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Positive Psychology and Technology

Exploring criteria for recovery from depression: The patient's perspective

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Abstract

Background: Recovery from depression is usually measured as pathology change based on experienced symptoms. However, there is a rising voice of (recovered) patients as well as from researchers and professionals, who are stressing the importance of additional, positive mental health related criteria, for measuring recovery. Nevertheless there is not yet a consensus about what criteria are important for people that recover from depression. One recovery model that aims to include those personal recovery criteria is the CHIME model, consisting out of *Connectedness, Hope* and *optimism, Identity, Meaning* and *purpose* and *Empowerment*. The aim of this study was to analyze what criteria are considered as essential to recovery from depression from the patient's perspective and to examine the appropriateness of the CHIME model in relation to recovery from depression.

Methods: A systematic literature review with a meta-analytic approach was used. Six studies with individuals in recovery or already recovered were included. Other criteria for inclusion were, that they reported on criteria of recovery from depression, used a qualitative study design, were available in printed or downloadable form and 5) were available in English. When patient reported psychotic or manic symptoms, they were excluded. The result sections of the papers were searched for statements that referred to recovery from depression. Those statements were ordered into criteria for recovery and the frequency and intensity effect sizes of those were examined.

Results: The CHIME model seems to capture successfully the personal recovery from depression, with its five categories. Most essential criteria for recovery from depression were found to be *Identity* and *Empowerment* according to the patient perspective. Further concretizing the categories might be helpful, for a more nuanced picture of personal recovery.

Conclusions: The concept of personal recovery is essential to measure and capture for the practice. As the CHIME model seems to cover essential patient-driven criteria of recovery, it has potential to become a useful tool for measurement in practice.

Keywords: Depression, Recovery, Positive mental health, Positive psychology, CHIME model, Qualitative research, Systematic review

Introduction

This systematic review aims to explore the relevant criteria for depression recovery according to the patient's perspective. It seems an important matter of concern, that the concept of recovery according to the clinical definition dominates in practice, while this does not necessarily reflect how affected individuals actually are defining their recovery. Since depression is one of the most frequently occurring mental diseases, it was considered as urgent to investigate how the personal dimension of depression recovery is experienced.

Background: Depression

Already since several decades, depression is a very prominent theme, in research as well as in practical contexts. It is one of the most common mental diseases and the leading cause of disability with 300 million people suffering from it world wide (WHO, 2017). Common symptoms of depression are depressed mood most of the day, a decrease of interest and pleasure, feelings of worthlessness and problems related to eating or sleeping patterns. In order to diagnose a depression the symptoms have to cause significant distress or impairment in important areas of functioning (*Diagnostic and Statistical Manual of Mental Disorders* 5th ed.; DSM–5; American Psychiatric Association, 2013). Main distinctions among various types of depression are made concerning the experience of manic episodes. In case manic episodes are experienced, it is denoted as bipolar affective disorder. Without manic episodes there is talk of a major depression, which is typically long-lasting. There can occur repeated depressive episodes of at least 2 weeks, which then is defined as recurrent depression. Grades of severity can vary between mild, moderate or severe. In severe cases depression can lead to suicide, from which 800.000 people are affected annually. It is identified as the second leading cause of death among people between 15 and 29 (WHO, 2017; *Diagnostic and Statistical Manual of Mental Disorders* 5th ed.; DSM–5; American Psychiatric Association, 2013).

Beside the burden a depression has on the individual, it has also some for the community. When leaving depression untreated, people run risk to become socially isolated and even destroy relationships and the social environment (Lépine & Briley,

2011; WHO, 2017). Furthermore depression causes consequences for mental healthcare and economics. People who suffer from depression are unable to function well in society, which pertains in their private lives as well as at work. In many cases they have to stop working in order to recover from the depression and cannot use their whole potential or are missing on workdays regularly (Lépine & Briley, 2011; Chipman, 2014; WHO 2017). This is the source of many indirect costs that arise through people that suffer from depression. So the estimated costs caused by depression in the US are coming down to 210.5$ billion dollar annually (Greenberg, Fournier, Sisitsky, Pike & Kessler, 2015). In addition to this, the disability that comes with depression in work- and social contexts, can cause stigma against which depressive patients have to fight. This might prevent them from getting better and healthy again (Stuart, 2006). It could be described as a reciprocal relationship between the prejudices and expectations of society and the mental health of depressed patients (Stuart, 2006).

It is possible to treat depression through therapy and/or medication. The concrete treatment depends on the severity and type of depression. The goal of the therapy is to reduce the symptoms of depression that are experienced. Even though it is treatable, a chronic development or a recurrence of depression after its remission is very common (Fava, Ruini & Belaise, 2007). Defining what recovery from depression actually comprises is therefore in debate and a critical issue, worthy of a closer look.

From clinical to personal recovery

Over the past decades the term „recovery“ in the context of mental illness has released a debate over its concrete meaning, if not even about its very existence. Especially the biological point of view of mental diseases, raised doubts whether recovery is even possible, because it was often considered as „illusion“ (Farkas, 2007; Leamy, Bird, Le Boutillier, Williams & Slade, 2011). Another point of view was given through assuming that going through crisis in life can be viewed as a normal process, so that recovery does not exist, as there is no talk of a clinical disease (Farkas, 2007). The one fact, most of the researcher of the debate agreed on, was that the term recovery was not clearly defined (Farkas, 2007). So for this study it seems important, to first take a closer look on what the term recovery means.

When suffering from mental disease, recovery was a long time reduced to the absence of disease, more concretely the absence of the symptoms and to regaining the level of functioning before the disease occurred (Young & Ensing, 1999). Even now this definition, might be the first one that comes into one's mind when talking about recovery. In line with this assumption, relevant criteria for being claimed as recovered are based on the absence of essential symptoms of the disease (Furukawa, Fujita, Harai, Yoshimura, Kitamura & Takahashi, 2008). Nevertheless there exists reasonable evidence that the meaning of recovery might be a lot more complex than that common assumption implies. The absence of symptoms merely refers to the *clinical* recovery. Clinical recovery is defined as an observable, objective and mostly dichotomous state that is rated by an expert and which definition is invariant across individuals (Slade, 2009; Slade, Amering & Oades, 2008). This makes it easy to operationalize the concept of recovery in medical contexts (Slade et al., 2008). The problems that arise with this definition, concern generalizing one concept of recovery to all individuals, who are, even when diagnosed with the same mental disorder, very different and complex. Therefore it is important to not only take into consideration the clinical perspective.

Especially from the movement of positive psychology, a more positive and personal dimension of recovery is stressed among recent literature (Slade, 2010; Keyes, 2002; Seligman & Csikszentmihalyi, 2000). Thus not (solely) the absence of symptoms or the level of functioning should be criteria for recovery but the presence of positive mental health related criteria, like wellbeing, quality of life and satisfaction should also play a separate role (Keyes, 2002; Seligman & Csikszentmihalyi, 2000). This assumption is also supported by the 2 continua model. This model states that mental wellbeing and psychopathology are two related continua instead of the opposites of one continuum. As this difference began to become more popular and important for the people that suffered from depression, it was important to take it into consideration for the view on recovery. Therefore, individuals that suffered from mental illness spoke up and shared their experiences of recovery. Also in their point of view, recovery should contain more than merely the absence of symptoms. Thus more than the clinical perspective, namely a *personal* perspective. As it is commonly sought that mental health professionals treat their

patients according to their wishes and how they themselves define their improvement (Lidz & Parker, 2003), this is especially important for the mental health practice in the future.

One of the most popular definitions of personal recovery is: *a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the 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. 527). The roots of his study is found the the psychiatric rehabilitation, but Anthony himself often uses the term „mental illness" so that his definition of recovery can be viewed broadly and also be considered as appropriate in the context of depression. As already stated in the previous paragraph, defining what personal recovery from depression includes, is not yet sufficient explored or even defined. Therefore, identifying the criteria of the personal recovery from depression is set as one goal of this study. This serves for conceptualizing the personal recovery from depression which can be a helpful tool for clinical practice and research.

When thinking about the stigma against which people that suffer depression have to fight, another dimension of recovery seems also important, namely social recovery. The social dimension and environment play a essential role in depression and can promote or prevent recovery, depending on its quality (Cruwys, Haslam, Dingle, Haslam & Jetten, 2014). Social support and safety of course do promote mental health, where against social pressure and instability do prevent it. Having to deal with social stigma and the prejudices of society against people with depression, of course can cause distress and prevent the patient from getting better (Stuart, 2006), which is why this dimension of recovery is assumed to be important.

The CHIME-model

In order to conceptualize the personal definition of recovery, Leamy and colleagues (2011), conducted a systematic review and narrative synthesis of recovery models. They based the review on severe mental illnesses in general, as the goal was to conceptualize a model of recovery that can be applied on a broad range of mental illnesses. They identified five key criteria of recovery processes, which are

Connectedness, Hope and optimism, Identity, Meaning and purpose, and *Empowerment* (CHIME). In order to have a better understanding of what is meant by these five words, they were further defined. *Connectedness* consists of peer support and support groups relationships, support from others and being part of the community. This criterium covers the social dimension of recovery and „being part of the community“ also deals with the perceived stigmata of the patients. *Hope and optimism* comprises the belief in possibility of recovery, the motivation to change, hope-inspiring relationships, positive thinking and valuing success and having dreams and aspirations. The category *Identity* can be further divided into dimensions of identity, rebuilding/redefining positive sense of identity and overcoming stigma. *Meaning and purpose* in life is defined as experiencing meaning of mental illness experiences, spirituality, quality of life, meaningful life and social roles, meaningful life and social goals and rebuilding life. The last category, *Empowerment*, is assumed to consist of personal responsibility, control over life and focusing upon strengths (Leamy et al., 2011).

Even though the CHIME model is a relatively new developed framework, it already proved to be a help- and successful tool for research especially when it comes to categorizing different strategies for interventions (Bird, Leamy, Tew, Le Boutillier, Williams & Slade, 2014). Its validity across different settings was tested by Bird and colleagues (2014) with the help of focus groups, which ascertained that even across different countries, CHIME takes into consideration the key criteria of recovery. Nevertheless, it was found that 3 other criteria may also play a role for patients in the recovery process namely practical support, a greater emphasis on issues around diagnosis and medication; and skepticism surrounding recovery (Bird et al., 2014). These findings underline the importance of further research about wether, how and when the CHIME model is appropriate for usage in clinical practice and research. This is accompanied by the question to what extent the patients' perspective is taken into consideration in this model. As it is based on theoretical frameworks it is important to investigate into its appropriateness when it comes to the practical context and if the patient's perspective is represented by this model.

The conceptualization of the complex definition of personal recovery might be a big help for further research and also for the practice. Nevertheless, it is a model

that is meant for a broad application which raises doubt if it is actually a good tool when it comes to a specific mental illness. Therefore exploring the usefulness of the CHIME model in the context of one specific mental disease, namely depression, is one goal of this study.

This study

This study will deal with the recovery from depression as there misses an important deal of investigation in in criteria for depression recovery, beyond the clinical perspective. To my knowledge there does not yet exist a systematic review that gathers the patients' individual views about their recovery from depression. However it is important to consider the perspective of the patient's: With the goal as their recovery, they will know best what it means to them (and also what not). It might differ from patient to patient, what is most important for them about recovery (Fava & Visani, 2008). Exploring criteria for the patients' recovery might therefore be a challenging task, which this research wants to accomplish. It could lead to a very complex and nuanced picture of the personal recovery because this study will take the variations of the individual perspectives into account. Considering the CHIME model, it will be analyzed to what extent the upcoming statements fit into the criteria that the model suggests. Does the CHIME model represent the contents that are important to the patients that recovered from depression or are there criteria that should be added? Or should there be work done in order to conceptualize a unique recovery model for depression?

Therefor a systematic literature review will be conducted in order to examine what is important concerning recovery to patients that suffer(ed) from depression. Through a systematic review, many studies about the recovery of depression can be compared to find common contents as well as variation, in order to gain better understanding about what the recovery of depression means for individuals suffering from depression. Therefore only qualitative studies are included in this review because they are especially useful for exploring the patients' perspective with great detail. Qualitative studies offer the possibility to gain insight into the personal experience of recovery in depression so that the studies are not running risk on reducing the recovery to clinical concepts.

Summarizing, the purpose of this research is to identify criteria of personal recovery distinctive for depression, according to the experiences of recovered individuals or individuals in recovery. Therefore the following research questions are stated:

Research question 1: What are the characteristics of the qualitative studies about recovery from depression that are chosen for this review?

Research question 2: What criteria define recovery from depression according to the patient's perspective?

Research question 3: To what extent do the contents that come up in the studies coincide with the CHIME model?

Method

Search strategy and selection of studies

In order to ensure the quality of this systematic literature review and to facilitate the searching an reporting process, guidelines from the PRISMA statement for reporting systematic reviews were used as a template (Liberati, Altman, Tetzlaff, Mulrow, Gøtzsche, et al., 2009). First of all, a systematic search in three electronic databases was performed: Scopus, Google Scholar and PsychINFO (final search date: 11.04.2018). The terms were searched within all fields. In Google Scholar the search was limited to the last 10 years, as there were broad searching outcomes. For the other databases no limits concerning the year of publication were set. The main search terms were: (Recovery OR Recovered OR Personal Recovery) AND (Depression OR Depressed) AND (Qualitative OR Interviews OR Patient's Perspective OR Narrative). The search resulted in 95 document results from Scopus and 1413 results from PsychInfo. In Google Scholar it was decided to take into account only the first 40 pages of the findings, ordered according the relevance. On every page 10 article were showed which results in 400 articles that were screened from Google Scholar. As there is only one researcher that screened all articles, possible duplicates were not taken into consideration or directly removed within the searching process.

Criteria for inclusion were studies that 1) reported on criteria of recovery from depression, 2) included recovered individuals or individuals on their way to recovery (it was sufficient when they considered themselves as such), 3) used a qualitative study design 4) was available in printed or downloadable form and 5) was available in English. Studies that investigated in the recovery of major depressive disorder will be taken into consideration, with all subcategories that are defined in the DSM-V. Depression with manic episodes or psychotic experiences are excluded from this review, as this study wants to explore what recovery from depression means and includes for the patients. Manic episodes or psychotic experiences add a new dimension to depression, which can give its recovery another meaning. Furthermore this paper also included studies that worked with individuals that were not (yet) fully recovered from depression or where this was unknown. The focus of this review is on the patient's perspective on recovery from depression and also individuals that not yet managed to reach recovery should be taken in to account with their point of view on this theme. This is especially important as the literature emphasizes to see recovery more as a process and not as something „finished" (Bird et al., 2014).

The first screening of the searching results was made based on the title. When a title seemed promising to be relevant the abstract was screened. Overall 1908 article titles were screened from which 1778 could be excluded. After this first automatic process of elimination based on the title, 130 articles were screened based on the abstract. In the following the possible 14 relevant articles were saved as a pdf and further assessed for eligibility based on the full text and with help from the criteria for inclusion. In total 6 studies were included in the meta-analysis. The process of the study selection is visualized in figure 1.

Procedure and Analysis

In order to being able to put the results of the included studies into the right context, it is important to assess the characteristics of the studies that are used in this review. Thereby research question 1 will be answered. The chosen studies that met all criteria for being involved in this review, were further analyzed based on characteristics that seemed to be important for understanding the results of the studies, because they might have influenced them. In this study, the chosen

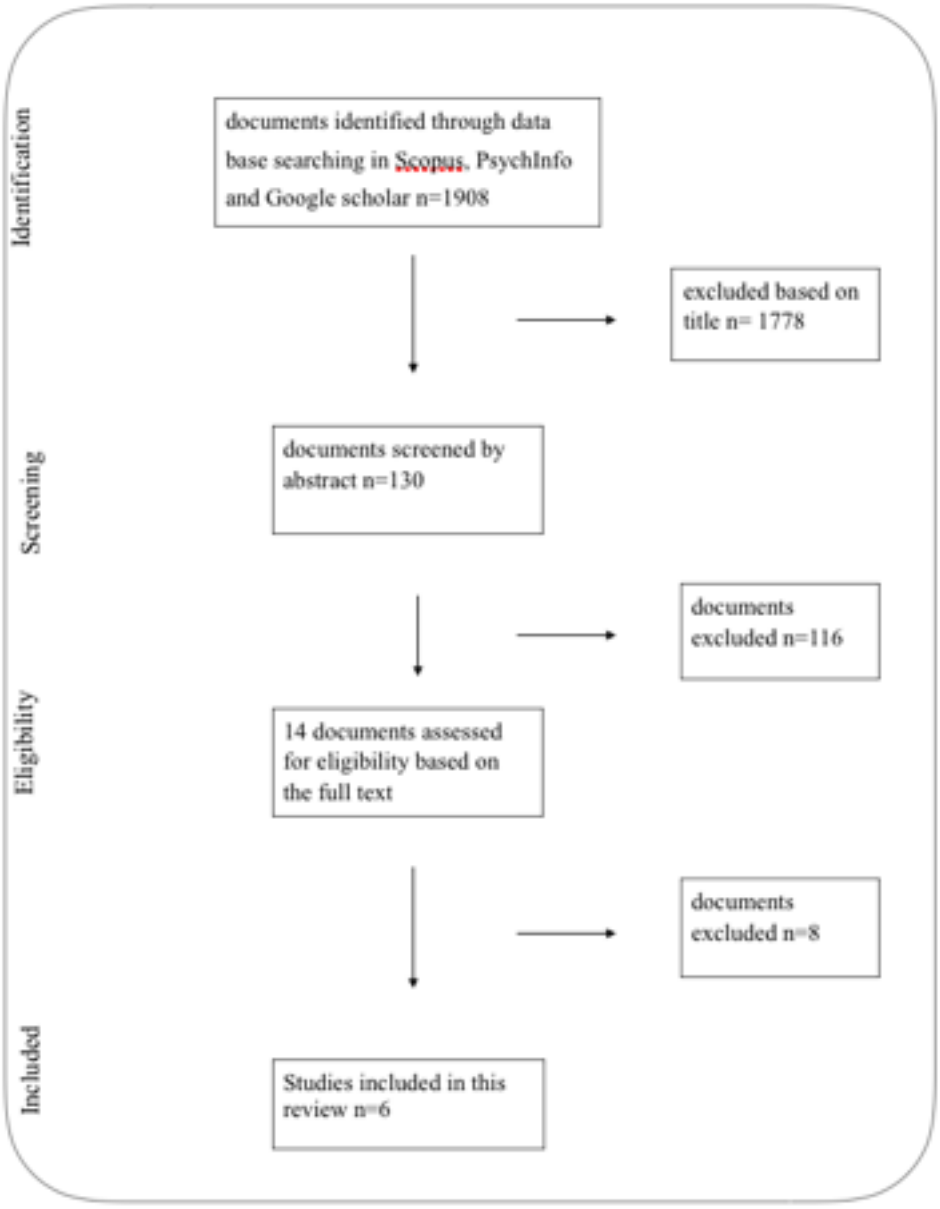

Fig. 1 visual representation of the study selection process

characteristics of the involved studies are the study design, the number of participants, the severity of depression of the participants and the received form of treatment.

For answering research questions two and three, the criteria for recovery that came up in the included studies were analyzed. Therefore, first all relevant statements from patients were extracted from the results section of each study. Included were all statements that were mentioned by the participants of the studies concerning recovery and also the process of recovery. They were stored in their original content which

resulted in a dataset of 101 statements. The raw dataset of statements that were noted per study can be found in the Appendix A.

In the second step of the analysis, these statements were ordered into more abstract categories that labeled the overarching content of the statements. Statements related with depression pathology were divided into 4 sub labels (*mood, physical functioning, cognitional functioning and social, occupational and other important areas of functioning*). These sub labels are based on the dimensional categories in which a patient can experience symptoms of depression (*Diagnostic and Statistical Manual of Mental Disorders* 5th ed.; DSM–5; American Psychiatric Association, 2013). For other contents, the CHIME model was used to categorize the statements into the sub labels *Connectedness, Hope and optimism, Identity, Meaning and purpose,* and *Empowerment.* This way, this study not only reveals important aspects concerning the recovery in depression, but also contributes to further research of the CHIME model and its utilization. In case a theme did not fit into any of the sub labels, it was first saved under „undefined“. This category was later analyzed for possible (overarching) labels of the statements. Table 1 gives an overview of the labels that are used with an definition of what it contents, which is important in case that some of the statements might overlap in categories, when no clear definitions are stated. The definitions from the criteria of the CHIME model have been taken from Bird et al. (2014). The categories in which symptoms of depression can be experienced are deduced from the DSM-5 (American Psychiatric Association, 2013). The data set of the sorted statements can be found in the Appendix B.

In the last step of the analysis the intensity effect sizes and the frequency effect sizes of the criteria were calculated for gaining an overview of how frequent statements of one criterium were mentioned in the primary studies and how essential they are to depression recovery. The frequency effect size was calculated though dividing the number of studies with the same criterium by the total number of studies. According to those frequency effect sizes, the criteria were ordered as insufficient evidence (reported by 0 - 25% of the primary studies), moderate evidence (reported by 26 - 50% of the primary studies), substantial evidence (reported by 51 - 75% of the primary studies) and strong evidence (reported by 76 - 100% of the primary studies) for depression recovery. Following the example of Voss and colleagues

(2017), that conducted a similar study over eating disorders recovery, those quartiles were chosen pragmatically to support the ease of interpretation.

The intensity effect sizes are calculated through dividing the number of findings for a criteria produced in all studies, by all findings and show how essential the different criteria are for depression recovery in comparison to each other.

Table 1. Labels

Recovery criteria	Definition
1. Depression pathology	
1.1 Mood	Reduction of negative emotional experience Reduced apathy and lethargy
1.2 Cognitional functioning	Attention, concentration and memory getting better Estimation of their own functioning and the difficulty of the task getting more realistic (negative thoughts and beliefs about themselves, others and expectations are reduced)
1.3 Physical functioning	Appetite and sleep is normalized Tension complaints reduced Fatigue / agitation reduced
1.4 Behavioral	Reduced withdrawal Increasingly active (in contrast to when experiencing depression) Daily rhythm normalized
2. Connectedness	Peer support and support groups Relationships Support from others

Table 1. Labels

Recovery criteria	Definition
3. Hope and optimism	Hope-inspiring relationships Motivation to change Belief in the possibility of recovery Positive thinking Having dreams and aspirations
4. Identity	Dimensions of identity Rebuilding/ redefining a positive sense of identity Overcoming stigma
5. Meaning and purpose	Meaning of mental illness experience Spirituality (including development of spirituality) Quality of life Meaningful life and social goals Meaningful life and social roles Rebuilding life
6. Empowerment	Personal responsibility Control over life Focusing on strengths

Results

Descriptives

The 6 included studies covered 740 participants from whom 553 are women and 287 men. The severity of the depression often ranged from mild to severe and could not be concretely determined per study. Also the duration of the depressive experience was very different per person and often not given in the studies. This also applies to the form of treatment of the participants. It is often not mentioned in the studies or ranging among different types of treatment so that no concrete statements can be made. When interpreting the results of the study, this should be kept in mind. The missing data could have been important for interpreting the statements of the

participants correctly and could have add valuable information to the results, especially for answering research question 1. For interpreting the following results, it is also important to have look on the study design that is used. The amount of structure that the researcher gives his study, determines how free the answers are given from the participants, without being directed from the questions. Especially in the structured interviews from Johnson and colleagues (2009) that are made with the computer assisted telephone, it can be assumed that not many open formulated questions were used. Furthermore it is probable that they did not give much time to answer, regarding the fact that there participated 576 people, who would have needed too much time. An overview of the most important characteristics of the studies is presented in table 2.

Table 2 Overview of the most important characteristics of the included studies.

Study	Study design	N		Severity of depression	Form of treatment
		m	f		
Kevin Steven Corney (2016)	in-depth qualitative interviews	10 3	 7	unknown	unknown
N. Lafrance & Stoppard, J (2006)	Semi-structured interviews (audiotaped)	15	15	significant distress and incapacitation	unknown
Ziebland, S & Ridge, D (2016)	video- and audiorecorded interviews	38 16	 22	mainly severe depression	different types of treatment
Johnson et al. (2009)	structured, computer-assisted telephone interview	576 408	 168	participants met criteria for „probably depressed“	unknown

Study	Study design	N		Severity of depression	Form of treatment
		m	f		
Fullagar, S and O'Brien, W. (2012)	In-depth interviews with a semi-structured format	80	80	ranges from mild, moderate, major, bipolar and post-natal depression	medication, therapy, changing work-leisure patterns, seeking social support and time out from the emotional labor of care
Rita Schreiber (2017)	90 min. interview, audiotaped per person	21	21	ranging from mild to severe	only 8 of the women engaged in a psychotherapeutic treatment

Criteria for depression recovery

In order to answer research question 2, that is: *What criteria define recovery from depression according to the patient's perspective?*, the researcher extracted statements that concerned recovery or the recovery process by reading the studies carefully. After that, the statements were ordered (as far as possible) into the labels that were stated based on the depression pathology and the Chime model. Thereby statements that were not „concrete" enough were eliminated and not included in this review. One example for such a statement was *I was functioning well.* This statement could not be included as it was not clear, to which domain of life it was concerning to. The statements that could not be ordered into one of the categories, mainly considered the relation with the therapist and are therefore ordered as a specification of „Connectedness".

After that, the intensity effect sizes and the frequency effect sizes of the criteria were calculated. See table 3 for an overview of the effect sizes that were calculated. It is noticeable that the categories *Identity* (100% / 35%) and *Empowerment* (83% / 17%) have the greatest effect sizes for frequency as well as for

intensity. They can be categorized as strong evidence for recovery from depression. Examples for the category *Identity* are „Increased love and trust of self“, which is related to a construct of self love, but also: „growth experience as they learn skills and develop knowledge“, which is related to the growth that happens through the experience of depression and how this changes the self and the identity. These two examples show already that there is wide variety among the statements of one criterium. Also Empowerment shows a variety in statements. There are statements like „full responsibility for recovering from depression“ which acknowledges the power to be responsible for one self, but also statements like: refusing to be responsible for everyone's happiness and learned to say no“, which describes the power of being able to make oneself not responsible for the happiness of other persons.

Further, according to the frequency effect sizes, Connectedness (66%) and Meaning and Purpose (66%) can be categorized as substantial evidences for recovery from depression. Especially Meaning and Purpose can be related to Identity and Empowerment, because often the purpose that was found in the suffering from depression was, that they came out stronger than they were before and and that they found their true self. The following quote describes such a meaning: „ (..) beneficial spiritual journey, depressive experience was meaningful (..) it promoted greater self awareness and a better life afterwards.“

Connectedness described often the way people could express their depression in front of people as this characterized for many a open and close relationship to their environment: „ (..) speak openly rather than keep their depression as a “massive secret. & „(..) move away from personal isolation and disclose your condition and true feelings, at least to a trusted few”. The main indicator for Connectedness however was the interest in social activity and relationship that came back when being in recovery: „ (..) desired relationship, an emotional compulsion that had until then been missing. “. Surprisingly, dealing with stigmata or prejudices of society was not a theme that came up in the statements, at least not directly. However, some statements could be interpreted when setting in the context of stigma and expectations of the social environment. For example „finding identity beyond conventional gender roles“ could be connected to experienced stigma and perceived expectations.

Nevertheless this is not distinctively mentioned and can not be stated with security, which is why it was not interpreted as stigma-related.

Connectedness and Meaning an purpose are followed from Hope and Optimism and Physical Functioning, that are classified as moderate evidence, but lying with 50% on the edge to a substantial evidence. With 33% Mood and Behavioral functioning are the smallest evidences of the original categories and are labeled as insufficient evidences. Out of the statements, that could not be defined in the first instance, the specification *Relation with therapist* of the criterium *Connectedness* was developed from the analysis. It is also classified as insufficient evidence with 17% frequency. Only cognitional functioning was not mentioned at all.

Table 3 Intensity and Frequency effect sizes of depression recovery criteria

Recovery criteria	Evidence for recovery	Frequency effect size	Intensity effect size
1. Depression pathology			
1.1 Mood	moderate	33%	3.%
1.2 Cognitional functioning	insufficient	0%	0%
1.3 Physical functioning	moderate	50%	8%
1.4 Behavioral	moderate	33%	7%

Recovery criteria	Evidence for recovery	Frequency effect size	Intensity effect size
2. Connectedness	substantial	66%	11%
2.1 Relation with therapist	insufficient	17 %	3%
3. Hope and Optimism	moderate	50%	6 %
4. Identity	strong	100%	35 %
5. Meaning and Purpose	substantial	66%	9 %
6. Empowerment	strong	83%	17 %

For answering research question 3, the frequencies of the CHIME model criteria and the depression pathology criteria were compared. Regarding the intensity effect sizes, summarized 81% of all statements could be categorized according the CHIME model and 18% were related to depression pathology criteria. Regarding the frequency effect sizes, there are 3 moderate evidences and 1 insufficient evidence among the depression pathology criteria. Among the CHIME model, there was 1 criterium classified as moderate, 2 criteria as substantial and 2 as strong.

Discussion

In the beginning of this research, 3 questions were stated that were meant to be answered along the way of this study. Concerning the characteristics of the studies it can be summarized that all included studies worked with interviews and included different types and severities of depression. The most important findings of this study are related to the criteria for recovery from depression. However it is striking when

regarding the results, that there are differences in how important the different categories of the CHIME model are to the patients. Based on the calculations, two criteria are especially emphasized by the patients, namely *Identity* and *Empowerment*. In the following the different criteria are discussed.

Criteria for depression recovery

Concerning Identity, based on the studies that were analyzed it seemed important to the individuals to find and explore their identity. Many mentioned, that depression helped them to reveal their true identity in the first place. Additionally, gaining insight into oneself played a key role for individuals in recovery. Based on the statements of the individuals, it seems that through depression people are more or less forced to care about themselves, to look into themselves and into their struggles. Thereby it is likely to gain new insights about oneself and to discover a new side of the own identity. This assumption also gains support from a survey in which the strongest determinants for recovery from depression, are concerned with constructs like self-confidence and a return to one's usual, normal self (Zimmerman, Glinchey, Posternak, Friedman, Attiullah and Boerescu, 2016). So, even if depression comes along with many destructive thought pattern about the self, people might be able to see themselves with greater clarity when being in recovery, especially when experiencing personal recovery.

Empowerment is the second most frequently mentioned criterium for recovery from depression. Taking a closer look on the statements from the individuals, an explanation can be found. Often they mentioned, that depression is a symptom of some behavior pattern that is not good for oneself, like for example to put the own needs behind in sake for other people. Through depression the own behavior pattern were explored and became visible for the participants. Changing them was often described as a challenge, but also went along with a feeling of choice and feeling more in control. Suffering from depression comes often along with helplessness and perceived uncontrollability of the emotions and the situation (Abramson & Sackheim, 1977; Pryce, Azzinnari, Spinelli, Seifritz, Tegethoff & Meinlschmidt, 2011). The level of functioning is significantly reduced in many areas of life and to reattain the control is an important part in the recovery of depression. This includes gaining the mastery

of depression and and controlling the own emotions, thus gaining empowerment over oneself. Concluding, the statements showed, that people can develop empowerment through experiencing depression, which can also lead to a more empowered life afterwards.

Identity and Empowerment are followed by Meaning and Purpose and Connectedness with 66% as substantial evidence. Especially Meaning and Purpose can be related to Identity and Empowerment, because often the purpose that was found in the suffering from depression was, that they came out stronger than they were before and and that they found their true self. In that case, depression was a reason to promote a better and more happy life afterwards when people were able to see the positive side of their depression and placing it into a positive context.

Connectedness is with 66% an substantial evidence and is thereby supporting the assumption that social relationships do play an essential role in depression (Cruwys, Haslam, Dingle, Haslam & Jetten, 2014). However it was surprisingly to take a closer look into the content of the statements that dealt with Connectedness. As already mentioned it was expected that dealing with stigma, would be an important theme for the patients but this was not the case in the statements of this study. One reason could be, that patients themselves are not perceiving the stigmata on a conscious way, but more unconscious. One example could be, that people do not open up about their depression because they are afraid of the accompanying consequences and how they are perceived as a person with depression. Another explanation could lie in the CHIME model. It is a model that is about personal recovery and covers many personal aspects. Looking from a personal context statements are interpreted on another way than they would in a social context. Furthermore, the statements that were used for this study, were probably not the original statements anymore. The researcher that worked with them in first instance may have interpreted the statements in a certain way, or used only certain statements, which is not comprehensible for this study. As those explanations are only suspicions and stigma was not concretely articulated from the patients, it is not to find in the results of this study.

From the undefined statements of this study, a specification of Connectedness developed, namely *relation with doctor*. It was classified as insufficient evidence for

recovery, but still was considered as interesting to mention as it supports findings of Bird and colleagues, 2014. As already mentioned in the introduction, they found in addition to the criteria of the CHIME model, a greater emphasis on issues around diagnosis and medication. Even if it is classified as insufficient evidence for recovery, issues around the treatment of depression seem to be an upcoming theme for patients that is not yet covered from the CHIME model.

Hope and Optimism (50%), Physical Functioning (50%), Behavior (33%) and Mood (33%) were categorized as moderate evidence for recovery from depression. However it is important to mention, that with 50% the first two are close to an substantial evidence. Physical Functioning was mainly described by bodily wellbeing and being able to be more active, like doing sport again. Hope an Optimism often manifested itself in long-term thoughts reflecting upon larger life goals, such as school and career. Both are representative for a certain quality of life, which explains their importance when it comes to recovery from depression.

Behavior and Mood were rarely mentioned in the studies. Especially with Mood this is surprising, as depression is an affective disorder so it would have been likely that recovery manifests itself in a change of mood of the people. That this is not the case and that other, more complex categories, are more related to recovery supports the assumption, that recovery from depression cannot be moored to the clinical perspective „no symptoms“. According to this perspective mood would have been one of the most important evidences.

Personal and clinical recovery

In the introduction the difference between clinical and personal recovery is thematized. Literature clearly emphasizes personal recovery as it is assumed that it better connects with the patient’s perspective and thus also their needs concerning the treatment (Lidz & Parker, 2003). Positive mental health related criteria should therefore also be taken into consideration (Slade, 2010; Keyes, 2002 & Seligman & Csikszentmihalyi, 2000). As the CHIME model aims to capture those criteria that are important to affected individuals, this research targeted the assessment of appropriateness of this model. Supporting previous literature, the results of this study clearly emphasize the importance of a dimension of recovery beyond the clinical

perspective. Only 18% of the statements were related to the clinical recovery and pathology change. This shows clearly that from the patient's perspective, the clinical dimension of recovery is less essential to recovery from depression than the personal dimension. It also reveals the alarming discrepancy between how recovery should be addressed in practice and how it actually is handled at the moment. The patient's perspective differs a lot from the clinical perspective that dominates the approach in the practice at the moment (Furukawa et al., 2008). This study has provided additional support for the argument, that a change in practice is needed concerning recovery. The CHIME model already initiates beginnings for this change through conceptualizing recovery from the personal perspective as it can make its implementation in practice easier. Therefore it is also important that the CHIME model has a good fit for capturing what is important to people that are in recovery. As only 3 statements of the patients did not fit in into the original categories of the model, this study supports the accuracy of the CHIME model concerning recovery from depression.

Summarizing, the criteria of the CHIME model cover 81% of all statements that were mentioned from the patients, which shows that this model achieves to generate a reasonable picture of what patients perceive as important in recovery. Thereby it can be stated that the CHIME model seems to capture the important dimensions of personal recovery, whereby Identity and Empowerment are especially important to people suffering from depression. However, it could be possible to develop specifications for further defining and concretizing the categories of the CHIME model. For example was noticed, that *Identity* could have been further divided into „self love", „self awareness" and „trust and confidence in oneself". Empowerment could be broadly divided into „having power over the depression" and „having the power to stand for oneself and taking the responsibility for the own needs". Those are different specifications of the category *Empowerment* and mean different things to the people that suffer from depression. In order to concretely discover what depression recovery does mean for an individual, it might be important to define the categories of the CHIME model more distinctively.

Limitations and Strengths

This study makes use of a meta analytic approach which takes 6 qualitative studies together in order to allow a comprehensive and complete picture of what recovery from depression means for people. According to my knowledge this study is the first meta analytic approach of qualitative studies about recovery from depression. The relatively high number of participants allows to make an assumption about the personal perspective of recovery from depression. Nevertheless it has to be considered that some studies fail to offer basic information like for example the treatment or severity of depression. As this information could have an important impact on the view of recovery and whats important in recovery for the participants, it is a limitation to this study, that not all information is given. Nevertheless it can be said, that the results of this study are very significant and very revealing. Despite the variety within the studies, the criteria *Identity* and *Empowerment* were extraordinary strong represented by the participants. This is intercesional for the results of the study and thus for the actual importance of those criteria in the practice.

Another limitation, is that only one researcher was performing this study. This lead to difficulties when ordering the statements into categories. Some statements were vague or could have applied to more than only one category. The researcher had no chance to get a second opinion on his assignments which could have led to inaccuracies concerning the allocation of the statements. Because of the difficulties during the allocation process, it first was considered to order statements into more than one category if there is an overlap. This consideration was not implemented as the effect sizes of the categories would have run the risk of not being meaningful anymore. That the statements often could have been applied to more than one category, shows one problem the CHIME model faces. In real live settings, feelings and perceptions do not belong to one category. It is much more complex than that and always in relation with one another. So it only shows the truthfulness of the statements that were worked with in this study because they could not simply be ordered to categories. A second researcher during the allocation process could have reduced this problem.

Furthermore it is questionable if there are studies that were not found during the searching process. Considering the great amount of articles with which the selection process was done and considering that the searching terms were quite broad in the beginning (getting more specific with time), it can be assumed that all relevant articles were found and included in this study. The searching strategy of this study can be regarded as exhaustive.

Further Research

The most important thing that comes out of this study, is the urgent need to adjust how the concept of recovery is implemented in practice. It is important to better connect with the perspective, needs and point of views from the patients. How this can be implemented should be an important theme for future research. For example it could be investigated if the implementation of the CHIME model into the practice would have added value through supporting the successful capturing of what a patient expects from his recovery. Finding a focus with the patient like for example *Identity* and *Empowerment*, which then are central to the treatment, could be one way of implementing it. Therefore it seems also important to investigate further into the CHIME model and how its categories can better be defined distinctively and more concretized.

Furthermore it would be interesting to investigate in the two most strong evidences of recovery from depression, *Identity* and *Empowerment*. An investigation about what makes them so important to people could additionally explain this phenomena and offer more isight into personal recovery. Additionally it would be interesting to compare the results of this study with other meta analytic approaches of qualitative studies in relation with other mental illnesses. In the previous it was explained why Identity and Empowerment seem to be important for people suffering from depression, which let's assume that for other mental diseases, other priorities would be set.

Conclusion

This meta analytic study was able to provide additional support for the assumption that the personal dimension of recovery is essential to patients that are healing from depression. The remission of the „clinical“ symptoms plays a more subordinated role and is not a sufficient approach for understanding what people ascribe to their recovery. The categories of the CHIME model, with especially regard to Identity and Empowerment, are a good representation of what people consider as important when it comes to recovery. Implications for practice are to implement the criteria of personal recovery and to determine those to the centrum of the treatment.

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Appendix A

Study	Statements
Ziebland, S & Ridge, D (2016)	- *recovery attitude messages like "Depression is only a part of you, not all of you"* - powerfully healing to connect with his "inner child" in therapy to work through his difficult feelings - becoming more aware of themselves and their place in the world - insight into their destructive thought patterns, distortions in the concept of themselves, and difficulties in their personal circumstances - tools to promote insight - gaining insight was linked by participants to feeling more positive and at ease with themselves —> shift of feelings about the self - separate out from their sense of who they are the distorted cognitive thinking that is part of depression (turn depression into a more manageable experience, recovery occurs also again and again - not only depression) - rewrite depression as a beneficial spiritual journey, depression is seen as meaningful —> promote greater self awareness and better life - discovering a very new way of being in the world, including a more robust self - depression had given them an opportunity to stop and rethink their lives, and identify what was most real and important to them - was to be "you," put yourself first, take time for yourself, look after yourself better, - move away from personal isolation and disclose your condition and true feelings, at least to a trusted few - more accepting an essential self—warts and all—than about trying to force change onto the self - full responsibility for recovering from depression

Study	Statements
Kevin Steven Corney (2016)	- increase in “energy,” a return to emotions such as “desire,” “hope,” or “peace,” or that they “wanted” to be happy - begin to engage with the world again rather than holding what energy she had back for herself during her depressive experience - sense of “desire,” that he “still wanted to have all the things that now I did not have” - desired relationship, an emotional compulsion that had until then been missing - my own emotions started to come back and what a relief to - be able to have a good old cry - sense of trust in the self - increased “love” and “trust” of self, a bodily sense of “well-being,” - increased interest in various elements of self and ways in which the participants “thought about” themselves - “trust” themselves was an indication that they were recovering - develop a sense of “knowingness” and to “trust” in that knowingness - knowingness that came from deep inside me. - “how I thought about myself,” - a “sense” of bodily well-being, - increased “trust” in self, feeling “more at peace,” “loving” and having a more “solid” sense of self, as well as a sense of “trust” and a “knowingness that came from deep inside me.” - benefits of depression, feel more able to choose whether or not to “go there” - were able to talk more openly about depression - able to find benefit from her depressive experience - more purposefully choose whether or not to fully engage with her depressive experience - see the benefits of depression - feel more choice over whether to engage or “get out” of the “old story” more easily - speak openly rather than keep their depression as a “massive secret.” - “awareness” that they “should” be making changes in their life, the feeling that they were in “control” and “responsible” for themselves - getting “bored” and wanted to reengage with life - importance of “awareness” and “making choices” because she was “responsible” for herself - physical level, better eating, exercising - importance of confidence in herself - feeling restless and I needed to be doing more and sort of engaging more in the world - increased sense of self-agency - eating better, attending yoga, - being able to “pull” out of the depressive state and take concrete steps towards life and away from suicide - sense of recovery in that her doctor would not recommend this activity if they did not think she was recovering - reflected upon larger life goals, such as school and career —> focus on these issues rather than obsessing over his planned suicide attempt - decision to “do something” - changes in interactions with friends and family members. - quality and the tone of his interactions with others shifted when he was recovering

Study	Statements
Kevin Steven Corney (2016)	- increased “interest” in her family & how she wanted these relationships structured - better able to handle the stressors of family - “emotionally available” to her children without being “irritable” or “impatient - „opening up process” while working with his therapist - relied on her doctor’s opinion
N. Lafrance & Stoppard, J (2006)	- today the difference is that, I think there was a shell [...] that through recovery breaking free and then like I stepped out. (…) more content with life now. - discovering the true self - recovery from depression involved letting go of their own high standards. - claim the identity of the good woman and reject the practices that flow from it - repositions herself in a way that enables her to resist being selfless, serving, and getting “worn out - dropped some of the things that I thought were required of me - a lot stronger person - learned to say no - attending to their own needs - changed from the “obedient wife, little girl” to the “feminist.”
Fullagar & O’Brien	- ambivalence about the possibility of achieving a successful recovery - battled with their reliance on medication - worried it will come back and take over your life - recovery from depression as an ongoing process of developing self-knowledge in the context of everyday life challenges, past history - desires for a different future - recovery is experienced as an “aliveness - recovery metaphors signified hope and change this certainly did not mean that the movement of self through depression was easy, - sense of their identity as multiple, including feelings of failure and weakness, and significantly also strength and courage - cured or fixed self - self-knowledge was a process of becoming alive and recognizing oneself as a woman with a range of capacities and desires - “grew into her own skin” - refusing to be responsible for everyone’s happiness and acknowledging the limits of their own emotional reserves - transformative experiences of “peace”, “contentment” or “calmness” also meant finding their identity beyond conventional gender roles - renewed feeling of trust or faith in women’s own capacities, abilities and potential - found “purpose” and “meaning” through changes in the home or work environment - engaging in meaningful and enlivening leisure experience - Self-knowledge developed when women created time and space to reflect on the whole range of changes being made in their lives beyond the immediacy of treatment regimes

Study	Statements
Rita Schreiber	- social context : made changes where the fit was poor - able to see themselves as competent human beings - considered flaws seen as part of themselves —> acceptance - re owning their own feelings - allowing themselves to be vulnerable - giving up negative self image - taking responsibility for oneself learning to identify own needs - ask for what one needs from others - complete with inconsistencies, shortcomings - including her vulnerability into the picture of who she is but also including her strengths - growth experience as they learn skills and develop knowledge
Johnson	- quality of the interaction - expression through the body - being more active or behaving as they had before - more interactive, more social, less time lying about the place - personal agency in recovery, ranging from the physical aspects (eating better, crying less, changes in sleep patterns) to specific activities, particularly those enjoyed before depression - physical indicators of recovery, such as changes in facial expression, body language or ,demeanour - happiness (or absence of sadness) was commonly judged by a person's appearance - feeling in control, feeling less anxious, feeling that one belonged or a change in understanding of self

Appendix B

Table 1. Labels

Recovery criteria	Statements
1. Depression pathology	
1.1 Mood	- feeling in control, - feeling less anxious, - my own emotions started to come back and what a relief to - be able to have a good old cry
1.2 Cognitional functioning	
1.3 Physical functioning	- a “sense” of bodily well-being, - better eating, - exercising - eating better, attending yoga - recovery is experienced as an “aliveness - personal agency in recovery, ranging from the physical aspects (eating better, crying less, changes in sleep patterns) - physical indicators of recovery, such as changes in facial expression, body language or ,demeanour - happiness (or absence of sadness) was commonly judged by a person's appearance
1.4 Behavioral	- increase in “energy,” - begin to engage with the world again rather than holding what energy she had back for herself during her depressive experience - getting “bored” and wanted to reengage with life - feeling restless and I needed to be doing more and sort of engaging more in the world - expression through the body - being more active or behaving as they had before - to specific activities, particularly those enjoyed before depression

Table 1. Labels

Recovery criteria	Statements
2. Connectedness	- move away from personal isolation and disclose your condition and true feelings, at least to a trusted few - desired relationship, an emotional compulsion that had until then been missing - changes in interactions with friends and family members. - quality and the tone of his interactions with others shifted when he was recovering - increased “interest” in her family & how she wanted these relationships structured - better able to handle the stressors of family - “emotionally available” to her children without being “irritable” or “impatient - social context : made changes where the fit was poor - quality of the interaction - more interactive, more social - speak openly rather than keep their depression as a “massive secret.”
3. Hope and optimism	- separate out from their sense of who they are the distorted thinking that is part of depression —> turn depression into a more manageable experience, recovery occurs also again and again - not only depression) - sense of “desire,” that he “still wanted to have all the things that now I did not have” - reflected upon larger life goals, such as school and career —> focus on these issues rather than obsessing over his planned suicide attempt - recovery metaphors signified hope and change - see the benefits of depression - a return to emotions such as “desire,” “hope,” or “peace,” or that they “wanted” to be happy
4. Identity	- powerfully healing to connect with his “inner child” in therapy to work through his difficult feelings - discovering a very new way of being in the world, including a more robust self - was to be “you,” - more accepting an essential self—warts and all—than about trying to force change onto the self - sense of trust in the self - increased “love” and “trust” of self, - an increased interest in various elements of self and ways in which the participants “thought about” themselves - “trust” themselves was an indication that they were recovering - develop a sense of “knowingness” and to “trust” in that knowingness - knowingness that came from deep inside me. - increased “trust” in self, feeling “more at peace,” “loving” and having a more “solid” sense of self, as well as a sense of “trust” and a “knowingness that came from deep inside me.” - “how I thought about myself,” - discovering the true self - importance of confidence in herself - recovery from depression involved letting go of their own high standards. - claim the identity of the good woman and reject the practices that flow from it - a lot stronger person

Table 1. Labels

Recovery criteria	Statements
	- changed from the "obedient wife, little girl" to the "feminist." - recovery from depression as an ongoing process of developing self-knowledge in the context of everyday life challenges, past history and desires for a different future - sense of their identity as multiple, including feelings of failure and weakness, and significantly also strength and courage - cured or fixed self - self-knowledge was a process of becoming alive and recognizing oneself as a woman with a range of capacities and desires - "grew into her own skin" - gaining insight was linked by participants to feeling more positive and at ease with themselves —> shift of feelings about the self - transformative experiences of "peace", "contentment" or "calmness" also meant finding their identity beyond conventional gender roles - renewed feeling of trust or faith in women's own capacities, abilities and potential - Self-knowledge developed when women created time and space to reflect on the whole range of changes being made in their lives beyond the immediacy of treatment regimes - able to see themselves as competent human beings - considered flaws seen as part of themselves —> acceptance - re owning their own feelings - allowing themselves to be vulnerable - giving up negative self image - including her vulnerability into the picture of who she is but also including her strengths - complete with inconsistencies, shortcomings - growth experience as they learn skills and develop knowledge - change in understanding of self
5. Meaning and purpose	- becoming more aware of themselves and their place in the world - rewrite depression as a beneficial spiritual journey, depression is seen as meaningful —> promote greater self awareness and better life - depression had given them an opportunity to stop and rethink their lives, and identify what was most real and important to them - able to find benefit from her depressive experience - today the difference is that, I think there was a shell [...] that through recovery breaking free and then like I stepped out. (…) more content with life now. - repositions herself in a way that enables her to resist being selfless, serving, and getting "worn out - dropped some of the things that I thought were required of me - found "purpose" and "meaning" through changes in the home or work environment or through engaging in meaningful and enlivening leisureexperience - label the depression in new ways

Table 1. Labels

Recovery criteria	Statements
6. Empowerment	- insight into their destructive thought patterns, distortions in the concept of themselves, and difficulties in their personal circumstances 90 - tools to promote insight - put yourself first, take time for yourself, look after yourself better, - full responsibility for recovering from depression - benefits of depression, feel more able to choose whether or not to "go there" give a name to this place such as their "safe little place**,"** "my hole" or "this massive secret**,"** and were able to talk more openly about depression - more purposefully choose whether or not to fully engage with her depressive experience - "awareness" that they "should" be making changes in their life, the feeling that they were in "control" and "responsible" for themselves - increased sense of self-agency - being able to "pull" out of the depressive state and take concrete steps towards life and away from suicide - decision to "do something" - learned to say no - attending to their own needs - refusing to be responsible for everyone's happiness and acknowledging the limits of their own emotional reserves - taking responsibility for oneself learning to identify own needs - ask for what one needs from others - , feel more choice over whether to engage or "get out" of the "old story" more easily - importance of "awareness" and "making choices" because she was "responsible" for herself
Undefined	- „opening up process" while working with his therapist - relied on her doctor's opinion concerning recovery - sense of recovery in that her doctor would not recommend this activity if they did not think she was recovering —> Relation with doctor _____ 99 statements Not concrete enough: - Absence of symptoms of depression - Functioning well