Recovery of Schizophrenia
-Biopsychosocial discourse-

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I. History of recovery—Schizophrenia—

- The history of debate on recovery

- One of the biggest challenges in psychiatry
Hippocrates

- An abnormality of the metabolism of bile, blood and mucus
- A vomiting inducer, and bloodletting
- The first person to attempt medical healing
Eradication of “insanity”

• Both feared and revered
• Regarded insane people as possessed by the devil
• Witch-hunt
Grand containment

Michel Foucault

“Histoire de la folie”
Phillippe Pinel

“Bicetre Hospital in Paris”
“Recovery” through institutionalization

The focus of the usual treatment was to protect patients from stimuli

- Water therapy
- Insulin coma therapy
- ECT
Discovery of chlorpromazine and the beginning of deinstitutionalization

- No need for segregating and restraining people with mental disorders
- Schizophrenia could be “Cured”
Ⅱ. Rise of Psychiatric Care in Local Communities
Trend for deinstitutionalization

- From a hospital to a local community

- The era of community mental health

“Fountain house” at NY
Recovery from “illness” can leave “disability”

1. Volcano Theory

Disabilities
(Negative symptom; Apathy, Autism, Poor life skill)

Positive symptom
(Hallucinations, Delusions, Excite, Disorganization)
2. Ampere Reduction Theory

50ampere → 30ampere
“Independence” needing support

- Day Program
- Half way house
- Assisted employment
- Transient employment
- Social welfare programs

Multidisplinary approach
Anti-psychiatry

- R.D. Laing
- T. Szasz
- D.G. Cooper
Therapeutic community

Maxwell Jones
Ⅲ. The Meaning of Recovery
Clinical theory vs. Personal theory

Patient

Psychiatrists 『Better Medication』 vs Co-medicals 『Life skills or Self-esteem』
Recovery by biomedicine

1. Psychopharmacology
2. Genetics
3. Molecular imaging research
4. Post-mortem brain study
5. Research on early schizophrenia

Biological recovery
Recovery
by psychosocial rehabilitation
William Anthony: "Psychiatric Rehabilitation" (1990)

1. The degree of compliance with pharmaco-therapy does not
determine the prognosis of rehabilitation.
2. Occupational therapy used in an institution does not
necessarily have a positive effect on the prognosis of
employment.
3. The psychiatric state is not deeply related to the prognosis of
future rehabilitation.
4. The diagnosis does not necessarily offer crucial information
on the rehabilitation.
5. The symptoms and skills of the patient are not necessarily
correlated.
6. A psychiatrist cannot necessarily predict the prognosis of
rehabilitation.
Beginning of the recovery model

“Recovery from Mental Illness” (1993)

1. Recovery can occur without professional intervention.
2. A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.
3. A recovery vision is not a function of one’s theory about the cause of mental illness.
4. Recovery can occur even though symptoms reoccur.
5. Recovery changes the frequency and duration of symptoms.
6. Recovery does not feel like a linear process.
7. Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.
8. Recovery from mental illness does not mean that one was not “really mentally ill”.
Trend of focusing on the person with illness

Medical model

「What’s been lost by illness?」

Community model

「People who are living ordinary lives」

“Strength”
“Empowerment”
“Resilience”
Ⅳ.Confusion of the Meaning of Recovery
“Clinical recovery” and “Personal recovery”

What do the people with mental disorders see as Recovery?
—Two ambivalent meanings—

1. Clinical recovery is aimed at.
2. To compensate for the limitation of clinical recovery you must adopt the concept of psychosocial recovery.
V. What We Must Do
To have the same concept of recovery

1. Schizophrenia is an illness.
2. One can clinically recover from this illness through medical treatment.
3. Even if the person recovers clinically, it does not mean s/he is cured. In most cases s/he remains inflicted with the disability unique to this illness, which makes it difficult to participate in society in terms of work, education, or marriage.
4. To suffer from schizophrenia does not necessarily mean that the person’s life is without hope.
5. How to enrich the life of a person with this illness and disability is the focus of “personal recovery”, which is different from “clinical recovery”. There are a variety of resources and supporters involved with such rehabilitation efforts. Just as the person with schizophrenia will work towards “clinical recovery” by consulting psychiatrists and using medication, hopefully s/he will strive for “personal recovery” by taking advantage of such resources. Some aspects of “personal recovery” include a sense of joy, self-confidence, and resilience.
Finally

We are warned not to expect too much from the discourse of “clinical recovery”. Likewise I feel we mustn’t expect too much from “personal recovery”. At present there are some misleading behaviours in this field. Some may only emphasize the “clinical recovery” aspect and thus falsely assure it, while others act as though pretending the disability does not actually exist is a way of recovery. I believe that we must be honest with the actual degree of “recovery” achieved, and try to further it from a more holistic point of view.