

## **An Integral Approach to Mental Health Recovery: Implications for Social Work**

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*The term recovery has become increasingly popular in the area of mental health care. Recently, it has been described by policy makers as the guiding vision for transforming the mental health system. Problematic, however, is that a lack of clarity continues to exist regarding how recovery is to be defined. Definitional attempts often appear to have competing opinions about what the concept exactly stands for. This causes confusion for both professionals and consumers desiring to adopt a recovery approach. Ken Wilber's integral theory is presented as a framework for organizing and connecting various viewpoints related to the "recovery" concept. Implications for social work are discussed.*

**KEYWORDS** *Mental health, recovery, integral approach, social work*

In recent years, the term *recovery* has become a buzz word in the area of mental health care. This is evidenced by the emphasis in the President's New Freedom Commission final report (2003) on recovery as the guiding vision for transforming the mental health system in the United States (Davidson, O'Connell, Tondora, Lawless & Evans, 2005). Considering that social workers constitute the largest group of practitioners in the mental health field (Bentley, 2002), it is important for the profession to have a clear understanding of the recovery vision. However, this is complicated owing to the heterogeneity of opinions regarding what *recovery* actually means in a contemporary context (Davidson et al., Jacobson & Curtis, 2000; Onken, Craig, Ridgway, Ralph & Cook, 2007; Young & Ensing, 1999). Throughout the literature, differing and sometimes seemingly contradictory opinions exist on key issues

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including the underlying etiology of mental illness, appropriate treatment approaches, primacy of the role of professional versus the consumer in the helping process, the validity and utility of diagnosis, how much focus should be given to symptoms and deficits versus strengths and capacities, and what the best indicators of recovery are. This has become problematic for policy makers and mental health agencies, many of whom are eager to transform services to make them more recovery-oriented (Jacobson, 2004). Also, mental health consumers and providers wishing to adopt a recovery framework are apt to be confused about what exactly constitutes recovery.

To help allay confusion, this article will organize and connect insights from different views of mental health recovery by drawing on aspects of Ken Wilber's integral theory (1995, 2006). The intention is to create a conceptual framework that brings together the competing ideological positions held by key stakeholders who have helped to shape the contemporary recovery paradigm. Ken Wilber is a widely recognized integral theorist who has begun to be referred to by social work scholars aiming to integrate the profession's various theoretical and ideological influences (Canda & Furman, 1999; Kerrigan, 2006; Larkin, 2006; Thomas, 2004). Implications for social work practice and education will be discussed.

## HISTORICAL BACKGROUND OF THE RECOVERY CONCEPT IN MENTAL HEALTH

During the past two centuries in the United States there have been several phases of mental health reform—each encompassing a different understanding of mental illness and recovery. In reviewing the historical background of the recovery concept, early mental health treatment approaches will be discussed, along with social work's early involvement in mental health care. The development of the modern recovery paradigm will also be explored. This will include a review of the main tenets held by four major stakeholder groups that have contributed to the recovery concept throughout the past half-century. Finally, current challenges will be presented.

### Early Mental Health Treatment Approaches

For approximately a 100-year period leading up to the middle of the 20th century, institutionalization was the primary mode of care for those considered mentally ill (Dain, 1976). The increased popularity of institutional care was much owing to the efforts of Dorothy Dix, a philanthropist who rallied state and federal governments to take action to improve the lot of the mentally ill. Dorothy Dix acted primarily out of concern to what she viewed as a lack of humane care, as many of the mentally ill were being housed in poorhouses and jails (Trattner, 1999). Federal and state governments responded and, by

the latter part of the 19th century, literally every state had built a public facility solely for the care of the mentally ill population.

Initially, public mental institutions relied on “moral treatment,” which was a form of treatment that had been popular in France and England since the end of the 18th century (Dain, 1976; Roberts & Farris Kurtz, 1987). The main premise was that mental illness was indeed treatable if it was recognized early enough and if the person was treated humanely, engaged in leisurely activities, and received rest in a relaxing environment removed from the community. The hope was that well-run hospitals would provide the necessary ingredient to allow people to recover. Actually, hospital superintendents fueled this aspiration by regularly boasting of high success rates, typically ranging from 40% to 60% (Dain). This contributed to feelings of optimism that recovery was indeed possible and that institutional care, under the guise of moral treatment, could be a successful mechanism for accomplishing such an aim. At the time, recovery was measured primarily in terms of discharge rates (Jacobson, 2004).

By the turn of the 20th century, the sense of optimism about the possibility that people can recover from mental illness began to fade. Two contributing factors were the overcrowding of public mental institutions, and new diagnostic developments introduced by European physicians (Dain, 1976; Jacobson, 2004). Overcrowding in public mental institutions coincided with an increase in the immigrant population (Roberts & Farris Kurtz, 1987). Initially, many states responded by increasing the amount, and size, of facilities. However, eventually, as funds became limited, conditions of public mental institutions began to deteriorate. This was well documented and made public on a large scale in 1908 with the publication of *A Mind That Found Itself*, a book written by Clifford Beers (1908), an ex-patient who later went on to co-found the National Committee of Mental Hygiene. Recounting his own experiences in a variety of institutional care settings, Beers revealed that not only were asylums overcrowded and the physical conditions very poor but many patients were subjected to physical abuses by poorly trained staff. Beers also reported that little was offered in the form of effective treatment (Dain). As a result, reported recovery rates declined, and mental illness soon came to be viewed as a chronic condition.

Contributing to the idea of chronicity was the formulation of a new diagnostic category in the late 1800s. European psychiatrist Emil Kraepelin used the term *dementia praecox* to describe a form of mental deterioration that was believed to incur lifelong mental deterioration (Jacobson, 2004; Strauss, 2005). *Dementia praecox* later came to be known as *schizophrenia* (Bleuler, 1911/1950). Recovery or “cure” was not expected. Rather, it was believed that those who were afflicted with this condition would always show a “defect” (Bleuler; Jacobson). By the turn of the 20th century, it was clear that the hopefulness of the possibility for recovery from mental illness that had been associated with moral treatment a generation earlier

had dissipated. Instead, institutions took on the role of custodial caretakers and, for the most part, it was to remain this way until the mid-20th century (Dain, 1976, Roberts & Farris Kurtz, 1987).

### Social Work's Early Involvement in Mental Health Care

Social work's first direct involvement in the care of people with severe mental illness (SMI) began in the first decade of the 1900s, as the new profession started to carve out a piece for itself in mental health in the form of aftercare. The idea of aftercare for the mentally ill was modeled after a voluntary organization in England known as the After Care Society (Schaefer Vourlekis, Edinberg, & Knee, 1998). Initially, the concept of aftercare was not easily accepted in the United States because institutionalization was the norm and there was little recognition that mental illness happened on a continuum of severity. In other words, those deemed well enough for discharge were viewed as no longer ill and were, therefore, expected to make their way in society just as anyone else. However, social workers, along with influential physicians, helped raise awareness that people discharged from mental institutions were indeed in need of assistance when returning to the community. Between the period of 1906 and 1918, formalized aftercare programs were established in psychiatric hospitals in New York, Illinois, and Massachusetts. Social workers were hired to take on the primary responsibility for the provision of aftercare services, creating a new area of specialization for the nascent profession, which came to be known as psychiatric social work (Jarrett, 1918; Schaefer Vourlekis et al., 1998). By 1930, a total of 176 social workers were employed by psychiatric hospitals in 24 states (U.S. Bureau of the Census, 1933, as cited by Schaefer Vourlekis et al., 1998).

Throughout the period between the 1920s and the 1960s, social work drew heavily on psychological theories (Goldstein, 1984). The impact of the mental hygiene approach was evident in an address given by Mary Jarrett (1918), an early psychiatric social worker and lecturer, at the 1918 National Conference of Social Work. Jarrett emphasized the role of psychiatric factors in a wide range of social problems, proposing that caseworkers involved in all areas, including those working with families and children, could help to avoid acute psychiatric episodes through early detection and treatment of mental and emotional difficulties in the community. Strategies such as addressing bad thinking habits, proper diet, and the development of emotional control were to be utilized to promote mental hygiene. Jarrett's address represented a widening of psychological understanding within the social work profession, as prevention became a central theme.

By the 1930s, psychoanalytically based understandings of human behavior began to permeate social work (Hamilton 1958; Perlman, 1957). The profession may have been attracted to psychoanalytic theory partly owing to the sense of prestige that was attached to it. Its methods were fashioned

after the “medical model” and deemed to be scientific. For the most part, psychological problems were believed to be the result of early childhood trauma, often connected to errors in child rearing. Techniques such as free association and dream analysis were employed with the goal of allowing unconscious materials to surface. One of the problems with psychoanalytic theory is that it had limited applicability for those who were the most seriously mentally ill (Nelson, 1994). Psychoanalytic theory could do little to reduce hospitalizations among people with SMI. By the 1940s, institutional care reached its peak, as approximately half of the hospital beds in the United States were occupied by psychiatric patients.

### Development of Modern Recovery Paradigms

Contemporary recovery paradigms stem principally from ideological and technological advancements that have occurred since the middle of the 20th century (Jacobson, 2004). Authors who write about recovery typically give credit to those involved in professionally led community integration efforts and mental health consumers for the development of the contemporary recovery vision (Jacobson & Curtis, 2000; Spaniol, Wewiorski, Gagne & Anthony, 2002). Some writers have made efforts to differentiate between those referred to as “consumers” and those who consider themselves “survivors/ex-patients” (Chamberlin, 1990). Others have pointed to the influence of the modern scientific paradigm (Jacobson, 2004). All of these viewpoints are taken into consideration in Table 1, which presents an overview of the contributions of four major foundational stakeholder groups: (a) the modern scientific paradigm, (b) professionally led community integration efforts, (c) survivor/ex-patient movement, and (d) contemporary mental health consumers. These four stakeholder groups are portrayed in terms of the primary viewpoints that they hold on etiology of mental illness, preferred treatment approach, professional and consumer roles, diagnosis, how the client is viewed, and what are the indicators of recovery. The purpose of Table 1 is to highlight the main tenets held by each group to better understand how each has contributed to the contemporary recovery concept. This does not negate recognition that there has been a significant amount of transversing of ideas among stakeholder perspectives throughout the years.

#### THE MODERN SCIENTIFIC PARADIGM

Although at various points throughout history a number of prominent philosophers, scientists, and scholars had proclaimed strong speculations that the underlying cause of SMI may be rooted in the material brain, this notion was pursued with a renewed rigor as a result of the discovery of antipsychotic medications in the 1950s (Floyd Taylor & Bentley, 2004; Nelson, 1994). Antipsychotics differed from previous medications in that they were capable of

**TABLE 1** Conceptualizations of Recovery: Positions Held by Major Stakeholders

	Modern scientific view	Professionally-led community integration efforts	Survivor/ex-patient movement	Contemporary mental health consumers
Etiology	Biology/brain disease	Biology/environment	Mental illness is a socially constructed concept	Biology/environment
Treatment	Primarily medications	Skills training/community integration services	Self-help	Illness self-management/self-help/medication/professional services
Professional/consumer roles	Professional is expert, consumer has passive role	Professional has expertise but mutual relationship is emphasized	Distancing from professional care desired	Consumer is at center; self-direction and responsibility is emphasized
Diagnosis	Diagnosis is viewed as necessary to understand and treat effectively	Diagnosis is accepted; acceptance of illness emphasized	Diagnosis is viewed as labeling or considered to be harmful and stigmatizing	Generally accepting of diagnosis; refute the idea of chronicity
View of client	Focus is primarily on symptoms and deficits	Recognize both deficits and strengths; move forward despite limitations	React strongly against mental health system's focus on pathology	High focus on strengths, capacities, and higher human goals
Indicators of recovery	Primarily symptom reduction	Improved social functioning and community integration	Empowerment/independence from mental health system/advocate for rights	Internal shift/movement from hopelessness toward hope/manage one's own care plan

producing improvements in thinking among people experiencing psychosis, whereas earlier pharmaceuticals merely had strong sedative effects (Marder, 2001). Psychopharmacological discoveries fortified a central position for a scientific understanding of mental illness, promulgating the notion of a “brain disease” etiology (Floyd Taylor & Bentley, 2004). The logic was that if medications could control symptoms, surely the cause of mental illness must have a biological basis. The “medical model” was to remain dominant in the mental health fields including psychiatry, psychology, and social work, albeit in a somewhat different form than the previously prevailing psychoanalytic model. Though the professional, namely the psychiatrist, maintained a position of authority and expertise, the primary role shifted from that of the insight-oriented analyst to medication specialist (Nelson, 1994). Biologically based explanations and treatments have continued to dominate throughout the past half-century. Advances in brain imaging techniques have helped scientists gain a clearer understanding of the role of brain chemistry while more effective and safer medications continue to be discovered. Although scientists have yet to discover a “cure” for SMI, they are hopeful that they may one day be able to do so. From a modern scientific standpoint, recovery is equated primarily with medication-induced symptom alleviation (Jacobson, 2004).

#### PROFESSIONALLY LED COMMUNITY INTEGRATION EFFORTS

Meanwhile, during the 1950s, there was a backlash against institutionalized care. The prevailing view was that long-term stays in mental hospitals were ineffective and could actually make people worse (Nelson, 1994). This sentiment, along with advances in medications discussed previously, eventually led to wide-scale deinstitutionalization beginning in the 1960s with President Kennedy’s 1963 Community Mental Health Centers (CMHCs) Act (Schnapp, 2006). Social workers, having had experience running groups for people with SMI in intermediate care facilities since the 1940s, played an important early role in helping to develop community-based mental health services (Stromwall & Hurdle, 2003). However, by the mid-1970s, it became evident that many CMHCs were not adequately equipped to meet the needs of those with the most serious mental illnesses (Dixon and Goldman, 2004; Rapp & Sullivan, 2002). This motivated the National Institute of Mental Health to sponsor a pilot program called the Community Support Program (Sullivan, 1995). Services primarily included the teaching of skills for independent living and vocational rehabilitation along with providing occasions for recreation and socialization with peers. Many link the sponsoring of community support programs to the birth of psychiatric rehabilitation (PR) services, which by the 1980s were being offered by hundreds of agencies throughout the United States (Cnaan, Blankertz, Messinger & Gardner, 1990; Sullivan).

Reviews of the PR field were conducted by Cnaan, Blankertz, Messinger, & Gardner in 1988 and then again 15 years later by Corrigan (2003). PR providers are multi-disciplinary in that they can come from a variety of training backgrounds including social work, psychology, psychiatry and rehabilitation counseling (Corrigan). Early models of PR had the professional in a more directive role although, in recent years, there has been an increased emphasis on mutuality in the client-worker relationship (Deegan, 1988; Jacobson, 2004). SMI is considered to be disease-related, likened to a physical disability (Corrigan). In the case of psychiatric illness, however, the disease element is believed to be operative through biological vulnerability that, when combined with stressful life events, results in psychiatric symptoms. It is also believed that once a person has developed a mental illness, societal stigmatization can exacerbate that person's problems beyond those caused by symptoms, through the blocking of social opportunities. Generally, acceptance of one's illness or "disability" is understood to be a necessary prerequisite for movement toward wellness to begin. Another important factor is symptom management. An inability to control symptoms is believed to undermine rehabilitation efforts. Strategies for symptom management consist of a regular medication regime, along with cognitive rehabilitation strategies.

The focus of professionally led community integration efforts is typically not on "curing" one's disability but instead on learning how to manage it and live with the limitations it imposes (Corrigan, 2003). Assisting clients to improve their social functioning is a primary goal. Successful employment, independent living, and the ability to engage in healthy social relationships are desired outcomes. Recovery is primarily defined by a person's ability to accomplish social gains. Jacobson (2004) uses the term *practical recovery* to describe this conceptualization of recovery.

#### SURVIVOR-EX-PATIENT MOVEMENT

Groups of discontented "ex-patients" have been gathering separately from the formalized mental health system since the beginning decades of the 20th century (Chamberlin, 1990). However, owing to a lack of written records, the early history of these groups remains obscure. By the 1970s, the survivor-ex-patient (S/E) movement began to be recognized nationally. Some of the most vociferous groups were founded in New York, Portland (Oregon), and San Francisco. These included the "Mental Patients' Liberation Project" (1971), the "Insane Liberation Front" (1970), and the "Network Against Psychiatric Assault" (1972) (Chamberlin, Jacobson, 2004; Stromwall & Hurdle, 2003). Most of the individuals who composed these groups were formerly institutionalized individuals, hence the term *ex-patient*. The term *survivor* represents having to survive what many individuals perceived as an oppressive mental health system.

The early S/E movement has been described as radical and reactionary in that hostility toward the formal mental health system was typically expressed (Chamberlin, 1990; Jacobson, 2004). There was a strong opposition to the medical model. One contention was that power inequalities caused users of mental health services to become passive and complacent. Another grievance had to do with the negative effects of labeling. Drawing from anti-psychiatry literature of the 1960s, S/Es questioned the popular view of mental illness as a disease. Rather, they followed the opinions of a group of scholars operating from a social constructionist ideological framework, who offered an alternative explanation of mental illness (Scheff, 1966; Szaz, 1961). For example, in his popular text, *The Myth of Mental Illness*, Thomas Szaz argued that labeling people “mentally ill” essentially represents a societal attempt to control unwanted or deviant behaviors. Furthermore, S/Es pointed to the societal stigma and discrimination they experienced as a result of carrying a label (Gilmartin, 1997). They argued that labels were responsible for blocking them off from participating in social opportunities, including obtaining satisfactory employment and adequate housing.

S/Es make use of self-help and advocacy as primary tools for promoting their cause (Chamberlin, 1990). Self-help is viewed as a positive alternative to services offered by the formal mental health system. For early S/Es, self-help served as an important vehicle of empowerment, as participants were allotted an opportunity to process their grievances with the mental health system. Advocacy is commonly utilized to fight discrimination inherent in the mental health system, society, and law. S/Es have long been strong opponents of forced treatment (forced medications) and involuntary commitment and have lobbied to change laws around these issues. From an S/E point of view, recovery is closely tied to an increased sense of empowerment, often through involvement in a collective social movement. Key indicators include no longer defining oneself narrowly as a “mental patient,” gaining freedom from the oppressive aspects of the formalized mental health system, and advocating for one’s rights. S/Es generally do not emphasize the need to accept the fact that one has an illness or symptom management as necessary prerequisites for moving toward recovery.

#### THE CONTEMPORARY MENTAL HEALTH CONSUMER

By the 1980s, the formalized mental health system became increasingly aware of existing non-professionally led self-help efforts and began to fund a variety of consumer run programs. According to Chamberlin (1990), this funding and involvement contributed to co-optation and an eventual thinning of the more radical S/E voice. Also occurring around this time was an increase of the use of the term *recovery* in the mental health field, initially primarily by mental health consumers who published their personal accounts in peer reviewed journals (e.g., Deegan, 1988; Leete, 1989; Lovejoy, 1984).

For contemporary consumers, recovery is portrayed primarily as a subjective experience, represented by an internal shift, or a change in one's outlook. Deegan describes the process as the point in which a person is able to move from anguish and hopelessness toward acceptance, hope, and the will to take action. By virtue of one's lived experience, consumers recognize their own expertise. They believe that they are in the best position to understand their illness and what is needed to move forward. Therefore, exercising self-responsibility for one's own wellness plan is emphasized (Deegan, 1988; Mead & Copeland, 2000). Consumers are open to working with professionals and using medications but also rely on the use of consumer-directed illness self-management tools (Copeland, 1992; Ridgway, McDiarmid, Davidson, Bayes & Ratzlaff, 2004).

Unlike S/Es who questioned the concept of "mental illness" altogether, the contemporary consumer tends to be accepting of the idea and does not rule out biology as a possible causal component. However, the concept of chronicity is drawn into question (Mead & Copeland, 2000). A group of longitudinal studies tracking previously hospitalized individuals have claimed positive outcomes for people who have transitioned into community living (Jacobson, 2004). One of the most commonly cited examples is a study by Harding, Brooks, Ashikaga, Strauss & Breier (1987), which followed up a group of 269 people with diagnosed schizophrenia over a 30-year period. About half of individuals reportedly showed improvements in terms of symptom reduction, along with the ability to function successfully in the community, as indicated by their ability to live independently, acquire satisfactory employment, and maintain a social support system. Consumers recognize the disheartening effect that the idea of chronicity can have on a person. Deegan (1988) illustrated this point clearly as she recounted her own experience after being given a diagnosis of schizophrenia at the age of 18. She reports that she was told by her doctor that she would not only need to stay on medications for the rest of her life but that the best she could look forward to was simply learning to "cope" with her illness. The author felt that her future was unfairly determined on the basis of the diagnosis she received. Little consideration had been given to her humanity, uniqueness, and higher potential. Deegan explains that offering such a bleak message leaves a person feeling hopeless, making it difficult to believe that it is worthwhile to put in the necessary effort to move forward.

Consumers use such examples to make the point that people with SMI have dreams and aspirations, just like anyone else (Mead & Copeland, 2000). They argue that, for too long, the mental health system has been overly focused on symptoms and deficits while ignoring strengths and capacities. Consumers believe in their abilities to fulfill roles such as parent and worker, engage in hobbies, and develop satisfying social relationships. Higher capacities such as personal growth, finding meaning and purpose, creativity, and spirituality are also viewed as important.

## Current Challenges

As stated previously, efforts to establish an agreed-upon definition of recovery have proven challenging (Davidson et al., 2005; Jacobson & Curtis, 2000; Onken et al., 2007; Young & Ensing, 1999). There is a clear existing struggle between various recovery proponents related to which elements of the concept to embrace. Definitional attempts are rarely able to represent all of the viewpoints held by the major stakeholders outlined earlier. Themes that are commonly debated in recovery literature include whether acceptance of illness is a necessary prerequisite for recovery, whether recovery entails complete symptom relief or simply trying to live a fulfilling life despite experiencing ongoing symptoms, the role of medications, the extent to which consumers should be the center of their own care plan and decision making, and whether recovery should be viewed primarily as a subjective experience or an objectively measurable outcome. It is beyond the scope of this article to describe in detail all of the existing debated issues associated with the contemporary recovery vision. The main point is that a more all-encompassing framework, one that allows consideration of all the contributing ideological positions, is needed.

Historically, social work has been in a similar predicament as the contemporary mental health recovery movement in that both draw on a host of theoretical orientations (Robbins, Chatterjee & Canda, 2006). Both have struggled with how to go about embracing diverse ideologies, especially ones that are seemingly competing or contradictory. Recently, a few social work scholars have looked to Ken Wilber's integral approach as a framework for uniting the profession's theoretical fragmentation (Kerrigan, 2006; Larkin, 2006; Thomas, 2004) and for creating a holistic approach to social work practice (Canda & Furman, 1999). In the same vein, Wilber's integral approach will be introduced as a strategy for uniting the variety of ideological contributions composing the modern recovery vision.

## INTEGRAL APPROACH EXPLAINED

### Wilber's Work

An early founder of the integral approach was Indian philosopher Sri Aurobindo. He combined ideas from East and West to offer strategies for integrating different disciplines such as science, religion and political thought (Thomas, 2004). A contemporary version of integralism is offered by Ken Wilber, who incorporated many of the ideas of Sri Aurobindo along with those of hundreds of the world's great thinkers (Vrinte, 2002). Over the past three decades, Wilber has written prolifically and extensively. Beginning with his book *Sex, Ecology, Spirituality* (1995), the author became increasingly interested in exploring how various forms of the world's knowledge fit

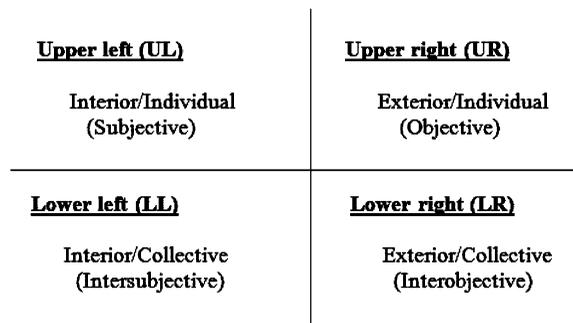
together. This is when the author began to present his integral theoretical perspective.

Wilber expressed concern about Western culture’s lack of openness to a multidimensional view of reality (Visser, 2003; Wilber, 1995). The author recognized fragmented and polarizing positions held in the social sciences. The problem, as he saw it, was that various perspectives have been unable to connect their understandings, as each tends to view their way as the only right way (Visser). Rather than adhering strictly to any specific ideological orientation, Wilber’s goal has been to create a framework which considers the best aspects of various forms of knowledge (2006). He believes that it is often the case that what appear to be competing viewpoints are actually just different ways of looking at the same thing.

Wilber (2006) explains that any event can be looked at from three perspectives: the “I,” the “we,” and the “it.” The “I” represents an individual’s subjective view, the “we” represents an intersubjective view (how “we,” as a group, view the world), whereas the “it” represents what is perceived objectively (science emphasizes this way of understanding). The “it” can focus on either the individual organism, as is the case with scientific understandings of the physical body, or on collective aspects of the outer world (e.g., ecological systems).

### Wilber’s Four-Quadrant Approach

Wilber takes the idea of the “I,” “we,” and “it” dimensions of reality and inserts them into a four-quadrant model (1995, 2006). The four quadrants present a framework for situating various theories, along with their corresponding methods of inquiry, into four specific domains (Figure 1) according to the particular lens through which the world is perceived. Included are the subjective (upper left-UL), objective (upper right-UR), intersubjective (lower left-LL), and interobjective (lower right-LR) domains.



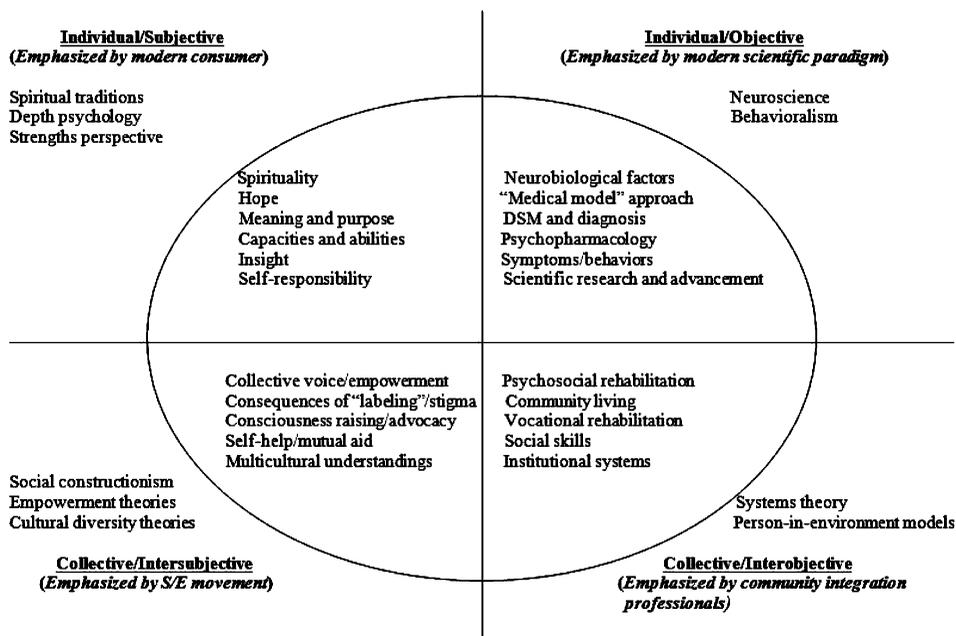
**FIGURE 1** Adaptation of Ken Wilber’s four-quadrant model in its basic form. Adapted from Sex, Ecology, Spirituality (Wilber, 1995, 2000). Reprinted by arrangement with Shambhala Publications, Boston, MA. <http://www.shambhala.com>

Note that the left side represents interior consciousness—both individual and collective—and the right side represents its exterior physical correlates—also both individual and collective. In other words, the left side refers to the subjectively understood world while the right side is concerned with the objectively perceived world. Wilber explains that each domain is associated with its own relevant methods of inquiry (Wilber, 1998). The UR quadrant includes scientific empiricism and behavioralism, whereas ecological sciences, systems theory, and structural-functionalism are associated with the LR quadrant. Truth claims in the left quadrants include introspection and phenomenology (UL) along with hermeneutics and collaborative inquiry (LL).

It is important here to point out that Wilber's four-quadrants represent only a part of the author's wider integral model. This aspect of his work has been singled out because of its stand-alone ability to function as a uniting framework. The author's complete theory consists of a culmination of ideas ranging over his career. Book titles such as *A Brief History of Everything* (1996) and *A Theory of Everything* (2001) represent the massive scope of knowledge areas that the author covers. Still, Wilber himself considers the four quadrants to be foundational to his integral vision (2006). Wilber's four-quadrant model is commonly referred to as AQAL, which stands for "all quadrants, all levels." "Levels," also called "stages," refer to hierarchies of development that take place within each quadrant. In other words, both individual organisms and social systems have a tendency to move toward more sophisticated levels of functioning (Robbins et al., 2006). Additional discussion about "levels" will be presented later in this article in the section on future considerations.

### Four-Quadrant Approach Applied to Mental Health Recovery

Outlined in Table 1 are the four foundational stakeholder positions that form the core ideological insights composing the existing recovery vision. As mentioned, stakeholders have varying perspectives related to a number of issues, many of which at first glance appear to be competing. Also argued was that many of the debates, confusion, and omissions affecting current recovery definitional efforts reflect not only a lack of a deeper understanding of the philosophical underpinnings that drive divergent standpoints but—more important—a lack of a suitable framework to hold competing viewpoints. Wilber's (1995) four-quadrant approach can be used as a strategy for resolving some of the difficulties related to defining mental health recovery in a contemporary context. This can be best accomplished by situating common recovery themes into the author's four-quadrant model, alongside their respective deeper level philosophical underpinnings (Figure 2).



**FIGURE 2** Recovery themes situated into quadrants alongside their respective philosophical underpinnings. Adapted from Sex, Ecology, Spirituality (Wilber, 1995, 2000). Reprinted by arrangement with Shambhala Publications, Boston, MA. <http://www.shambhala.com>

Each of the knowledge domains in Figure 2, as represented by the four quadrants, are actually composed primarily of themes and ideological positions closely associated with one of the major recovery stakeholder positions described earlier in Table 1. For example, the UL quadrant, which represents individual subjective understandings of reality, contains ideas that are most in common with those of the modern consumer perspective. Some of the themes associated with this domain include personal meaning, hope, inner capacities, self-responsibility, and spiritual propensity. The LL quadrant, consisting of ideas associated with a collective subjective viewpoint, includes concepts such as consumer "voice" and empowerment, stigmatization, advocacy, and mutual aid. These themes align most closely with the S/E perspective. Ideas included in the UR quadrant are mostly affiliated with those of the modern scientific paradigm, including neurobiological understandings, symptoms-focused, psychopharmacology, and the role of diagnosis. The primary focus remains on the individual, and an objective perception of reality.

Finally, themes included in the LR quadrant contain factors associated with the exterior environment as it is objectively perceived. Included themes are psychiatric rehabilitation, community living, and vocational rehabilitation.

These are most representative of a professionally led community integration perspective.

Note that listed in each quadrant in Figure 2, on the outside of the circle, are a set of theories that are strongly associated with the various included themes. The themes included in the UR quadrant are those typically emphasized by spiritual traditions, depth psychology, and the recent strengths perspective. Most of the themes in the LL quadrant can be linked to social constructionism, empowerment theories, and cultural diversity theories. Concepts included in the UR quadrant are most associated with neuroscientific theories, along with behaviorism. Finally, both systems theories and person-and-environment approaches frequently give emphasis to ideas included in the LL quadrant. Most of the aforementioned theories have also been influencing factors in the social work profession throughout its history.

An important next step associated with Wilber's four-quadrant approach is to recognize the interrelatedness of the four knowledge domains. Figure 2 includes a connecting circle surrounding the various recovery themes that span the four domains. The circle represents the interconnection between all standpoints and ideas. It reiterates that no particular viewpoint or quadrant represents the whole truth on its own. Wilber (1998) gave a simple example of the interconnectedness between the quadrants by pointing to the relationship between the interior mind (UL quadrant) and the exterior brain (UR quadrant). The mind can be known only interiorly or subjectively, whereas the brain organ is observed in an exterior or objective manner. Both, however, are simply two different ways of looking at the same phenomenon—experiences of the interior mind have correlates in the exterior brain and vice versa.

In applying Wilber's logic to mental health recovery, the concepts "labeling" and "diagnosis" will be considered. As discussed earlier, emphasis on "labeling" in the mental health field has been influenced by social constructionist thinking (LL), whereas the idea of diagnosis is associated mostly with the scientifically oriented medical model (UR). At first glance, these two positions may appear to hold contradictory and perhaps irreconcilable viewpoints. However, once the useful contributions of each approach are clearly identified, the two sides may not seem so far apart.

Starting with "labeling," some social constructionist thinkers who oppose labeling have been noted as refusing to give any credence to the role of biological factors in at least some forms of mental illness (Szaz, 1961; Taylor, 2006). Rather, the "whole of mental illness" is explained in terms of societally imposed labels that have no basis in physical reality. Using Wilber's reasoning, this would represent reductionist thinking because it does not acknowledge the other ways of knowing. Also representing reductionist thinking would be a medical model proponent who fails to acknowledge people as multi-dimensional beings and instead narrowly views them in terms of the diagnosis they receive. An example of this would be people

who are referred to as “schizophrenic” rather than as a whole person (Rapp, 1998).

The next step is to recognize the healthy contributions of each approach. One of the greatest contributions of labeling ideology is that it has drawn attention to the important issue of stigmatization and all of the ill-effects that it entails. Additionally, proponents of the modern scientific paradigm claim that the use of diagnostic categories, although an imperfect tool, aids greatly in attaining a substantive understanding of people’s mental and emotional difficulties, and, therefore, helps to guide treatment planning (Taylor, 2006). Also, some consumers may experience less self-blame by viewing mental illness as a diagnosable “disease” (Floyd Taylor & Bentley, 2004). Following Wilber’s logic that no single quadrant can represent “all of reality,” both viewpoints can be considered as partial truths contributing to an integral understanding (Wilber, 1998). Those who draw attention to labeling have legitimate concerns that make much sense when considering reality from a collective subjective perspective. Diagnosis becomes important to those attempting to objectively understand and treat a person’s thinking and behavioral concerns.

The concepts labeling and diagnosis also have relevance to the remaining two quadrants (UL and LR quadrants). Individuals operating from these perspectives seem to have less of a tendency to be locked into dichotomous thinking. For example, modern consumers (UL quadrant) recognize that labeling can negatively affect one’s self-concept, and, therefore, they make efforts to establish a self-identity beyond that of mental illness. Conversely, modern consumers typically understand the relevance of diagnosis as it pertains to treatment. Those operating from a LR quadrant perspective also give credence to both concepts, except the concern is mostly with how these affect community integration efforts. For example, community integration professionals are likely to be sensitive to the effects of carrying a “label” on employment and housing opportunities. Meanwhile, acceptance of one’s diagnosis is generally considered to be an important and necessary factor for moving toward recovery.

## IMPLICATIONS FOR SOCIAL WORK

The social work profession has a vested interest in focusing its attention on the contemporary recovery paradigm. First, despite existing definitional confusion, it has attracted the attention of policy makers in recent years (Jacobson, 2004). Several states have already adopted recovery as their guiding vision for mental health services, and more are expected to do so in the future (Jacobson & Curtis, 2000). Second, social workers have played a significant role in providing care for people with SMI since the profession’s earliest years and continue to do so. Currently, social workers are employed

in multiple mental health settings and fill a variety of roles including that of case manager, therapist, crisis counselor, program evaluator, administrator, and policy analyst (Bentley, 2002). Social work schools have been offering training in mental health since as early as 1918 (Field, 1980). Presently, nearly every social work school offers coursework that is mental health-specific (Bentley; Lacasse & Gomory, 2003). Finally, a number of social work scholars have been significant contributors in forming and promoting the implementation of recovery oriented services (e.g., Rapp & Goscha, 2006; Ridgway et al., 2004).

Taylor (2006) notes that in certain social work textbooks and published articles, some authors condemn virtually all aspects of the medical model, including biological understandings of mental illness. Conversely, in their 2003 study of 71 psychopathology course syllabi from 58 social work graduate schools, Lacasse & Gomery concluded that a one-sided approach to mental health was being taught, with the biomedical approach dominating. As pointed out earlier, most existing debates are the result of an inability to integrate differing ideological positions. Social work could benefit from considering Wilber's four-quadrant approach as a unifying framework for integrating various theoretical and ideological influences related to mental health care. The model introduced in Figure 2 is especially relevant because the profession shares many of the same goals and values inherent in the contemporary recovery paradigm. For example, both strive for human well-being, empowerment of people, client self-determination, promotion of client capacities, emphasis on environmental factors, and willingness to incorporate recognized relevant knowledge, including that which is empirically based (National Association of Social Workers, 1999).

Finally, social work has prided itself on its efforts to possess a holistic understanding of the person. The profession's dual focus on both the person and environment is a prime example. Throughout the years, social work has presented a variety of approaches designed to blend these two aspects of reality. This was evident in Mary Richmond's seminal book, *Social Diagnosis* (1917). The author made a plea for a balanced approach for understanding human difficulties, one that would consider both individual and environmental factors. Other significant attempts include efforts to incorporate ideas from ego psychology in the 1940s and 1950s (Perlman, 1957), the introduction of the ecological and life models in the 1970s and 1980s (Germain, 1979), and adoption of the biopsychosocial approach (Taylor, 1997). Each of these approaches, however, has been noted as falling short in various ways (Larkin, 2006; Robbins et al., 2006)

Despite giving more consideration to environmental factors than had been the case with its psychoanalytic predecessor, ego psychology was ultimately accused of being too person-focused (Goldstein, 1984). The ecological and life models, influenced by systems theory, initially held much hope in providing a suitable framework for unifying the profession's varying

interests. However, even this model was eventually accused of being too narrow in its failure to adequately address macro-level change (Larkin, 2005; Robbins et al., 2006). Another criticism of the ecological approach is that it has little applicability to the SMI population (Taylor, 2006). This is primarily because people's difficulties are explained chiefly as problems of living while biological factors receive little attention (Gitterman & Germain, 1976; Taylor, 2006). The biopsychosocial approach represents a significant effort by social work to adopt a framework that has strong relevance to the SMI population (Taylor, 1997). A main strength of this approach is that it attempts to be holistic, particularly by acknowledging the role of biological factors and psychopharmacology, along with psychological and social aspects. A weakness is that little attention is given to people's higher capacities (i.e., creativity, spirituality) or their collective realities (cultural beliefs and empowerment). Wilber's integral approach allows for a more comprehensive form of holism than what has been available to the profession thus far (Larkin, 2006). By clearly outlining and embracing the multiple dimensions from which reality is understood (e.g., the four quadrants), a wealth of existing forms of knowledge can be brought together and simultaneously considered. The connecting of various ideological positions related to the mental health recovery concept, as illustrated in Figure 2, is a prime example.

## LIMITATIONS AND FUTURE CONSIDERATIONS

As mentioned, the four-quadrant framework utilized in this article represents only a part of Wilber's larger approach. Wilber's ideas regarding "stages" or "levels" warrant further mention because of their centrality to his overall theory and potential applicability to mental health recovery. Early in his career, the author was interested primarily in mapping out stages of development related to individual consciousness (Visser, 2003). His main emphasis was on explaining higher-level transpersonal stages. In his later works, Wilber expanded his focus to consider evolutionary stages existing in the sociocultural and physical spheres. Wilber's conclusions about the existence of stages are based on his comparison of the works of hundreds of developmental theorists spanning disciplines including psychology, anthropology, and Eastern philosophy (1998). Wilber concludes that the various theorists are all describing a similar identifiable pattern of growth in all that exists. Wilber's ideas about stages do not come without criticism, however (Robbins et al., 2006). A common complaint has been that promoting stage theories runs the risk of reinforcing ethnocentric and elitist thinking. Wilber has responded to this criticism in two ways. First, he points out that various developmental perspectives spanning through history and across cultures have come to similar conclusions, thus giving credence that much existing information about stages is rooted in reality (Wilber, 2000). Second, Wilber

(2006) explains that developmental stages should be seen “not as a rigid ladder, but as fluid and flowing waves of unfolding” (p. 23).

The idea of developmental stages may have applicability to the contemporary recovery paradigm. Throughout the literature, attempts have been made to identify specific stages of recovery (Andresen, Oades, & Caputi, 2003; Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Young & Ensing, 1999). At this point, however, existing recovery stage models do not have a high degree of consistency among one another. Once they are further clarified and a higher degree of consensus is reached, the idea of stages could have important implications for the four-quadrant model described earlier. It may be worthwhile to explore how stages of recovery apply to the various knowledge domains. In other words, it would be interesting to determine whether one's stage of recovery influences those knowledge domain consumers are most likely to draw upon. It is possible that themes most associated with the UR quadrant, such as symptom control and medications, have more relevance for someone who is in an earlier stage of recovery, whereas concepts such as tapping into higher capacities (UL quadrant) and empowerment (LL quadrant) become increasingly important at later stages (Frese et al., 2001). As stages of recovery are further clarified, two cautions are important to consider. One is related to viewing recovery as a linear process (Deegan, 1988; Mead & Copeland, 2000). Mental health consumers are quick to point out that recovery often includes multiple periods of movement forward followed by setbacks. Finally, consumers remind that recovery is an individualized process and, therefore, should not be reduced to a measurable outcome.

## CONCLUSION

The contemporary recovery vision has been a topic of much debate in mental health in recent years. Despite this “new” vision's already having been adopted by a number of policy makers, scholars and researchers, practitioners, and consumers, definitional confusion continues to be a noted problem. Various conceptualizations of the term appear to contain competing and sometimes contradictory ideas. The goal of this article has been to provide a framework that positively addresses existing differences. Ken Wilber's integral approach is ideal in that it provides a strategy for bringing together diverse ideological positions, including those that at first may seem to be contrary to one another. The result is a more comprehensive understanding. It is expected that “recovery” will continue to be a heavily used concept in the mental health fields for years to come. The social work profession, with its strong emphasis on holism, is in an ideal position to take a lead role in embracing an integral understanding of the mental health recovery concept.

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