the columns

correspondence

Recovery: beyond mere survival

Sir: David Whitwell (*Psychiatric Bulletin*, October 1999, **23**, 621–622) argues that 'recovery' is a myth, promulgated by over-optimistic therapists of all persuasions. If 'recovery' means getting back to exactly how you were before (as he argues), then no doubt he is right, at least for many people with significant mental health difficulties. But the mental health world needs optimism – not over-optimism, that a person can rebuild a satisfying, hopeful life and contribute to society despite the continued presence of mental health problems. Indeed, this is precisely how recovery is defined in the now extensive American literature: there is no way back to life before problems started, but there is a way forward (Deegan, 1988; Anthony, 1993; Young & Ensing, 1999).

The experience of physical disability shows just how powerful this type of 'recovery' can be, even in the face of the most extreme impairment. After Jean-Dominique Bauby's massive stroke he could only move one eyelid, his sole means of communication. There is no doubt that he would have agreed with Whitwell's interviewee who said that 'I will never be the same person again'. However, he was able to find some meaning and purpose, however, limited, in his highly restricted new life in 'writing' what the *Financial Times* described as, "one of the great books of the century" (Bauby, 1997).

As Patricia Deegan (1988) puts it:

> "Recovery does not refer to an end-product or result. It does not mean that my friend (with quadriplegia) and I were 'cured'. In fact, our recovery is marked by an ever-deepening acceptance of our limitations. But now, rather than being an occasion for despair, we find that our personal limitations are the ground from which spring our own unique possibilities."

Whitwell's interviewees at times seemed to be equivocal about whether they had, in fact, 'recovered' – an ambivalence from which Whitwell concluded that they did not think they had recovered. Here there seems to be some confusion between recovery as an ongoing process and 'being recovered' as an end-point. Deegan (1988) makes precisely this point when she argues that recovery does not mean 'cure', it is not an end-point – 'recovered' – but a continuing journey: ". . . an ongoing process. It is a way of life. It is an attitude and a way of approaching the day's challenges" (Deegan, 1992).

The challenge for service providers is how to reduce the barriers which impede the re-building of a person's life. How to help people to gain more opportunities: for work, income, friends and social networks. Whitwell also illustrates the importance of helping people to appreciate the "strength they have derived from the damage they have sustained and overcome".

People 'disabled' by mental health problems can do more than just 'survive'. If the Disability Rights Commission, coming into force in April 2000, succeeds in breaking down some of the barriers of discrimination faced by mental health service users; and if professionals follow the National Service Framework recommendation to support users in gaining social inclusion – then chances for recovery could increase. Not cure, but new meaning.

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Sir: I read with interest Dr Whitewell's comments about the myth of recovery from mental illness (*Psychiatric Bulletin*, October 1999, **23**, 621–622). The topic, particularly resonated with me as the institution where I work is being featured in a television series entitled 'The Talking *Cure*' (my italics). I would agree with Dr Whitewell's premise that we live in an age where expectations are high and there is a pressure on psychiatrists to provide 'solutions' or 'cures' through whatever treatment they offer be it psychotherapy, pharmacotherapy or some combination of the two.

It seems to me that the current emphasis on clinical governance and evidence-based medicine as well as the need for randomised-controlled trials to prove that our treatments are effective is part of this culture. While I would not argue against the value of quality assurance and evidence-based medicine, perhaps a more realistic appraisal, in broader terms, of the likely outcome of our treatment is needed.

The most up to date antipsychotics do not 'cure' schizophrenia in the same way that psychodynamic psychotherapy does not cure people with borderline personality disorders. In child psychiatry there is a pressure for clinicians to provide a cure for conditions such as Attention–Deficit Hyperactivity Disorder (ADHD), with medication such as methylphenidate. ADHD is increasingly regarded as a 'thing' that can be 'cured' whereas it is actually more of a conceptual tool which may help us to address a complicated area of child psychiatry. Of course, we often do offer valuable therapeutic interventions, otherwise what would be the point of us existing, but let us be realistic about what we can achieve. In this way too, patients may feel more empowered to find their own ways of alleviating their difficulties without relying excessively on clinicians.

Essentially, I would agree with Dr Whitewell that the desire for complete or absolute cure is a primitive one. Sometimes after a session with a particular family or child I wonder what help I have offered them. It may well be that they

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