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The Experience of Recovery from Schizophrenia: Towards an Empirically-Validated Stage Model.

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Abstract

Objective: The consumer movement is advocating that rehabilitation services become recovery-oriented. The objectives of this study were to gain a better understanding of the concept of recovery by (1) identifying a definition of recovery that reflects consumer accounts, and (2) developing a conceptual model of recovery to guide research, training and inform clinical practice.

Method: A review was conducted of published experiential accounts of recovery by people with schizophrenia or other serious mental illness, consumer articles on the concept of recovery, and qualitative research and theoretical literature on recovery. Meanings of recovery used by consumers were sought to identify a definition of recovery. Common themes identified in this literature were used to construct a conceptual model reflecting the personal experiences of consumers.

Results: The definition of recovery used by consumers was identified as psychological recovery from the consequences of the illness. Four key processes of recovery were identified: (1) finding hope; (2) re-establishment of identity; (3) finding meaning in life; and (4) taking responsibility for recovery. Five stages were identified: (1) Moratorium; (2) Awareness; (3) Preparation; (4) Rebuilding, and (5) Growth.

Conclusions: A five-stage model compatible with psychological recovery is proposed, which offers a way forward for attaining recovery-oriented outcomes. After further empirical investigation, a version of this model could be utilised in quantitative research, clinical training and consumer education.

Keywords: schizophrenia, mental disorders, recovery, outcomes, rehabilitation

The belief that rehabilitation services should be recovery-oriented is now gaining wide acceptance. The concept of recovery started gaining momentum in the 1980's when consumers¹ began publishing accounts of their recovery from serious mental illnesses such as schizophrenia. Many people felt that when they received their diagnosis they were given a "prognosis of doom" [1], which denied all hope of recovery or even a satisfying life. However, many managed to overcome the problems imposed by the illness and went on to enjoy a full life. Since then, the consumer movement has been working towards breaking down the notion that schizophrenia necessarily has a long-term deteriorating course. This idea is supported on a number of fronts.

The traditionally pessimistic view of the course of schizophrenia has been blamed on diagnostic classification systems that are seen as confounding the prognosis with the diagnosis [2]. Disorders that are the same as schizophrenia in every respect are diagnosed differently if the person improves; the classification of schizophrenia excludes people who recover [3]. Contributing to the negative attitude is the "clinician's illusion". Clinicians see only the most needy people, and are denied feedback from clients² who improve and no longer use the service [3,4]. Contributing to this hopeless attitude towards schizophrenia is the apparent lack of motivation in some people with the illness. However, a number of factors that are not an essential to the illness can contribute towards this 'avolition'. First, conventional medications have been shown to cause some of the 'negative symptoms' and cognitive deficits [5,6]. The neuroleptic-induced deficit syndrome (NIDS), which includes anhedonia, apathy, feelings of emptiness and slowing of thought processes, can be misinterpreted as disease symptoms. Fortunately, atypical antipsychotics have been shown to have fewer side effects, reduce secondary negative symptoms [7] and improve cognitive functioning [8,9], thereby increasing the possibility of successful rehabilitation [10].

Another treatment effect that contributes to chronicity is engulfment in the "patient role", in which the person's identity becomes organised around the role of psychiatric patient, and the person becomes resigned to being a passive recipient of care [11]. Estroff asserts that '*Becoming a schizophrenic* is essentially a social and interpersonal process, not an inevitable consequence of primary symptoms and neurochemical abnormality' [12, p.194]. The patient role is one of the few remaining open to the person, and although negative, it serves to organise the person's experience better than no identity at all [13]. An apparently similar, but experientially different, phenomenon is motivated withdrawal. Consumers have described withdrawal as a strategy for self-protection from the 'numerous ... psychological assaults inflicted by the disorder, by society and even by oneself' [14, p 184]. In a first-person account of recovery, Deegan described apathy and indifference to others as 'a strategy that desperate people, who are at the brink of losing hope, adopt in order to remain alive' [15, p.93]. Therefore, rather than resulting from a lack of volition, withdrawal can be very much goal-directed [14].

A number of longitudinal studies have shown that people do recover from schizophrenia. For example Harding [16], in a long-term follow-up study involving only the most disabled, long-stay patients³ who had been released from hospital, found that 68% were functioning at a level that most people would consider normal. Combining these data with four other studies, Harding found that, of 1300 ex-patients, one half to two-thirds had recovered or significantly

¹ The term "consumer" will be generally used in this paper to denote people who have received a diagnosis of serious mental illness, as it widely used in the recovery literature.

² The term "client" will be used when referring to a consumer in relationship with a service provider.

³ The term "patient" will be used when discussing studies involving hospital patients.

improved. More-recent studies have lent further support to these findings that the outcome of schizophrenia is not a foregone conclusion [17-19].

International studies have found differences in outcome between locations [17,20,21], with people in traditional cultures often having a more positive outcome than those in Westernised countries [22]. Suggested reasons for this finding are the differences between industrialised and traditional cultures in labelling and in opportunities to integrate into the community [3,22]. In the U.S., the provision of rehabilitation services predicts better longitudinal course and outcome [23,24]. Cultural environment therefore appears to play an important role in the course of schizophrenia [25], leading to the conclusion that psychological and social factors may contribute a great deal to the chronic course of schizophrenia over and above disease factors [16].

Encouraged by this evidence of hope for recovery for everyone, the consumer movement has advocated a shift towards a recovery-oriented approach to rehabilitation. However, in order to develop services that promote recovery, we first need consensus on a definition of recovery. Harrison [20] called for careful operationalisation of the concept of recovery, which has traditionally been assessed with objective measures such as symptomatology, hospitalisation history and functioning. In view of the large and growing consumer literature on recovery, we should endeavour to conceptualise recovery in terms of people who have experienced it. We can then investigate what facilitates recovery and assess outcome in terms meaningful to consumers. This paper presents the results of preliminary work in developing a conceptual model of recovery, starting with identifying a definition of recovery as represented by consumers.

Method

In order to develop a model faithful to the experiences of people who have recovered, Medline, PsycInfo and Cinahl databases were searched using combinations of these keywords: recovery; schizophrenia /mental illness (or disorder) /psychiatric /psychosis /psychotic; and consumer /first-person /experiential/ (subjective or personal) experience. Results were limited to journal articles, and the selection criteria were that the article was a consumer account of recovery, or a paper based on consumer accounts. This search resulted in 89 articles, of which a convenience sample of 36 was reviewed. This sample was supplemented by material at hand and relevant works cited within this literature. Especially valuable were Spaniol and Koehler's compendium of experiential accounts of recovery [26], and the Schizophrenia Bulletin, which regularly publishes first-person accounts. The final literature review included 28 published experiential accounts of recovery from schizophrenia or serious mental illness [15,27-53], 14 articles on recovery written by consumers [1,54-66] and eight qualitative studies [67-74]. Additionally, papers on the concept of recovery illustrated with consumer accounts, and a number of theoretical and empirical articles on aspects of recovery were perused.

A preliminary overview of this literature revealed that (1) there are different understandings of the meaning of recovery; (2) there are strong common themes among the consumer accounts of recovery, and (3) recovery is a stage based process. These observations provided a conceptual framework for reviewing the literature with respect to the research questions, with three aspects now to consider: (1) What definition of recovery is used by the consumer movement? (2) What are the key processes of recovery? (3) How can we best define the stages of recovery?

To choose a definition of recovery, articles on the concept of recovery were reviewed, and consumer narratives provided insight into individual differences in beliefs about recovery. To identify the component processes of recovery, the 28 consumer narratives, 10 consumer articles on the recovery concept [1,54,56,57,61-66] and the 8 qualitative studies were analysed for common themes. A constant comparison method was used to reduce the number of themes to the key component processes. The focus was on the personal experience of recovery rather than on interventions that assist the recovery process. Stages or phases of the recovery process were identified in the qualitative research, and parallels were drawn between the findings of the various studies to generate a stage model of recovery.

Results

Defining recovery as represented by consumers.

The literature on the concept of recovery indicates that there were several meanings of the term recovery. Fitzpatrick [75] described the meanings of recovery as being on a continuum, with three identifiable points: (1) the medical model, (2) the rehabilitative model and (3) the empowerment model.

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 [76]. The medical model is often used in outcome studies of schizophrenia and serious mental illness. Outcomes such as symptomatology, hospitalisation, medication and functioning are implicitly based on a medical model. The medical definition is not the one used by the recovery movement. 'One of the biggest things I've had to accept is that recovery is not the same thing as being cured' [1, p.20]. However, it is the definition that is understood in common discourse, and confusion can occur when consumers infer this meaning [76]. Given that the medical definition of recovery requires a return to a former state, consumers who, to the outside observer, do not appear to have a mental illness, may not consider themselves recovered under this definition. This may be because (a) they do not feel like the same person that they were before, (b) they continue to use medication or other illness management strategies, or (c) they do not believe that it is possible for people with a mental illness to get better [25,76]. It is important, therefore, for clinicians and researchers to be clear in their own meaning of recovery [76].

The *rehabilitative model* of recovery holds that, although the illness is incurable, with rehabilitation efforts the person can return to a semblance of the life they had before the illness [77]. This model is based on the medical model, in that it assumes serious mental illness to be incurable, in much the same way as a permanent spinal injury. It presupposes that the person will always be disabled but can learn to live well within the limitations of the disability.

The *empowerment model* holds that mental illness does not have a biological foundation, but is a sign of severe emotional distress in the face of overwhelming stressors [25]. How a person responds, and is responded to, plays a crucial role in their further development. With understanding, optimism and empowerment the person can heal and resume their previous social role, avoiding the mental illness label [25]. Advocates of the empowerment model are not satisfied with the notion of continued mental illness, and the strong version of this model denies the need for medical treatment.

Psychological Recovery. Our findings indicate that a definition that falls between the rehabilitative model and the empowerment model – that of psychological recovery – is most compatible with consumer beliefs. Psychological recovery refers to the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination. The person recovers from the psychological catastrophe of the illness [78]. These definitions from the consumer literature capture the essence of psychological recovery:

The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration to live, work and love in a community in which one makes a significant contribution [36, p.54].

It was being able to live in the community, to be able to work, to be accepted by myself and by others, it was taking responsibility for myself, it was learning how my mental illness was hurting people that loved me, it was a willingness to change myself to become all that I wanted to be. It was accepting the illness, but working towards health [49, p.3].

...the spirit of the recovery process [is]: I am no longer defined by myself or by others as my mental illness or disability, nor am I limited in opportunity, responsibility or direction. It is not who I am – though it may be a small part of me at times [57, p.2].

Psychological recovery is not grounded in any causal theory of mental illness, and is silent on whether illness is still present in recovery. Although the empowerment model holds much the same principles, it makes strong statements regarding the aetiology of mental illness, the need for medication and the return to expected roles, which are at odds with the stories of many consumers. In choosing a definition, the following findings from the consumer accounts regarding some of the criteria for recovery were considered.

The return to a former state

Recovered consumers may not feel the same as they did before developing the illness [76]. As Crowley explains, ‘Much can be accomplished when we let go of who we were and get to know who we are now and who we can become’ [56, p.11]. Furthermore, many feel they are a better person for having experienced and recovered from the illness, even if their current role may have lower social status. As Watson says:

The struggle can enrich us or it can make us bitter. As I talk with others thus afflicted, it is my gut feeling that this struggle has not embittered most of us nor defeated us, but has made us more compassionate, sensitive and courageous. We have also learned some valuable lessons along the way [51, p.74].

Others are adamant that they do not *want* to be the same as they were before, as their development had been hampered by the illness [79].

The return to expected roles

Consumers did not appear to take the return to expected roles as a criterion of recovery. For example:

Sometimes in the face of illness, our dreams blow up in our face. It is important to dream a new dream, and once you've done this to pick some aspect of it and begin working toward it in any increment. [56, p.16].

On the other hand, one should not assume that consumers cannot return to socially valued roles, as Mead and Copeland assert:

We have learned that we are in charge of our own lives and can go forward and do whatever it is we want to do. People who have experienced even the most severe psychiatric symptoms are doctors, lawyers, teachers, accountants, advocates and social workers... [63, p.316].

Absence of symptoms

Although a number of consumers felt that their treatment was worse than the illness and had blocked their recovery [e.g. 54,61,63], and some saw their cessation of medication use as a mark of their progress [e.g. 27,49,62,66], others see the controlled use of medications as fully compatible with recovery:

Being in recovery means that I don't just *take* medications. ... Rather I *use* medications as part of my recovery process. In the same way, I don't just go to the hospital Rather I use the hospital when I need to [1, p.21].

Furthermore, Tooth et al. [73] reported that only 14% of respondents understood recovery as freedom from symptoms. 'Many of us have learned to monitor symptoms to determine the status of our illness, using our coping mechanisms to prevent psychotic relapse or to seek treatment earlier, thereby reducing the number of acute episodes and hospitalisations' [42, p.199].

In light of these differences, the concept of psychological recovery is consistent with consumers' use of the term, allowing for recovery in the presence of ongoing management of illness. It places no limitations on the possibilities for the person, and at the same time does not confine the definition of recovery to externally valued roles.

Developing a conceptual model of psychological recovery

Strong themes emerged from the experiential accounts. Although consumers did not necessarily claim to be 'recovered' and were generally not attempting to describe the process or definition of recovery, themes from their accounts were mirrored in consumer articles on recovery and in qualitative research. Identified themes are illustrated with quotations from the narratives. We focused on two psychological dimensions of recovery revealed in the literature: *component processes* and *stages* of recovery.

Component Processes of Recovery

Four component processes of recovery were salient: (1) finding hope, (2) redefining identity, (3) finding meaning in life and (4) taking responsibility for recovery.

Hope. The importance of hope pervades the literature on recovery. References to hope were found in 19 of the 28 consumer narratives, in nine of the 10 consumer articles and in all eight

qualitative studies. Just as hopelessness is central to chronicity in schizophrenia [1,80,81], finding hope is the catalyst of the recovery process. Snyder has identified hope as the common factor in all successful therapy [82]. Snyder's definition of hope comprises three distinct elements: a goal, envisaging pathways to the goal and belief in one's ability to pursue the goal. Miller [83] described hope as anticipation of a continued good state, an improved state or a release from perceived entrapment. Using these definitions, themes such as hope for the future, personal agency, the helpfulness of others, and sources of inspiration were subsumed under the theme of 'hope'. Hope was described as coming from within the person, or as being triggered by a significant other, peer or a role model. For Deegan it was an awakening of self-determination in the face of having her life depicted as a 'closed book' at the age of 17:

When my psychiatrist told me the best I could hope for was to take my medications, avoid stress and cope, I became enraged...just after that visit I made up my mind to become a doctor [15].

For others, it was the unflinching belief and support of loved ones that eventually encouraged the person to try make the first steps in the recovery process. Tenney illustrates the power of a vestige of hope when transmitted by a health professional:

Of course, I was told I could only recover from my alcoholism. But I did not care. Somebody – a psychiatrist at that – was telling me, the seriously, persistently mentally ill person, that I could recover. My life changed instantly [66, p.1438].

Hope is not only the trigger for recovery, but also maintains the recovery process: 'I have met people who have healed from this disorder and what has distinguished them for others was their belief that they could heal. They were also determined to do the necessary work.' [53, p.83].

Self Identity. An horrific, and well documented, impact of mental illness is the loss of a sense of identity, and 42 of the 46 articles reviewed referred to some aspect of this issue. Deegan described the loss of her future self: 'My teenage world in which I aspired to dreams of being a valued person in valued roles ... I felt these parts of my identity being stripped from me' [1, p.16]. The process of self-redefinition is central to recovery:

My illness eradicated my sense of self, and now I am engaged in the lifelong process of obtaining, maintaining and slowly modifying my sense of who I am [28, p.25].

Pettie and Triolo described two approaches to reconciling one's self with the illness [84]. First, the illness can be accepted as part of the self in a spirit of growth. Alexander accepted the experience as one to be treasured, and explains: 'My identity was focused away from being a patient or ex-patient, but to my own life experience which was validated by literature and philosophy' [30, p.38]. Alternatively, the illness can be seen as something separate from the 'real' self, which has to be lived with [84]. '...the key ... is to know yourself, know your illness and to know the difference between the two' [28, p.25]. Curtis described recovery as movement from being engulfed by the illness to accepting the illness as but a small part of the whole self [57]. 'Once you and the illness become one, then there is no one left inside of you to take on the work of recovering, of healing, of rebuilding the life you want to live' [1, p.19].

Meaning in Life. Forty-two articles described the importance of meaning or purpose in life. Often a person's previous life goals are no longer available to them, and they face the task of reassessing their values and goals in life. Alternatively, a person may find other ways of expressing their core values. This theme is strong in accounts of all types of recovery, not solely from mental illness [85]. Mary found that her in-service training work in nursing gave her a reason to get out of bed in the morning, and ... 'sometimes I don't feel confident. I just have to push myself. I don't allow myself to give in to that. If you're working you're expected to turn up' [45, p.19]. But employment is not the sole provider of meaning. Leete urged that personal growth be facilitated by 'discovering what makes life valuable and enriching to us as individuals' [Leete, 1994, cited in 65]. For example, Fox, while living 'a simple life, but a good life,' embraces life to the full, and is grateful for 'my second chance to enjoy my family and pursue my dreams' [38, p.365]. For others, creative pursuits provide a sense of purpose [e.g. 46]. Moreover, the work of recovery can be meaningful in itself, 'I learned that I want to dedicate myself to this recovery process for myself and others....' [31], and offering peer support or involvement in advocacy work is frequently mentioned, 'It all seemed so strange, my life's suffering led to my life's work' [62]. For some, spirituality gives meaning to the struggle. Watson believes God's love insures that '...our courage will not be wasted or in vain. As we are strengthened by our courage, we shall ultimately emerge victorious to a life richer in joy, peace and love' [51, p.75]. Murphy captures the essence of finding meaning:

An integral part of my recovery has been my search and discovery of meaning for my life. This is a philosophical and psychological issue that goes beyond mere chemical imbalances in the brain. In this search, I have developed a new world view [64, p.188].

These examples illustrate that, while finding meaning in life is integral to recovery, the source of that meaning can vary greatly between individuals, and possibly over time.

Responsibility. Thirty-eight articles referred to taking responsibility for one's recovery: 'I now realize that I needed to take some responsibility for my recovery; I can't just wait for the pills to save me.... I've begun to make a start and I see some hope where I saw none before' [29, p.14]. Taking responsibility includes self-management of wellness and medication, autonomy in one's life choices, accountability for one's actions, and willingness to take informed risks in order to grow: '... we must have the opportunity to try and to fail and to try again.... Professionals must embrace the concept of the dignity of risk, and the right to failure if they are to be supportive of us' [15, p.97]. This entails empowerment and self-determination, as highlighted by Mead and Copeland:

The person who experiences psychiatric symptoms should determine the course of his or her own life. No one else, even the most highly skilled health care professional, can do the work for us. We need to do it for ourselves, with your guidance, assistance, and support [63, p.328].

Recovery requires determination and commitment. As Wentworth described, 'While my intention to heal never wavered, everything else did, my feelings, my behavior, and my situation. My intention was the thread I held on to' [53, p.83].

Personal Goals and Recovery.

The re-establishment of important goals, or the identification of new goals is a pervasive theme, and the previous four components can be linked by the concept of the pursuit of

personal goals. Hope is the perceived ability to reach identified goals, identity and meaning are linked to one's valued roles and goals in life, and responsibility involves autonomy in the pursuit of them. The power of meeting seemingly small autonomous goals to engender agency and hope is illustrated by Davidson:

Nancy arrived one morning and announced proudly to the staff and patients that she had been successful...in purchasing her first, very own, spool of thread.... Following this purchase of thread, Nancy's mood seemed to change from that of anxious despair to eager exploration, as she became active in investigating a psychosocial club and vocational program she could attend... [86, p.203].

The Stages of Recovery

Five studies identified phases or stages in the recovery process. Although the focus of the research varied, and there is no consensus on the exact delineation of the stages, a pattern emerged that provided a model for further empirical investigation. A brief summary of the findings of each of these studies follows.

Davidson and Strauss [68] conducted a series of interviews over a two to three year period with 66 participants with serious mental illnesses (25 with schizophrenia). They focused on the reconstruction of a sense of self in recovery. Four aspects are described: (1) discovering the possibility of a more agentic sense of self, (2) taking stock of one's strengths and limitations, (3) putting aspects of the self into action and (4) using this enhanced sense of self as a resource in recovery.

Baxter and Diehl [67] used a semi-structured interview, based on constructs in the recovery literature, with 40 consumers. Three psychological events were identified: (1) Crisis, followed by a stage of recuperation accompanied by denial, confusion, and despair; (2) Decision to get going, followed by rebuilding the ability to resume normal life roles, suffering setbacks and developing a more integrated sense of self; and (3) Awakening to restructured personhood, followed by the stage of recovery and rebuilding healthy interdependence. This stage is characterised by future goals, meaningful work, advocacy and fun.

Pettie and Triolo [84] used two case examples of people with serious mental illness to illustrate the process of reconstructing identity. They described two steps to the recovery process: (1) 'Why me?' – followed by the search for the meaning of the illness to the person; and (2) 'What now?' – followed by the task of developing a new identity and positive sense of self.

Young and Ensing [74] conducted a qualitative study with 18 people with a severe psychiatric disorder who were living independently. Three main phases were identified: (1) Initiating recovery, involving accepting the illness, finding hope, and the desire to change; (2) Regaining what was lost and moving forward, including taking responsibility, self-redefinition, and a return to basic functioning; and (3) Improving quality of life, involving an overall sense of well-being and striving for new potentials. A number of tasks and processes are described within each phase.

Spaniol et al. [72], in a longitudinal qualitative study involving 12 people with schizophrenia, identified four phases of recovery: (1) Overwhelmed by the Disability, in which the person feels confused, out of control of life, lacking in self confidence and lacking connection with

others; (2) Struggling with the Disability, characterised by finding an explanation for the illness, learning to cope, fear of failure, building strengths; (3) Living with the Disability, including managing the disability, a stronger sense of self, meaningful roles and a satisfying life within the limitations of the disability; and (4) Living Beyond the Disability. This phase was identified from the literature, and is described as living a contributing life that unlimited by the disability, and characterised by a sense of meaning and purpose to life.

The findings of these qualitative studies can be conceptualised as a five-stage model of recovery. The left-hand column of Table 1 shows the five stages as we have named them. These stages are compared to those identified in the studies. The five stages of the model are:

1. Moratorium: This stage is characterised by denial, confusion, hopelessness, identity confusion and self-protective withdrawal.

2. Awareness: The person has a first glimmer of hope of a better life, and that recovery is possible. This can be an internal event, or it can be sparked by a clinician, significant other or a role model. It involves an awareness of a possible self other than that of “sick person”: a self that is capable of recovery.

3. Preparation: The person resolves to start working on recovering. This stage involves taking stock of the intact self, and of one's values, strengths and weaknesses. It involves learning about mental illness and services available, recovery skills, becoming involved in groups, and connecting with peers.

4. Rebuilding: In this stage the hard work of recovery takes place. The person works to forge a positive identity. This involves setting and working towards personally valued goals, and may involve reassessing old goals and values. This stage involves taking responsibility for managing the illness and taking control of one's life. It involves taking risks, suffering setbacks and coming back to try again.

5. Growth. This final stage of recovery could be considered the outcome of the recovery process. The person may not be free of symptoms completely, but knows how to manage the illness and to stay well. The person is resilient in the face of setbacks, has faith in his or her own ability to pull through and maintains a positive outlook. The person lives a full and meaningful life, and looks forward to the future. He or she has a positive sense of self, feeling that the experience has made them a better person than they might otherwise have been.

Table 1 Comparison between stages or phases of recovery identified in five studies

Stage of Recovery	Davidson & Strauss (1992)	Baxter & Diehl (1998)	Young & Ensing (1999)	Pettie & Triolo (1999)	Spaniol et al. (2000)
Stage 1 Moratorium		1. Crisis <i>Recuperation</i>		Why Me?	1. Overwhelmed by the Disability
Stage 2 Awareness	1. Awareness of a more active self		1. Initiating Recovery	<i>Meaning of Illness</i>	
Stage 3 Preparation	2. Taking Stock of Self 3. Putting self into action	2. Decision		What now?	2. Struggling with the Disability
Stage 4 Rebuilding	4. Appealing to the Self	<i>Rebuilding independence</i>	2. Regaining & Moving Forward	<i>Reconstructing Identity</i>	3. Living with the Disability
Stage 5 Growth		3. Awakening <i>Building healthy interdependence</i>	3. Improving Quality of Life		4. Living Beyond the Disability

The Outcome of Recovery

Although consumers see recovery as an ongoing process, the description of the final stage of recovery suggests some measurable constructs. Elements of the final stage of recovery closely mirror the dimensions of Psychological Well-Being (PWB), defined as Personal Growth, Self Acceptance, Autonomy, Positive Relationships, Environmental Mastery, and Purpose in Life [87,88]. The positive psychology movement emphasises the pathway to Psychological Well-Being through the pursuit of personal goals, with the self-concordance of one's goals being the key to both goal attainment and psychological well-being [e.g.89,90]. This paradigm is compatible with the concept of recovery from serious mental illness. It is now widely accepted that clients and clinicians should collaborate in setting goals [e.g.91,92-94]. Our findings highlight the central importance of ensuring that the truly authentic goals of the client are elicited. Another quality of the growth stage is resilience, or the ability to endure setbacks without giving up hope [88]. Therefore, constructs such as Psychological Well-Being and resilience warrant further investigation as outcome measures compatible with consumer experience.

Conclusion

A definition of psychological recovery was described in which hope and self-determination lead to a meaningful life and a positive sense of self, whether or not mental illness is still present. A model of recovery has been suggested which identifies five stages: Moratorium; Awareness; Preparation; Rebuilding and Growth, and four component processes: finding hope; re-establishment of identity; meaning in life and responsibility for recovery. This Stage Model of Recovery may assist both clinicians and consumers in conceptualising the recovery process, and may also help to validate consumers' experiences. It may prove useful for determining the treatment approach that would be best suited to an individual at a given time. The Stages of Recovery Instrument (STORI) [Andresen et al: unpublished manuscript] has been designed to test the validity of the model and to investigate the pattern of component processes across the stages of recovery. An empirically-validated model would provide a basis for moving recovery research from qualitative to quantitative studies within a consumer-oriented framework.

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