Recovery and Schizophrenia

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Abstract

The term "recovery" seems self-evident to physicians, as it has been traditionally used in medicine to denote a restoration of health to the patient's state before illness or injury. The term is now appearing increasingly in connection with schizophrenia, which brings to light a new definition that has emerged from a grassroots advocacy movement. It must be acknowledged that in mental health, "recovery" means different things to different people. This article briefly outlines current thinking on the topic.

Key Words: Schizophrenia, Recovery, Outcomes, Peer Support

People recover from cancer. People recover from influenza. People recover from an orthopedic fracture. The term recovery is widely used in medicine and has a connotation of wellness and of having "gotten over" some illness or affliction. As physicians, we are trained to work toward enabling a state of steady improvement toward a symptom-free outcome. An uneventful, uncomplicated recovery ending in full restoration of health is the best possible outcome to be desired from the intervention of a surgeon, for example. Recovery in this sense achieves a "cure."

The term is used with less certainty when applied to chronic illnesses. A person may "recover" from an exacerbation of chronic obstructive pulmonary disease (COPD), or a person might recover eyesight after a hyperglycemic episode with diabetes mellitus. In either case, however, there is the expectation of continued vigilance and of an ongoing vulnerability. This is even more complex in mental health. People recover from anxiety. People recover from depression. People with substance abuse problems get "into recovery." But what does "recovery" mean for schizophrenia, typically considered the most severe of mental illnesses?

Can a person recover from schizophrenia? The answer must be a definitive "yes." However, it must also be a "qualified yes," explaining both terms and expectations. This brief article hopefully puts this in context and illuminates current thinking in this area.

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The Diagnostic "Entity" Schizophrenia is "Stacked Against" Recovery

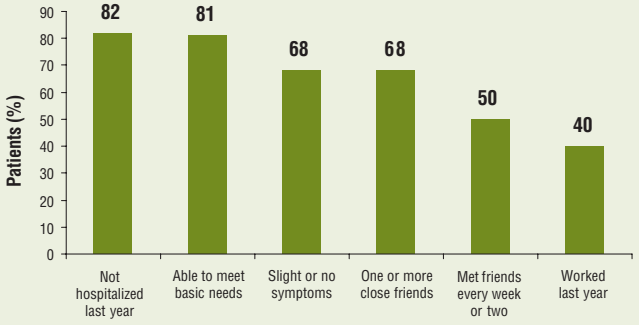
Current nosology, according to the nomenclature of the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*, defines schizophrenia by enduring and debilitating symptoms. Less debilitating and more short-lived psychoses get different names (brief psychosis, schizophreniform psychosis) and are more likely to result in a better outcome and recovery (1). Hegarty and colleagues have chronicled this effect over time, giving the appearance that we clinicians have made relatively little headway on improving patient outcomes over the past 30 years (2). This is just one facet cited in favor of the proposal among mental health consumers that the name of this condition now be changed (3). Schizophrenia has been considered too pessimistic a term and not readily associated with the notion of recovery.

On the other hand, two studies (both following the outcome of very chronically ill patients) stand in sharp contrast to the findings of Hegarty and colleagues. In the landmark study by Harding and colleagues, a substantial proportion of patients previously diagnosed with chronic schizophrenia were asymptomatic and "recovered" on evaluation some 30 years later (4). The findings of this seminal study are salutary (Figure 1), and they are well known to consumers. More recently, Harrow and colleagues also reported on the 20 year follow-up of another chronically ill patient sample. In this study, 46% of patients were asymptomatic and "recovered" (5).

Recovery as an Outcome: Definitions and Distinctions

So how, then, do you define recovery and measure it as an outcome? This is problematic and has dogged our field

Figure 1 The Vermont Study: Schizophrenia 32 Years Later



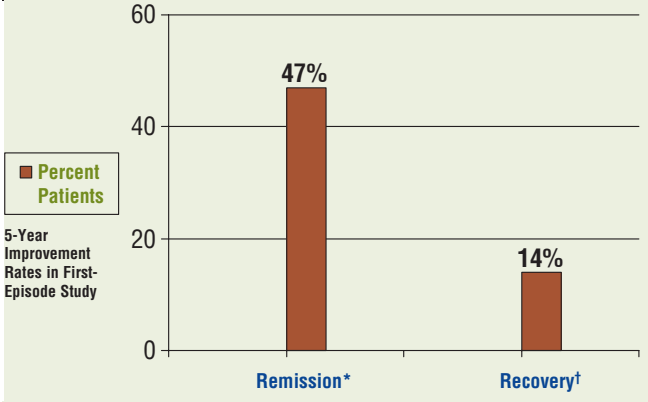
Harding CM, Brooks GW, Ashikaga T, et al. The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. Am J Psychiatry 1987;144(6):727-35.

Table 1 Operational Research Criteria for Recovery

• Symptoms- BPRS score ≤ 4 on positive and negative psychosis items
• Functioning- ≥ half time work/school - weekly socialization - independent management of funds
Sustained duration- 2 years

Liberman R, Kopelowicz A. Recovery from schizophrenia: a concept in search of research. Psychiatr Serv 2005;56:735-42.

Figure 2 Remission and Recovery as Outcomes



Robinson DG, Woerner MG, McMeniman M, et al. Symptomatic and functional recovery from a first episode of schizophrenia or schizoaffective disorder. Am J Psychiatry 2004;161(3):473-9.
*Andreasen N, Carpenter W, Kane J, et al. Remission in schizophrenia: proposed criteria and rationale for concensus. Am J Psychiatry 2005; 162:441-49.
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for some time. More recently, Liberman and colleagues have articulated strict operational criteria for defining when a person with schizophrenia is "in recovery" (Table 1) (6).

Robinson and colleagues applied these stringent criteria to describe the outcome of people who were evaluated five years after treatment for their first episode of schizophrenia. In this sample, only 14% of patients had "recovered" (Figure 2) (7).

In an effort to advance the field, Andreasen and colleagues proposed important criteria for another outcome: remission. These criteria are highlighted in Table 2 (8). Application of these criteria (less stringent than recovery-based criteria) to the aforementioned Hillside first episode sample by Robinson and colleagues showed that 47% of patients had met these criteria (Figure 2). These remission criteria have gained a lot of interest as our field continues to try to "raise the bar" on expectations from pharmacological and nonpharmacological treatments (9-11).

Recovery as a Process: Toward Clarifying the Concept

For those less focused on treatment and outcome studies in schizophrenia, the term "recovery" has a different (and arguably more complex) connotation. The roots of this term lie in consumerism and in the growth of advocacy movements. These developments are well described in other excellent articles (12-14). For mental health consumers, for families, for advocates, for policy makers and administrators, and now for an ever-increasing group of mental health clinicians, the term recovery refers to the "journey of healing" that people with serious mental illness travel towards maximizing their human potential. It is not simply an absence of symptoms. Nor is it even some distinct functional outcome. It is experiential. Because of that, it has been difficult to conceptualize this term "recovery" and, thereupon, to arrive at some common definition. A sample of definitions is given in Table 3. Recovery is a process. In a profoundly influential 1988 article that drew on her own personal experiences living with schizophrenia, Deegan introduced the concept to the pages of peer-reviewed journals: "Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times, our course is erratic and we falter, slide back, regroup, and start again." (18)

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) attempted to create a consensus definition that would unify future researchers (19). It states: "Mental health recovery is a journey of healing and transformation for a person with a mental health disability to be able to live a meaningful life in communities of his or her choice while striving to achieve full human potential or personhood."

Table 2 Operational Research Criteria for Remission

Dimension of Psychopathology	DSM-IV Criteria	SAPS and SANS Criteria	PANSS Criteria	BPRS Criteria
Psychoticism (reality distortion)	Delusions Hallucinations	Delusions (SAPS) Hallucinations (SAPS)	Delusions Unusual thought content Hallucinatory behavior	Grandiosity Suspiciousness Unusual thought content Hallucinatory behavior
Disorganization	Disorganized speech Grossly disorganized or catatonic behavior	Positive formal thought disorder (SAPS) Bizarre behavior (SAPS)	Conceptual disorganization Mannerisms/posturing	Conceptual disorganization Mannerisms/posturing
Negative symptoms (psychomotor poverty)	Negative symptoms	Affective flattening (SANS) Avolition-apathy (SANS) Anhedonia-asociality (SANS) Alogia (SANS)	Blunted affect Social withdrawal Lack of spontaneity	Blunted affect

DSM-IV=*Diagnostic and Statistical Manual of Mental Disorders, 4th Ed;* SAPS=Scale for Assessment of Positive Symptoms; SANS=Scale for Assessment of Negative Symptoms; PANSS=Positive and Negative Syndrome Scale: BPRS=Brief Psychiatric Rating Scale.
Adapted from: Andreasen N, Carpenter W, Kane J, et al. Remission in schizophrenia: proposed criteria and rationale for consensus. Am J Psychiatry 2005;162:441-49.

SAMHSA has also articulated ten "Fundamental Components of Recovery" (Table 4). Despite the intuitive appeal of the term "recovery" and of SAMHSA's ten components, these are not empirically driven. For instance, we don't know how much one or more—or in which order—hope is more important than empowerment? What exact role does spirituality play? Which of these components contributes to a person's capacity to lead a "journey of healing?" Also, several of these are overlapping constructs. Finally, some constructs clearly transcend (and even antedate) the recovery model, raising a concern that this model is too overarching and/or too complex. Even if these ten components are "the right stuff," how do we measure "the right stuff?" And if we can't measure it, we can't validate it. As Liberman and Kopelowicz eloquently titled their article, "Recovery from schizophrenia [. . .is. . .] a concept in search of research" (6). Measurement and validation of the constructs remain elusive. Additionally, there remains the potential for misunderstanding the fundamental difference between the recovery of the traditional medical model and the "recovery" described by Deegan. Those who have lived the experience refer to it as "recovery in," not "recovery from." Signs and symptoms, events and complications, setbacks and mistakes are the norm. With stress and risk come opportunities for challenge, growth, and progress to overcome what can often be an initial wave of overwhelming personal losses that come with the diagnosis. Thus, recovery embraces a sense of expectation for people that their lives can improve (20).

From a public health and policy viewpoint, espousing a recovery model makes a powerful statement about psychiatry. Both the Surgeon General's (first ever) report on mental health (21) and the President's New Freedom Commission (16) set the stage for meaningful dialogue on recovery. This has translated into SAMHSA's definition of recovery (19) and an action plan for systems transformation (22). The public health significance of this administrative shift and support of recovery is evident. Additionally, this administrative endorsement also helps combat stigma of mental illness. Stigma, of course, is a major barrier toward positive outcomes for our patients and for our field.

The Development of Peer-Support Services

Central to the notion of recovery is the belief in the ability of others who are recovering to assist other people in their recovery (23,24). This is, of course, a founding principle of Alcoholics Anonymous. Peer support can mean direct involvement in care as a paid mental health service provider (a peer-support specialist), peer-to-peer educational services, and peer-run self-help groups. The state of Georgia has taken this approach to heart. As of January 2007, the Department of Human Resources has trained, tested, and approved more than 300 individuals, and there are now Peer-Support Specialists who are eligible for employment providing Medicaid–reimbursable services throughout the state. Through a grant we received from the Veteran's Administration (VA) Central Office, our local VA hospital now has a peer-support specialist on staff. Our own medical school, through a grant we received from Georgia's Division of Mental Health, Developmental Disabilities, and Addictive Diseases, now has a peer-support specialist (Gareth Fenley) working with our residents on curricular development and education on recovery. Our initial evaluation of resident experience and interest shows a readiness to explore this model and its application (25). This is not a

Table 3 Emerging Definitions of Recovery

Definition	Source
Recovery from schizophrenia: no psychotic symptoms above 3 on the Brief Psychiatric Rating Scale during a six-month period, measures of work, community functioning, subjective quality of life, hospitalizations and symptoms.	Liberman & Kopelowicz (2005) (6)
Recovery from schizophrenia: GAF (Global Assessment of Functioning) greater than or equal to 65.	Torgalsen & Bjorn (2002) (15)
Recovery from schizophrenia: six month remission from symptoms of schizophrenia.	Andreasen, Carpenter, Kane, Lasser, Marder, & Weinberger (2005) (8)
". . . An ongoing process of learning to live with one's disability and gradually rebuilding a sense of purpose, agency, and meaning in life despite the limitations of the disorder."	Frese, Stanley, Kress, et al (2001) (13)
Recovery is the ability to "live, work, learn, and participate fully in the community . . . [it is] less about returning to a former self and more about discovering who one can become."	New Freedom Commission on Mental Health (2003) (16)
". . . Recovery is not understood as a static 'end product or result.' It is neither 'synonymous with cure' nor does it simply involve a return to a premorbid state. Rather, it is a life-long process that involves an indefinite number of incremental steps in various life domains."	Davidson, O'Connell, Tondora, Staeheli, & Evans (14)
". . . Goals and processes that are indicative of recovery for one person may be different for another person."	Anthony, Rogers, & Farkas (2003) (17)

straightforward process. Recruiting a peer colleague who is willing and able to work in the complex environment of an academic medical center is an important first step. The process of developing and synthesizing a curriculum is complex and is ongoing. The extent to which such training should be "blended in" or free-standing from the psychiatry residency core competencies has been another important consideration.

Bottom Line

Although the term 'recovery' carries different connotations, advancing it in front of the public and the mental health community is affirming of progress made in the treatment of schizophrenia.

Table 4 SAMHSA Ten Guiding Principles of Recovery

1. Self-Direction	6. Strengths-based
2. Individualized and person-centered	7. Peer support
3. Empowerment	8. Respect
4. Holistic	9. Responsibility
5. Nonlinear	10. Hope

SAMHSA-Substance Abuse and Mental Health Services Administration. National Consensus Statement on Mental Health Recovery. 2004 Consensus. [accessed 2006 May 26]. Available from: http://www.samhsa.gov.

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