Understanding Recovery from Psychosis: A Growing Body of Knowledge

Jean Pierre Wilken

There is strong evidence that persons with severe psychotic disorders can and do improve their quality of life. Accumulating knowledge shows which factors are important in the process of recovery.

Anthony (1993) traces the origin of the recovery construct in the United States back to the 1970s. During that time period, a new self-help ideology was becoming increasingly popular. A number of factors have influenced this self-help movement, like the human rights movement, and the wish to reduce stigma. Anthony challenged the rehabilitation movement and the mental health system to really address people's multiple residential, social, vocational and educational needs and wants. He defined recovery as:

> a deeply personal, unique process of chang-ing one's attitudes, values, feelings, and goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life (p. 15).

In this article the concept of recovery is explored. The current body of knowledge about recovery from severe psychosis will be reviewed. The following questions will be addressed: What is recovery? What is known about the course and outcomes of a recovery process? Which are factors which hinder and facilitate the process? Especially the answers to the last question lead us to the role mental health professionals can play to facilitate the recovery process. Recovery appears as a multidimensional concept. We will describe a number of different perspectives, review the studies which are available and subsequently point out the relevance of a multi-perspective approach for practice.

What is Recovery?

Longitudinal studies in which people with long-term psychiatric problems were followed for more than twenty years show that more than half the persons had a full or partial recovery. Some persons displayed fairly severe symptoms of basal dysfunction, while others had almost no symptoms at all. Many clients led socially integrated lives. Usually, the recovery process does not start until after several turbulent years of severe mental illness and a number of hospitalizations have passed. How the process works is something that we do not as yet fully understand.

Patricia Deegan (1996) wrote a moving account of her own recovery process:

> It is very important for me to say that, yes, I have a disability, but that does not make me a disabled person. I have learned that it is possible to lead a worthy and healthy life despite my disability. People often think that the two don't go together, but they're wrong. I have a psychiatric disability and lead a full and healthy life. I succeed in this because I am working on my recovery. I believe that I will recover. … One of the lessons that I had to learn was that recovery isn't the same as being cured. After having lived with my illness for 21 years,

it hasn't gone away. I don't suppose that I will ever be cured, but I am recovering. Recovery is a process, not an end or goal. Recovery is an attitude, a way of getting through the day and tackling the challenges that come my way. … Knowing what I can't do lets me see the numerous possibilities still open to me.

Other clients define recovery as:

Recovery is an ongoing process of growth, discovery, and change (Stocks, 1995).
A recovery paradigm is each person's unique experience of their road to recovery ….
My recovery paradigm included my reconnection which included the following four key ingredients: connection, safety, hope, and acknowledgment of my spiritual self" (Long, 1994, p. 4).
What there is now that is new is the beginning of trust that the bad times will pass and the underlying strength will prevail. What there is now is insight about how externals affect me and how to better manage myself in connection with outside factors. What there is now is acceptance. I reinforce what I learn with an annual life review (Caras, 1999, p. 2).

Although recovery seems to be a very individualized process ("every client has his own story", Strauss, 1996), as research is providing an increasing amount of data, it seems possible to generalize recovery factors.

It is remarkable that in the psychiatric literature the recovery concept is seldom defined. In the professional view, for long dominated by a medical view, a person could either be cured from a psychiatric illness, was diagnosed to have a chronic illness or became chronic over the years. Cure was mostly defined as the absence of symptoms, measured by clinical methods and no remaining (need for) treatment. As a third element the social effects or disabilities resulting from the illness were taken into consideration. From a psychodynamic point of view, whether or not the person shows "insight" is still another factor in clinically determining recovery. An absolute definition of recovery in a medical sense would be that recovery is defined by the absence of symptoms, treatment and resulting social effects. In the epidemiological research literature a distinction is made between "total or symptomatic recovery" and "social recovery" (Liberman et al., 2002; Warner 1985). In the experiential research literature, recovery is mostly seen as a process in which complete absence of symptoms may occur, but is not an end goal. Learning to cope with the illness and achieving a desired quality of life is regarded essential elements of recovery.

We will now have a look at two types of studies: the longitudinal studies conducted in the past century, and the experiential studies since the 1990's.

Outcomes of Longitudinal Studies

Longitudinal studies which have been conducted over the past century show quite clearly that many people with a serious mental illness seem to be able to manage their life despite their symptoms, that a certain group becomes completely symptom free and that many individuals are leading socially integrated lives at follow-up (Table 1).

Table 1. Longitudinal studies of recovery from serious mental illness (Source: Harding & Zahniser, 1994)			
	No. of subjects	% totally recovered	% socially recovered	% recovered

Table 1. Longitudinal studies of recovery from serious mental illness (Source: Harding & Zahniser, 1994)				
Bleuler, 1968, Zürich Switzerland	208	23	43	66
Ciompi, 1980, Switzerland	289	27	22	49
Tsuang et al., 1979, Iowa USA	186	20	26	46
Huber et al., 1980, Germany	502	26	31	57
Ogawa et al., 1987, Japan	140	31	26	57
Harding et al., 1987, Vermont USA	269	34	34	68

Davidson and McGlashan (1997) reviewed studies about course and outcome as of the 1980's. They located nine follow-up studies in western countries and five cross-cultural studies. In Table 2 some results are summarized from the American and Western-European studies. As in the earlier studies, recent follow-up studies continue to find a broad heterogeneity in long-term outcome in schizophrenia, with 17 % to 57 % of subjects achieving a good outcome ranging from mild impairment to recovery.

Table 2. Studies showing a broad heterogeneity in long-term outcome in schizophrenia (Source: Davidson & McGlashan, 1997)			
	No. of subjects	Findings	% symptomatically and/or socially recovered
Carpenter & Strauss, 1991, USA (11 years follow-up study)	40	Level of functioning in life domain before onset most predictive of outcome; outcome at 2 and 5 years follow-up remains stable at 11 years follow-up	57 %
Mason et al., 1995, UK (13 years follow-up study)	67	97 % living independently in the community, 22 % employed	55 %
Carone et al., 1991, USA (young patients)	79	Improvement between 2.5 (10 %) and 5 years (17 %) follow-up after hospitalization; decrease of hospitalization over the years despite persisting symptoms	17 % after five years
Breier et al. 1991, USA (young patients)	58	More negative symptoms with longer duration of illness; 24 % experienced at least one period of major depression; level of symptoms related to functional capacity in social, work, and	21 % after six years (41 % poor outcome; 38 % moderate outcome)

Table 2. Studies showing a broad heterogeneity in long-term outcome in schizophrenia (Source: Davidson & McGlashan, 1997)

		independent living domains. Responsiveness to medication favours good outcome.	
DeSisto et al. 1995, USA (retrospective study 32 years after discharge from hospital)	180	Comparison of the Vermont-study (Harding et al., 1987) with a cohort in Maine USA. Vermont subjects showed better outcomes. Attributed to rehabilitation and community support programmes in Vermont, which were not available in Maine.	49 %
Helgason, 1990, Iceland (20 year follow-up study with persons not hospitalized at the time the study started)	107	20 year follow-up of non-hospitalized patients, with an average delay of 6–7 years between the onset of the illness and first psychiatric contact. Outcome was extremely poor for 21 %. Patients who sought treatment earlier in the course of the illness had a more favourable outcome.	33 %

The studies provide further evidence that deterioration occurs within the first few months of onset, followed by a plateau in functioning which then may or may not be followed by gradual improvement. Affective symptoms and depressive episodes appear to be predictive of a more favourable outcome.

Outcomes of Experiential Studies

Over the past decade an increasing amount of personal accounts and qualitative studies have been published, which form a growing body of knowledge about the process and phenomena of recovery. These publications illustrate the many and varied ways in which recovery takes place. But it also becomes obvious that recovery is a complex process, consisting of different dimensions.

Wilken (2005) made a review of 13 qualitative studies, where goals were to identify important recovery factors drawn from the personal experience of people in the process of recovery or having recovered from a serious mental illness (Table 3).

Table 3. Qualitative studies which identifies recovery factors drawn from the personal experience of people in the process of recovery (Wilken, 2005)

Authors	Year of publication	Type of study
Hatfield & Lefley USA	1993	Analysis of autobiographic literature
Sullivan USA	1994	Open-ended interviews and focus-group discussions (n = 46)

Table 3. Qualitative studies which identifies recovery factors drawn from the personal experience of people in the process of recovery (Wilken, 2005)		
Ralph et al. USA	1996	Focus-group and rating questionnaire (n = 251)
Tooth et al. AUS	1997	Qualitative interviews and focus groups (n = 57)
Ralph et al. USA	1999/2000	Focus-group interviews and analysis of recovery literature
Young & Ensing USA	1999	Literature research and qualitative interviews (n=18)
Smith USA	2000	Qualitative interviews (n = 10)
Ridgway USA	2001	Analysis of first person recovery narratives (n = 4)
Torgalsboen NOR	2001	Qualitative interviews (n = 17)
Topor SWE	2001	Qualitative interviews (n = 16)
Boevink et al. NL	2002	Focus group with emphasis on learning from narratives (n = 8)
Spaniol et al. USA	2002	4-year follow-up study using in-depth interviewing (n = 12)
Onken et al. USA	2002	Structured focus groups (n = 115)

On the basis of a meta-analysis five relevant clusters of recovery factors could be identified (Wilken, 2005):

1   Recovery as a developmental and self-empowering process over time
2   Motivation/drives for recovery
3   Competences/skills for coping with the illness, the environment and self-care
4   Social engagement/shifting the social status
5   Environmental resources

The first cluster represents the *process dimension* of recovery. In order to initiate and foster this development and growth process, *motivational factors* are indispensable. The third cluster represents the *competences* which are necessary to advance in personal recovery. The fourth cluster represents the factors which seem to be important for *social and community participation*. Finally, *resources from the environment* are important to support the person in his/her recovery process. This cluster consists of three subcategories: social network resources, mental health care resources and material resources. The five clusters form a multidimensional model which puts the different clusters of factors as well as the process character of recovery in perspective. The model is depicted in Figure 1.

Figure 1. *Multidimensional model of recovery factors (Wilken, 2005)*

Cluster 1: Recovery as a Developmental and Self-Empowering Process over Time

A number of authors have conducted studies and developed ideas about the course of a recovery process (Spaniol et al. 2002; Strauss et al., 1987; Young & Ensing, 1999). Although it is clear that every recovery process is unique, these studies provide insight in the paths a recovery process can follow and in the phenomena which occur. All models describe a developmental process from the onset of the illness, often accompanied by a state of serious crisis and disintegration of the self, leading to a state in which the person either knows how to cope with the illness and its consequences, or to a total recovery. During this process, two parallel processes evolve: a process in which the person has to come to terms with him-/herself, and a process of reconnecting to the world.

Reconnection is a word which describes the focus of both processes well. The persons have to re-connect to them self, finding their core identity, taking control over their disability and their own life. They also have to re-connect to the world around: their social network, the school, the neighbourhood, the job.

All studies acknowledge the fact that "the way back" or "the road to recovery" is not a linear process. The boundaries between phases are not precise, and there is a movement within and between phases. The pace of the recovery process can differ from person to person. Some studies show a fast recovery (within 1–2 years), others a slow recovery (taking decades). Within an individual process, at some time there is some standstill (a moratorium), at another time there is a fast progression.

Recovery seems to be an interactive process of psychological, biological and environmental factors. How this interaction works and when it leads to progress or to deterioration, is still not clear. One important aspect seems to be that people's attributions or casual explanations of what has happened to them, including those pertaining to degree of control (controllable vs. uncontrollable), locus of control (internal versus external), and degree of stability (stable vs. unstable) strongly influence people's attitudes and behaviours.

The course of a recovery process can be roughly divided into three phases: stabilization, "reorientation" or reassessment, and re-integration, see Table 4 (Wilken & Den Hollander, 1999).

Table 4. Three global phases in a recovery process (Wilken & Den Hollander, 1999)		
Stabilisation	**Reorientation**	**Reintegration**
Focus: controlling symptoms en diminishing the suffering	Focus: exploring the implications of the illness for the near future; exploring how to get back to a normal life	Focus: restoring meaningful activities, relationships and social roles

The stabilisation phase is preceded by a phase of loss of control and disintegration. A person's life falls apart. All social roles grind to a halt until only the role of patient remains. All attention is focussed on combating the illness, and the person becomes highly dependent on the expertise of medical practitioners. Hospitalization, if it occurs, places the person in an alien environment with its own regulations and procedures. This may result in confusion or even mental shock. Bury (1982) describes this life event as an acute biographical disruption. Accepting treatment can be difficult, too, as it requires a certain level of submission which may reinforce the feeling of having lost control. As the treatment progresses, the person's medical psychiatric condition stabilizes, as well as his/her psycho-logical condition. The real and possible consequences of the illness become gradually apparent and re-orientation sets in. This is when the process of mourning starts, which may include periods

of denial, desperation, anger and grief. The person mixes up different roles and may have adjustment pro-blems. Another important part of this phase is the person's struggle to find some meaning in life: What purpose, what meaning does the illness have in my life? As the process progresses, peace of mind and control slowly return. At some point, the person's attention shifts away from what (s)he cannot (yet) do to what (s)he can: How can I best cope with my illness, my limitations, my disability? What (coping) skills will I need? Which social roles could be restored, which skills could I regain? In this process the person learns to get a new hold on life, which in time will reveal a new perspective for the future.

In the third phase, a person gradually picks up his/her life, his/her biographical time line. Re-integration occurs at all three levels: the personal level, the interpersonal level and the community level. Communication with the outside world is restored. Persons set their first steps on the rocky road of learning to live with a new perspective. The person is at the centre of his/her own recovery process, but support from others is still crucial. Slowly, the person's self-esteem grows; coping skills are practised and reinforced. Social contacts are established and a daily routine takes shape. All of this leads to increased independence, interdependence and competence. After being (re)integrated in a particular area of life (housing, working, leaning, socialising), stabilisation is required on a higher level. It is important to keep the acquired quality of life and balance.

Cluster 2: Motivation and Drives for Recovery

In the process of recovery there is a line going from being disrupted, disconnected and disintegrated to being connected and integrated. In this process the person tries to come to terms with the illness and its consequences.

A recovery process needs powerful fuel. There may be many different types of fuel, both intrinsic and extrinsic motivational factors. These motivational factors are incorporated in the term *empowerment*. There are two forms of empowerment: self-empowerment and envir-onmental empowerment. The latter should feed the former. Empowerment is a combination of internal and external factors where the internal strength is combined with interconnectedness to provide the self-help, advocacy, and caring about what happens to ourselves and to others (Ralph, 2000). The goal of empowerment becomes one of people gaining power and control over their lives through access to meaningful choices and the resources to implement those choices. The findings document the crucial role that *choice* plays in empowerment. Having information on, and access to, a range of meaningful and useful choices and options fosters recovery (Onken et al., 2002). People are empowered when they make the choices regarding where they live, housing, finances, employment, personal living/daily routine, disclosure, who they associate with, self-management and -treatment. Individuals talk about the empowering experience of choosing "how I see myself, my disorder, my situation, my quality of life". But for such empowerment to occur, meaningful options must exist and people must have training and support in making choices, and the freedom to take risks and fail. Too often quality of life choices seemed beyond the realistic reach of many persons with a mental illness. Options are limited, lousy, or nonexistent. Independence (defined as: not being subject to the control of others, and not requiring or relying on others) also falls within the empowerment dimension. People expressed it as both a process and goal of recovery.

Independence is achieved through making one's own choices and decisions, exercising self-determination (such as advanced directives), enjoying basic civil and human rights and freedom, and having a liveable income, a car, affordable housing, etc. Some people talk of the importance of both

independence and interdependence, reaching beyond the goal of independence to that of embracing interdependence. Interdependence is a term that implies an interconnection or an interrelationship between two entities and is used to describe the link of people to people. Seeking independence and seeking interdependence are not mutually exclusive.

Many studies describe *hope* to be an important empowering factor (Hatfield & Lefley, 1993; Onken et al., 2002; Ridgway, 2001; Van de Langenberg et al., 2004; Young & Ensing, 1999).

Deegan (1988) considers hope as a turning point in the process of recovery, which must be followed by a willingness to act. Hope seems to be an attitude, which is inviting or encouraging making changes for the better. *Believing that recovery is possible* and having this belief supported by others (friends, family, peers, and staff) helps fuel self-agency (the process of intentionally living one's life on one's own accord). Participants want to understand what they are experiencing, they want to be educated, have good information and actively participate in making important choices. Some of the findings seem to indicate that certain cultural affiliations, such as tribal community, may modify the emphasis on self-agency through activating kinship or tribal mores that stress interdependency or living for the good of the larger social unit (Onken et al., 2002).

From a number of studies it appears that many persons view *spirituality* as a positive force supporting their recovery. Many people rely on religious faith for strength and sustenance (Spaniol et al., 2002; Sullivan, 1994; Torgalsboen, 2001; Young & Ensing, 1999). Belonging to a church community also offers a person protection and a valued role as a church member.

Cluster 3: Developing Competences

A recovery process is endorsed by (re)-using different skills and developing new competences which are needed to cope with the vulnerability and its consequences. These competences encompass:

–   Learning to cope with the illness and its consequences (skills for coping with illness, activity and participation restrictions)

      Developing psychological competence to put life and identity into (new) perspective
      Self-care and social skills
      In the stabilisation phase an important task is *to get some control over the illness* itself. Hatfield and Lefley (1993) use the concepts of *stress*, *coping* and *adaptation* as a framework for thinking about processes of recovery. This is often achieved by the use of effective psychotropic medication and developing effective coping skills and strategies for dealing with symptoms and stressors. In the reorientation phase of the process of recovery putting the illness into the perspective of the self and the discourse of life requires other competences. In this phase there is the judgment of *abilities and disabilities*: What skills do I (still) possess, what skills are lost or are necessary to develop in order to live my life as I want it? The most important type of skills revealed by the studies we reviewed is the skills to cope with the vulnerability. These skills include: monitoring and recognizing warning signs, skills for stress management and medication management. Another type of skills mentioned is practical skills for maintaining a household and a good physical health, as well as skills to socialize with other people.

The International Classification of Human Functioning (ICF; WHO, 2001) defines three possible consequences of a biological disorder: changes in physiological or psychological functions or structures, in activity patterns, and in participation in social life. Activity limitations are related

to exercising skills and the use of resources. Participation restrictions refer to fulfilling social roles and participation in community life. Being confronted with a serious mental illness often causes serious problems in all the three areas, because they are so interconnected. A difference between psychiatric disorders and other disorders is that the cognitive functions themselves are part of the impairments. Therefore individuals have to use an impaired cognitive system to repair or to cope with the same system. This requires a great competence of *resilience* and *adaptation*. One of the most fascinating aspects of recovery is that many people apparently succeed to accomplish what seems virtually paradoxical or a mission impossible. The person not only has to cope with his/her illness and the consequent disability, but also with a *history* of disruption and hospitalization, being cut off the own trusted self, social relations and social roles. Understanding what has happened, mourning about what has been lost and to some extent being able to accept things as they have occurred, are important aspects of the phase of reorientation. "First regain and then move forward", as Young and Ensing (1999) put it.

A second type of competence to advance recovery is developing the ability to put life and identity into (new) perspective. This concerns the *development of self*. Participants in the study of Onken et al. (2002) talked about the internal sense of self, inner strivings and their whole being (physical, emotional, mental, and spiritual) as affected by and affecting the recovery process. They described various personal qualities, attitudes and conditions that can help (self-reliance, personal resourcefulness, self-care, self-determination, self-advocacy, holistic view) or hinder (not taking personal responsibility, shame, fear, self-loathing, invalidation, disabling health and mental conditions). The personhood dimension is also about hope, purpose, faith, expectancy, respect and creating meaning. Participants described how developing a sense of meaning, purpose and spirituality as well as having goals, options, role models, friends, optimism, and positive personal experiences support recovery.

> My recovery process began 2 years ago when I took responsibility for me, and I recognize my behaviour and I try to make it a point to kind of look at myself very objectively… like an outsider and recognize what I am doing. If I don't recognize it I'm never going to stop it or change it. (Example from: Young & Ensing, 1999, p. 226.)

In many studies, to acquire some *insight*, to get to know your self, is described as an important factor in recovery. This theme has different aspects: to face and accept your disability, to learn about your own vulnerability and how to cope with it (Boevink et al., 2002). Insight is related to consciousness: to know what your pitfalls are and your strong sides. Consciousness is essential to get and keep the direction over your own life.

Cluster 4: Social Engagement and Shifting the Social Status

At a certain point in their life, people make a certain more or less conscious decision: to change behaviour, not to bother anymore about a certain hallucination, to move to another place, to take life in their own hands. This often marks a changing point, as described by Strauss ((1987). An important change point in recovery processes is when someone is making an *overt transition*, which means actually moving into action. The studies mention two types of engagement: *engaging in meaningful activities* and *engaging in social roles*. Motivation is paired with action. Sometimes it means taking up old activities and roles, sometimes it means starting new activities or roles, like in the domain of work

or recreation. By entering this engagement, a shift in social status is made. One is (re)entering the "real world". This emphasises the "normal" part of the self and reinforces self-confidence.

Spaniol et al. (2002) call this "the third task of recovery" (the first task being developing an explanatory framework for understanding the experience of a psychotic illness, the second task to get some control over the illness itself). The challenge is *to move into roles that are meaningful*, productive and valued by the larger society.

This means having a core of active, interdependent social relationships, being connected through families, friends, peers, neighbours, and colleagues in mutually supportive and beneficial ways. Recovery is enhanced through engaging in meaningful activities that connect one to the community. Often this can be achieved through a meaningful job and career, which can provide a sense of identity and mastery. There are other options, such as advancing one's education, volunteering, engaging in group advocacy efforts, and/or being involved in programme design and policy level decision-making (Onken et al., 2002).

> I needed to be able to relate to other people what I felt – why I felt so stigmatized by my illness that I couldn't relate to anybody. I felt very alone and very lonely. (Example from: Young & Ensing, 1999, p. 228.)

Cluster 5: Environmental Resources

The last cluster is the cluster of "environmental supports and resources". A division can be made between the subcategories social support resources, mental health care and other social resources, and material resources. We deliberately divided mental health care resources from the other types, although mental health care also may include being part of a social network of a client, or providing shelter and food. It is important to make this distinction to filter out the contribution of mental health services from "natural resources".

The term resource refers to the fact that there is a meaning for the person with regard to the recovery process. This cluster includes a material and a social support system. There appears to be no straightforward correlation between a particular environment and recovery. Although certain environments provide a wider range of opportunities, it is up to individual factors whether or not these opportunities are going to play a role in the recovery process.

Social Support

People who have recovered see relationships with others, both people and pets, as being of central importance in their recovery process. Personal support is support offered by specific family members, peers, friends, and professionals, who facilitated the recovery process by offering hope, encouragement, and opportunities. To work with other clients on your own life story helps to get more control over your own life and your environment (Boevink et al., 2002). Social support can also be obtained from pets. To have a pet gives you responsibility and forces you to care, to maintain a daily rhythm and discipline.

According to Topor (2001) others fulfil a number of functions:

Serving as vicarious bearers of hope

Providing material support

Recipients of meaningful behaviour

Symbolising continuity and wholeness in the person's life

Providing a relationship which can be used to test the viability of the recovery

In the community, *stigma* is regarded to be the most critical burden suffered by persons with serious mental illnesses, and a major obstacle for recovery. There are many different aspects of stigma:

- Persons may be regarded as dangerous or lazy; this leads to problems getting or maintaining housing and work.
- Clients may have internalized the stigma attached to having a mental illness or being hospitalised (Campbell, 1989; Estroff, 1989). From a research conducted by Link (1991) we learn that there was a relationship between the degree to which clients expected devaluation and discrimination, and the degree to which they were employed and had social support. Link concludes: "The uncertainty, tentativeness, and withdrawal that can result may affect performance in the job market, social network ties, and a patient's view of himself/herself" (p. 5).
- A general way in which stigmatization occurs is that people are judged by their appearance, manner of speaking, occupational role and ascribed status in life. Once people reveal that they have a disability, there is immediately the danger to be stigmatized. No wonder that people often try to hide their psychiatric background. The consumer movement is often a good vehicle to "come out", to build self-esteem, to fight stigma and to advocate for citizen's rights.
- Yet another obstructing factor is to have to deal with the double stigma of race and mental illness, which was experienced by African-American participants (Spaniol et al., 2002).

Material Resources

Basic resources such as money, food, clothing and shelter are contributing to recovery.

Topor (2001) mentions that a social insurance system which acknowledges mental disability and which provides financial support when working is not (yet) possible can be an important condition for recovery.

Social and personal isolation, poverty, immigrant status and social stigma impede the recovery journey (Onken et al., 2002; Spaniol et al., 2002). Participants in the Onken study report high rates of unemployment, underemployment, and exploitation. Training and education opportunities are lacking, benefits have employment disincentives, prejudice and discrimination hamper efforts, and individual wishes and decisions are disregarded. A number of participants in the Spaniol study were or had been homeless and lived on meagre resources available through entitlement and benefit programmes. In general, those persons demonstrated considerable skill and resourcefulness in obtaining the resources needed for their daily survival. At times, dealing with poverty was a greater challenge than dealing with mental illness. The efforts to obtain or retain basic resources and to establish some measure of personal security consumed a great deal of time and energy.

Mental Health Resources

Psychiatric hospitals are often regarded by consumers as restricting and dehumanizing places. Clients are treated as abnormal and infantile, not being able to speak for themselves. Staff is using "technical" language, speaking in medical terms. On the other hand, a number of clients also report positive feelings toward psychiatric hospitals, as they provided a *safe haven*, a place where there could be experimented with medication, and evaluations could be made about what has happened in crisis situations.

From the studies a number of mental health resources prove helpful in the recovery process.

First of all effective *medication* is an important support factor in many cases. Effective medication is defined as alleviating the acute symptoms without causing too many side-effects. Many clients describe the time-consuming struggle before finally finding the right medication and the right dose. A good collaboration with a psychiatrist, who considers the client as the most important source of information for indicating whether or not a specific type of medication is helpful, is valuable (Sullivan, 1994; Tooth et al., 1997; Topor, 2001).

Secondly, *access* is needed to supportive therapeutic environments as well as to medical, substance abuse and psychiatric *treatment*. A broad range of *rehabilitation services* and programmes should be available and accessible. *Psychotherapy* is valued if it provides insights and helps learning to cope with mental problems, such as hearing voices and handling irrational beliefs.

With regard to the services of *individual professionals*, a number of characteristics appear. The professionals who are most helpful for recovery are persons who:

- have an attitude of equality, partnership, unconditional acceptance, understanding and empathy
- have a strong belief in recovery, and express hope and confidence
- have a holistic focus
- are focused on facilitating recovery, and
- offer on-going, consistent, support

Epilogue

There is strong evidence that persons with severe psychotic disorders can and do improve their quality of life. Accumulating knowledge shows which factors are important in the process of recovery. For mental health care professionals it is important to use these facts and insights to improve their services. In a number of countries, like the United States, Denmark and the Netherlands, *Recovery Oriented Services* are being developed. Criteria for Recovery Oriented Services have been developed by the American Association of Community Psychiatry (AACP, 2003). The United States government has declared a recovery orientation as the "single most important goal" to be adapted by the mental health service delivery system. Recently, a National Consensus Statement on Mental Health Recovery was released (Samsha, 2006). In the coming years the city of Århus in Denmark will transform all its services for social psychiatry into recovery based services. In the Netherlands, a national consensus document on psychosocial rehabilitation provides a framework in which recovery support services can be developed (Wilken et al., 2003; Wilken & Den Hollander, 2005). The essential ingredients of these comprehensive services include providing, in a respectful way, individualized and person-centred support, aimed at empowerment, increasing self-direction and strengths, promoting peer support and community participation.

Prof. Jean Pierre Wilken

Storm Rehabilitation,European Centre for Psychosocial
Rehabilitationand Community CareP.O. Box 347, NL-3500 AH
Utrechtj.p.wilken@stormrehabilitatie.nlwww.stormrehabilitatie.nl

Jean Pierre Wilken

Jean Pierre Wilken is a social scientist and a clinical psychologist. After working for many years in the field he is currently director of research and development of Storm Rehabilitation, which is a European Centre for Psychosocial Rehabilitation and Community Care, based in the Netherlands. The centre is a research, development and training centre for professionals in mental health care and community care, offering support to mental health agencies to specialize in psychosocial rehabilitation, community care and recovery oriented services. He is a professor of Social Work at Utrecht University for Professional Education, and the head of a research group working on issues of social integration and community support for persons in vulnerable positions. The department is providing knowledge to the educational programmes of both social workers and nurses. He has published a number of books and many articles, most of them are in Dutch. His most recent publication in English is: *Rehabilitation and Recovery: A Comprehensive Approach*. Amsterdam; SWP Publishers.

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From a meta-analysis taking into account a number of international studies, recovery from severe psychosis appears as a multidimensional concept. Five clusters of factors emerge. Recovery can be defined as a personal, developmental and self-empowering process (1). In order to initiate and foster this development and growth process, motivational factors are indispensable, such as generating hope and belief that recovery is possible (2). A number of competences are necessary to advance in personal recovery (3). These include: managing the illness and its consequences and developing psychological competence to put life and identity into a (new) perspective. In the recovery process certain turning points appear. These are points in time where a person actually makes a change in the direction of social and community participation (4). The last cluster of factors represents resources from the environment (5). These are important to support the person in his/her recovery process. Resources include: material resources like decent housing and income, support from the social network, and professional services. Quality criteria' for recovery oriented mental health services include: providing safe places for episodes of vulnerability, adequate medication and professionals who are recovery sensitive', meaning being able to provide flexible types of support on the basis of continuous assessment of the factors a person perceives as valuable and helpful.

Keywords: recovery, psychosis, schizophrenia, rehabilitation