Kandirikirira 2007), a renewed sense of hope for better prevention of illness relapses, or the development of a sense of empowerment, which encompasses increased self-efficacy in coping with mental illness, active participation in the planning of individualized services (Adams and Drake 2006; Drake et al. 2009), and advocacy for defending rights as consumers (Onken et al. 2007). In short, the building of protective factors against mental illness and their related subjective processes are aligned with a pathogenic view of recovery and with the use of mental illness indicators as outcomes.

## *A Salutogenic Perspective of Recovery*

In addition to the pathogenic view, consumer-oriented definitions emphasize another side of the recovery experience in which the pursuit of positive emotions (e.g., happiness, life satisfaction) and the engagement in fulfilling activities are highlighted despite the presence of mental illness. Positive mental health is at the center of this view of recovery and underlies a salutogenic conception of mental health, although never recognized as such. The dimensions of flourishing (see Table 13.1) are used as a framework to propose linkages between recovery and positive mental health, drawing on three lines of literature.

First, qualitative research and personal accounts (Ridgway 2001; Spaniol and Koehler 1994) call attention to consumers' experiences and aspirations that are aligned with positive mental health (see Table 13.1). Brown and Kandirikirira (2007), for instance, found that persons in recovery require and strive for a positive identity, which reflects *self-acceptance*. Individuals also said they require and seek to engage in meaningful activities and to develop positive relationships with other people and with their environments, which reflect *purpose in life*, *positive relations with others*, and *social acceptance*. Narratives of persons in recovery also reveal their need and aspiration for living in communities where they are seen as more than their illness and where their contributions are valued, which are signs of positive mental health called *social integration* and *social contribution*. Persons in recovery also need and strive to manage their lives, stay healthy, and be resilient to setbacks, which reflect *environmental mastery* and, to some extent, *autonomy* (i.e., confidence to express personal opinions, needs).

Several dimensions of positive mental health are indeed targeted in recovery interventions. Consistent with hedonic well-being, having pleasure, fun, and happiness in life through involvement in leisure and social activities is promoted in supported

socialization (Davidson et al. 2003, 2004, 2006). With regard to positive functioning, psychological well-being is enhanced in a self-development program (Oades 2008) and other treatment programs, for example, Well-Being Therapy (WBT) (Fava and Ruini 2003) for persons with recurrent depression or functional Cognitive Behavioural Therapy (fCBT) (Cather et al. 2005) for those with schizophrenia. In line with social well-being, peer support encourages those individuals who want to contribute to social changes and to engage in pro-social behaviors, such as using political strategies to increase access to resources (e.g., housing, paid work) (Mead et al. 2001). In this vein, capabilities approaches (Nussbaum 2000; Sen 1999) are increasingly used as guides to promote measures of social inclusion, such as securing access to participatory structures in local organizations in order to join collective efforts oriented toward the welfare of the whole community (Ware et al. 2007).

Finally, several dimensions that are assessed in recovery instruments strongly resemble the dimensions of subjective well-being that make up the assessment and diagnosis of positive mental health. For instance, subjective quality of life, as indexed by life satisfaction, reflects hedonic well-being and has been widely used in clinical practice and evaluation research. The Recovery Assessment Scale (Corrigan et al. 2004) is a self-report questionnaire that is widely used and relies on five dimensions—personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and no domination by symptoms—which all somewhat overlap with purpose in life, environmental mastery, autonomy, and positive relations with others. The RAS reflects psychological well-being, for the most part (see Table 13.1), and is even stronger for post-traumatic growth. This latter concept refers to positive shifts in personality schema and assumptive worlds following significant life crises (e.g., bereavement, chronic disability) (Tedeschi et al. 1998) and captures the process of thriving in recovery or becoming better off than before mental illness (Onken et al. 2007). The three dimensions of post-traumatic growth overlap with those of psychological well-being: changes in philosophy are aligned with the dimensions of purpose in life and with autonomy; changes in perceptions reflect those of environmental mastery, personal growth, and self-acceptance; and changes in relationships mirror the dimension of positive relationships with others (see Table 13.1). In this vein, the evaluation of psychological well-being (Ryff and Singer 1996) has been particularly recommended for tracking changes in growth in longitudinal studies (Joseph and Linley 2008). However, it should be emphasized that flourishing implies thriving and also directs attention to other meaningful experiences, such as positive emotions and a sense of fulfillment in social life. Finally, a special focus has been recently placed on the need for a better understanding of changes in self-experience over the recovery process, and the Scale to Assess Narrative Coherence (STAND) (Lysaker et al. 2006) has been developed to measure the extent of a coherent story about self-experience based on personal narratives of persons with schizophrenia. Four specific dimensions of self-experience are evaluated, namely, social worth, connectedness with others, agency, and illness conception. *Social worth* concerns a positive view about oneself in private and public life, reflecting the dimensions of self-acceptance and social contribution. *Connectedness with others* refers to a fulfilling and intimate relationship with at

least one person, in line with the dimension of positive relationships with others. *Agency* corresponds to the perceived ability to affect one's own destiny and to engage meaningfully with others and reflects the dimensions of mastery and positive relationships with others. Finally, *illness conception* refers to the ability to address and face diverse personal challenges, including those related to the management of schizophrenia, and overlaps with the dimensions of mastery and personal growth. Those four aspects of self-experience are thus aligned with several dimensions of positive functioning (see Table 13.1).

In summary, personal and environmental changes contributing to the improvement of psychiatric symptoms and illness impairments represent an important side of recovery and underlie a pathogenic view of this experience. A salutogenic perspective is also represented, as other transformations target the achievement of optimal levels of emotional well-being and positive functioning. The ability to function well in a life, toward which one also feels good, is the *sine qua non* of good mental health (i.e., flourishing) and, therefore, of complete recovery.

## Recovery of Complete Mental Health

The two continua model (Keyes 2007) incorporates the pathogenic and salutogenic perspectives into a unitary, complete view of recovery. Here, this experience is redefined as two complementary processes and outcomes: restoration from mental illness and optimization of positive mental health. Keyes's model underscores the need to better understand and intervene in factors and conditions that help persons, with and without mental illness, to flourish in life. Several of them have been previously discussed as key elements related to the pathogenic and salutogenic views of recovery, respectively, underlying the processes of restoration and optimization. A brief overview of strategies for promoting those two processes is now presented.

Through restoration, persons in recovery take steps to manage, and make the most of, the limitations imposed by mental illness. At the individual level, peer and psychiatric rehabilitation interventions (Copeland 2000; Corrigan et al. 2008; Drake et al. 2005) may provide support for the development of illness management skills, the reduction of deficits in a variety of domains (e.g., cognitive, social, and role functioning), and the restoration of roles, including those performed in normative settings. At the environmental level, strategies are oriented toward the alleviation of stress in the family (e.g., reduction of expressed emotions) and other milieus (e.g., provision of work accommodations) (Becker and Drake 2005; Glynn et al. 2006). In addition, other interventions are provided for decreasing stigma and discriminatory behaviors within surrounding environments and the general population (Corrigan and Gelb 2006; Corrigan et al. 2005).

Through optimization, persons in recovery take steps to move up the continuum of positive mental health. As previously mentioned, this may involve the use of supported socialization (Davidson et al. 2004), WBT (Fava and Ruini 2003) or fCBT (Cather et al. 2005) for enhancing positive emotions or positive functioning.

Building on personal strengths represents another strategy for promoting positive mental health. For instance, a self-report measure has been developed to assess a series of character strengths that are classified into six broad virtues: wisdom and knowledge (e.g., love of learning), courage (e.g., perseverance), humanity (e.g., kindness), justice (e.g., citizenship), temperance (e.g., self-control), and transcendence (e.g., spirituality) (Peterson and Seligman 2004). This survey instrument has been used as a tool for helping people with severe mental illness to identify their top five character strengths, also called signature strengths. Such activity was perceived as enjoyable and as having contributed to an increase in a sense of pride and self-esteem in participants (Resnick and Rosenheck 2006). At the environmental level, optimization strategies are oriented toward the provision of support for interpersonal flourishing (Ryff and Singer 2000), which includes opportunities to develop intimate and reciprocal relationships (Mead et al. 2001; Ware et al. 2007). Actions directed at community development are also undertaken to promote social inclusion. They entail initiatives for encouraging civic and social participation, such as those that increase access to participatory structures within mental health and nonmental health organizations (Ware et al. 2007). Other community-level interventions aim to reduce poverty and to improve access to basic resources (e.g., education, employment, affordable housing), such as those documented in the field of mental health promotion (Barry 2009). It is also worthwhile to mention the Strengths Model (Rapp and Goscha 2006)—a case management program targeting the maximization of personal and environmental strengths—and its potential efficacy for enhancing positive mental health.

Of additional relevance are strategies that are likely to promote positive changes in both restoration and optimization processes. For instance, supported approaches in employment (Becker and Drake 2005), education (Mowbray et al. 2003), and housing (Fakhoury et al. 2002) tailor activities, roles, or living environments based on the person's deficits, strengths, and aspirations. Other combined strategies can be found in helping processes that promote recovery (Anthony et al. 2003; Drake 2005). These include developing relationships with peers or professionals in which learning from illness relapse is emphasized, focusing on the optimal use of strengths, and promoting shared decision-making in the planning of individualized services (Adams and Drake 2006; Drake et al. 2009). Spiritual (e.g., meditating, praying) and wellness strategies (e.g., exercising) are also used to overcome difficulties in dealing with mental illness and for living as fully as possible (Russinova and Cash 2007). Finally, the recovery-oriented system of services (Anthony 2000) is concerned with the alleviation of mental illness and the promotion of positive mental health. Whereas treatment and crisis services specifically target the alleviation of mental illness, enrichment services support the maximization of personal strengths and wellness/prevention services aim at the enhancement of positive mental health and physical health (e.g., healthy life styles). Self-help services also sustain the development of personal empowerment over the management of mental illness and positive mental health. Another example is case management, which coordinates and secures access services across several intervention programs, including mental health promotion services.

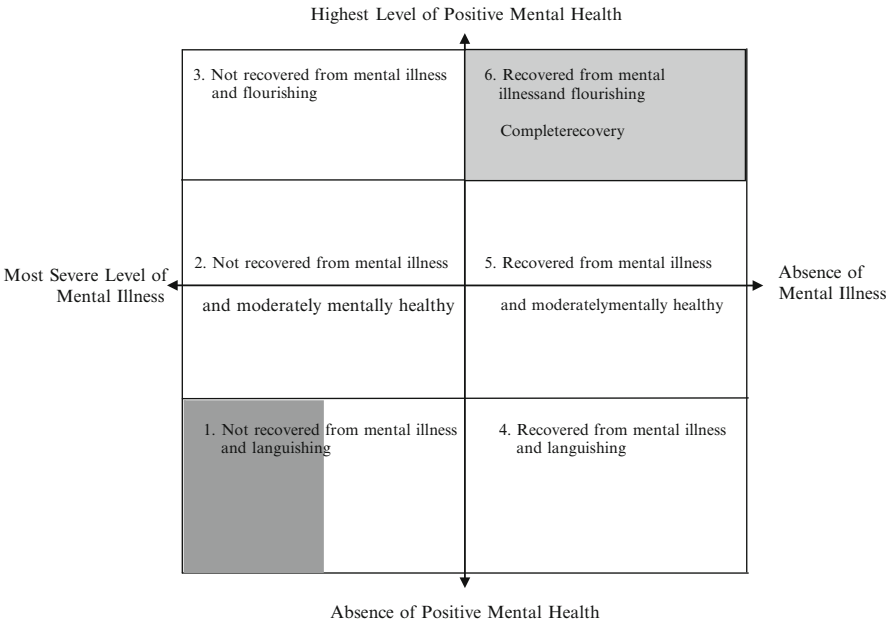


**Fig. 13.1** Pathways to complete mental health in recovery

## *Pathways to Complete Mental Health in Recovery*

Recovery is a nonlinear and highly individualized process (Spaniol et al. 2002), and changes in complete mental health occur throughout this journey and are viewed as recovery outcomes. To illustrate such dynamics, a categorical approach is proposed for evaluating pathways in recovery along two continua: mental illness and positive mental health. With regard to the mental illness continuum, Liberman and Kopelowicz's (2005) criteria are used to distinguish among those who are recovered and those who are nonrecovered from mental illness, with schizophrenia as an example of psychiatric disorder. With regard to the positive mental health continuum, Keyes's (2005a, 2007) criteria are used to differentiate between persons who are flourishing, who are moderately mentally healthy, or who are languishing.

Figure 13.1 shows two perpendicular axes that are used to illustrate pathways in complete mental health over the recovery process. Based on the criteria proposed by Liberman and Kopelowicz (2005), the horizontal axis represents the presence or absence of recovery: individuals who are located at the right of the midpoint are considered as recovered from mental illness, whereas those who are at the left are viewed as not recovered. More specifically, the midpoint indicates moderate levels of symptoms (i.e., score of four or less on each of the positive and negative symptom items of the Brief Psychiatry Rating Scale) and the restoration of roles in normative settings. In addition, individuals who are located at the right side of the midpoint

hold a part-time or full-time competitive work, whereas those who have other work status are located at the left (e.g., unemployment, prevocational training). Recovered individuals also have to live on their own (without supervision) and be involved in weekly social or recreational activities with persons without mental illness; those who do not meet these criteria are located at the left. From the pathogenic view, individuals are thus declared recovered when they fulfill all of the above criteria for at least two consecutive years. Based on the criteria proposed by Keyes, the vertical axis represents the diagnoses of positive mental health, namely, languishing, moderate mental health, and flourishing. From the salutogenic view, individuals are thus declared recovered when they meet the requirements for flourishing.

Six states of recovery emerge from the combination of mental illness and positive mental health outcomes: (1) nonrecovered from mental illness and languishing, (2) nonrecovered from mental illness and moderately mentally healthy, (3) nonrecovered from mental illness and flourishing, (4) recovered from mental illness and languishing, (5) recovered from mental illness and moderately mentally healthy, and (6) recovered from mental illness and flourishing. Altogether, these six states of complete recovery highlight that the route to recovery lies not in the alleviation of mental illness exclusively but in the enhancement of positive mental health as well.

Persons who are viewed as *nonrecovered from mental illness and languishing* (recovery state 1) have little hope or motivation for making their lives better. They may not be engaged in the exploration of personal strengths and opportunities within their environments that would allow them to build on their potential. They may also see themselves as psychiatric patients and as having a "career" in mental illness. Involvement in roles and activities is likely to be perceived as ways of passing time and keeping oneself busy. At the extreme bottom left of Fig. 13.1, the shaded area corresponds to the initial phase of recovery, where the individual is overwhelmed by the disability (Spaniol et al. 2002). These individuals have little control over the mental illness or of life in general, lack self-confidence, and feel disconnected from the self and others.

Persons who are viewed a*s nonrecovered from mental illness and moderately mentally healthy* (recovery state 2) are struggling to build a meaningful and satisfying life. In contrast to those who are languishing, they have a more positive outlook on their lives and their own potential to better enjoy and function in life. They may be in the process of discovering that they possess positive assets and strengths and may be engaged in activities in which they can further develop. They may also place more importance on who they *want to be* rather than who they *no longer are* (Pettie and Triolo 1999). Being active and doing things that bring joy and pleasure are important to them, such as participating in social activities, volunteering, or working in sheltered settings. Such activities help them to realize that they have the potential for playing a more active role in society. Among persons belonging to this profile, individuals who have reached some illness stability bear some resemblance to those who are involved in the second phase of the recovery process where individuals struggle with the disability (Spaniol et al. 2002). Building a sense of confidence in being able to act in their own interests characterizes their journey.

Persons who are viewed as *nonrecovered from mental illness and flourishing* (recovery state 3) have not reached partial symptomatic remission but are involved in nonnormative activities and roles that are perceived as enjoyable, satisfying, and fulfilling. This highlights the fact that consumers differ a great deal in their choice of meaningful and challenging activities; some value normative activities while others do not. Several reasons may account for preferences in nonnormative activities (e.g., volunteering, transitional work) or occasional self-employment, such as having control over work hours, pacing the reentry to the regular market, or prioritizing creative or independent work over other types of jobs (e.g., Brown and Kandirikirira 2007). Individuals who are flourishing and performing those activities may see their impairments as part of a positive identity through disability pride. In line with the social model of disability (Sayce 2000), they may reject the sick role, perceive social oppression as the main source of disability, advocate for their rights and entitlements as disabled persons (e.g., housing and benefits services), and request supportive and socially inclusive measures for living their lives as fully as possible (e.g., vocational or educational opportunities, peer support, leisure activities). On the other hand, other individuals belonging to state 3 may have built a sense of positive identity apart from impairments, no longer viewing them as core aspects of their selves. This may have emerged from the cultivation of personal strengths and positive assets through volunteering or self-employment which provided a less-structured work pattern that allowed them to flourish alongside other preferential activities, such as leisure or artistic work (e.g., painting, writing) (e.g., Brown and Kandirikirira 2007). Peers, acting as role models, may help individuals who want to move from nonnormative to normative roles, strengthening their sense of hope and personal empowerment in the pursuit and the achievement of those goals (Russinova 1999).

Persons who are viewed as *recovered from mental illness and languishing* (recovery state 4) have been successful in at least partially restoring what has been altered by the illness, but they remain quite unsatisfied with their lives and are involved in normal activities and roles that are not perceived as self-fulfilling. As recovery is a nonlinear process, it is possible that those individuals experience setbacks from the fifth or the sixth state (see Fig. 13.1). For instance, a person who is recovered from mental illness and moderately mentally healthy (state 5) decides to quit a job for another one that is believed to be more challenging. After a short enrollment in this new position, the person realizes that it does not fit with previous expectations in that the tasks are quite repetitive and dull, provide few opportunities for self-actualization, and generate an overall sense of dissatisfaction. As a result, this person may show a lower level of positive mental health, possibly moving from the state of being moderately mentally healthy to languishing.

Persons who are viewed as *recovered from mental illness and moderately mentally healthy* (recovery state 5) are similar to those who are living with the disability, the third phase of the recovery process (Spaniol et al. 2002). They look for normal and meaningful activities and roles that help them to build on their personal strengths and improve their quality of life. Although some still may feel limited by the illness, they value themselves as persons of worth and become more and more able to use environmental resources to meet their personal goals. Those individuals perceive

that they are making progress in finding their real places (or niches) in society. They are proud of their accomplishments and are optimistic about their futures.

Persons who are viewed as *recovered from mental illness and flourishing* (recovery state 6) shared characteristics with those who are living beyond the disability, the final and fourth phase of the recovery process (Spaniol et al. 2002). This profile corresponds to the shaded area located at the top right of Fig. 13.1. Individuals who belong to this category have reached optimal levels of subjective well-being. They look for opportunities to challenge themselves and to reach a sense of serenity and peace of mind. They are involved in diverse normal roles and activities, such as work or parental and intimate relationships, and are more self-accepting and like who they are or who they have become. They see their futures as promising, and the pursuit of personal goals is viewed as a challenging experience. Roles and activities are perceived as concrete means of self-actualization and as ways of contributing to society (Provencher et al. 2002). Some individuals may be involved in advocacy activities not only to defend their own rights but also the rights of others. Apart from the illness, a healthy sense of self is now well established, which results from successful efforts to maximize personal strengths and from the optimal use of experiential knowledge that has been acquired throughout the recovery process. When deficits are still present, individuals are well aware of them and take them into consideration in the pursuit of challenging goals, knowing how to best use them while continuing to grow and optimize their own potential. For example, a person who has sleeping problems at night will look for jobs during evening or night shifts. Finally, individuals feel well connected to their pasts and accept former aspects of themselves. With regard to social connectedness, they have learned how to build positive relationships with others and how to resolve conflicts when they occur. They both receive and provide support to others.

## *Additional Reflections on Complete Mental Health Recovery*

Whether recovery should be viewed as an outcome or as a process is still being debated in the literature (Davidson et al. 2010; Roe et al. 2007). Proponents of recovery as a process (Davidson et al. 2010) argue that the restoration of altered capacities leading to *recovery as an outcome* (e.g., symptoms, impaired functioning) is rather incomplete, as personal and social transformations that sustain pleasant and fulfilling experiences in recovery are still being overlooked. We endorse those views. However, having a good life is not an outcome of recovery for those proponents, and we do not hold this view. As previously mentioned, more than 40 years of research have contributed to the definition of what constitutes a good or flourishing life, and we have proposed several linkages between dimensions of positive mental health and recovery. Unlike previous conceptions, our model posits positive mental health as an outcome of recovery and uses the view of mental health as a complete state to reframe recovery. Complete mental health recovery thus involves two

independent but complementary experiences—restoration from mental illness and optimization of positive mental health—and each one is defined both as a process and an outcome. What is differentiated here is the mental health approach that underlies each experience: mental illness outcomes that result from the process of restoration (e.g., a disease-oriented view) and positive mental health from the optimization process (e.g., a good mental health view). Our model does not reject a pathogenic conception of recovery but views it as insufficient to define recovery in that it requires the addition of a salutogenic conception that focuses on the promotion of positive mental health.

Subjective process elements may act as protective factors against mental illness and the achievement of positive mental health. Although their detailed discussion is beyond the scope of this chapter, they include self-redefinition, hope, empowerment, and connectedness with others (Noordsy et al. 2002; Onken et al. 2007) and are redefined within the specific contexts of restoration and optimization. For instance, the development of personal empowerment over mental illness (e.g., strategies for preventing relapses) complements the acquisition of skills used for coping with languishing states, as learned in WBT (Fava and Ruini 2003). Another example concerns the development of a positive identity, along with the reduction of self-engulfment (e.g., viewing oneself only as a schizophrenic) (Lally 1989), self-stigma (i.e., negative view of oneself resulting from the internalization of social prejudices against persons with mental illness) (Corrigan et al. 2008), and the building of a health-oriented sense of self that is based on personal strengths and assets (Davidson and Strauss 1992). In addition, several objective or illness-related dimensions are viewed as playing an important role in moderating or mediating recovery, including substance abuse, duration of untreated psychosis, good initial response to neuroleptics, adherence to treatment, and premorbid history (Liberman and Kopelowicz 2005). How they may interact with subjective factors remains unclear as well as how their separate and interactive influences work to reduce mental illness and maximize positive mental health.

Our model draws attention to individuals who are flourishing, regardless of their involvement in nonnormative (state 3) or normative (state 6) activities, which is consistent with consumers' viewpoints on recovery. It can be inferred that both types of activities provide opportunities for optimal experiences, which are characterized by full absorption (i.e., when an awareness of time disappears), high involvement in the task regardless of external rewards (e.g., paid work), enjoyment, sense of accomplishment, and perceived control over the task although still viewed as challenging and as one that maximizes competencies (Della Fave and Massimini 2004). In particular, more research is needed to further determine the profile of individuals who perceive optimal experiences when doing nonnormative activities (Frese et al. 2009). A variety of factors may be explored, such as illness-related factors (e.g., premorbid functioning, cognitive, and functional deficits), personal factors (e.g., values, life goals, meaning of recovery), and how they interact with environmental factors (e.g., support for the person's own choice and pursuit of activities).

## Discussion

Keyes' model has been of heuristic value in drawing attention to the alleviation of mental illness and the promotion of positive mental health as two independent but related goals in recovery. However, limitations of the proposed methodology for assessing pathways to complete mental health in recovery still have to be addressed, as well as proposals for the direction of future clinical interventions and research.

### *Limitations*

The proposed typology of complete recovery states should be seen as a first attempt at bridging mental illness and positive mental health indicators. Liberman and Kopelowicz's operational criteria for recovery have been used for three main reasons: It allows for both symptomatic and functional recovery to be assessed, it provides clear guidelines that are proposed for evaluating each criterion, and it provides support for its discriminant and predictive validity (Liberman and Kopelowicz 2005). However, the most controversial aspect is, without a doubt, the return to normal roles as a recovery criterion, which is particularly disputed by consumers (Deegan 1996). For them, roles and activities that bring a sense of satisfaction in life, pleasure, and fulfillment are crucial issues, whatever their performance in normative or nonnormative settings. With regard to domains of recovery, previous research has demonstrated that improvements in symptoms are relatively independent from the restoration of cognitive and psychosocial functions in persons with schizophrenia, in contrast to those with anxiety disorders for whom mild symptoms coexist with mild disability (Andreasen et al. 2005). For instance, a person with schizophrenia who holds a competitive job may still show moderate levels of psychiatric symptoms. Therefore, criteria for evaluating specific domains of recovery have been strongly recommended, such as recovery of symptoms, cognitive functioning, or psychosocial functioning (i.e., recovery of vocational functioning) (Lieberman et al. 2008; Lysaker et al. 2010). The operational definition of functional recovery remains a controversial topic (Wunderink et al. 2009). The ongoing debate needs to clarify issues that are related to both the level (e.g., attempts, progress, and success in normative and nonnormative activities) and the breadth (e.g., independent living, productivity, and social activities) of accomplishment (Harvey and Bellack 2009). For instance, there is considerable variation in the social life of healthy individuals, which raises the question of what exactly are the minimal standards for determining whether individuals with mental illness have recovered in this area. That is to say, is it necessary to have an active social life in addition to employment and independent living?

The three states of positive mental health—languishing, moderate, and flourishing—have been mainly studied in persons with depression and anxiety disorders. There is a strong need to further validate existing measures of subjective well-being in persons with severe mental illness (e.g., schizophrenia, bipolar disorders), including the Mental Health Continuum-Short Form (Keyes 2009a). This scale offers the

advantage of measuring positive functioning rather than mere emotional well-being (i.e., satisfaction with life). In addition, hedonic and eudaimonic well-being may be used as a framework to develop new scales on subjective recovery outcomes. Additional research has to be done to validate the diagnostic criteria of positive mental health and to determine the prevalence of the three states in persons with severe mental illness. Future research should also translate the list of assessment criteria into expert clinical assessment in order to track changes in positive mental health and to compare self-reports with clinical assessments. This refinement is particularly needed as the assessment of positive mental health relies on the use of self-report instruments, which can be questionable in persons with poor insight and severe cognitive deficits. Duration criterion also needs to specify how long minimal requirements are to be and how long they must be maintained for flourishing, moderately mentally healthy, and languishing states.

## *Directions for Future Research*

An important area of future research is the study of mechanisms that will allow us to better understand how the experience of restoration from mental illness can contribute to the optimization of positive mental health and vice versa. One hypothesis concerns both the resources developed during the restoration process (e.g., empowerment over the illness) and the role they may possibly play in promoting positive mental health in addition to preventing exacerbation of the illness. Another hypothesis involves the possibility that a flourishing mental state may counteract the reappearance of the illness, acting as a buffer (Keyes 2007). Additional work is required to determine whether individuals who are recovered from mental illness and have moderate or flourishing mental health are more likely to counteract the detrimental effects of stress, and to even grow from it, as compared to those who are recovered from mental illness but languishing. A final hypothesis deals with the potential role of languishing as a risk factor in the recurrence of mental illness (Keyes 2007). For instance, individuals with mental illness who are languishing may be more likely to deal with stressors in an ineffective way, having at their disposals a more limited set of coping options.

The study of flourishing in persons recovering from mental illness also calls for additional theories to better understand turning points from which may emerge positive emotions and a sense of growth. For instance, previous research on meaning-based coping (e.g., redefining priorities in life in a more meaningful way) has shown that this type of coping triggers positive emotions and sustains efforts to overcome chronic stress (Folkman and Moskowitz 2000). Its role as a potential mechanism underlying the promotion of positive mental health in recovery deserves more attention (Provencher 2007).

Finally, longitudinal data are required to better understand the evolution of individuals within each state and among the six states of recovery over time, including the process of moving from one state to another. The six states may represent specific stepping stones in the recovery process.

## Conclusion

The purpose of this chapter has been to elevate the place of positive mental health and complete mental health when attempting to understand the experience of recovery. Restoration from mental illness and optimization of positive mental health are viewed as two complementary processes and outcomes in recovery. Individuals who are flourishing in life and who show low functioning in the pathogenic sense deserve more research attention, which would entail a better understanding of the nature and the meanings given to their optimal experiences. Additional efforts are needed to further develop and test interventions that enable persons with mental illness to achieve a flourishing life.

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