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OPINION: BEYOND SYMPTOM REDUCTION: THE IMPORTANCE OF PERSONAL RECOVERY IN PSYCHOTIC DISORDERS

ABSTRACT

The concept of personal recovery has gained increasing attention in mental health research and clinical practice, generating a growing body of theories and applications. However, more critical reflection is needed on how mental healthcare and wider society understand and enable personal recovery for people with psychotic disorders. This opinion paper argues for personal recovery as a central goal in the prognosis of psychosis, while drawing attention to constrained choice within mental health services and structural barriers to social inclusion, including employment and intimate relationships. Advancing recovery-oriented care requires not only supporting individual agency but also addressing the structural conditions that shape opportunities for meaningful inclusion in society.

KEYWORDS: PSYCHOSES, RECOVERY, FREEDOM OF CHOICE, SOCIAL INCLUSION

INTRODUCTION

Personal recovery has gained increasing attention in mental health services and research of severe mental illnesses, including psychotic disorders. Personal recovery is a key phenomenon of recovery orientation [1]. Recovery orientation is a framework that brings together ideas from the human rights movement, various psychological theories—such as positive psychology—and the social inclusion of people with severe mental illnesses [2]. From the point of view of mental health service users, the use of recovery orientation can improve the quality of mental health services [3,4].

Personal recovery was first defined by Anthony in 1993 as a unique, deep and individual change process of feelings, skills, values and attitudes with a central feature of personal experience of a meaningful and satisfying life despite the limitations caused by the mental illness [5]. Personal recovery is a process that is multifaceted and not straightforward, with the possibility for the person to try and fail [6]. According to a recent publication, several practical work models of personal recovery have been developed [7]. The CHIME framework is the most widely adopted model of personal recovery in both mental health practice and research [6,8]. In recent years

adaptations of the CHIME [8], as well as models of personal recovery for specific diagnostic [9] and age groups [10], have been published.

The CHIME framework consists of five recovery processes: Connectedness, Hope, Identity, Meaning and Empowerment [6]. Additionally, for severe mental disorders different approaches on personal recovery have been proposed. Stuart, Tansey and Quale (2017) elaborated the CHIME framework, arguing that it should also consider Difficulties that burden persons with severe mental illness, and proposed a modification with CHIME-D [8]. Jaiswal et colleagues (2020) developed a completely new practical model of care for personal recovery: the recovery elements model. The model proposes three main elements of personal recovery: Relationships, Sense of Meaning and Participation [11]. In conclusion, existing models of personal recovery consistently highlight core elements such as social inclusion, identity, hope and a sense of meaning [7].

WHAT RESEARCH TELLS US

Fifteen years ago, Leamy and colleagues had already identified 97 scientifically developed models of personal recovery. These

models were derived primarily from qualitative research focusing on lived experiences of recovery, most often among people with psychotic disorders, including schizophrenia [6]. While firmly grounded in empirical research, this body of work reflects a predominantly qualitative tradition, and still today studying personal recovery using quantitative methods remains challenging [12,13]. As a deeply individual, non-linear process without fixed stages or a clear endpoint, personal recovery does not lend itself easily to measurement. Nevertheless, further research work is needed to establish meaningful cut-off points and reference ranges for personal recovery in different cultures.

One field of research interest has been the possible connection of personal and clinical recovery. Research has shown that they are distinctive constructs [14] with, for example, a temporal difference – personal recovery is a continuum, whereas clinical recovery is an endpoint [15]. However, also commonalities between the concepts have been found [14,16]. For instance, clinical recovery is positively associated with personal recovery, showing a relationship between the two phenomena [16,17]. Across studies, the proportion of individuals with schizophrenia who meet criteria for both clinical and personal recovery has varied widely, ranging from 5% to 38% [14,17,18].

When looking at research on personal recovery in psychotic disorders, a consistent message emerges – psychotic symptoms themselves do not define a person’s capacity for recovery. Studies have repeatedly shown that symptom severity is not directly linked to personal recovery outcomes [19,20], however, affective symptoms are associated with lower levels of personal recovery [20,21]. What seems to matter in personal recovery are the subjective and relational dimensions of the phenomenon. Furthermore, in a one-year follow-up study among people with schizophrenia, Dubreucq and colleagues (2022) found that a higher level of personal recovery at baseline predicted a fivefold increase in the likelihood of clinical recovery at follow-up. At the same time, being in clinical recovery initially increased the odds of improved personal recovery threefold one year later [17]. These findings challenge symptom-focused models of care and suggest that supporting personal recovery is not a secondary goal, but a prerequisite for broader recovery outcomes. If personal recovery were seen as a first-line goal in the prognosis of psychotic disorders, what steps would need to be taken?

FREEDOM OF CHOICE UNDER CONSTRAINT

Psychiatric care has historically been marked by paternalistic practices, where decisions about care were largely made on behalf of patients rather than with them [22–24]. Within recovery-oriented practice and the concept of personal recovery, freedom of choice in one’s own mental healthcare is often presented as absolute. Individuals are seen as having the right to choose whether to use mental health services—and which services to use—without these choices being judged by professionals or viewed as barriers to personal recovery [25].

In practice, however, this ideal of unrestricted choice is far from straightforward. Refusing medication, particularly in psychotic disorders, frequently places mental health service providers in a position of tension and discomfort, exposing the limits of tolerance for patient choice [26,27]. At the same time, freedom of choice is constrained by structural inequalities: evidence-based mental health interventions are not equally available across geographical regions [e.g. 27]. Moreover, organizational traditions or service provider orientations—for instance, a strong focus on trauma-informed approaches—can shape which interventions are prioritized and which remain inaccessible. As a result, what is framed as “choice” may in reality be a choice among limited or predetermined options.

On the other hand, there is a risk that an emphasis on autonomy of choice may slide into the abandonment of people who are in need of support. When “personal recovery” is treated as synonymous with complete self-management or framed through overly optimistic expectations, responsibility for recovery can be shifted almost entirely onto the individual. These risk obscuring the critical role of social context, structural conditions and access to resources in shaping recovery processes [8,29]. Autonomy and individuality are not achieved through withdrawal of support, but through relational practices—such as shared or supported decision-making—that actively recognize both personal agency and interdependence [27,30].

SOCIAL INCLUSION OR A PARALLEL SOCIETY?

From multiple perspectives, social inclusion is a key component of personal recovery. Central aspects of social inclusion are social relationships and employment [30]. Personal recovery has been closely linked to social relationships [16,31] and to quality of life [12,18,31,32], while research has shown that one important contributor of quality of life is employment [33,34], showing an indirect association between employment and personal recovery. In the literature, peer relationships

are proposed as an important means of fostering social connection among people with psychotic disorders [35,36]. These opportunities are often provided by non-governmental organizations and may even lead individuals to train as peer support workers or experts by experience.

However, I would argue that this does not necessarily promote inclusion in the wider society, but rather inclusion within a specific, marginalized subculture centred on mental health. In such contexts, one's primary reference group often consists of others with similar diagnoses. While this can be meaningful and supportive, it may not represent a form of social inclusion that suits everyone. True inclusion should also mean having the opportunity to participate in any part of society—not only in spaces defined by mental health services or identities.

One of the most persistent forms of social exclusion faced by people with psychosis is access to the open labour market. Individuals with psychotic disorders have low employment rates [37–40]. There are no simple solutions to making labour markets more inclusive, as barriers are shaped by broader structural factors such as economic conditions, changing demands of working life and employment legislation. Although various interventions have been proposed to improve employment outcomes—most notably supported employment—these approaches alone cannot address the underlying societal issues. As such, they risk focusing on adapting the individual to the labour market, rather than questioning how the labour market itself may exclude those with mental health conditions.

However, exclusion is not limited to employment; it also extends into more intimate areas of life, including close and romantic relationships. Individuals with severe mental illness value intimate relationships and perceive them as a core component of recovery [41,42]. Such relationships foster hope, connectedness and a sense of inclusion, thereby contributing to a meaningful life for people with psychotic disorders [43]. Recent research in a population with first-episode psychosis suggests that, compared to community controls, involvement in romantic relationships may be associated with greater social integration [42]. Nevertheless, mental health service providers may hold ambivalent or even negative attitudes towards these relationships [44–46]. Moreover, issues related to sexuality and intimacy are frequently marginalized or overlooked within mental healthcare settings [43,47]. This is perhaps most clearly reflected in the lack of structured interventions addressing challenges such as initiating and maintaining romantic relationships, sexuality and family formation among individuals with psychotic disorders, with only a limited number of approaches described in the literature [48,49]. In this sense, the boundaries of what

is considered “appropriate” within mental healthcare may inadvertently constrain the scope of personal recovery.

CONCLUSION

The case has been made for personal recovery as the primary goal in the prognosis of psychotic disorders. To achieve this collectively, it is essential to move away from paternalistic attitudes toward psychotic disorders, both within society and in mental healthcare practices. At the same time, psychotic disorders should be recognized as illnesses rather than matters of personal choice or responsibility. Individuals living with these disorders deserve the same rights to care, rehabilitation and support as those with any other health condition. Finally, efforts should be directed toward promoting genuine social inclusion, including access to employment and meaningful social relationships. Everyone should have the opportunity to pursue a meaningful life of their own choosing.

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