



Exploring the concept of recovery in schizophrenia

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The concept of recovery in psychosis has gained much momentum in recent years in the UK. Current government policy describes its underpinning philosophy as the way forward for mental health services. Many mental health professionals now claim to embrace this concept yet fail to make the desired impact upon the care and treatment of individuals with schizophrenia. This article reviews some of the literature and explores what the concept of recovery means. The formal evidence will be augmented with personal accounts about recovery written by individuals who have schizophrenia. In doing so the main components that appear to have influenced the recovery process will be highlighted, and the implications for mental health nurses and practitioners will be discussed.

Keywords: implications for mental health practitioners, recovery, schizophrenia, survivor

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Introduction

... suppose a mountain has gold and no one is allowed to mine it anymore; the water will bring it to light, the water which reaches into the silence of the stone, it does the wanting.

Rainer Maria Rilke, 1903/1981, *Das Stundenbuch*, p. 29

Few topics in psychiatry have been researched as frequently over as long a period of time as has recovery from schizophrenia. Ever since Emil Kraepelin focussed on the deteriorating course of the illness in defining dementia praecox, psychiatrists throughout the Western world have been interested in comparing the recovery rates of their patients with those of patients of other physicians (Warner 2004).

However, more recently the concept of recovery from psychosis has gained considerable momentum and exposure both politically and clinically. It has given new hope to individuals with psychosis and their families. The Early Intervention movement now offers real optimism to those individuals in the early stages of illness as recovery is at the heart of early detection and treatment (Lieberman 2002).

Indeed, the strategies, such as relapse prevention, health promotion and normalizing psychotic experiences, have led to other mental health services, in particular rehabilitation services, embracing these idealisms and relabelling themselves as recovery services. On the surface this appears to be a move forward. But is there real substance behind these moves, and why are such beliefs merely focusing upon rehabilitation services? Surely, this philosophy should cut across all service areas and be the set of values that underpin all aspects of mental health care. Moreover, can recovery create the paradigm shift that is so badly needed to break through those areas that still retain traditional ways of thinking and working, when it comes to individuals with illnesses such as schizophrenia and their families?

Schizophrenia: a review of recovery and an exploration of what the concept means

Warner (2004) describes schizophrenia as one of the functional psychoses. He states 'it is a severe mental disorder in

which the person's ability to recognise reality and his or her emotional responses, thinking processes, judgment and ability to communicate are so affected that his or her functioning is so impaired. Hallucinations and delusions are common features of psychosis'. Warner (2004) also acknowledges that it is by no means universally clear what is schizophrenia and what is not, and that it could equally be a group of illnesses or federation of states.

However, many of the current concepts on the aetiology and pathophysiology of schizophrenia are still based on biological mechanisms, which have consequently led to a high preponderance of research on biological treatment (Lieberman 1998). This in turn has fostered the reductionism attitude that all treatment relies heavily on pharmacological interventions. Modern day practice demonstrates this by the virtual routine prescribing of antipsychotic medication as first-line intervention to treat psychosis. Some studies (Rogers *et al.* 1993, Shepherd *et al.* 1995; Campbell 1996) have shown huge differences in the goals of service users and service providers, mainly that service users mostly want choice, accessibility, advocacy, equal opportunities, employment and self-help. Despite this, many psychiatrists and mental health nurses remain reluctant to fully embrace the recovery paradigm, preferring to concentrate on a traditional approach to treatment that involves professional support, treatment and monitoring (Repper 2000a). The traditional treatment approach may be driven by the firm belief outlined in the first of the two questions posed by Warner about schizophrenia. These questions are: is schizophrenia an inherently catastrophic illness that only modern psychiatric treatment can afford relief; or is it a condition with a considerable, spontaneous recovery rate upon which treatment has little long-term effect? Harding (2002) feels that the modern pessimistic view of schizophrenia has developed partly because psychiatrists and others who care for individuals with schizophrenia were trained from textbooks based on the work of Kraepelin and Bleuler. Such texts subscribe to the view that improvement and recovery are not to be expected. Despite this, individuals improve without fanfare and frequently without much help from the mental health system (Harding 2002). Many recover because of sheer persistence at fighting to get better, combined with support from others such as family members, colleagues, consumer and non-consumer friends (Ralph 1998). Although some patients shake off the illness in 2–5 years, others improve much more slowly. Yet people have recovered even after 30 or 40 years with schizophrenia (Harding 2002).

Recovery, however, does not necessarily mean cure (Anthony 1993). McGuire (2000) suggests that the traditional medical model view of treatment in schizophrenia has defined a good outcome only in terms of a total cessa-

tion of symptoms, with no further hospitalizations. People who embrace the recovery paradigm feel such criteria are irrelevant (Deegan 1990).

What is recovery?

The word recovery means different things to different people. Some see it as a set of values that challenge the dominant dichotomies such as lack of choice, loss of responsibility, imposed care and treatment that exist in mental health services today.

Others see it as a philosophy by which to live. Recovery does not mean that all suffering has disappeared, or that all symptoms have been removed, or that functioning has been completely restored. The medical model assumes that mental illness is a physical disease, and recovery refers to a return to a former state of health: the person is cured (Whitwell 1999). Deegan (1992) suggests that recovery is 'marked by an ever deepening acceptance of our limitations . . . we find our personal limitations are the ground from which spring our own unique possibilities. It is a way of life, an attitude of approaching the day's challenges'.

Recovery is very individual and encompasses a range of qualities and experiences encountered on the journey towards recovery. Recovery can be an ongoing struggle for those individuals who have a live experience of mental distress. It is an experience of personal growth and learning, taking risks, failing and trying again, being able to live with oneself and with others, and being part of a living community (Turner 2002).

Anthony (1993) defines recovery as 'the development of new meaning and purpose as one grows beyond the catastrophe of mental illness. Episodic symptoms may still persist, however, one can still believe and feel they're recovering.'

Repper & Perkins (2003) suggest that recovery also involves redefining identity in a way that includes, but moves beyond, that 'illness'. Recovery is important whether or not a person's symptoms can be cured. It involves overcoming not only the challenge of mental health difficulties themselves, but also the effects of the discrimination and exclusion that accompany them.

Is recovery from schizophrenia possible?

Levant (1999) writes that recovery from a major disorder such as schizophrenia was not only possible, but it was happening regularly. He states that 'the old treatment models viewed patients as hopeless cases who needed to be stabilized with hospitalization and then maintained with medications. The tranquillising effects of these drugs made

management of patients easier, although they only masked the disease.

Harding (2002) supports this further in her writings. She refers to 'the old clinicians used to write about burned out schizophrenics, like the burned out shell of a person. But given half a chance, people can significantly improve and recover'. She also reports that 'a very large group of consumers have achieved remarkable recovery. They are people who, in spite of ongoing symptoms, have carved out a life. They have goals, make choices, they improve their situation with the right type of interventions'.

R.D. Laing and the antipsychiatry movement embraced some of these ideals by approaching the patient as an individual human being. They saw aberrant behaviour as a problem of acceptance for a narrowly conservative society. In Laing's terms, the patient had to put on a false self for society (Lucas 1998). The problem with this approach during that era was that it appeared to ignore the fact that there were entities called acute episodes. At that time these presented great management problems. Laing's enthusiasm eventually waned because of the demanding nature of the work, but it could be argued that he had planted the seed for liberating people with schizophrenia towards recovery.

Torrey (2002) reports that the stereotype everyone has of this disease is that there is no such thing as recovery. The fact is that recovery is more common than people have been led to believe. It is not known for sure exactly how many people recover. Researchers speculate that recovery may reflect both an ability to be able to manage illness that accompanies age, and the natural decline beginning in the mid-forties in the levels of brain chemicals that may be linked to schizophrenia. Frese *et al.* (1997) state that 'one reason nobody knows about recovery is that those people who do recover don't tell anybody because the stigma is too great. Many of us who have spoken about our recovery are confronted with the statement that you couldn't have been schizophrenic, you must have been misdiagnosed'.

Survivors such as Frese and Deegan also write about the recovery movement in America. They say the movement supports the philosophy that instead of focusing on the disease or pathological aspect of schizophrenia, as does the medical model, emphasis should be placed on the potential for growth in the individual. That potential is then developed by integrating medical, psychological and social interventions (Bachrach 2000).

Long-term studies

Recovery from schizophrenia has been documented by a number of studies tracing the course of the illness over a

number of years. Before these studies were completed it was believed that no one could recover (McGlashan 1988) and the rule of thirds was in place: it was believed that one-third of those with schizophrenia needed to be hospitalized all their lives, another third were hospitalized intermittently and the remaining third were able to live with extensive support and some disability (Wing 1988).

Bleuler (1965) studied 208 individuals hospitalized with schizophrenia in 1942 and followed them up until 1965. Of those with first admissions, 66% recovered completely, and 53% of those who had had re-admissions recovered. Thus, Bleuler wrote, 'I have concluded that the prognosis of schizophrenia to be more hopeful than it has been considered'.

Ciampi (1980) followed up 289 individuals and examined their entire lives. For most of these patients the history of illness extended back more than 35 years, and in many cases, more than 50 years. The outcome showed that 57% had either mild disability or had recovered fully from their schizophrenia. Furthermore, within a large group of 502 people who had been hospitalized for 23 years, Huber *et al.* (1980) found that the average recovery rate was 56%. Indeed, through this large study, it was possible to identify that individuals fell into one of three groups. Group A recovered in all but one area; they still had delusions but they used self-control with them, worked at jobs and did relatively well. Group B had no signs of schizophrenia; they lived in communities and functioned well except socially; they had very few friends. Group C consisted of individuals who were doing well but were not working. Further positive conclusions were drawn when over a 27-year period Ogawa *et al.* (1987) identified that out of 140 individuals, 57% made full or partial recovery, as although some had minor psychological difficulties, they were still able to function well socially. In the Vermont studies Harding *et al.* (1987a) observed 269 individuals from the back wards of Vermont State Hospital for an average of 32 years. Most of these individuals were chronically ill with schizophrenia; however, half to two-thirds showed significant improvement or recovered. Among them, 45% had no symptoms after two decades, and another 23% lost all symptoms of schizophrenia but developed symptoms of other more treatable mental disorders.

The evidence from these studies supports the swing of the pendulum favourably in the direction of recovery. Thornton (2000) suggests that there is not one predictable outcome for an individual with schizophrenia. There may be a variety of outcomes depending on how the illness impacts on the person, his or her family and the kind of treatment received, with other variables such as the person's personality and individual goals taken into account.

Harding (1999) comments that time is on our side. Schizophrenia often becomes less severe as an individual grows older. Those in their 30s tend to do better than those in their 20s, and those in their 40s and 50s may do better still. This may be due to the plasticity of the brain. Mother nature is always trying to correct itself from mid-age onward.

Survivors accounts of recovery

There is now a growing number of recovered individuals ('survivors') who have written accounts of their treatment experiences and about their own journey of recovery. By examining these stories, it may be possible to tease out: what recovery means to them; what factors influenced and aided their recovery; and what they see as crucial to the recovery journey.

One of these individuals is Patricia Deegan. When she was told at the age of 17 that she had schizophrenia and that there was no hope of recovery, she refused to accept the diagnosis and its bleak outlook. She decided to become a psychologist to prove that she was still a person with hopes and dreams. Her psychiatrist thought she had delusions of grandeur, but she persisted in what she calls her 'survivor vision', believing that she found the calling for her life.

She received her doctorate in psychology and is today one of the strongest advocates in the recovery movement. One of her many projects is finding the unmarked graves of those who died while in mental institutions and putting up markers for them, letting the world know that they were once alive (Thornton 2000).

She writes that 'recovery refers to the lived or real life experiences of people as they accept and overcome the challenge of the disability. They experience themselves as recovering a new sense of self and of purpose within and beyond the limits of disability. Recovery is about growth. Recovery can and does happen without professional intervention. Recovery is not just specific to psychosis. Recovery is about taking back control. Recovery is about hanging in there through the long and often slow process of healing. Recovery is a process, not an end point or destination. In many ways, everyone who seeks healing is in transit, always trying to move forward. The journey itself maybe what heals us, not whether we reach a set destination. Everyone's recovery journey is different and deeply personal. Hope is central to recovery' (Deegan 1993).

Fred Frese is another individual who has survived schizophrenia. He tells the story of walking into a large lecture hall where his students were all seated and he asked if anyone who had spent time in a locked ward, dirty and dishevelled, to please stand.

When no one stood, he said 'well since I'm the one only standing, I must be the only one who has'. He believes that being open about his experiences and his ability to function well between hospitalizations enables others with schizophrenia to believe that 'if he can do it, so can I' (Thornton 2000). On recovery he writes about the 'need to recognise recovered individuals and think of them whenever we feel hopeless. Those of us who are not ill with schizophrenia, who are "chronically normal", must remember that recovery can be a very long, slow process and that it often consists of two steps forward and one step back. It is hope that sustains us in this dance that is the underlying melody that moves like an invisible force through the dancers as well as the dance' (Thornton 2000).

Components of recovery

Although recovery is very individual, certain themes arise from the literature that appear common to recovered individuals. These components appear to have played a significant part in some people's recovery process.

Hope

Hope is seen as an essential ingredient in recovery from schizophrenia. Hope is seen to affect one's physiology, influence health, impact on relationships and shape the future (Harding *et al.* 1987b). Deegan (1996) talks of hope in recovery as like a sea rose. She says 'the sea rose teaches us a lot about hope. It teaches us that hope emerges out of the darkness. It teaches us that hope can grow in nurtured environments that allow one to become rooted and secure. It is the spirit of hope that helps us to recover'.

McGuire (2000) states that 'there is no way of knowing who will be the ones to recover. At the onset of the illness recovery should not be ruled out as a possibility for anyone. Recovery is not something that we wait until later to talk about. By allowing this possibility, we then can enable the road to be made by walking'.

Key to the recovery process is the ability to learn from experience that can be found in an environment of hope. An environment of hope can be characterized by some of the following (Turner 2002): high expectations; taking risks, failing and trying again; access to objective information; validation of coping strategies and experience; (re)establishing skills for work, education, creativity, leisure; keeping healthy; self-help systems of support; self-management; social inclusion and involvement within the community; support to deal with fear of change; and support of family and/or friends.

Mentorship

People who have significantly recovered from schizophrenia have frequently reported that they were greatly helped by someone who believed in them.

Fisher (1999) writes about a woman who reported 'the most important aspects to my recovery were having a mentor, a connection and a relationship . . . someone I made a strong connection to and they made one to me and I knew it . . . there was a knowing in their eyes that I saw that said I see you and I really believe in you. Someone that carried me, somehow, that encouraged me not to fall backwards'.

Stocks (1995) comments, 'She believed in me . . . she sent me a card that said "keep up the good work". She saw a spark in me. She told me from the start I had a good deal going for me. She helped encourage me. She gave me incentive'.

Leete's (1989) observations on helping relationships suggests 'the safety of being liked and prized as a person seems a highly important element in a helping relationship'. He goes on to say, 'if I accept the other person as something fixed, already diagnosed and classified . . . then I am doing my part to confirm this limited hypotheses. If I accept him as a process of becoming, then I am doing what I can to confirm or make real his potential'. Buber (1958) also described the importance of having someone believe in you. He called this characteristic 'confirming the other . . . confirming means accepting the whole potentiality of the other'. He said, 'I can recognise in him the person he has been created to become'.

Spirituality

Deegan (1993) describes spirituality in recovery as being about finding meaning and hope in suffering.

Recovery from schizophrenia, like recovery from any catastrophic illness, presents a great challenge to the human spirit. So shattering to the human personality are neurobiological disorders, so intense and comprehensive the suffering, that the deepest questions of the human condition are raised in the mystery and meaning of suffering. It is therefore not inappropriate to speak of recovery, from such illnesses in terms of a spiritual process (House 2001).

Great religious and spiritual traditions can play a vital role by guiding the recovering person as they integrate and heal the deep wounds of their illness. The overarching spirituality is broad enough to encompass the extremes that are experienced by the individual with schizophrenia. This spirituality can restore to the recovering person a proper and healthy perspective that affirms both the 'choseness' of that person for a special way marked by the unique extremes of mental suffering and yet at the same time

embraces that person as a human being worthy of love, healing and community (House 2002).

Growth

While recovery may be a painful process, it can also be a process of self-discovery, self-renewal and growth.

Spaniol *et al.* (1997) see one or more talents or abilities in us all that need to be allowed to grow and develop. They say 'who knows what works of literature, music or art, what achievements or what acts of courage and compassion are waiting to be released in every individual who has schizophrenia'.

Coleman (1999) sees the growth in recovery in terms of grieving for what is lost, understanding what has happened and discovering the meaning of life.

Being an individual

Thornton (2000) has written about the importance of treating people with schizophrenia as individuals and not as a disease. She writes that, 'when someone you love is very ill with schizophrenia, it may be almost impossible to believe this person can recover. This does not mean that they are cured or that the illness goes into complete remission, although this has happened in some instances. It means that over time, in an often long, difficult process, individuals come to terms with their illness. They learn how to accept it and then how to move beyond it, to believe in every cell of their being that they are not "schizophrenic" defined solely by an illness. They are individuals, whole and complete in themselves, with strengths as well as limitations, with the capacities to love and be loved, to work and to find joy and meaning in their lives despite illness'.

Anthony (1993) advocates survivors to refuse to be called schizophrenic. He says 'every one of us is a person, not an illness. If individuals with schizophrenia remind others that they are more than their illness, they will also remind themselves'.

Implications for mental health nurses and practitioners

With an increasing focus by government policy (DoH 2001) and user groups on this concept, mental health nurses and practitioners therefore can no longer ignore the formal and informal evidence of recovery. Whichever part of the mental health service they are working in, nurses and practitioners in general need to review their approach and attitudes to individuals with schizophrenia. Service users continue to experience prejudice from the very people professing to help them (Repper 2000a). Therefore, in line

with what service users have been saying for years, existing working practices at every level need a complete overhaul. In order to promote recovery, Andreason *et al.* (2003) suggest that there needs to be a common consensus on what recovery means among those working with individuals with mental illness. By having an underpinning philosophy of recovery, mental health nurses and practitioners would treat service users as individuals, respect them and empower them to take control of their own lives and futures (Repper & Perkins 2003). This would be achieved if they incorporated the attributes Coleman (1999) suggests, that is, to support people to take control, help them make real choices based on objective information and assist them to develop a sense of self-worth. Furthermore, they should aim to create an environment that encourages through self-awareness the growth of self-confidence, self-esteem and self-acceptance. Moving away from medical model outcomes such as symptomatology, hospitalization, medication and functioning, would promote a more consistent empowerment model approach, which is more favoured by the recovery movement (Ahern & Fisher 2001). The empowerment model suggests that mental illness is a sign of severe emotional distress in the face of overwhelming stressors. How a person responds, and is responded to, plays a crucial role in their further development. Using hopeful language that incorporates understanding, optimism and empowerment, helps a person to heal and resume their previous social role, and thus the mental illness label is avoided (Andreason *et al.* 2003).

Mental health nurses need to give hope to people that they can recover and assist in the provision of opportunities to enable this to happen. By taking a more active role in the promotion of social inclusion (Repper 2000b), the recognized barriers, negative attitudes and stigma can all be challenged. Hocking (2003) suggests that mental health professionals can reduce stigma and discrimination by increasing awareness and knowledge of the nature of psychosis and by improving public attitudes through more use of, and positive reporting by the media about illnesses such as schizophrenia. Finally, moving away from stigma-inducing diagnostic labels to a more individual formulation-based approach, which is carried out in collaboration with the individual, is a step in the right direction and will ensure that truly authentic goals are elicited.

Conclusion

Despite over a century of research, psychiatrists who specialize in schizophrenia still do not know what it is, what causes it or how the illness will manifest in individuals. The majority do not actively promote a recovery philosophy and still work within a maintenance model that makes

decisions for people and imposes ways to live their lives upon them. Torrey (1983) admits 'it is likely that the twentieth century psychiatrists as a group have done more harm than good to people with schizophrenia'.

On the whole, the psychiatric literature still remains silent about the personality characteristics of people who fully recover from schizophrenia and reacts defensively (Siebert 2000) to feedback that it makes mistakes and could be more effective.

However, despite the odds, people with schizophrenia are recovering and through their accounts are beginning to question the efficacy and validity of the medical and maintenance models of treating people with this illness. Their stories, coupled with the emerging empirical data and new ways of working such as early intervention, show that the prognosis for people who experience illnesses such as schizophrenia does not need to be so dire.

In order for the concept of recovery to become reality, better and improved ways of approaching the treatment of schizophrenia need to happen. All practitioners in the field of mental health should review their own attitudes and assumptions and learn to respect and value service users as individuals and focus on their strengths. The traditional systems and ineffectual ways of working that lack evidence need to be challenged and greater emphasis needs to be placed on what service users actually want, such as the provision of vocational and employment opportunities and social inclusion. There is also a need to facilitate a paradigm shift so that services are based on the principles of recovery as well as dealing with the bigger barriers that get in the way of enabling individuals to recover.

A starting point would be for all nurses and practitioners to acknowledge that recovery in schizophrenia can and does happen, and to adopt a philosophy of recovery as the alternative to the maintenance approach that exists within most mental health services today. It is important to add that any changes that are made have the blessing of those who experience such illnesses and do not just result in 're-arranging the chairs on the deck of the Titanic, which in the long term only achieves a better view going down'.

References

- Ahern L. & Fisher D. (2001) Recovery at your own PACE. *Journal of Psychosocial Nursing and Mental Health Services* 39, 50–51.
- Andreason R., Oades L. & Capiti P. (2003) The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry* 37, 586–594.
- 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.

- Bachrach L. (2000) Psychosocial rehabilitation and psychiatry in the treatment of schizophrenia – what are the boundaries? *Acta Psychiatrica Scandinavica* 102 (Suppl. 407), 6–10.
- Bleuler M. (1968) A 23-year longitudinal study of 208 schizophrenia and impressions in regard to the nature of schizophrenia. In: *The Transmission of Schizophrenia* (eds Rosenthal, D. & Kety, S.), pp. 244–254. Pergamon Press, Oxford.
- Buber M. (1958) *I and Thou* (trans. Smith R.G.). Charles Scribner's Sons, New York.
- Campbell P. (1996) What users want from mental health crisis services. *Mental Health Review* 1, 19–21.
- Ciampi L. (1980) Catamnestic long term study on the course of life and aging of schizophrenics. *Schizophrenia Bulletin* 6, 606–608.
- Coleman R. (1999) *Recovery: An Alien Concept*. Handsell Publishing, Gloucester.
- Deegan P. (1996) *Recovery and the Conspiracy of Hope*. Available at: <http://www.namisc.org/newsletters/February02/PatDeegan.htm>.
- Deegan P. (1990) *Spirit Breaking: When the Helping Profession Hurts*. Routledge, New York.
- Deegan P. (1992) The independent living movement and people with psychiatric disabilities: taking back control over our own lives. *Psychosocial Rehabilitation Journal* 15, 5–19.
- Deegan P. (1993) Recovering our sense of value after being labelled mentally ill. *Journal of Psychosocial Nursing and Mental Health Services* 31, 7–11.
- Department of Health (2001) *The Journey to Recovery. The Government's Vision of Mental Health Care*. Department of Health, London.
- Fisher D. (1999) *Someone who believed in them, helped them to recover*. Available at: <http://www.namisc.org/newsletters/november/fisher.htm>.
- Frese F., Walker W. & Davis J. (1997) The consumer-survivor movement, recovery and consumer professionals. *Professional Psychology: Research and Practice* 28, 243–246.
- Harding C. (2002) Beautiful minds can be recovered. *New York Times*. Available at: <http://www.nytimes.com/2002/03/10/opinion/10HARD.html>.
- Harding C., Brooks G., Ashikaga T., Strauss J. & Breier A. (1987a) The Vermont longitudinal study of persons with severe mental illness: 2. long term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry* 144, 727–735.
- Harding C., Zubin J. & Strauss J. (1987b) Chronicity in schizophrenia: fact, partial fact or artifact? *Hospital and Community Psychiatry* 38, 477–485.
- Harding C.M. (1999) *Recovery is Possible with Psychosocial Rehabilitation*. Available at: <http://www.apa.org/monitor/Feb00/schizophrenia.html>.
- Hocking B. (2003) Reducing mental illness, stigma and discrimination: everybody's business. *Medical Journal of Australia* 178, 47–48.
- House G. (2001) *Litanies for All Occasions*. Judson Press, Cleveland, OH.
- House G. (2002) *Spirituality, Meaning and Recovery from Serious Brain Disorder*. Judson Press, Cleveland, OH.
- Huber H., Gross J. & Schuttler R. (1980) Longitudinal studies of schizophrenic patients. *Schizophrenia Bulletin* 6, 592–605.
- Leete E. (1989) How I perceive and manage my illness. *Schizophrenia Bulletin* 15, 197–200.
- Lieberman J. (1998) *Re-integration of the Schizophrenic Patient*. Science Press, London.
- Lieberman J. (2002) Investigating the early stages of schizophrenia: the hillside prospective study of first episode schizophrenia. In: *The Early Stages of Schizophrenia*. (eds Zipursky, R. & Schulz, C.). American Psychiatric Publishing Inc, Washington.
- Lucas R. (1998) R.D Laing – his life and legacy. *Journal of Psychoanalysis* 79, 1229–1239.
- McGlashan T.H. (1988) A selective review of recent North American long term follow up studies of schizophrenia. *Schizophrenia Bulletin* 14, 515–542.
- McGuire P. (2000) New hope for people with schizophrenia. *Monitor on Psychology* 31, 1–11.
- Ogawa K., Miya M., Watara A., Nakazawa M., Yuasa S. & Utena H. (1987) A long term follow up study of schizophrenia in Japan – with special reference to the course of social adjustment. *British Journal of Psychiatry* 151, 758–765.
- Ralph R. (1998) *A review and synthesis of recovery published and unpublished literature*. University of Southern Maine. Available at: <http://www.mhsip.org/recovery.html>.
- Repper J. (2000a) Adjusting the focus of mental health nursing: incorporating service users experiences of recovery. *Journal of Mental Health* 9, 575–587.
- Repper J. (2000b) Social inclusion and community integration. In: *Mental Health and Disorder*, 3rd edn (eds Thompson, T. & Matthias, P.). Chapman & Hall, London.
- Repper J. & Perkins R. (2003) *Social Inclusion and Recovery: A Model for Mental Health Practice*. Ballière-Tindall, London.
- Rilke R.M. (1903) *Das Stundenbuch* (trans. Bly, R.). In: *Selected Poems of Rainer Maria Rilke* (ed Bly, R.). Harper & Row, New York.
- Rogers A., Pilgrim D. & Lacey R. (1993) *Experiencing Psychiatry: User's Views of Services*. Macmillan, Basingstoke.
- Shepherd G., Murray A. & Muijen M. (1995) Perspectives on schizophrenia: a survey of user, family care and professional views regarding effective care. *Journal of Mental Health* 4, 403–422.
- Siebert A. (2000) What is wrong with psychiatry? *Journal of Humanistic Psychology* 40, 34–58.
- Spaniol L., Gague C., Koehler M. (1997) Recovery from serious mental illness: what it is and how to assist people in their recovery. *Continuum* 4(4), 3–15.
- Stocks M. (1995) In the eye of the beholder. *Psychiatric Rehabilitation Journal* 19, 89–91.
- Thornton L. (2000) *Finding Hope in Schizophrenia: Healing & Hope for Everyone in The Family*. APA Books, Washington.
- Torrey E.F. (1983) *Surviving Schizophrenia: A Family Manual*. Harper & Row, New York.
- Torrey E.F. (2002) Beautiful- but not rare- recovery. *Washington Post*, 12 February, p. he01.
- Turner D. (2002) Mapping the routes to recovery. *Mental Health Today July*, 29–31.
- Warner R. (2004) *Recovery from schizophrenia: psychiatry & political economy*, 3rd edn. Routledge & Kegan Paul, London.
- Whitwell D. (1999) The myth of recovery from mental illness. *Psychiatric Bulletin* 23, 621–622.
- Wing J. (1988) Comments on the long term outcome of schizophrenia. *Schizophrenia Bulletin*. 141, 669–672.