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Defining recovery from schizophrenia then and now: may psychoanalyst be asked?

Definindo a recuperação da esquizofrenia ontem e hoje: os psicanalistas podem participar?

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Recovering from schizophrenia is a vast field yet to be explored. Review of literature shows that theories have considerably evolved since daementia praecox has been described. Kraepelin's description has had the consequence of associating schizophrenia to an adverse evolution — and so it is for the severe mental illness as a whole. Catamnestic studies have contradicted this conception, but it is mainly due to the patients and families of patients associations and first person accounts that the fields of psychiatry and psychology will owe these changes. Then, different paradigms were used to model remitting, recovering or rehabilitation. If the outlooks of recovery are today quite well spread, the blind alleys that it encounters, as far as the evolution of medical fields are concerned by long-run illnesses, show the way to research towards taking account of subjective factors, and that constitutes one avenue for future research in psychoanalysis.

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Introduction

The concept of recovery in psychosis has been concerning international psychopathology research for some time, not only from the point of view of understanding the psychotic process but also from the point of how to build up new professionals' practices, mainly through rehabilitation programs promoted by the biopsychosocial approaches.

Though the existence of psychiatry patients gone back to ordinary social life has been well known for a long time (Lantéri-Laura, 1997), these recoveries seem to have always constituted exceptions for practitioners who necessarily receive patients at the time they need it most.

However, the advent of the psychic handicap notion has come to hit the psychiatry field thus changing the concept of "recovery", and consequently contributing to draw the attention towards the subjective working out of the patient at the between time separating the moment of collapse and the moment of recovery (Moreau, 2010). While "care" used to be the main dimension in severe mental pathologies, today a social support to various aspects of life is proposed, a backing which one would find among many diverse medical or social approaches in which case management is the frame (Mueser, Bond, Drake and Resnik, 1998).

Scientific research papers on the outcome of schizophrenic patients have undoubtedly helped to change researchers' perceptions, but they seem to have been under-used because of the prevalence of the neurobiological pattern. It seems to be rather the patients' and families' associations that we have to thank for the changing position of research, and so it should be for many helpful published autobiographies.

Psychiatry has then tried to adapt the somatic concept of symptomatic remission; and afterwards in front of the difficulty of applying it to the mental pathology, a new pattern of recovery has

been built up. The heterogeneity of individuals who consider themselves recovered has led to the consideration of the increasingly developed notion of subjective factors (Martin & Franck, 2013), which now seems to represent a real turning point in psychiatry as well as in various medical fields. Recently, a systematic review showed the interest of considering the experiential dimension of delusion (Feyaerts et al., 2021) or the meaning of delirium (Ritunnano et al., 2022). This is another argument for including subjective factors in the definition of recovery itself. Psychoanalysts, following Freud, considered delirium as an attempt at recovery or, more generally, the symptoms of psychotic patients as contributing to the elaboration of an 'elegant solution' (Lacan, 1966; Peoc'h, 2022). However, the a-theorism of the DSM seems to have contributed to the fact that this idea has received little attention in modern psychiatry (Andreasen, 2006). As a scientific discipline, psychiatry excludes the subject (Almeida & Fabbrini, 2016). This has consequences both for the description of schizophrenia, which is epistemologically conceived as a pathology exogenous to the individual, with a natural evolution whose course we may or may not be able to alter. Psychoanalysis, with its ethics, is in dialogue with science and can thus produce a critique of the curative goal pursued by psychiatry (Almeida & Fabbrini, 2016). Conversely, it can also enrich the current debate on the consideration of subjective factors in remission.

Is schizophrenia really a chronic illness?

Considering severe mental pathology as being mainly a chronic disease is a quite recent conception (Lantéri-Laura, 1997). The building up of the schizophrenic concept, as acknowledged by Eugen Bleuler himself, has seemed to have been conducted so as to go against the unrecoverable prognosis of the Kraepelian Dementia Praecox (Bleuler, 1993). Though from the beginning of Psychiatry, therapeutic successes had often been raised, not only by Pinel (Allen & Postel, 1993), by Esquirol (1805, p. 6), by William Battie (1759, p. 61.) or by the Tuke (1996, p. 133), the information had had some hardness to reach the places of asylum as well as popular opinions. In fact, Kraepelin built up the entity of "dementia praecox" throughout the successive editions of his book on the essential feature of a dementia prognosis (Garrabé, 2003). He thus followed the research of his compatriots, Hecker and Kahlbaum (Adityanjee, Aderibigbe, Theodoridis & Vieweg,

1990), but he was also influenced by two prevailing psychiatric theories (at the time): that of the French Benedict-Augustin Morel degeneration (Hautsgen & Sinzelle, 2010), whose name indicates the irreversible outcome, and that of the German Griesinger's evolutive monopsychosis. For this author, we can only hope for recovery in rare cases and only at the beginning of the disease process (Griesinger, 1865). For Morel, there was little hope of recovery from the moment the pathology became part of a degenerative hereditary constitution.

While he noted the lack of operability of a concept that could only be diagnosed with certainty after the patient's death — for Kraepelin, this was the condition for a dementia outcome; recovery, even if delayed, excluded demantia praecox — he above all noted the large number of patients who returned to a normal life at the end of their hospitalisation and were considered well, even if they were "a little strange or mad" (Bleuler, E., 1993, p. 338). In the 20th century, three great catamnestic studies concerning the future of schizophrenic patients give the proof that of a favorable evolution concerns a great part of patients. The first serious research is published by Manfred Bleuler in 1968 (Bleuler, M., 1968) in which seven patterns of schizophrenia evolution are described showing the different ending ways of schizophrenia. To critics who supposed that his sample was ill-diagnosed, Manfred Bleuler answered that he "was born and grown up surrounded by psychotic patients", which gave him some sort of experience. Though, the required criteria to diagnose schizophrenia today are different from those of that time, let's point out that Manfred Bleuler stuck to the original criteria described by his father, the nosology inventor. Some years later, Bonn's research (Huber, Gross, Schüttler, & Linz, 1980), first published in 1973, counts 35 per cent of deficit schizophrenia evolution among a schizophrenic population followed up for 22.4 years. In 1976, Ciompi and Müller published the findings of a research conducted for about 36.8 years which concerned a sample of schizophrenic patients living in Lausanne Township. They describe eight evolution patterns which are regularly used by more recent works. Less than 50% of the observed patients progress with a "medium or severe".

Though schizophrenia prognosis continued to be considered as poor by the major part of population, these studies had not sunk into oblivion. As an example, Carpenter and Kirkpatrick used in 1988 the findings of these great studies in order to propose a synthesis. In 2003, Modestin, Huber, Satirli, Malti and Hell seized Manfred Bleuler's findings and redefined the population patients upon the DSM IV-TR criteria, then they concluded that a

significant part of the patients had had a favorable evolution and for whom a schizophrenia diagnosis could still be applied. At last, the World Health Organization report, published in 2007 and drafted at the beginning of the 2000s, about schizophrenic patients' future came as well to respectively 56% and 60% of recovered patients in the incidence and prevalence groups (Hopper, 2007); These findings are the result of the synthesis of a large number of studies carried out all over the world. Despite these consistent findings throughout history, the assumption that chronicity is a common course of schizophrenia continues to be an argument used to justify the efficacy of rehabilitation programmes (Fan et al., 2021). This perspective also overlooks the complexity of defining remission, which is now based on at least three aspects: clinical, social and personal remission (Castelein et al., 2021).

Construction and definition of recovery in mental disease

Since the origins of psychiatry, there have been two main schools of thought. It is certainly possible to trace this dichotomy back to ancient medicine, where, as early as the 5th century, Caelius Aurelianus associated physical treatment with the invitation to listen to philosophers or "to train the mind deeply" (Postel & Quétel, 2012). These two dimensions of care have given rise to two major causal theories: one psychogenetic and the other more biological. In fact, the debate is far from being settled by biological research and its dynamics are still at work in the rich scientific debates of psychiatry.

From the point of view of modern science, it was Smythies' research (1963), which offered a biochemical pattern capable of explaining schizophrenia, that led research in this direction, while Johnstone's research in 1976 showed a specificity of the cerebral ventricles of schizophrenic patients. Despite these discoveries, the conclusions of which were subsequently more or less debated, and which gave rise to numerous researches, no outstanding features have yet emerged to gain enough widespread support to define a population of patients on a somatic basis (Peneau, 2014, p. 58). Existing animal models for understanding schizophrenia have also been criticised, mainly for the lack of a subjective dimension (Wong & Josselyn, 2016). The reproduction of animal somatic and behavioural manifestations of psychosis is not sufficient to reproduce human subjectivity. Yet, for ages, these data and all the papers which came as a following consequence contributed to support

the idea, on the sole basis of a scientific optimism far from the laboratories' reality, that schizophrenia is a unitary condition deeply chronic. Thus, bibliographical research shows that studies centered upon the schizophrenia recovery perspective have been absent from the main researches for some twenty years. In 1988, in front of the findings of a new synthesis of the three great catamnestic follow-up, Carpenter and Kirkpatrick's thesis was based upon the individual evolution diversity of the neurons involved in the dopaminergic circuit: this is evidence of the domination of the neuronal pattern which still prevented from considering subjective factors other than from the cerebral architecture point of view. Demonstrating the importance of the personal meanings of delusion (Ritunnano et al., 2022) means that a clinic based on subjectivity, rather than neurological diversity, might be put back at the heart of practice.

And yet, since the 1980s, the growing number of patients who have recovered from psychosis who have written autobiographical life histories seem to have contributed to bringing the concept of "recovery" back to the center of research, as evidenced by the First-Person Accounts of the Schizophrenia Bulletin for some years now. We owe to the American physician, Georges Engel, to have coined the term "biopsychosocial" to refer to a method which is based on the constant interaction between the state of mind and the social environment according to the notion of "the biological potentiality". This pattern is not particular to psychiatry; the author suggests in his original paper to study a patient's case history who had suffered from myocardial infarction in order to mark the unity of medicine and to help define psychiatrists' place within the becoming future physicians training (Engel, 1980). Engel had in mind to report, through a multifactorial pattern, the complexity of clinical cases which cannot be taken into account and handled by scientific studies, and which can single out a factor or another precisely where the physician has in front of himself a multidimensional subject. He followed the aim to reintroducing *the care for the patient* as the value of *a biological truth* which tends to invade the medical field. One of the consequences of the biopsychosocial pattern in psychiatry was a noticeable change in the development of patterns considering the influence of the environment on the expression of genes or metabolism. Among these, the most developed in mental medicine are undoubtly the gene-environment interaction; so is it for the so-called stress-vulnerability pattern which supposes an ill potentiality which can be reactivated by an environmental stress factor (Azorin, 2005). Although some of these patterns were developed

before Engel's publication, it seems right to place these concepts in the same field, as the word 'biopsychosocial' has now acquired an important place in medicine.

Since the impact of psychosis at an individual size is no more referred to exclusively from a biological basis, a growing number of researches, mainly from behavioural cognition focused on the study of recovery factors going farther than the essentially somatic dimension of the concept of remission. They have first been led in the field of severe depression (Frank et al., 1991), then it concerned schizophrenia. These modifications of the perception of schizophrenia had led in 2005 to the proposition of a scale which would allow the setting of a consensus about the remission criteria (Adreasen et al., 2005), this pattern is essentially symptoms based. This medical pattern makes every effort to describe the improvement of objective symptoms without considering the individual's functioning, moreover it suggests to make a difference between remission and recovery, this latter should take into consideration both dimensions of the well-being and then social functioning.

Considering subjective factors: recovery in schizophrenia

Recovery, as a dynamic process, is inspired by the medical remission pattern, in that it supposes an incurability to mental illness (such as a disabling spinal disorder for instance) (Andresen, Caputi & Oades, 2010). It assumes that these ill persons will forever be disabled but will learn to live better within the limits of their disability. Recovery is a variable including more psychological references than the remission notion which focuses upon the reached stage. Over the past ten years some French-speaking researches turn towards this viewpoint. For Koenig-Flahaut, Castillo & Blanchet (2011), it is in a great part due to the adaptation programs set up at the end of the 20th century that we have to bestow the best schizophrenia prognosis.

The short historical review previously discussed in this article stands against this position, the wrong expectations of severe mental illnesses prognoses have never been set up on serious statistics. Esquirol already attributed recoveries to the Pinel course of moral treatments beneficial effects (Esquirol, 1805), Sakel's cure and electroconvulsivotherapy which were said as being responsible for recovery (Hegarty, Baldessarini, Tohen, Waternaux & Oepen, 1994), the first antipsychotics then their second generation; though the percentage of recovered subjects seem to have remained relatively stable

during the century. Nevertheless, in a shorter time scale, it is right to say that since the advent of biomedical patterns, the hypothesis of the genetic and/or neurological impairment made a name for itself thus narrowing the way in psychiatry to research studies about recovery from a subjective point of view. And so, it is for a great part of the cognitive behavioural therapy current researches which had focused their interest upon the cognitive impairment and upon the intellectual quotient restoration; they also focused their attention upon the deficit point of view, not on what can be name "self-therapeutic productions", occupations which have been claimed by patients to be their most important support (for example: practicing hobby, job, art, activism, new lifestyle). Introducing the viewpoint of rehabilitation assumes the consideration of other data than those stemming from somatic medicine, and then links contemporary psychiatry to its roots off which it tended to cut because of neurophysiology promises. Indeed, one of the recovery definitions considers that the dynamic process has to be studied as it is the case about rehabilitation or readaptation (Koening-Flahaut, Castillo & Blanchet, 2011) rather than considering the biological mechanisms.

However, the actual recovery notion in mental illness assumes a patient reeducation as a key for his improvement and the notion remains subject to a curative vision. Andresen is probably one of its most important promoters since he had suggested with his team, at the beginning of the 2000s, a recovery pattern according to which the patient has to pass a number of stages, it is a pattern which has been refined later on. They propose to choose a definition they consider near the patients' expectations concerning remission, they not only defend psychiatric rehabilitation but they also add an empowerment component.

In 2003, four recovery processes built in five stages had been developed (Andresen, Oades and Caputi, 2003). Three years later, these processes allowed the same team to propose the StORI Scale (Stages Of Recovery Instrument) (Andresen, Caputi & Oades, 2006) which is used to measure a patient recovery process in which he is in order to adapt the readaptation. To find hope, to build up again an identity, to find a meaning to life and to become responsible of one's recovery; thus, these would be the four processes to activate, whereas the moratorium, consciousness, preparation, reconstruction and growth would be the five stages to go through (Andresen, Oades & Caputi, 2003). The moratorium would be assimilated to a withdrawal period, of depression; the consciousness is the stage where the subject sees a glimmer of hope; the preparation is a moment when the subject

tries to get off the assignment to the disease; reconstruction stage, a phase according to which the patient builds up a new identity; at last, the growth stage is deduced from the narration of patients who make of their illness episode a resource, since there are patients who say that they have learnt from their illness (evocation of a new force to face life in particular).

The recovery pattern as an empowerment assumes that mental illness is an individual answer to a sum of stressing stimuli, and healing would go along with the abilities strengthening allowing to face these situations (Andresen, Oades & Caputi, 2003). It is plainly congruent with the psychosocial rehabilitation aims which at its center the subject rehabilitation is an actor of his own recovery (Koenig-Flahaut, Castillo & Blanchet, 2011); it is as well congruent with the stress-vulnerability etiological pattern. Noiseux and Ricard (2005, 2008) wish that the subject's personal abilities be recognized instead of focusing the attention on the deficit side. Though this approach proves to be linked to a humanist ethics, there is an obvious limit. The matter is to help the subject to get back to the prior state of the condition; but the patients' accounts do not go towards this way, since many acknowledge that they have been deeply changed (Harvey & Bellack, 2009; Koening, Castillo & Blanchet, 2011). For Noiseux and Ricard, recovery is thus "a process involving intrinsic, non-linear progress that is primarily generated by the role as actor that the individual adopts to rebuild his or her sense of self and to manage the imbalance between internal and external forces with the objective of charting a path through the social world and regaining a sense of well-being on all biopsychosocial levels" (Noiseux & Ricard 2008, p. 1148). Seven steps on the way to recovery in schizophrenia have been described:

1) The first one is called "descent to hell" (hopes and dreams fall, family exclusion… etc.)
2) "Start of an ounce of hope "
3) "Developing insight", that is to say to find the motivations to find the desire to live, to find landmarks in order to build up again one's life
4) "To reactivate one's instinct to struggle against the disease": the will to stop the disease, to carry on towards a new quest for life.
5) Discover the keys to well-being
6) Maintain a balance between inside and outside forces
7) To see the light at the end of the tunnel, that is to say, to be able to recognize the well-being signs.

And yet, when recovery is considered as a process which aim would be the patient autonomy it is hence a pattern which does not take into

consideration the variety of subjective trails. Some patients consider themselves as recovered though they do not correspond to the empowerment criteria; a great deal of them follow the seven steps only under some sort of theoretical pressure (Koening, Castillo & Blanchet, 2011), and nothing in this theory allows to conceptualize the subjective personal work on oneself other than in terms of will. But, as Davidson, O'Connell, Tondora, Lawless & Evans notice "recovery from serious mental illness does not require remission of symptoms or other deficits" (2005, p. 484). To consider oneself as recovered is not limited by the fact of fitting with the consensual definition of recovery. To account for this clinical fact, some French speaking teams have tried to build up the functional recovery concept. They started to build a scale which measures functional remission. "Functional remission" is a concept at the crossroads of remission and recovery (Llorca et al., 2009). Having to face some examples of schizophrenic patient's social reinsertions who do not fit completely with the scale criteria — a scale criteria which have to evaluate the patient's recovery — some researches have been trying for years to consider the subjective factors which contribute to a positive evolution thanks to data gathering and narratives analyses. Cognitive disorders — which is the main stigma of schizophrenia onset for the disability-oriented psychiatric paradigm — explain little the observed insertion differences (Martin & Franck, 2013.)

Some researchers then have engaged in a work of categorization of recovery predictive factors. Four subjective recovery rehabilitation are singled out in order to build up a model: metacognition, "process in between neurocognitive disorders and functional handicap" (Martin & Franck, 2013, p. 24), it is a subjective notion and hardly possible to quantify; the insight, or the patient's ability to figure out his illness: the ability to recognize the ill side of some manifestations, drug acceptation; stigma internalization: the patient identifies to the society's madman image as it is reflected; motivation: risk which seems important to consider in the rehabilitation field (Martin & Franck, 2013). Recovery notion would go further than these simple signs if regarding subjectivity. "We all know patients who, despite a persistent symptomatology, keep a satisfying social insertion level. Considering recovery implies then a change of view and the requirement to get rid of a strictly medical viewpoint" notice Martin and Franck (2013, p. 30). "Recovery is then thought of less in medical or functional terms than in terms of 'self' definition or redefinition of the Self" (Martin &d Franck, 2013, p. 31). Hence, it is necessary to assume a position more patients' subjectivity centered.

Today, more and more studies are focusing on functional recovery, i.e. taking into account aspects of the individual's social functioning. This seems sensible insofar as exclusion from social ties is frequently associated with schizophrenia. However, even if it seems essential to focus on these disabling aspects, this approach remains marked by an exogenous vision of the illness. Social disability is said to be a consequence of schizophrenia, an autonomous pathological entity. A meta-analysis of 29 studies and 6727 patients diagnosed with schizophrenia shows that symptomatic remission is inversely correlated with personal remission (Ponce-Correa et al., 2023). Therefore, it is important to look at the person's own opinion rather than the psychiatric symptoms of the illness. However, recent studies involving researchers including some with lived experience of psychosis (Moernaut et al. 2023) demonstrate the importance of narrativity in the recovery process. This makes it possible to affirm the importance of recognising the subject's knowledge of his or her own symptoms in order to truly take subjective factors into account.

Psychoanalysis and the recovery of psychotic subjects

Freud had the revolutionary idea that subjects were driven by self-therapeutic tendencies in search of some form of balance. In 1924, for example, in The Loss of Reality in Neurosis and Psychosis, he wrote that the second stage of psychosis is also aimed at compensating for the loss of reality. From the point of view of delusion, a phenomenon that is certainly noisy but above all, linguistic (the classical approach would place more emphasis on errors of judgement, on the notion of morality or passions than on meaningful content), Freud (1924) considers that psychosis creates "a new reality which no longer raises the same objections as the old one that has been given up" (p. 4095). For Freud, the work of the psychotic subject is to create a world worth living in. As soon as he saw the curative potential of delirium, however, Freud was pessimistic. In his study of the Schreber's case in 1911, he wrote that success after disaster is more or less great, but never total. While pointing to the delusional solution, he does not fail to mention its limitations. Current testimonies of recovery from decompensation are not all so categorical, but there are subjects who consider themselves cured or recovered who still experience hallucinatory or delusional phenomena (Koenig-Flahaut et al., 2012), in line with Freud's observations. The return to the previous state is not total, but the subject lives in a world that suits him or her. Freud was

very pessimistic about dementia praecox, the precursor of schizophrenia. For him, the regression in dementia praecox would be aggravated by a move into the object relations register, the prognosis of which Freud did not consider good. In 1913, Freud warned analysts against the possibility of overlooking early onset dementia, in which case the doctor is unable to keep his promise of cure. However, in a letter to Jung in 1908, he judged the position of the precociously demented person to be the resolution of a psychic conflict. Thus, although his theories of psychotic mechanisms were not yet well established, Freud retained a guideline that enabled him to approach symptoms — psychotic or neurotic — as subjective elaborations aimed at achieving psychic balance. Freud's suggestion that treating should not be the primary goal is important for understanding the boundary with psychiatry. While Freud frequently used the term 'cure' and did not deny psychoanalysis a curative aim, by aiming for something beyond well-being he distanced himself from the desire to normalise subjects.

Lacan, for his part, wrote his thesis of psychiatry in 1931, about the recovery of a paranoid subject — the case of Aimée (2015). As early as the 1955 seminar on psychosis (1955-56/1981), he showed that the symptoms of psychosis should be approached not so much through meaning as through the logic of subjective economy. Later, the Borromean clinic would make it possible to consider psychosis as a subjective structure in which the imaginary, the symbolic and the real are not linked by the Name-of-the-father, but can nevertheless be linked by an invention, a "sinthome" (Lacan, 1975-76/2005; Vanheule 2014). Today, a growing number of psychoanalytic studies are investigating the processes of recovery in schizophrenia employing the paradigm of case history (Grammatopoulos, 2017; Peoc'h, 2022). In keeping with the ethics of psychoanalysis, the authors of these papers focus on the knowledge that can be gleaned from the testimony of expert patients, or seek to establish a link between psychoanalytic subjective logic and personal recovery. The aim is not so much to identify the meaning of delirium or certain symptoms of schizophrenia, but to identify their logic, drawing on the work of Lacan and some of his disciples. The psychoanalytic hypothesis of lucid ordinary psychosis (Maleval, 2004; Trichet 2018) could be invoked. This hypothesis allows us to understand the logic of subjects who remain psychotic in their structure (in the psychoanalytic sense), but have sufficient knowledge of their mode of functioning to avoid crises.

Discussion and conclusion

That psychiatry considers mental illness as mainly a chronic condition is a recent paradigm; It is not long ago that this paradigm holds a leading place and it seems that it is already showing signs of decay. Neurobiology and therapeutic behavioural approaches no more provide the optimism of their beginning; the subjectivity model seems to stand against their spreading (Parnas, Sass & Zahavi, 2013). On the opposite, the stress-vulnerability patterns emerging as biopsychosocial approaches shed light on the importance of environment in psychosis recovery process (Azorin, 2005). The medical field is increasingly returning to a highly personalised practice, for example by developing narrative medicine within the framework of chronic disease. Psychiatry does not escape from this movement thus resuming anew with the subjectivity dimension which made its own specificity, especially when psychoanalytic theories were took into consideration. In addition, research shows the importance of looking at recovery from the patient's point of view, rather than focusing solely on symptoms or on a level of functioning assessed according to standard criteria.

Evidences showing the importance of considering subjective factors in recovery process led to a renewed interest for psychodynamic studies which have kept as a heritage the monography method favored by Freud; thus, putting forward subjective singularity and diversity of problematics. The publication of the book titled *Living outside mental illness: qualitative studies of recovery in schizophrenia* (Davidson, 2003) has certainly made in reconciling psychiatry with qualitative researches stressing on the singular inner journey that is recovery at an individual scale. Recent papers have showed the efficiency of such therapeutic approaches (Lysaker et al., 2015; Leonhardt et al., 2017; Moernaut et al., 2023), and the need for more research to be done. In our opinion, psychoanalyst should profit from this renewed interest for subjectivity. We have shown that psychoanalysts have always based their model on the subject's knowledge rather than that of the psychoanalyst. This ethic is therefore perfectly compatible with that which considers recovery from the point of view of the patient rather than that of the doctor.

Yet nowadays model based on empowerment terms meet some limits as discussed above, although they have been used to link recovery and narrative medicine (Koenig, 2017; Moernaut, 2023). Moreover, the studies focusing on these themes concentrate mainly on schizophrenia and on severe depression

(Montoya et al. 2016). No research seems to be nowadays interested in the subjective factors of recovery in delusional disorders; it is certainly a sign of one of the weaknesses of the pattern which remains at an impairment viewpoint of psychosis whereas recovered subjects' narrative accounts militate for the consideration of a singular subjective functioning rather than a disabled one. Psychoanalysis, who pay attention to individual skills, could make significant contributions to the theory of recovery, following a Freud example with is honorary professor, D. P. Schreber (Freud et al., 1992, p. 44). The aim of psychoanalysis is thus to restore the subject's knowledge of what he or she is experiencing (Anninot Zicot, 2017), rather than to aim at healing. A dialogue between psychoanalysis and psychiatry on the question of recovery in schizophrenia, both in terms of its definition and the ways in which the singularity of patients can be accommodated, could therefore be fruitful.

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Resumos

(Definindo a recuperação da esquizofrenia ontem e hoje: os psicanalistas podem participar?)

A recuperação da esquizofrenia é um vasto campo à ser ainda explorado. A revisão da literatura mostra que as teorias evoluíram consideravelmente desde que a daementia praecox foi descrita. O estudo de Kraepelin teve como consequência associar a esquizofrenia à uma evolução adversa — e assim é o caso para a doença mental grave como um todo. Os estudos catamnésicos contradizem essa concepção, no entanto é principalmente graças aos pacientes e seus familiares, assim como às associações de pacientes e à relatos em primeira pessoa, que os campos da psiquiatria e da psicologia devem essas mudanças. Assim, diferentes paradigmas foram usados para modelar a remissão, a recuperação ou a reabilitação. Se as perspectivas de recuperação estão hoje bastante difundidas, os becos sem saída com que se depara, no que diz respeito à evolução dos campos médicos das doenças de longa duração, indicam o caminho para a investigação tendo em conta os factores subjectivos, e isso constitui um caminho para futuras pesquisas em psicanálise

Palavras-chave: Recuperação, esquizofrenia, subjetividade, psicanálise, psiquiatria

(Le rétablissement de la schizophrénie d'hier à aujourd'hui: Les psychanalystes pourraient-ils participer au débat?)

Malgré les résultats des premiers aliénistes démontrant les potentialités de guérison de la maladie mentale, la description de la démence précoce par Kraepelin aura pour conséquence d'associer la psychose à une évolution déficitaire. De grandes études catamnestiques viendront contredire cette conception, mais c'est surtout aux associations d'usagers, et aux témoignages à la première personne, que la psychiatrie devra sa mutation dans le domaine. Si les perspectives de rétablissement sont maintenant assez bien diffusées en ce qui concerne la schizophrénie, les impasses qu'elles rencontrent, de même que l'évolution des disciplines médicales s'occupant des maladies au long cours, orientent actuellement la recherche vers une prise en compte de facteurs subjectifs d'évolution, ce qui constitue une piste pour de futures recherches en psychanalyse.

Mots-clés: Rétablissement, schizophrénie, subjectivité, psychanalyse, psychiatrie

(Definiendo la recuperación de la esquizofrenia entonces y ahora: ¿se le puede preguntar al psicoanalista?)

Recuperarse de la esquizofrenia queda aún un vasto campo por explorar. La revisión de la literatura muestra que las teorías han evolucionado considerablemente desde que se describió la daementia praecox. La descripción de Kraepelin llevó a asociar la esquizofrenia con una evolución deficiente/deficitaria, y lo mismo ocurre

con cualquier enfermedad mental grave. Los conocidos estudios catamnésicos van a contradecir esta concepción. Sin embargo, la transformación de la psiquiatría y la psicología se debe en gran parte a las asociaciones de pacientes, a los testimonios de familiares o relatos en primera persona. Si hoy las perspectivas de recuperación de la esquizofrenia se conocen bastante bien, los callejones sin salida a los que se enfrentan así como la evolución de los especialidades médicas dedicadas a las enfermedades de larga duración, apuntan en esta investigación la necesidad de integrar los factores subjetivos de la evolución, lo que constituye una vía / una pista/ que seguir para futuras investigaciones en psicoanálisis.

Palabras clave: Recuperación, esquizofrenia, subjetividad, psicoanálisis, psiquiatría

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