

Recovery from a psychiatrist's viewpoint

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Preview

Recovery is not the same as cure. Recovery from mental illness is the process of having more to life than just illness. It is an ongoing process rather than simply a goal that can be achieved. Recovery from the stigma of mental illness may be as difficult as recovery from the illness itself. Several common, but incorrect, beliefs can interfere with the recovery process. Myths include the belief that the illness has an inherently downhill course, that rehabilitation is useful only after stabilization, and that people with schizophrenia can only work at low-level jobs. People who have schizophrenia have reported that their own process of recovery was helped by their determination to get better, an understanding of the illness, taking personal responsibility, having friends who accept them, an optimistic attitude, and spiritual beliefs that help them find meaning in life.

Introduction

Until recently, most psychiatrists were trained to believe that schizophrenia was a “deteriorating” illness that led to loss of functioning and inability to recover. Our clinical experience on hospital wards tended to reinforce these beliefs. Most people with schizophrenia treated in the hospital seemed to live a very limited life, and those who tried to reject the role of “chronic patients” would usually relapse. The attitudes engendered by these beliefs and clinical experience have made it difficult for psychiatrists to accept the concept of recovery in people with schizophrenia. This article

presents one psychiatrist's perspective on how the vision of recovery in schizophrenia can move the treatment relationship away from alienation and struggle to one of collaboration and hope.

Defining recovery

What does the term “recovery” mean in the context of schizophrenia? Webster's 3rd New-World Dictionary¹ defines “recovery” as “the act of regaining or returning toward a usual state.” Recovery does not mean cure. Rather it is an active process in which the person is “regain- ing” or “returning.” Recovery is not something that is finally

achieved or accomplished but an ongoing process that can change the way that a person can cope with and overcome the illness of schizophrenia.² Recovery, as used in this article, is very different from the idea of remission as defined by Andreason and colleagues³ or in the UCLA recovery criteria proposed by Liberman and coworkers.⁴ Their more traditional medical approach uses the terms remission and recovery to indicate little or no current evidence of illness. A psycho-rehabilitation approach towards recovery is not about symptoms or complete absence of illness, but about having as complete a life as possible, even in the face of continuing symptoms or problems caused by illness.

The term “recovery” can refer to many different components of “getting better.” Ron Coleman, a man who describes himself as a someone who hears voices but does not necessarily have a mental illness, describes clinical recovery as the absence of symptoms, which he sees as the focus of most psychiatric treatment.⁵ He also talks about social recovery, which involves having an occupation you like, friends, functioning well in society, and avoiding behavior that distresses others. There is also economic recovery—being able to support yourself. Finally, there is personal recovery—how you define and feel about yourself. When a person asks the question, “Who am I?”, is the primary answer “I am a schizophrenic?” or is the answer “I am a person with friends; I am a person who likes to play the piano; I am a person who is trying to become an artist; I am a person who also has schizophrenia that I have to deal with?”⁵ While the ability

to function and economic self-sufficiency are important, “recovery” as used here also refers to a subjective sense of how one defines oneself in the world. Recovery involves redefining one’s own life, so that it includes more than just experiencing and receiving treatment for an illness.⁶

Although a decrease in symptoms such as auditory hallucinations or an increased ability to care for one’s self or plan for the future may aid the recovery process, such measures of clinical improvement are neither necessary nor sufficient for the person to be engaged in the process of recovery. While a reduction in positive symptoms is one measure of improvement for some people with schizophrenia, others seem less bothered by hearing voices or having unconventional beliefs. People can hold a job, live independently, and have close friends even if they hear voices. What, then, is involved in the process of recovery?

The process of recovery from a major mental illness can be compared to recovery from major diseases that can be catastrophic and life changing. Immediately after a heart attack or being diagnosed with cancer or other serious illness, the illness becomes the focus of our entire life. We feel as if we are seen by others as a “heart attack” walking down the street. We become the cancer and have a hard time thinking of ourselves as anything except a person with cancer. Over time during recovery, we reconnect with ourselves apart from the illness. We become a person who had a heart attack, who still has to worry about his or her heart, but now goes on about the process of living. We become a person who is

a cancer survivor, whose cancer may recur, who may have residual effects from chemotherapy, who may even have significant limitations and disability, but who has his or her life back. The cancer or the heart attack becomes a smaller and smaller part of how we think about ourselves. As we recover, we are again more than just our illness and regain the capacity to focus on play, friends, work, and family. The same things that fill the day-to-day lives of people without illness again fill the life of the person recovering from cancer, a heart attack, or schizophrenia. Recovery means taking an active interest in one’s life and moving towards achieving life goals, despite the presence of ongoing symptoms. The process of recovery means ensuring that being a person with schizophrenia is not the *only* way that people see themselves or are seen by the rest of the world.

These concepts of personal recovery can be at odds with standard medical models that employ a brain disease model of schizophrenia. In fact, there is convincing evidence that consumers who “accept” the diagnostic label of schizophrenia are more depressed than those who develop a more personalized explanation of their experience.⁷ Some individuals may be better off rejecting the standard psychoeducational message that schizophrenia is a disease of the brain. At least one randomized clinical trial⁸ found psychoeducation seemed to worsen thoughts about suicide compared with usual care. Supporting a personalized recovery can help decrease the effect on self-esteem and morale caused by accepting

the pejorative label “I am a schizophrenic.”

The maintenance approach to schizophrenia treatment focuses on preventing relapse and rehospitalization. This approach derives from the neurodegenerative (or Kraepelinian) hypothesis of schizophrenia as a deteriorating illness, so that achieving stability is considered a major achievement and the priority is relapse prevention. Such a maintenance approach suggests that people who have schizophrenia who are stable should not be “pushed” to go beyond their capacity and should not expect much more improvement. It is important for clinicians to “unlearn” these attitudes or at least consider the growing evidence supporting the concept of recovery in schizophrenia. Based on long-term follow-up studies, we know that many people with schizophrenia will be more stable and accomplish much more than was previously thought possible if we engender hope and help them to have a real life that is more than just illness.

Recovery requires both internal and external conditions. *External conditions* are things mental health professionals can do to foster recovery, such as supporting the rights of each person to live where he or she wants, maintaining a respectful and empathic attitude, striving for cultural competence, and believing each person can have a meaningful and fulfilling life. *Internal conditions* are what the individual, on his or her own or with the support of others, can bring to the recovery process. We as mental health professionals can support these internal conditions, but the individual ultimately

controls them. Internal conditions include *healing*, which involves developing a sense of self apart from the illness; *empowerment*, which refers to taking back control over one's life and decisions; *connection*, which involves becoming connected to the world in ways other than through illness; and finally, *hope*.⁹ Hope is perhaps the most important of these internal conditions. We survive bad or painful parts of our lives because we hope things will get better. Without hope, we would give up. "The hope that creates recovery is both a belief that recovery is possible and a commitment to making it happen. Hope sustains, even during the inevitable periods of relapse or other bad patches."⁹

Recovery versus improvement

SYMPTOMS—We prescribe medications, develop psychosocial interventions, and test new psychotherapies with the goal of helping consumers "get better." With other disorders, such as major depressive disorder or anxiety disorders, a decrease in symptoms closely parallels a decrease in the impact of the illness on the person's life. If a person is less depressed or anxious, then he or she is better. This finding is less obviously true with schizophrenia. Until recently, treatment for schizophrenia focused primarily on positive symptoms. However, data indicate that positive symptoms, such as auditory hallucinations or delusions, are poorly correlated with the ability to hold a job, maintain independent housing, or participate in society.^{10,11}

Instead, recent research suggests that the disabilities associated with schizophrenia are attributable primarily to cognitive

dysfunction.¹² While one might consider an improvement in cognitive function a better gauge of clinical outcome than a reduction in positive symptoms, cognitive symptoms are very difficult to assess in a standard psychiatric interview. For this reason, one of the most important domains of recovery in schizophrenia—cognition functioning—is not usually assessed or monitored in a way that allows physicians to track the improvements that are most meaningful to the consumer.

Another problem that complicates an understanding of improvement in schizophrenia is the development of post-psychotic depression and intense suicidal despair. Depressive symptoms tend to be at their most intense shortly after psychotic symptoms resolve. It is unclear how much of this depression is connected to biological changes that are part of the disorder and how much of it is connected to the impact of the psychotic episode on the person's life, although it is likely that both components play a part.

While clozapine is clearly more effective, the other newer antipsychotics appear to be roughly equivalent to the older conventional antipsychotics in helping to control an acute psychotic episode or resolve positive symptoms. The newer antipsychotics seem to have different and perhaps more tolerable side effects, and do seem more effective in helping with the affective symptoms and cognitive dysfunction that are prominent sources of frustration and suffering. The newer medications, insofar as they help increase effective thinking and cause fewer stigmatizing side effects such as making the

person appear drugged or "zombie-like," can help the recovery process to proceed further than was possible with the older medications. The effectiveness of the newer atypical antipsychotic medications in helping with negative and cognitive symptoms may explain some of the improvement in occupational and social functioning observed in consumers.¹³⁻¹⁵

HOSPITAL RECIDIVISM

Although decreased use of the hospital is a traditional indicator of improvement, from a recovery perspective, keeping the person out of the hospital is clearly inadequate as a primary aim of treatment. For example, it is not a sign of improvement if a person ends up homeless or in jail, rather than hospitalized. A decrease in rehospitalization is too often a better indicator of public policy and availability of hospital beds than of real improvement in a consumer.

LEVEL OF FUNCTIONING

The ability to function is another important indicator of "doing better." Being able to take care of one's self and meet one's basic needs are important parts of any concept of recovery. However, the ability to function is not an attribute that resides solely within the person but rather involves an interaction between the person's skills and the requirements of his or her social context. For example, a person may be able to function with significant independence while living in his or her hometown, working on a farm adjacent to the family's farm, and surrounded by familiar people, but might find it impossible to function if forced to find an apartment, open a checking account, find a new job among

strangers, and live surrounded by people he or she does not know.¹⁶⁻¹⁸

WORK AND ECONOMIC SELF-SUFFICIENCY—Being able to function well enough to hold a job is a critical indicator of improvement. Work is not only a source of income, but also a way to structure time, meet friends, and feel productive. Work is how we define ourselves. “What do you do?” is often the first question we ask when we meet a stranger. It is important to remember that many people in our society *without* mental illness seem to function well without working, either because they are retired or wealthy or have some other way of defining themselves besides their occupation. In many other cultures, work is much less important in defining one’s identity than it is in the United States. Men and women also often have very different concepts of the importance of work.

Recovery versus rehabilitation

Rehabilitation is what professionals do. Recovery is what the person with the illness is doing. Recovery is an intensely personal process. The process may start with the person getting a job or buying a car, but at its core involves learning to live one’s life without always focusing on the illness. As health care professionals, we can make this process easier or harder, but we cannot *make it happen*. The person’s own experience is at the center of recovery.

At times, people—both with and without mental illness—have unrealistic goals of what they can accomplish. Although such unrealistic goals can interfere, they can also serve as motivation. People

with serious mental illness sometimes have a hard time determining which goals are realistic and which are not. They may be so convinced of failure that they have little motivation to think seriously about goals. For example, if one is absolutely convinced of failure at *any* kind of job, it makes sense to have the goal of being an astronaut rather than a janitor. There is little shame in failing as an astronaut but much more shame in not even being able to work as a janitor. The process of rehabilitation involves taking a person’s own goals, whether realistic or not, and helping the person pursue them in a serious way. If someone wants to be an astronaut, the first step might be securing a high school equivalency degree or developing better work habits. This is not an attempt to mislead the person about his or her goals, but rather to take those goals very seriously. Surprisingly often, as people grow and develop real options, they develop goals that are more obtainable, and they learn to separate goals from dreams so that both can be kept alive.

Getting a job or going back to school may be a destabilizing stressor for someone with a serious mental illness, but it can also be a goal, an accomplishment, and a source of strength that can help give a person the determination to persevere and fight the illness. It is also possible to “push” a person to do too much too soon—often a fine line exists between adding stress and adding hope. Too often, clinicians make these decisions with little input from the consumer. It is important to find out what the person with the illness thinks about the stress of work or school and to

consider how we can moderate that stress. Consumers often want to begin school or work full time, despite years of disengagement. Slowing down the stress of transition by encouraging the person to start out with just a single course or begin by working only part time is very different from telling a patient to return to doing nothing because he or she is not yet ready for a “real job.”

Myths about schizophrenia

Several commonly held myths can interfere significantly with recovery. Years ago, these myths were included in psychiatry textbooks, and they continue to form part of our unexamined beliefs that may lead us to dismiss data that conflicts with them.

MYTH 1: SCHIZOPHRENIA HAS AN INHERENTLY DOWNHILL COURSE—Data from a number of research studies¹⁹⁻²¹ done around the world demonstrate that long-term outcomes from schizophrenia are extremely heterogeneous. For example, the Vermont long-term follow-up study^{21,22} examined 262 consumers who met DSM-III criteria for schizophrenia and had been inpatients in the Vermont state hospital for at least 5 years. Consumers were assessed 20 to 25 years after hospital discharge using structured outcome measures. Many of these individuals who had been very seriously ill and extremely symptomatic earlier in the course of their illness went on to do very well after 2 or 3 decades. On follow-up, roughly one third of the people in the Vermont study were doing well without medication and without treatment, another third were doing quite well, although still receiving medication and other

mental health treatment, and only a third continued to have major struggles with their illness after many years.^{21,22} Long-term studies have also demonstrated that it is very difficult to predict who will go on to do well and who will not. The author has personal experience of people with schizophrenia who were extraordinarily disabled for many years, but who are now living independently, working, self-monitoring their own illness, and being responsible for their own medication.²³ Virtually all of these consumers still have some symptoms and limitations imposed by their illness, but they are functioning at a higher level than would have once been thought possible.

MYTH 2: PEOPLE WITH SCHIZOPHRENIA CAN ONLY WORK AT LOW-LEVEL JOBS— Fred Frese is a man with schizophrenia, who is currently on the board of the National Alliance for the Mentally Ill and recently retired from being the chief psychologist at the largest state hospital in Ohio—the same hospital in which he had been committed years earlier. Despite continuing to be bothered by psychotic symptoms, Fred is able to function in a very high-level position. Most people with schizophrenia are not able to function at this level, but then most people *without* schizophrenia cannot function at this level either. It is clear that having schizophrenia puts an extra burden on a person and makes it more difficult to function in a job, especially a very demanding job. This does not mean that functioning in such a job is impossible or even that unusual.

Boston University has assembled a database of approximately 500 people with major mental illness who are able to work in professional or supervisory jobs.^{24,25} Of this group, 73% reported full-time employment and 62% had held their jobs for longer than 2 years. The yearly income of most participants in the study was over \$20,000 per year; 61% were satisfied with their current job, a rate probably similar to that of the current general U.S. population at present. The person's specific diagnosis was not related to professional status, and more than 10% of these occupational high-achievers had a diagnosis of schizophrenia. Most of the people in the study had been hospitalized and many of them had lived on social security disability income at some point. Most of the people were currently taking medications, including those who had higher-level jobs.

MYTH 3: CONSUMERS NEED TO BE TOLD TO TAKE MEDICATIONS FOR THE REST OF THEIR LIVES—It is very clear that the vast majority of people who have schizophrenia will have a more stable and better quality of life if they continue to take antipsychotic medications. Despite this reality and regardless of what a physician says, most consumers, especially early in the course of their illness, choose to stop their antipsychotic medications at some point. It makes little sense to get into power struggles over this issue. A better approach for many consumers is to acknowledge that some people who clearly needed medication at one point can sometimes successfully stop medication at some later time. We hear about the

people who stop taking medication and do poorly, but physicians tend to forget about the people who, after many years, cease taking medication and continue to function quite well. The important point is that, for most people, their lives will be *much* better if they continue to take medication now. The physician's job is to help people understand that taking medication is not a dead-end street. Too often, medication is viewed as something that is "done to" the person. Instead, we should help the consumer understand that medication is a tool that a person with schizophrenia can use to take greater control over his or her own life. The goals of medication should be to support the person's own goals, whether it is to live independently, get a job, or have more friends. The focus should not be on the length of the medication course or the dose he or she can take, but rather on how to maximize the effectiveness of medication to help the person live the kind of life that he or she wants to live.

MYTH 4: THE ONLY TREATMENT THAT CAN HELP REDUCE THE SYMPTOMS OF SCHIZOPHRENIA IS MEDICATION—Recent research has focused on the utility of psychosocial interventions that can help individuals with schizophrenia learn new social and occupational skills and improve their ability to cope with their symptoms. Research has supported the efficacy of a number of psychosocial interventions for schizophrenia, including skills training, psychoeducation, family interventions, cognitive-behavior therapy (CBT), and assertive community treatment (ACT), with the most positive findings

reported for CBT and ACT.²⁶⁻³¹ An ongoing healing relationship, while less formally studied, seems to be an important part of what helps people with schizophrenia start and maintain the process of recovery. Although medication is extremely important for most people with schizophrenia and is often a central factor in their recovery, medication alone is never enough. Table 1³²⁻³⁶ summarizes some of the factors and myths that can complicate perceptions of recovery from schizophrenia.

Research on recovery

Several research projects around the world have asked consumers what they mean by “recovery” and what has helped them get as far as they have. Rather than focusing on objective indicators of “doing well” (eg, a certain score on the Global Assessment of Functioning [GAF] scale or being able to work full time), these studies have examined consumers who identified themselves as being in the process of recovery. These investigations of the subjective elements of recovery have produced very similar findings across different sites.³⁷⁻⁴⁰ Tooth and colleagues⁴¹ in Queensland, Australia conducted comprehensive, structured interviews with 60 consumers with schizophrenia who identified themselves as being in the process of recovery and asked these individuals what recovery meant to each of them and what had supported or interfered with their recovery process.

The study participants reported that the following factors were most helpful in the process of recovery: a determination to get better, an understanding of the

illness, taking responsibility for themselves, managing their own illness, having friends who accepted them, an optimistic attitude, and spiritual beliefs that helped them find meaning in their lives. Subjects mentioned both the need to take medication, as well as how the negative aspects of medication interfered with the process of recovery. The negative impact of stigma was mentioned by more than half of the subjects as a barrier that interfered with their recovery.

The consumers in some of these studies often noted that health professionals collectively had not been useful in supporting their recovery. Interviews from studies included examples of mental health professionals who had discouraged people in their goals and had actively impeded recovery. On the other

hand, most of the consumers who indicated that most mental health professionals were not useful went on to describe particular individuals who had played an important role in the recovery process (eg, a particular nurse who was helpful, a social worker who listened in a different way, or a psychiatrist who, besides prescribing medication, viewed the consumer as an individual and believed in him or her). These catalytic relationships appeared to involve much more than a professional doing a good job. Toward the subjects, they felt intensely personal, transcending the boundaries of normal professional disengagement.

Key points about recovery

Clinicians should keep the following points in mind in fostering recovery:

Table 1. Factors and beliefs that complicate perceptions of recovery

Factor	Comment
Diagnostic biases limit understanding of full range of presentations	Clinicians may try to avoid making a diagnosis of schizophrenia in the subgroup of consumers with better outcomes, skewing outcomes because people with better outcomes are not included. ³²
Follow-up too short to see long-term improvements	Most follow-up studies end within 2 years; however, positive and negative symptoms tend to abate between the 2- and 10-year follow-up. ³³
Skewed estimate of prognosis	Because consumers leave clinical settings when they improve, prognoses are usually worse among clinical consumer populations than in community consumer populations. ³⁴
Lag between introduction of new treatments and publication of outcome studies	When treatments are changing rapidly, outcome studies may not reflect the best options available. For example, Robinson et al's first-episode <i>patients</i> were treated with older antipsychotics, ³⁵ whereas the prognosis for first-episode psychosis may be better with atypical antipsychotics. ³⁶

Adapted from Strauss JS, Carpenter WT;³² Eaton WW, Thara R, Federman B, et al;³³ Cohen P, Cohen J;³⁴ Robinson D, Woerner MG, Alvir J, et al;³⁵ and Lieberman JA, Tollefson G, Tohen M, et al; HGDH Study Group.³⁶

1. **Recovery is not the same as cure.** Recovery is a process, a journey, in which people move toward regaining as much of their personhood as possible, despite their illness. This process is never complete. People can be at the very beginning of the journey, barely seeing themselves apart from their illness, or well along despite the vicissitudes of living with a terrible illness.

2. **Defined this way, recovery can occur even in the presence of significant psychotic symptoms.** People can recover the ability to function, have friends, live independently, and get a job even with psychotic symptoms. People can also learn to cope with their illness, even when at times they deny having an illness. John Nash, as described in the book, *A Beautiful Mind*⁴² continued to have hallucinations and delusions, but was able to learn to disregard them, even though he could never stop them from occurring.^{42,43} Psychotic symptoms may be major impediments to recovery for some people, especially when they are distressing and distracting. Although it is important to treat positive symptoms, complete eradication of hallucinations and delusions is neither necessary nor sufficient for recovery. As a psychiatrist who helps guide medication choices, this author has learned that physicians need to target a broader range of symptoms. A good starting point is to ask the consumer about the symptoms that seem to be most distressing and that interfere with his or her recovery. Often, the

person will identify problems with memory, concentration, or mood as major barriers. Fortunately, as discussed in the article on switching antipsychotics (see Weiden, page 27), more treatment options are now available that can address this broader range of symptoms.

3. **Recovery is highly individualized.** One person's recovery is going to be very different from another's. One person might start the process by getting a job; another might begin by making a friend. For yet another person, the beginning might be saying hello to a neighbor once a day. It may take a long time, months or even years, for some people to take the first step toward recovery, while others may be able to begin immediately. Again, the focus of treatment should be what is distressing *to the person*, rather than what the physician perceives to be the problem. Sometimes we need to put away our personal emphasis on working, and let the focus of the recovery be "nonproductive" goals such as experiencing pleasure and relaxation for the first time. We also need to allow the consumer some latitude to take risks in their medication treatment plan, even if it means losing some efficacy. Some consumers, like John Nash, would only tolerate a medication that did not cause any cognitive problems, even if the dose was too low to completely prevent relapse.⁴³

4. **Recovery is inherently nonlinear.** In everyone's life, change takes an up-and-down, bumpy course. The fiction is that we

all get a little better, every day, in every way, but that is not how people really change. For example, a person who has schizophrenia may get a job and then lose the job and then get another job. He or she may make a friend and then lose that friend and then later form another friendship that may be more lasting. It is hard to predict what will help people make a major gain in their lives or what can cause a hard-won accomplishment to be temporarily lost. Change often takes time. It is important for staff, families, and consumers to remember this and have patience to minimize frustration that could hinder the recovery process.

5. **Recovery from the pain of stigma associated with having a mental illness may be more difficult than the recovery itself.**⁴⁴ As physicians working with consumers who have schizophrenia, we have a responsibility to do all we can to fight stigma and to protect our consumers from its harmful effects. Unfortunately, our behavior is often not any better than that of the uninformed public. Not that long ago, a job applicant who admitted having a history of major mental illness would have been screened out from any clinical position in my own mental health system. Such an applicant would not have been offered the job on some pretext. We, as mental health professionals, did not honestly believe that anyone could recover. We believed that if someone had schizophrenia, that person would always be less competent and reliable

than someone without that diagnosis and history. I am glad to say that at my mental health center and many others around the country, we now hire people who are competent, without consideration of medical history or diagnosis.

Clinicians also need to consider the stigmatizing impact of antipsychotic medications themselves. Until the introduction of the atypical antipsychotics, most medications used to treat schizophrenia caused extrapyramidal symptoms (EPS). The very medications that were used to treat the illness produced extremely stigmatizing side effects (eg, movement disorders, “looking like a zombie,” or more subtle loss of spontaneity, and a sense of “woodenness”).⁴⁵⁻⁴⁷ Although the newer medications are less likely to cause EPS, they can cause other stigmatizing side effects of which clinicians should be aware. Physicians should work with consumers to help reduce or avoid the weight gain and persistent sedation that can accompany use of some of the newer medications. In addition to interfering with interpersonal relationships, sexual side effects (eg, amenorrhea, galactorrhea, impotence) can also be stigmatizing and embarrassing and can accentuate problems with self-esteem.⁴⁸

Final thoughts: The importance of hope

The reason any of us endures pain is in the hope that it will stop. The reason we take medication is that we hope it will make our life better in some way that is important to us. Hope has many components and may involve changing one's attitude. Hope can mean coming to recognize

and accept limitations or disabilities as well as focusing on strengths. Hope means looking forward rather than backward and is often sustained by small changes rather than major life restructuring. At the center of hope is a change in priorities, ie, paying attention to what is going well in one's life rather than what is not. Hope is nourished by a sense of optimism that the world can and will get better.

Hope is also connected with spirituality, that is, developing a sense of connection to something bigger, more important, or more permanent than one's self. People who are going through any kind of severe pain or serious illness often find themselves becoming more spiritual. People whose external world has been severely disrupted often search for some meaning in life and for a creative way to deal with what has happened to them. Mental health professionals are often uncomfortable thinking about spirituality because, as a group, we tend to be hyper-rational. Hope may not be rational, but it is still critically important. Based on my research, people who rate themselves as having more hope have better quality of life on every other dimension. On the other hand, if you think of yourself as having less hope, you will rate your quality of life less well in every other way.

Tooth and colleagues⁴¹ quoted one consumer with schizophrenia, who said “I think one of the keys is remembering what your life was like before you got sick. You've spent so long sick and you get into such a mind-set of hospital situations and being looked after and everybody feeling sorry for you and so and so, then you

get into that mind-set where you don't want to be well, you don't want to be normal. It seems acceptable to sit around and do nothing and go through life being treated like a schizophrenic. You start to believe that that's quite a good way of living, doing nothing.”

As a mental health professional, as a family member, as a friend, I believe that instilling hope is the most important thing we can do. If I look into someone's eyes and all I see is a chronic schizophrenic, then I participate in diminishing that person's hope. But if I look into that person's eyes and I see somebody who can work, who can have friends, who can have a lover, who can have a life that is meaningful in ways that are important to that person, then I will instill that hope in that person, and I will help the recovery process. I cannot fake this. It has to be something I feel in my soul.

I often work with people who have lost hope. The most important thing I can do for them is not merely prescribing the right medications or making the right diagnosis, but to hold hope in a crucible and blow the embers to keep hope alive until the person is strong enough to take that crucible back and hold the hope themselves. Recovery is the personal process of change that people can go through to recapture their own lives, to find meaning in life, and to become more than just a schizophrenic or just a patient. We, as mental health professionals, can promote this process. By our willingness to be part of a real relationship, to support strengths and goals, to accept risks and acknowledge the importance of empowerment,

and above all support hope, we can promote the personal journey that is the core of recovery. ■

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