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Introduction

During the last three decades the concept of personal recovery in mental illness has become generally understood as an ongoing process that emphasizes hope, identity, meaning and personal responsibility. Recovery models of mental illness has been gaining popularity worldwide for several decades. Most recently, non-Western countries are also incorporating recovery concepts into mental health service planning and development. This article debates and critiques the concept of personal recovery using a Middle Eastern contextual lens. The article also explores some limitations of implementing personal recovery-oriented mental health services in diverse contexts.

Background

Modern treatment of mental illness generally focuses on the elimination of symptoms, an approach that has been greatly facilitated by the relatively recent development of antipsychotic medications. Within this clinical treatment model, patients are assessed, usually by a psychiatrist, a diagnosis is given, medications are prescribed, and the therapeutic effect of the medication is monitored. The overarching goal of this approach is clinical recovery, which refers to a return to normal function after an illness (L. Davidson *et al.*, 2005). However, while full recovery is possible in many cases, there are those whose symptoms will persist throughout their lives; medications are simply not effective for some people with mental illness (McEvoy *et al.*, 2006). Additionally, even when medications reduce symptom frequency and severity, non-adherence is common (Chapman & Horne, 2013; Lacro *et al.*, 2002). Furthermore, even if symptoms are cured, stigma and discrimination persist (Repper & Perkins, 2003). Because of these limitations, a goal of clinical recovery is neither adequate nor appropriate for many people with mental illness (Slade, 2009; South London and Maudsley NHS Foundation Trust & South West London and St. George's Mental Health NHS Trust, 2010).

Accounts from individuals from English-speaking countries have resulted in an alternate conception of recovery, one that perhaps began as a protest against the short comings of the clinical model (Frese & Davis, 1997). These accounts describe the ongoing impact of mental illness outside of the hospital setting and share insights on how to overcome or mitigate day-to-day challenges.

For example, Houghton (1982) was one of those for whom a model of clinical recovery was unhelpful:

> …my hospitalization was an entombment; the medications were an embalmment. I walked among the living dead. It was not so much cruel as morbid and morose. It lasted 5 eternal weeks.
>
> In the real world the sense of death remained for years, until I stopped ingesting medications. The transformation was extraordinary: My face was no longer swollen; extra pounds melted away; my hair grew thicker and more manageable; my movements were no longer mechanical and forced; my energy levels increased. I had a tremendous sense of rebirth (Houghton, 1982, p. 549).

In describing what did work, her *personal* recovery, Houghton offers the following:

> To survive and cope, I had to begin my life over again, to adopt a new, healthier style of living. By learning more about myself, my limits, and weaknesses and strengths, and by making changes in my way of life, I have been able to maintain my health and prevent a recurrence of mental illness (Houghton, 1982, p. 549).

Deegan (1988), a clinical psychologist, also with a diagnosis of schizophrenia, echoes Houghton's sentiments of personal recovery:

> For months I sat and smoked cigarettes until it was time to collapse back into a drugged and dreamless sleep. But one day something changed…A tiny, fragile spark of hope appeared and promised that there could be something more than all of this darkness…Hope is the turning point that must be followed by the willingness to act…I began in little ways with small triumphs and simple acts of courage…I rode in the car, I shopped on Wednesdays, and I talked to a friend for a few minutes…I took responsibility for my medications, took a part-time job,

and had my own money…One day at a time, with multiple setbacks, [I] rebuilt [my life]

(Deegan, 1988, p. 14).

These and other pioneering narratives (e.g., Leete, 1987; Lovejoy, 1982; Unzicker, 1989) led to an alternate conceptualization of recovery in mental illness, that of personal recovery. During the last three decades the concept of personal recovery has become generally understood as an ongoing process that emphasizes hope, identity, meaning and personal responsibility (Andresen *et al.*, 2003; Ralph *et al.*, 2002; Spaniol *et al.*, 2002). Some refer to the process as recovery in, rather than recovery from, mental illness because in many cases the symptoms never go away (Larry Davidson *et al.*, 2007; L Davidson & Roe, 2007). The concept of personal recovery acknowledges that people with mental illness have expertise by experience and emphasizes personal responsibility over professional authority (Slade, 2009). It stresses the social context of mental illness and fosters empowerment and growth rather than being limited to the treatment of symptoms (Repper & Perkins, 2003). The goal of personal recovery is for the individual to learn to live well within the limitations of symptoms, rather than trying to eliminate the symptoms (Anthony, 1993). However, despite a general consensus on the potential value of a recovery approach to services, considerable debate exists as to the nature and universality of the concept of personal recovery. Table 1 shows keys differences between clinical and personal recovery models.

This article will discuss and critique the concept of personal recovery through an Arabic sociocultural lens. The article will also will explore some of the limitations of implementing services that aim to support personal recovery.

Discussion

Definitions of personal recovery

Many definitions of personal recovery have been proposed. Some emphasize the individual nature of the recovery process:

A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993, p. 4).

The establishment of a fulfilling, meaningful life and a positive sense of identify founded on hopefulness and self-determination (Andresen *et al.*, 2003, p. 588).

Other definitions emphasize the difficult and ongoing struggle to persevere:

…overcoming the effects of being a mental patient – including poverty, substandard housing, isolation, unemployment, loss of valued social roles and identify, loss of sense of self and purpose in life, and iatrogenic effects of involuntary treatment and hospitalization – in order to retain some degree of control over their lives (L. Davidson *et al.*, 2005, p. 481).

Recovery refers to the … real life experiences of persons as they accept and overcome the challenge of the disability (Deegan, 1988, p. 15)

While parts of these definitions may be valid in an Arabic society, the lack of inclusion of family and community, and the overwhelming focus on the individual, suggest that certain aspects may not fit well. These aspects of Arabic culture and their potential relationship to personal recovery will be discussed in more detail throughout the article.

Empirical concepts and models of personal recovery

Anthony (1993) developed one of the first models of personal recovery in mental illness. He drew upon the personal accounts of recovery published in the 1980s to propose a recovery vision: "any person with severe mental illness can grow beyond the limits imposed by his or her illness" (Anthony, 1993, p. 9). Guided by this vision he combined aspects of the community support system model (Turner & TenHoor, 1978) and a disabilities model developed by the World Health Organization (Wood, 1980). Anthony's recovery model highlights the range of impacts that a diagnosis of mental illness can have on an individual (e.g., impairment, dysfunction, disability, disadvantage) and lists which aspects of services can address these areas. However, this model is not empirically based, and Anthony acknowledges the need for further development through empirical investigation of people's accounts of recovery.

This call has been taken up by many in the field, resulting in the development of numerous concepts, models, and frameworks over the ensuing decades. Some of these are outlined in the following paragraphs. This section is not meant to be a comprehensive review of the recovery model. This information can be found elsewhere (Leamy *et al.*, 2011; see Slade, Leamy, *et al.*, 2012). Instead this article will discuss select exemplars to

highlight the similarities and differences between the models as well as the strengths and weaknesses across the models.

Western models. Jacobson and Greenley (2001) describe a conceptual model of recovery that was developed in the United States. The main concepts were decided upon in consultation with a diverse stakeholder group that included health care professionals, people with mental illness, policymakers and advocates. These concepts are somewhat similar to other recovery concepts described below: Hope, healing, empowerment and connections. These are very positive concepts that are intuitively appealing, which may lead to a situation where personal opinions are more likely to have an impact on treatment decisions than research evidence (Green, 2000). The only rationale that Jacobson and Greenley give for choosing these particular concepts is "an analysis of numerous accounts…" (Jacobson & Greenley, 2001, p. 482) without even citing these accounts. The reader is given no information about the number or characteristics of the individuals who provided these accounts, or where the accounts were from. Thus, it is unclear whether the model is based on characteristics of the local population or whether it may be appropriate for people with mental illness in other contexts.

Repper and Perkins (2003) describe six concepts of personal recovery. They title this section "What might recovery involve?" and state that "These must not be taken as a recipe or a set of predetermined stages"(Repper & Perkins, 2003, p. 51). It is obvious that the authors recognize the hazards in promoting a universal model, which would ultimately set many people up for failure (Deegan, 1988). The rationale for presenting these

concepts is to provide several broad areas they feel mental health professionals must be aware of in order to provide recovery-oriented care. The concepts include: restoring hope; the importance of relationships; spirituality, philosophy, understanding; taking back control; coping with loss; and, the quest for meaning and value. The authors also offer an insightful description of recovery that overcomes one common criticism – that the process of personal recovery is not one where people actually recover from their illness (P. D. Davidson Larry *et al.*, 2006; Slade, 2009). Instead of recovery from illness, Repper and Perkins emphasize the recovery of a meaningful and valuable life.

Andresen, Oades and Caputi (2003) developed a set of concepts based on a literature review of 50 articles containing the personal narratives of people with schizophrenia. The concepts include: finding hope, re-establishment of identity, finding meaning in life, and taking responsibility for recovery. The concepts implicitly indicate a role for mental health professionals in promoting recovery, for example, by encouraging a patient to be hopeful, by helping a patient to focus on positive aspects of their identity and life in general, and by promoting personal responsibility. However, while the simplicity is helpful for guiding professional care, it also suggests that the process itself should be simple (Larson, 1999). This creates a risk that patients will be expected to 'simply' find hope and move on. The actual process of doing so is a complex one that is different for everyone and not easy to achieve (Drake & Whitley, 2014). Unfortunately, this complexity is lost in Andresen's model. Additionally, the article tends to generalize the

results as a model for all of mental health care. However, generalization should be limited since the review focused only on people with schizophrenia.

Slade (2009) criticizes models of recovery because they are static, while recovery is not. He offers a personal recovery *framework*, which confusingly, is based on a modified version of Andresen et al.'s (2003) model. The concepts, Slade labels them domains, that form the foundation of his recovery framework are hope, identity, meaning, and personal responsibility. These concepts have been modified from Andresen's original model based on a report published by the National Institute for Mental Health in England (National Institute for Mental Health in England, 2004). However, the concepts/domains remain so similar to those identified by Andresen that it creates a question about the generalizability of Slade's framework: the foundations of the framework are based heavily on Andresen's model; Andresen's model is based only on the experiences of people with schizophrenia; and, it is simplified to the point that it loses the complexity involved in the individual recovery experience.

Furthermore, it is unclear how Slade's (2009) 'framework' differs from a model. It is perhaps because Slade goes a step beyond the concepts to identify four recovery tasks: developing a positive identity, framing the 'mental illness', self-managing the illness, and developing valued social roles. These tasks operationalize the recovery concepts/domains and serve to organize the actual framework. The tasks are aimed at helping a person develop in the four domains listed above. One positive aspect of this model is that it allows for recovery to be an ongoing process and does not prescribe the order in which

the tasks takes place (Larry Davidson *et al.*, 2010). Additionally, it is less concrete than other models. This allows more flexibility for individuals to define their own recovery journey (Office of Mental Health, 2004).

One of the limitations of our current knowledge is that recovery models/concepts/frameworks are based on a relatively uniform population, mainly Western Anglophones. Recovery literature from the United States has been criticized as being overly individualistic; literature from the United Kingdom has been based mainly on majority population and does not account for ethnic differences (Gould, 2012). Even within Anglophone populations, differences in the main foci in personal recovery are emerging: Australian models tend to emphasize personal strengths, models from the UK and USA emphasize community integration and participation, and the importance placed on meaning in life is higher in Canada and the UK (Slade, Leamy, *et al.*, 2012).

If differences exist in these relatively similar Anglophone populations, what should be expected in contexts that are socially and culturally dissimilar? A small body of literature that documents recovery in diverse populations has emerged in recent years. I will now turn to this body of work to examine the fit of the recovery model from more diverse perspective.

Non-Western models. Song and Shih (2009) examined the factors and processes associated with recovery in a sample of 15 Taiwanese participants with mental illness. One difficulty in comparing this study to the body of literature on personal recovery is that the authors define recovery as 'not having any admissions for the past year'. This is more in

line with clinical recovery and, according to the majority of the literature on personal recovery, not necessarily related to the vision of living well within the limitation of illness (Larry Davidson *et al.*, 2005; Repper & Perkins, 2003; Slade, Williams, *et al.*, 2012). Despite this limitation, the article identifies several interesting aspects of 'recovery' as it relates to a Taiwanese population. In particular, the authors identify three cornerstones for recovery. First is symptom remission or gaining control, where participants begin to be able to manage more easily despite symptoms and medication side effects. This first component is somewhat in contrast to Western models. For example, Taiwanese participants discuss being 'cured' and the importance of medication in this process. In the West, medications are acknowledged as being important for many but they are more often viewed as a necessary evil rather than as a foundation (Slade, 2009).

Self-reliance, hardiness and resilience is the second foundation identified by Song and Shih (2009). This aspect seems more congruent with Western models, particularly American models. This foundation also aligns well with the concept of hope from Western models as Taiwanese participants often referred to having the courage to face challenges and never giving up.

The third foundation, family support, was the least surprising, considering the importance of the family in Taiwanese culture (Thornton *et al.*, 1994). The family, particularly the parents, were seen as being essential in providing unconditional positive regards and encouragement to participants. This support provided both motivation and a sense of duty to overcome the challenges imposed by mental illness (Song & Shih, 2009).

In another Asian study, Sung et al. (2006) investigated recovery among eight

Korean university students with schizophrenia. Their definition of recovery was broader

that that used by Song and Shih (2009) and included school attendance, social activity, and

peer relationships in addition to symptom remission. However, the sample is small and

specific (i.e., university students).

The Korean study identified themes in participant narratives according to whether

the participant was on a 'recovering course' or a 'deteriorating course'. Both courses

included major themes related to both family and social interaction. Similarly, successful

social engagement is a key factor in Western models of recovery (Leamy *et al.*, 2011).

However, it seems that social engagement in this Korean sample is not so much about

being successfully engaged in meaningful activity and relationships, as it is about the

quality of relationships with others and how high quality relationships provide a sense of

inclusion. While both Asian studies have limitations, there are clear differences from

Western conceptualizations of recovery. These differences warrant further, rigorous,

investigation.

A final, hybrid example is a narrative study of 20 Maori (indigenous) and 20 non-

Maori individuals with mental illness conducted in New Zealand (Lapsley *et al.*, 2002).

While non-Maori participants would be considered 'Western', the Maori people are an

indigenous population with unique culture, language and customs (New Zealand Ministry

for Culture and Heritage, n.d.). The authors of this study identified stories relating to the

journey *into* mental illness and the journey *out of* mental illness and developed two

frameworks to support recovery. They also identified several aspects of Maori's recovery experiences that differed from their Western counterparts and are unique to the recovery literature.

First, the extended family played a major supportive role for Maori's with mental illness. This was not simply emotional support as highlighted in the Asian studies (Song & Shih, 2009; Sung et al., 2006) but also included an important functional role (e.g., providing childcare, housekeeping, housing, etc.). Second, Maori's cultural interpretations influenced how they perceived the cause of current signs and symptoms, and also whether or not a psychiatric diagnosis was accepted. For example, one participant felt that his condition was the result of an illegal land transfer by his family several generations past, and not due to biochemical imbalances as he had been told. Finally, the majority of Maori participants reported using traditional healing practices. Many reported positive outcomes from these treatments, mostly derived from feelings of reassurance and connectedness.

Despite Maori's recovery having these unique dimensions (compared to Western counterparts), a separate model of recovery was not created. Instead, a one-size-fits-all approach was taken, with enough flexibility incorporated into the model to allow for individual and, presumably, cultural differences. The authors do not address how this model could be incorporated into services or how cultural differences should be accounted for. Cross (2000) writes that when beliefs about health and illness differ from the context where a particular approach to health care developed, a modified approach to

health and wellness is necessary. However, in the case of New Zealand, the model was developed using a culturally diverse population. Whether this will enable the development of supportive mental health services that are appropriate to both cultural groups (i.e., Maori and non-Maori) is currently unclear.

Recovery-oriented mental health services

Throughout this paper it has been established that people recover from mental illness in spite of the fact that signs and symptoms sometime remain. We have argued that concepts are similar but that there are slight differences in every model. Additionally, there are obvious limitations to these models. In particular, continued research is needed in diverse contexts to examine the recovery of people in these contexts. If local understanding is not developed, there is a risk of imposing a value-laden model that has the potential to cause more harm than good.

Despite the confusion, debate, and potential risks, Anthony's (1993) original vision remains strong, and in fact, it is been increasingly incorporated into international practices and policies (Gagne *et al.*, 2007). The USA, the UK, Canada, and many other Western countries have published guidelines on national mental health care that call for a shift to recovery-oriented services (see for example, Bartram & Mental Health Commission of Canada, 2012; Her Majesty's Government/Department of Health, 2011; United States Public Health Service, 1999), even though it is often unclear how these services should be organized.

The State of Qatar has recently followed suit with the publication of the National

Mental Health Strategy (Supreme Council of Health, 2013). This document outlines a vison

for the redevelopment of services based on people's potential to lead meaningful lives

despite their illness. The report also acknowledges that the lack of local knowledge

creates a barrier to efficient service development.

Slade (2009) argues that the main objective of mental health services should be to

support personal recovery. More specifically, Davidson et al. (2006) advocate for services

to be designed in a way that emphasizes people's strengths, resources and competence as

well as enhancing their membership in the community. To achieve this would require a

shift in professional values, giving priority to individuals' long term concerns over

shortsighted "clinical preoccupations and imperatives" (Slade, 2009, p. 3). However, this

approach may not be culturally congruent with a collectivist Arabic society where group

membership and loyalty are seen as more important than individualism.

Islamic ethical principles highlight the importance of the collective over the

individual. For example, benefit to society can supersede autonomy in Arabic countries

(Abdur Rab *et al.*, 2008; Fadel, 2010). The guiding ethical principles of Islam place the

community before the individual in order of importance. One could hypothesize from this

position that recovery-oriented services in an Arabic society might emphasize the long

term needs of the community as well as, or even ahead of, the individual. In fact, even in

Western countries it has been argued that the strong emphasis on individualism

marginalizes the value of interpersonal and community support (Deegan, 1988; Mind,

2008). However, one strength of the recovery approach is that it does not commit to a particular social, spiritual or organic understanding of mental illness (Anthony, 1993). Therefore, there is potential for successful adaptation to diverse contexts.

Repper and Perkins (2003) also focus on individuals' long term concerns as a defining feature of recovery-oriented services. They argue that services should aim to help people "retain or rebuild a meaningful and valued life…within and beyond the limits imposed by the [mental illness] (Repper & Perkins, 2003, p. ix). Once again, however, they stress the importance of the individual, rather than the family or the community. Additionally, their view on recovery stems from the assumption that discrimination and exclusion, rather than symptoms, cause the greatest degree of disability for people with mental illness. This may also be true in Arabic countries, where a high degree of stigma exists (Bener & Ghuloum, 2011). However, the impact of stigma in the Arab region has not been well studied so it is difficult to support such a claim. Furthermore, differences in beliefs towards mental illness in developing countries means that promoting recovery may have unique challenges (Lauber & Rössler, 2007).

The doctor-patient relationship is another area where a recovery model may not fit well with mental health services in Arabic countries. Within a recovery model, professional expertise is seen a resource that may or may not be used, or helpful to, all patients. Patients decide what is helpful and what is not and are considered experts by experience. Rahsad (2004) describes a health care system in Egypt where the doctor is the authority and the patient does, or is supposed to do, what the doctor tells him/her. While

Rashad seems somewhat critical of the system, El-Islam (2008) suggests that Arabic

patients prefer an authoritative approach. He describes how patients want their

psychiatrists to remove (i.e., cure) their illness, and will accept little personal responsibility

for their treatment. Rather, it is the Arabic family who often works with the psychiatrist to

enable treatment (El-Islam, 2008). It is worth noting that paternalism is not unique to the

Arabic health care system and has been well documented worldwide (Cody, 2003).

However, there has been a slow shift in developed countries to a more collaborative

approach over the past several decades (Nys, 2008).

Summary

It is widely accepted that personal recovery is an individual process and that what

works for one person may not work for someone else. Because of this, "there can be no

invariant generalizable theory or model" (Slade, 2009, p. 77). However, personal recovery

is increasingly being framed as a professional initiative through model/framework

building, jargonizing, and crystalizing concepts so that they can be fed to the scientific

process. This approach has scientific merit; defining and operationalizing concepts enables

scientific investigation as well as the development and evaluation of recovery-oriented

services. However, one risk of raising recovery to a professional level lies in reducing a

complex process to a few discrete categories. This course of action has the potential to

make the entire process inaccessible to the people who do it (i.e., people with mental

illness). Deegan (1999) as cited by Repper and Perkins (2003) argues that a recovery

approach becomes less useful for patients as it becomes more systematized. Alternatively,

the reduction of complex personal experiences into common or core concepts can provide

a manageable way for health professionals to approach treatment and understand illness

(Charmaz, 2014; Glaser & Strauss, 1967). Finding a middle ground between acknowledging

complexity while simplifying concepts just enough so that they are useful in professional

practice is perhaps one of the most difficult challenges in implementing a recovery

approach to mental health care.

For mental health practitioners, personal recovery might be better viewed as a

philosophy of care (Anthony, 1993), rather than a model or framework. It involves

prioritizing patients' concerns even when they are in contrast to the status quo of clinical

treatment, or even with one's own personal values. It also involves a longitudinal outlook;

mental health professionals should aim to promote personal recovery over time, not treat

acute 'episodes' of mental illness. Granted, this is often difficult for hospital-based staff

who rarely have contact with a patient along other points in the recovery path. Finally, a

recovery philosophy means accepting and embracing the well documented fact that it is

possible for people with mental illness to have a meaningful, productive life. Perhaps it

would be helpful for mental health professionals to remember that "people with mental

illness want to work, love, play, make choices, be citizens – all the normal entitlements,

roles and responsibilities of being a person" (Slade, 2009, p. 137).

Successful implementation of the recovery model in non-Anglophone contexts

depends even more upon understanding the specific population receiving treatment. This

article provides several examples of how current conceptualizations of personal recovery

may not suit people with mental illness in an Arabic context. An uncritical incorporation of a Western-biased recovery model into non-Western mental health services may lead to imposition of inappropriate values on people receiving treatment (Cross *et al.*, 2000). Continued research into the strategies that people use to manage their illness, as well as what services can do to support this self-management, is needed in a range of ethno cultural contexts. This will help to help to identify culturally appropriate ways to improve services and contribute to the global discussion on personal recovery in mental illness

Finally, the primary motivation for future recovery research in diverse contexts should not be to validate current academic models of recovery. Even within a Western context, it is obvious that there are differences in recovery models and that there is no universal model or approach. Subsequently, recovery research should be conducted with the aim of discovering how people manage to live rewarding lives within the limitations imposed by the struggles and challenges they face. The motivation for recovery research in new contexts should be practical (e.g., to enhance the lives of individuals with mental illness) and based on priorities set by service users and not academics (Lapsley *et al.*, 2002).

Competing Interests

The authors declare that they have no competing interests.

Authors' Contributions

All authors made substantial contributions to the conception and design of this article. XX was responsible for the literature review and manuscript preparation. XX and XX were

responsible for critically review and revision of the manuscript. All authors read and

reviewed the final manuscript.

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Table 1. Comparison of clinical and personal recovery models

	Clinical Model	Personal Recovery Model
Goal	Absence of symptoms	Recovery and maintenance of a meaningful life
Time span	Short, usually focused on the period of the hospital stay	Long, throughout the lifetime
Decision making responsibility	Psychiatrist	Service user
Treatment approach	Medications	Empowerment