The experiences of recovery from schizophrenia: development of a definition, model and measure of recovery

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THE EXPERIENCE OF RECOVERY FROM SCHIZOPHRENIA:
DEVELOPMENT OF A DEFINITION, MODEL AND MEASURE
OF RECOVERY

A thesis submitted in fulfilment of the requirements for the award of the degree

DOCTOR OF PHILOSOPHY

from

UNIVERSITY OF WOLLONGONG

by

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B.Sc. (Hons)

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2007
DECLARATION

I, Retta Andresen, declare that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the School of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Retta Andresen
30 October 2007.
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ACKNOWLEDGEMENTS

First I must thank the people who have struggled with mental illness and shared their stories of recovery with the world. These generous and courageous people provided me with the inspiration for my work, as well as the material for my research. I also thank the research volunteers who participated in my research, for giving their time and sharing their experiences to advance the understanding of recovery. The stories and experiences shared by people with a mental illness not only inspired my work, but also challenged me to dare to grow as a person. Any problem I encountered on my journey was insignificant compared to the challenges that they have faced and overcome.

I would like to thank my supervisors, Dr Lindsay Oades and Dr Peter Caputi of the University of Wollongong, for all their help and encouragement. I thank Lindsay especially for his creativity and conceptual discussions, and Peter especially for his statistical insights and for the benefit his experience. I thank both of them for their mentorship, for always being there when I needed them and for their belief in me. I feel that our relationship has grown into a sound research team over the years. I would also like to thank Professor Frank Deane for his support, his interest in my work and for providing a space for me to work within the Illawarra Institute for Mental Health. Thanks also to my fellow students and colleagues for their encouragement and support.

My family have been extremely important to me during my studies. I thank my parents, Martin and Janet Milroy, for their interest in my work, their pride in my achievements, and their unconditional love throughout my life. I also thank my children: Dave, Paul, Tony and Mandy for their love, support and understanding through my long years of study. Special thanks to Mandy, for her empathy, her creativity and especially her laughter, and for providing the musical soundtrack as we both worked. Also not forgotten is the love, interest and encouragement always shown by my brothers and sisters, near and far.

Most important has been the constant and steadfast support of my wonderful husband, John. I could not have completed my studies without his love, understanding, encouragement and practical support. The bountiful love of all my family is the greatest gift I could wish for in life.
The traditional view of schizophrenia as having a deteriorating long-term course and an outcome of permanent disability has been challenged both anecdotally and empirically. Therefore, the consumer movement advocates that rehabilitation services become recovery-orientated. Recovery-orientated and empirically-validated services have now become policy internationally. However, the meaning of *recovery* in a medical or research context is different than the meaning used by consumers. The objectives of this research were, therefore to (a) formulate a consumer-oriented definition of recovery; (b) develop a conceptual model of recovery to guide research and evaluation and inform clinical practice; (c) design a measure of recovery, based on the model, and (d) to seek empirical support for the model of recovery.

Study One involved a review of the consumer-oriented literature on the concept of recovery, with four aims: (a) to understand the meaning of recovery used by consumers; (b) to identify the components of recovery; (c) to formulate a definition of recovery; and (d) to define the stages of recovery. An examination of consumers’ experiential accounts produced a definition of *psychological* recovery from the consequences of the illness. Four key processes were identified: (i) finding hope; (ii) re-establishment of identity; (iii) finding meaning in life; and (iv) taking responsibility for wellness and life generally. Five stages were synthesized from the extant qualitative research: (i) moratorium; (ii) awareness; (iii) preparation; (iv) rebuilding and (v) growth. A model of four processes developing over five stages is discussed in the light of the wider literature surrounding recovery from loss and the positive psychology literature. It is concluded that the philosophies of the positive psychology movement have much to offer in recovery-oriented approaches to treatment and research.

In Study Two, a brief measure, the Self-identified stage of recovery (SISR), was designed in order to test the model. The aims were to (a) test the validity of the stage measure against continuous recovery measures; (b) to test the notion of
recovery assessment as opposed to conventional measures of outcome, and (c) to
seek support for the stage model of recovery. The SISR was completed by a
clinical population participating in a larger study. High correlations between the
recovery measures ($r_s = .262, p = .01$ to $r_s = .712, p = .01$) supported the validity
of the SISR, while the pattern of correlations between the recovery measure
subscales supported the validity of the SISR as a measure of level of recovery.
Negative to low correlations between recovery and conventional measures ($r_s = -
.375$ to $r_s = .191$) supported the divergent validity of recovery as an outcome as
distinct from conventional measures. In addition, an effect of stage was found on
one conventional measure ($F (4,127) = 2.9, p < .05$) and all recovery measures ($F (4, 141) = 2.87, p < .05$) to $F (4, 141) = 4.68 (p < .001)$, lending support to the stage model
of recovery.

The aims of Study Three were to (a) produce a longer, more reliable measure that
would better capture the richness of the experience of recovery; (b) examine the
validity and reliability of this measure; and (c) seek further support for the stage
model of recovery. The Stages of Recovery Instrument (STORI) consists of 50
items, each representing a psychological process at a stage of recovery. The
STORI yields five stage subscale scores.

A postal survey of volunteers revealed that the STORI correlated with six
psychological health variables ($r_s = 0.45 (p < .01)$ to $r_s = 0.62 (p < .01)$. Correlational analysis provided support for an ordinal relationship between the
stage subscales. An effect of stage was found on all recovery-related variables, ($F (3,110) =10.70 (p <.01)$ to $F (3,111) = 24.44 (p < .01)$. However, a cluster analysis of
items resulted in three subscale clusters, rather than the expected five, revealing
an overlap between adjacent stages.

The results provide preliminary empirical validation of the STORI as a measure of
the consumer definition of recovery. Although an effect of stage was found,
refinement of the measure is needed to improve its capacity to discriminate
between the stages. It could then be used in comprehensively testing the stage
model using longitudinal methods and the inclusion of objective measures.
The concept of recovery elucidated in this research underlines the importance of taking a positive stance to recovery, focusing on values, meaning and growth rather than on illness-focused approaches to care. The five-stage model has proven useful in clinical training and as a framework for research into recovery. Validation of the model with longitudinal research is planned. Further development of the STORI is underway in separate research, and when refined, the measure should provide an outcome assessment tool that is meaningful to consumers and a useful adjunct to conventional clinical measurement.