



editorial

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Recovery in psychiatry

In recent years, the concept of recovery from severe mental illness has increasingly gained relevance in the mental health field. Countries all over the world have been introducing recovery policy into mental health services (e.g. Australia, Ireland, New Zealand, USA), including England and Wales (Department of Health, 2001). However, there is still debate about the concept, such as whether symptom reduction is central (Lieberman & Kopelowicz, 2005) or not (Roberts & Wolfson, 2004). This editorial proposes a conceptual framework for recovery and identifies emergent practical issues.

One term, two meanings

Two classes of definitions which emerged from two different influences, can be identified for the term recovery in mental health. In psychiatry the idea of recovery is based on longitudinal studies demonstrating a widely heterogeneous course for severe mental illnesses (Davidson *et al*, 2005*b*). In this context, remission is defined as an improvement in symptoms and other deficits to a degree that they would be considered within a normal range. Recovery can be seen as a long-term goal of remission (Andreasen *et al*, 2005). We call this the service-based definition of recovery.

A second definition of the term recovery came from the self-help and consumer/user/survivor movement. Here, recovery may include, but does not require, symptom remission or a return to normal functioning. However, recovery is seen as a process of personal growth and development, and involves overcoming the effects of being a mental health patient, with all its implications, to regain control and establish a personally fulfilling, meaningful life (Davidson *et al*, 2005*b*). We call this the user-based definition of recovery. This is exemplified by the National Institute for Mental Health in England definition of recovery as the 'achievement of a personally acceptable quality of life' (National Institute for Mental Health in England, 2004).

Service-based recovery definitions

Some examples of prominent service-based and user-based definitions are given below. For schizophrenia, over a period of at least two consecutive years (Lieberman *et al*, 2002):

- symptom remission (≤ 4 on the positive and negative symptom items of the Brief Psychiatric Rating Scale)
- full- or part-time involvement in work or school
- independent living without supervision by family or surrogate caregivers
- not fully dependent on financial support from disability insurance
- having friends with whom activities are shared on a regular basis.

For schizophrenia (Torgalsbøen, 1999):

- a reliable diagnosis of schizophrenia at an earlier time
- criteria for diagnosis not fulfilled at present
- out of hospital for at least 5 years
- present psychosocial functioning within a 'normal range' (e.g. scores > 65 on the Global Assessment Scale)
- not on antipsychotic drugs or only on a low dosage (less than half 'defined daily doses').

For eating disorders, over a period of at least 12 months no more than minimal symptoms (Kordy *et al*, 2002):

- body mass index > 19
- no extreme fear of gaining weight
- no weight reduction by vomiting or laxative use
- no binges
- no preoccupation with figure.

The service-based definition of recovery is most easily applicable to people who return to a premorbid state of health, for example after a single episode of psychosis.

User-based recovery definitions

Some examples of user-based definitions of recovery are given below:

- overcoming the effects of being a patient in mental healthcare, to retain or resume some degree of control over one's own life (Davidson *et al*, 2005*b*)
- establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination (Andresen *et al*, 2003)



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- process of personal discovery of how to live (and how to live well) with enduring symptoms and vulnerabilities (Roberts & Wolfson, 2004)
- deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles (Anthony, 1993)
- way of living a satisfying, hopeful and contributing life even with limitations caused by the illness (Anthony, 1993)
- development of new meaning and purpose as one grows beyond the catastrophe of mental illness (Anthony, 1993).

Several other types of recovery (within the unifying framework of the user-based definition) may apply to people with a prolonged course of illness. For example, recovery can be the process of overcoming a traumatic event, achieving and maintaining sobriety or deriving useful personal developments from apparently useless experiences, such as psychotic episodes (National Institute for Mental Health in England, 2004; Davidson *et al*, 2005b).

The divergence of these two perspectives, however, has in practice led to a situation in which recovery can have a lot of different meanings for different people. Hence recovery orientation can arbitrarily be claimed to be applied to a range of services without any universally accepted criteria or guidelines.

Components of recovery

In contrast to the mostly clearly defined service-based criteria for recovery, the user-based approach is much more complex. From a narrative literature review of user-based recovery we identified conceptual works by Davidson *et al* (2005a,b), Andresen *et al* (2003) and Jacobson & Greenley (2001). These were synthesised into an emergent framework identifying the key components of recovery, as shown below.

User-identified key components of the recovery process

Hope

Hope has been described as the individual's belief that recovery, or change, is possible, or as a determination to get better. It is a trigger of the recovery process and also maintains it. It involves:

- recognising and accepting that there is a problem
- committing to change
- reordering priorities
- focusing on strengths rather than weaknesses
- looking forward and cultivating optimism
- believing in the self.

Spirituality

Spirituality is an important source of hope and meaning when redefining one's life after the catastrophic event that severe mental illness may be for an individual.

Responsibility and control

Re-assuming responsibility and control over one's life, illness and recovery can be seen as an act of emancipation

in a system fostering dependency. It involves gaining back a sense of independence and is strongly linked to most other domains, especially the concept of empowerment.

Empowerment

Empowerment can be seen as a corrective for the lack of control, the sense of helplessness and dependency that many users of mental health services develop over time. It involves:

- autonomy, which in turn depends on knowledge, self-confidence and the availability of meaningful choices
- courage, which involves the willingness to step out of the safe routine and to take risks
- assuming control and personal responsibility
- demanding the same rights and taking the same responsibilities as other citizens.

Connection

This element stresses the highly social aspect of recovery – the path from being isolated in one's illness to rejoining the social world. It involves establishing and maintaining relationships, assuming social roles and having friends.

Purpose

To have meaning and purpose in life is a basic human need. Because of the experience of the illness, previous life goals may no longer be available to an individual, who then has to reassess their values and goals and to find alternatives. Associated tasks involve finding and moving into meaningful roles, working, and enjoying recreational activities.

Self-identity

The re-conceptualisation of the self in the face of the overwhelming experience of severe mental illness is an important element in the recovery process. Redefining the self involves:

- accepting the illness
- developing an explanatory framework to understand the experience
- grieving for what has been lost and understanding what has happened
- defining the self apart from the illness, the illness as only a part of the self
- re-establishing a sense of identity
- developing self-esteem and self-respect.

Symptom management

Although complete symptom remission is not necessary, the ability to manage symptoms in some way is essential. There may be periods when symptoms may be more or less under control, but overall, a shift occurs from simply receiving services to actively participating in and using treatments of one's own choice. The power to define the importance of symptom control is shifted to the service users, who may for example decide to rather live with increased symptom levels than with medication or its side-effects. Managing symptoms involves:

- knowing the illness and knowing available services
- developing coping skills and illness management strategies

- medication
- fostering wellness and finding a healthy lifestyle.

Stigma

Overcoming the social consequences of being a mental health patient has been described as a second healing process. It is an active process strongly linked with redefining the self and becoming empowered.

Stages of recovery

According to the user-based definition, individuals tend to go through phases in their recovery process in which they approach the tasks outlined above. Although named differently, the various outlines of recovery phases in the literature are largely consistent (e.g. Andresen *et al*, 2003; National Institute for Mental Health in England, 2004). The National Institute for Mental Health in England outlines four consecutive stages:

- dependent and unaware
- dependent and aware
- independent and aware
- interdependent and aware.

The starting point is described as a state of dependency owing to the experience of illness/distress, the impact of the mental health system, traumatic events and the disruption of daily life and relationships. This period of crisis is characterised by denial, confusion, hopelessness, identity confusion and self-protective withdrawal. The goal and final stage of the recovery process is a state of psychological well-being, defined as personal growth, self-acceptance, autonomy, positive relationships, environmental mastery and purpose in life. Characteristics of this stage are not necessarily the absence of symptoms but the ability to manage the illness and live a fulfilling and meaningful life, show resilience in the face of setbacks and have a positive attitude towards the future.

To proceed from the initial state of disruption towards well-being, the individual first has to become aware of their condition as well as the fact that recovery is possible, and start to work on recovery. This early phase in the recovery process (dependent and aware) involves recognising one's values, strengths and weaknesses, beginning to set goals, learning about mental illness and services available, acquiring recovery skills and connecting with peers. The next stage (independent and aware) involves setting and working towards personally valued goals, taking responsibility for managing the illness and taking control of one's life, developing increasing knowledge and skills, and building and maintaining relationships. An important characteristic of this phase is the constant growth in resilience, which requires the opportunity to take risks (i.e. to try something new); this requirement is challenging for risk-averse mental health services.

The step from being overwhelmed or resigned to gaining awareness, hope and determination is frequently described as a turning point in an individual's life, and may be triggered by an event, a clinician, a role model or a significant other. It can also be a conscious decision arrived at after being ill for a long period (Andresen *et al*, 2003; Davidson *et al*, 2005a).

Recovery orientation in service provision

Overall, two shortcomings in current practice are identified by proponents of recovery orientation in mental health services:

- best available evidence is not followed
- there are limitations to the evidence base (Frese *et al*, 2001).

Those who focus on the needs of individuals with the most serious disabilities tend to demand evidence-based interventions, since many service users do not have a full choice of treatments. An example is the over-reliance on pharmacotherapy (Office of the Deputy Prime Minister, 2004) even for conditions where guidelines indicate psychological interventions should be the first-line treatment (National Institute for Clinical Excellence, 2004).

On the other hand, people who have recovered from mental health problems often report that very individual things helped them, things that may have never been scientifically investigated (Frese *et al*, 2001). They call for the implementation of user-based recovery orientation in mental health services. An understanding that the planning, arrangement and delivery of support should be determined by the needs of the service user has now received policy endorsement (Department of Health, 2004).

One step in this direction internationally is the programme of the current president of the World Psychiatric Association – 'Psychiatry for the Person' – which considers

'the whole person within his/her context as the centre and goal of clinical care, health promotion and research' (Mezzich, 2006).

From this perspective, the primary aim of psychiatric care is to enable people to function within their individual social context, irrespective of their symptoms, and to help them live a personally fulfilling and meaningful life, irrespective of their need to use professional help in times of crisis.

This perspective on recovery may be reminiscent of the concept of quality of life, which also takes into account a whole range of aspects of daily life and aims to place the consumer at its centre. However, similar to the concept of recovery, there is still no single universally accepted definition of quality of life, and the distinction, interplay and importance of subjective and objective factors remains debated. It has also been shown that subjective (or user-based) and objective (or service-based) appraisals of quality of life often bear little relation (Ruggeri *et al*, 2001).

To some extent, similar tensions exist between the two classes of recovery definitions. However, the user-based concept of recovery goes far beyond the concept of quality of life or a simple needs-based service approach. The individual consumer is not only placed at the centre of attention but actively encouraged to take the responsibility for their own life, with the aim of true power-sharing, consumer participation and a reduced dependence on services. Recovery-oriented systems of mental health are supposed to flexibly adapt to the consumer's needs, focus on strength rather than on



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deficits or dysfunction and include a wide range of alternative facilities, such as peer-run services or faith communities (National Institute for Mental Health in England, 2004). These ambitious aims, although national policy, are far from being realised in England and empirical research on the application of recovery-oriented principles in service provision is largely lacking.

What needs to change?

Adopting a recovery-oriented approach may have profound implications for mental health services. The goals of mental healthcare have to be redefined to focus on the individual's life goals and to respect service users' rights to make individual decisions about all aspects of their recovery. It is now recognised in legislation that a person 'is not to be treated as unable to make a decision merely because he makes an unwise decision' (Mental Capacity Act 2005). Indeed, the evidence of equivalent rates of mental incapacity between psychiatric and non-psychiatric in-patients (Raymont *et al*, 2004) suggests that the traditional reservations of psychiatric services towards ceding decision-making power to service users because they lack 'insight' may not be empirically justified. A successful example of such shared decision-making is joint crisis plans, which realise advanced agreements and directives for mental healthcare that have long been advocated by user group organisations (Henderson *et al*, 2004).

Equally the values and attitudes of staff may have to shift. Recovery orientation for staff may mean redefining their roles from that of 'outside experts' for people's illnesses to that of companions and helpers on people's paths of life, accepting equal partnerships with their clients. This shift in roles changes the balance of power and may be challenging for staff. However, limited, mainly qualitative, research indicates that adapting such an individual and holistic approach may have a positive impact on the recovery process (Farkas *et al*, 2005).

The National Institute for Mental Health in England outlines a whole range of working practices for clinicians to support recovery. These include demonstrating hope and offering encouragement, for example in supporting people to achieve their individual goals, providing comprehensive information on the illness and available treatments, making shared decisions with clients, engaging families, facilitating peer interaction, supporting social, cultural and spiritual activities, etc.

In service structures, recovery values may be reflected in the organisation, administration and staffing: in a mission statement identifying recovery outcomes; policy statements and guidelines providing recovery-based principles for service delivery, quality assurance developed, implemented and monitored collaboratively with service users; staff selection, training and supervision according to recovery values and with user involvement. Recovery-oriented services ideally work in flexible networks, adjusting to the individual's support needs and their personal resources in their environment (Farkas *et al*, 2005). The importance of user involvement, which is

particularly emphasised in the user-based recovery approach, has been known and applied in other fields, such as management or information technology, since the 1980s. In the mental health field, however, both sound practical experience with and systematic empirical research on the value, practicability and the effects of user involvement remain limited to date.

Without doubt, implementing recovery orientation in service provision will be a challenging and time-consuming process, with respect to both practice and research. In mental healthcare practice, a first step may be the promotion of understanding of the concept and its implications among the stakeholders (National Institute for Mental Health in England, 2004). Recovery orientation is intended to complement rather than replace existing roles, functions, therapeutic interventions and structures. The central implementation challenge may be moving beyond an oppositional user–professional discourse that emphasises the shortcomings of mental healthcare (and hence alienates mental health staff) towards a value-adding discourse that harnesses the professional and personal qualities of staff. Such a partnership model of change will be difficult. Service user activists, who have previously defined their role by opposing a 'biomedical model', will be asked to shift towards a collaborative approach in which their constructive input is needed by mental health services to develop practice change. In addition, giving power to 'experts by experience' may not be a welcome development for some service users. For staff, the central challenges may be in meeting demands to change practice, to be less in a formal professional role when working with distressed (and distressing) individuals, to manage the anxiety involved in supporting the person to take chances, and in not imposing their values and models on service users.

However, it may be detrimental to the evolving recovery movement if service developments are ahead of research. In order to guarantee that the recovery concept will outlive its current fashion and acquire lasting importance for service delivery, a firm evidence base needs to be created on the distinct components of recovery orientation within mental health services, their acceptability, applicability and effects. Some important groundwork has already been laid: there is a wealth of qualitative research; several attempts to systematise the concept; and some newly developed measurement tools, such as the Stages of Recovery Instrument (STORI; Andresen *et al*, 2006), the Recovery Process Inventory (RPI; Jerrell *et al*, 2006) and the Recovery Assessment Scale (RAS; Corrigan *et al*, 2004). However, much research, especially that using such quantitative tools, still needs to be conducted to explore the challenges, possibilities and benefits this concept of recovery orientation can provide for both service users and staff.

Declaration of interest

None.



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References

- ANDREASEN, N. C., CARPENTER, W. T., KANE, J. M., et al (2005) Remission in schizophrenia: proposed criteria and rationale for consensus. *American Journal of Psychiatry*, **162**, 441–449.
- ANDRESEN, R., OADES, L. & CAPUTI, P. (2003) The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, **37**, 586–594.
- ANDRESEN, R., CAPUTI, P. & OADES, L. (2006) Stages of recovery instrument: development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry*, **40**, 972–980.
- ANTHONY, W. (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, **16**, 11–23.
- CORRIGAN, P. W., SALZER, M., RALPH, R. O., et al (2004) Examining the factor structure of the recovery assessment scale. *Schizophrenia Bulletin*, **30**, 1035–1041.
- DAVIDSON, L., BORG, M., MARIN, I., et al (2005a) Processes of recovery in serious mental illness: findings from a multinational study. *American Journal of Psychiatric Rehabilitation*, **8**, 177–201.
- DAVIDSON, L., O'CONNELL, M. J., TONDORA, J., et al (2005b) Recovery in serious mental illness: a new wine or just a new bottle? *Professional Psychology: Research and Practice*, **36**, 480–487.
- DEPARTMENT OF HEALTH (2001) *The Journey to Recovery: The Government's Vision for Mental Health Care*. Department of Health.
- DEPARTMENT OF HEALTH (2004) *The Ten Essential Shared Capabilities. A Framework for the Whole of the Mental Health Workforce*. Department of Health.
- FARKAS, M., GAGNE, C., WILLIAM, A., et al (2005) Implementing recovery oriented evidence based programs: identifying the critical dimensions. *Community Mental Health Journal*, **41**, 141–158.
- FRESE, F. J., STANLEY, J., KRESS, K., et al (2001) Integrating evidence-based practices and the recovery model. *Psychiatric Services*, **52**, 1462–1468.
- HENDERSON, C., FLOOD, C., LEESE, M., et al (2004) Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. *BMJ*, **329**, 136.
- JACOBSON, N. & GREENLEY, D. (2001) What is recovery? A conceptual model and explication. *Psychiatric Services*, **52**, 482–485.
- JERRELL, J. M., COUSINS, V. C. & ROBERTS, K. M. (2006) Psychometrics of the recovery process inventory. *Journal of Behavioral Health Services and Research*, **33**, 464–473.
- KORDY, H., KRAMER, B., PALMER, R. L., et al (2002) Remission, recovery, relapse, and recurrence in eating disorders: conceptualization and illustration of a validation strategy. *Journal of Clinical Psychology*, **58**, 833–846.
- LIBERMAN, R. & KOPELOWICZ, A. (2005) Recovery from schizophrenia: a concept in search of research. *Psychiatric Services*, **56**, 735–742.
- LIBERMAN, R. P., KOPELOWICZ, A., VENTURY, J., et al (2002) Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry*, **14**, 256–272.
- MEZZICH, J. E. (2006) *Institutional Consolidation and Global Impact: Towards a Psychiatry for the Person*. <http://www.wpanet.org/bulletin/wpae3701.html>
- NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2004) *Clinical Guidelines for the Management of Anxiety (Panic Disorder, with or without Agoraphobia, and Generalised Anxiety Disorder) in Adults in Primary, Secondary and Community Care*. NICE.
- NATIONAL INSTITUTE FOR MENTAL HEALTH IN ENGLAND (2004) *Emerging Best Practice in Mental Health Recovery*. NIMHE.
- OFFICE OF THE DEPUTY PRIME MINISTER (2004) *Mental Health and Social Exclusion*. Social Exclusion Unit.
- RAYMONT, V., BINGLEY, W., BUCHANAN, A., et al (2004) Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. *Lancet*, **364**, 1421–1427.
- ROBERTS, G. & WOLFSON, P. (2004) The rediscovery of recovery: open to all. *Advances in Psychiatric Treatment*, **10**, 37–48.
- RUGGERI, M., BISOFFI, G., FONTECEDRO, L., et al (2001) Subjective and objective dimensions of quality of life in psychiatric patients: a factor analytical approach: The South Verona Outcome Project 4. *British Journal of Psychiatry*, **178**, 268–275.
- TORGALSBØEN, A. K. (1999) Full recovery from schizophrenia: the prognostic role of premorbid adjustment, symptoms at first admission, precipitating events and gender. *Psychiatry Research*, **88**, 143–152.

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