

Nurses' Perceptions and Practices Regarding Recovery from Schizophrenia: A Descriptive Qualitative Study¹

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บทคัดย่อ

เป็นที่ยอมรับในระดับสากลว่าแนวคิดการดูแลบุคคลที่มีปัญหาทางจิตควรมีการปรับเปลี่ยนจากการควบคุมอาการของโรค (Illness orientation) ไปสู่การส่งเสริมกระบวนการฟื้นตัว (Recovery process) เพื่อให้ผู้รับบริการสามารถเรียนรู้ที่จะอยู่ร่วมกับภาวะการเจ็บป่วยได้อย่างมีความสุข อย่างไรก็ตามแนวคิดเรื่องกระบวนการฟื้นตัว (Recovery Model) ยังเป็นเรื่องใหม่ต่อวงการพยาบาลไทย ดังนั้นจึงควรมีการสำรวจความรู้ ทัศนคติ และกิจกรรมการพยาบาล ที่เกี่ยวข้องกับกระบวนการฟื้นตัวในผู้ป่วยจิตเวช การศึกษานี้เป็นงานวิจัยเชิงคุณภาพแบบพรรณนา โดยมีวัตถุประสงค์เพื่อศึกษาการรับรู้ และกิจกรรมการพยาบาลของพยาบาลเกี่ยวกับกระบวนการฟื้นตัวในผู้ป่วยจิตเวช การวิจัยได้ทำการสัมภาษณ์พยาบาลจิตเวชจำนวน 24 คน ที่ปฏิบัติงานอยู่ในโรงพยาบาลจิตเวช โรงพยาบาลฝ่ายการ และในชุมชน ผู้วิจัยวิเคราะห์ข้อมูลสัมภาษณ์ ด้วยวิธีการวิเคราะห์ประเด็นเนื้อหาร่วม (Thematic analysis) โดยประเด็นที่ได้จากการวิเคราะห์ข้อมูลสามารถแบ่งได้เป็น ความหมายของกระบวนการฟื้นตัวในผู้ป่วยจิตเวช ลักษณะแสดงถึงกระบวนการฟื้นตัว และกิจกรรมการพยาบาลเพื่อส่งเสริมกระบวนการฟื้นตัวในผู้ป่วยจิตเวช ผลการวิจัยสรุปว่า แนวคิดชีวิทยาทางการแพทย์ (Biomedical model) มีอิทธิพลต่อการรับรู้ของพยาบาล และต่อกระบวนการฟื้นตัวในผู้ป่วยจิตเวช รวมถึง กิจกรรมการพยาบาลต่อผู้ป่วยจิตเวช ดังนั้นพยาบาลควรมีการปรับเปลี่ยนแนวคิดในการดูแลผู้ป่วยให้สอดคล้องกับแนวคิดการส่งเสริมกระบวนการฟื้นตัวแบบบูรณาการ (Recovery orientation) เพื่อให้ผู้ป่วยจิตเวชเกิดกระบวนการฟื้นตัวที่ดี อันจะก่อให้เกิดการพัฒนาในตัวเอง ตลอดจนมีความพึงพอใจต่อการดำรงชีวิตและการเจ็บป่วย

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Abstract

Internationally, psychological recovery has become increasingly recognised as a key concept driving mainstream of mental health services for individuals with schizophrenia. This involves a shift from a purely medical model of recovery that focuses on symptom remission to a consideration of 'living well' with the illness. Nurses play an important role in promoting a client's recovery from schizophrenia. However, the recovery concept is relatively new in Thailand and nurses may have to develop their knowledge, attitudes, and skills to better provide recovery-oriented care. This is a preliminary study using a descriptive qualitative study to explore nurse's perceptions on the concept of recovery from schizophrenia and nursing practices to promote recovery. Semi-structured interviews were conducted with twenty-four nurses, who delivered care to clients with schizophrenia in three settings including

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psychiatric wards of general hospitals, psychiatric wards of tertiary psychiatric hospital, and a community setting. Thematic analysis revealed three main themes from the interview data, which have been named the meaning of recovery from schizophrenia, signs of recovery from schizophrenia, and nursing practices that promote recovery from schizophrenia. The findings reveal that nurses' understanding a recovery from schizophrenia and the interventions used by nurses to promote the client's recovery from schizophrenia fall under a dominant of a biomedical model approach to health. The findings suggest that nurses should change the paradigm of mental health nursing from a biomedical model to a recovery approach, and that they should incorporate the principle of the recovery approach to their nursing practices in order to promote client's recovery processes.

Keywords: Recovery model, Mental health Nursing, Schizophrenia, Psychosocial rehabilitation, descriptive qualitative study

Background

Traditionally, a medical model has dominated mental health services for many years. However, critics argue that it tends to emphasize illness rather than well-being, weakness rather than strength, and limitation rather than potential for growth (Munetz & Frese, 2001). The services that have a strong medical model focus tend not to allow clients to contribute to decisions on their treatment plan. Bellack (2006) criticizes traditional mental health services and suggests they are likely to generate feeling of hopelessness and helplessness. To promote dependence and to foster stigma, therefore, there is a need of new

paradigm that contributes to a well-being and growth for mental health consumers (McAllister & Walsh 2003).

In 1993, Anthony (1993) introduced a new concept of recovery from mental illness, contributing to a great change in mental health services. This concept is considered a broad value-based approach that underpins good practices for mental health care and befits many health problems including schizophrenia. Mental health services based on a recovery orientation are essential for individuals with schizophrenia because such services can help clients to experience improvement in terms of personal functioning and quality of life (Anthony, 1993; Kelly & Gamble, 2005). With an emphasis on promoting client's strengths and hopefulness, recovery-oriented mental health services provide clients with opportunity to make their own decisions to improve essential skills and to promote self-determination. It has been argued that people with schizophrenia appear to gain more benefits from recovery-oriented services in terms of reduced hospitalization, functional improvement, and personal acceptance (Mead & Copeland, 2000).

The recovery concept is a relatively recent addition in the Thailand mental health system. In 2005, Thailand's Department of Mental Health revised the national mental health policy and emphasized improving accessibility to mental health services, promoting consumer involvement and advocacy for people with severe mental illness, and improving quality of life among people with severe mental illness (WHO, 2006). Several of these policy descriptions were broadly consistent with a more recovery-oriented system. Thus, the Thai mental system is heading toward the integration of more recovery-oriented practices in

the future.

Although the concept of recovery is widely accepted in mental health systems, it is a recent arrival in the area of mental health nursing. Mental health nurses have to learn more about how to operationalise this concept into nursing practice (Till, 2007). Clement (1997) suggests that mental health nurses need to review their knowledge, attitudes, and skills to deliver recovery-oriented care. However, in Thailand, models of nursing care for clients with schizophrenia are not well articulated, and there are no published studies in Thailand regarding recovery from schizophrenia. Thus, there is a need to explore Thai nurses' perceptions on recovery and the models of care consistent with a recovery-orientation that they have already provided. Therefore, this study is a preliminary study aiming to seek an in-depth understanding of what Thai nurses understand regarding recovery and the nursing practice used to promote recovery in the Thailand mental health system.

Objective

A preliminary study using a descriptive qualitative study was conducted to explore nurse's perceptions on the concept of recovery from schizophrenia and nursing practices to promote recovery.

Methods

Study design

This study employed a descriptive qualitative approach. Sandelowski (2000) suggests that this method does not necessarily require a detailed theoretical framework for the phenomenon of interest. Furthermore, it does not require the researcher to move far away from original data or to use high level of abstraction for data analysis.

Semi-structured interviews were used to collect in-depth data. The participants were asked to describe their perceptions on the concept of recovery from schizophrenia, including the meanings and signs of recovery from schizophrenia, and nursing practices they use to promote recovery from schizophrenia. All interviews lasted between 60-80 minutes and were audio recorded and transcribed to improve accuracy.

This study received ethical approval from the Human Research Ethics Committee of the University of Wollongong, Australia (approval number HE07/344).

Participants

Participants were 24 mental health nurses who provided nursing cares for clients with schizophrenia in three settings including psychiatric wards of general hospitals, psychiatric wards of tertiary psychiatric hospital, and a community setting. A purposive sampling technique was used with the aim of recruiting participants with a range of ages, education, and work experience.

Data analysis

All interviews were transcribed verbatim in Thai in order to enable an accurate and comprehensive record of each interview. After that, each transcription was translated into English by the researcher. The process of translation in qualitative research is a controversial issue. Translating into other languages has a potential to produce inaccurate data because of mistranslation due to words not having equivalent versions in different language (Birbili, 2000; Kapborg, 2002). However, translation of raw data into English was needed because it helped the researcher to

manage descriptive data using 'Nvivo' computer software (QSR n. d.). To minimize mistranslation, some English transcriptions were randomly reviewed by an independent bilingual expert in Thailand.

In the process of data analysis, thematic analysis was used to identify, analyze, and report themes and concepts within qualitative data (Braun & Clarke, 2006). All textual data were transferred into the Nvivo qualitative data management software program. After that, the researcher followed the procedures of thematic analysis suggested by Braun and Clarke (2006). These procedures included repeated reading to get familiarity with the data, generating initial codes, collating codes into potential themes, checking the relationship of the coded extracts and the potential themes, and refining and naming themes. Throughout the process of generating codes and themes, discussion among the researcher and research supervisors was undertaken to confirm and refine themes.

Findings

Sample

The sample population for this study consisted of 5 men and 19 women with a mean age of 41.17 years. The youngest participant was 26 years old and the oldest was 50 years old. The duration of work experience in mental health field ranged from 3 years to 27 years. Of these, 7 nurses worked in a community setting, 8 nurses worked in psychiatric wards of two general hospitals and 9 nurses worked in inpatient psychiatric wards of a tertiary psychiatric hospital. Regarding education, 15 of the participants completed a graduate certificate in advanced psychiatric nursing, 13 got Master's degrees in

various areas related to mental health nursing, including psychiatric nursing, mental health, and community nursing, and 7 participants had both graduate certificates in advanced psychiatric nursing and Master's degrees.

Themes

Six tentative themes emerged from interviews with nurses; however, only three themes are reported in this paper. These are elaborated in more detail along with direct quotes from participants to illustrate the theme.

Table 1 Major themes emerged from the study

Theme 1: Meaning of recovery from schizophrenia
Controllable state
Returnable state
Theme 2: Signs of recovery from schizophrenia
Clinical signs
Functional signs
Psychological signs
Theme 3: Nursing practices that promote recovery from schizophrenia
Symptom stabilization
Relapse prevention
Promoting social inclusion
Emotional support

Meaning of recovery from schizophrenia

The majority of nurses made a number of comments that highlighted the meaning of recovery from schizophrenia. They considered recovery from schizophrenia as the state where there were remission of psychotic symptoms and a regained functioning. While some nurses discussed recovery related to clinical criteria generally used for a diagnosis of schizophrenia,

other nurses applied a functional perspective that was associated with consideration of one's ability to continue with daily life functions; however, whichever perspective they used, all described two states in recovery, a controllable state and a returnable state.

Most nurses mentioned recovery from schizophrenia as a controllable state. This means the state in which there is a reduction of psychotic symptoms, such as delusion, hallucination and uncontrollable behaviours. The nurses appeared to use a medical model and commented that recovery from schizophrenia was the state whereby there was a control of psychotic symptoms or a control of chief complaints that led patients to be hospitalised. As one nurse commented:

I think recovery from schizophrenia means an improvement of clinical outcomes. For example, in case that patient is taken to the hospital because of aggressive behaviours or auditory hallucinations, recovery for this case means that, such symptoms can be controlled, or that this patient can control his behaviours [P19, 26 yrs, psychiatric nurse of psychiatric hospital].

Aside from a state of control, some nurses defined the meaning of recovery from schizophrenia as a returnable state, suggesting a return of patient's ability to functions as they did before becoming ill. These nurses appeared to use rehabilitation framework and commented that the meaning of recovery from schizophrenia was the state that individuals with schizophrenia obtained when they were able to regain the ability to continue their functions of daily living, work life, and social life. For example:

I think recovery from schizophrenia means that clients with the disease have the relieved

symptoms, and can return to live with their family. In addition, they can continue their functions, such as daily living activities, working and social participant [P5, 50 yrs, psychiatric nurse of general hospital].

Interestingly, some nurses defined recovery from schizophrenia as an ability to live with the illness. They considered schizophrenia a persistent illness with a risk of repeat relapse so they pointed out that, recovery from schizophrenia was associated with one's ability regardless of symptoms of the illness. For example:

I think it [recovery from schizophrenia] does not mean that clients with this illness have no psychotic symptoms because some of those can independently live even though they still have psychotic symptoms... In addition, it does not mean that the clients can regain full functioning. Some of those have changed their roles or works because of the illness and its treatment [P22, 41 yrs, CMHN].

Signs of recovery from schizophrenia

Nurses commented on a number of signs or indicators that reflected recovery from schizophrenia. These signs can be categorised into three major sub-themes including clinical signs, functional signs, and spiritual signs. The most frequently mentioned signs involved clinical signs related to clinical symptoms of schizophrenia. Nurses stated that recovery from schizophrenia was manifested by a control of clinical symptoms or an absence of the chief complaint.

Signs of recovery from schizophrenia can be indicated by that patient's symptoms are able to be controlled, or there is no chief complaint that lead patients to be treated in a hospital [P16, 44 yrs, psychiatric nurse of general hospital].

Aside from clinical signs, some nurses commented that a consideration of clinical outcome as the sign of recovery from schizophrenia was problematic and narrow. They emphasised the regaining of functioning after the illness as a sign of recovery. These included regaining daily living functions, and living an independent life.

Recovery from schizophrenia can be characterised by that clients can regain awareness and functioning so they can continue their living activities, and that they can continue their function despite having mind symptoms. In addition, signs of recovery are reflected by clients in community can do their function and join social activities. Only an absence of hallucination and other psychotic symptoms cannot be used as the signs of recovery because schizophrenia is incurable [P17, 47 yrs, psychiatric nurse of general hospital].

In addition, psychological signs were viewed as signs of recovery from schizophrenia. These signs are associated with a psychological state that leads individuals with schizophrenia to accept the situation of the illness, and to have a happy life despite a persistent illness.

I think that there are two aspects used to indicate a recovery from schizophrenia. These are a self-acceptance and an ability of functioning. Clients who can recovery should accept their illness and can live beyond the illness [P10, 32 yrs, CMHN].

Nursing practices to promote recovery from schizophrenia

Participating nurses made a number of comments that highlight their responsibilities promoting client's recovery from schizophrenia. Nurses indicated that they delivered the nursing

practices to clients in both hospital and community settings. Their nursing practices were dedicated to four main purposes: symptom stabilisation, emotional support, promotion of social inclusion and relapse prevention.

Although some nurses commented that recovery processes were able to be developed despite a presence of symptoms, all nurses highlighted symptom stabilisation as the first priority to promote recovery from schizophrenia. The task for symptom stabilisation mentioned by nurses was that nurses work collaboratively with a psychiatrist in order to control client's psychotic symptoms. These practices were relatively dependent on somatic treatment prescribed by a psychiatrist. To control psychotic symptoms, nurses commented that they firstly started their nursing care by assessing patients, transferring patients to a psychiatrist, and administrating drugs prescribed by a psychiatrist.

I start nursing care for patients with schizophrenia by assessing clients. Client's information is obtained from both clients and their relatives [P12, 49 yrs, psychiatric nurse of general hospital].

After assessing clients, I take them [patients] to visit a psychiatrist. When medication treatment has been prescribed, I administrate prescribed drugs to each client. In addition, I detect the signs of unwanted effects due to prescribed psychotic drugs [P19, 26 yrs, psychiatric nurse of psychiatric hospital].

Aside from symptom stabilisation, 'talk therapy' (an interaction between a nurse and a client for therapeutic purpose) was applied for emotional support. Most participating nurses highlighted the importance of emotional support. They commented that after finishing routine tasks,

they spent time to talk to clients with the purpose of allowing them to express their feeling, emotional support and illness acceptance.

I individually talk to clients in order to improve their insight and understanding about their illness. Sometimes, I spend time to clients so that they can have someone available to listen to their complaints and understand their feeling [P14, 44 yrs, psychiatric nurse of psychiatric hospital].

Remarkably, Buddhist belief was adopted for the provision of emotional support, especially the belief of 'Karma'. Karma is a belief that any experience in present life is a consequence of particular action one did in a past life. One nurse commented that she applied the concept of Karma to improve client's illness acceptance and to give client's encouragement.

I apply Buddhist belief to help clients to accept their illness. I inform them that, all have own Karma and clients' Karma contributes to illness. However, it does not mean that one with schizophrenia cannot do anything. Despite a diagnosis of schizophrenia, clients can do many things for themselves, and for others [P2, 29 yrs, psychiatric nurse of general hospital].

In addition, participants commented that they always focused their nursing practices on relapse prevention. Providing education appears to be an important tool that nurses used to improve client's medication adherence. Nurses expressed that they always gave education about schizophrenia and medication treatment to both clients and client's relatives in order to improve client's medication adherence and to minimise the possibility of symptom recurrence.

I also promote client's medication adherence by giving education. I inform them

about schizophrenia, psychotic drugs and their side effects, and strategies to deal with unwanted effects of medication. In addition, I give education about such topics to not only the clients but also their relatives so that they can understand and support the clients [P11, 32 yrs, psychiatric nurses of psychiatric hospital].

Finally, participating nurses, especially community mental health nurses, highlighted the importance of social inclusion as a facilitating factor of recovery for that they promoted the clients to live in the community. A positive attitude toward individuals with schizophrenia appeared to be a challenging task for community mental health nurses. Various strategies such as community health education and a solution focused self-help group were used to address this issue.

In community, I improve public attitude toward schizophrenia. I inform the villagers that they might be annoyed, either directly or indirectly, by one with schizophrenia if they do not support such person. Thus, they should help the professionals to prevent symptom relapse. In addition, I invited key persons in the community to join in a group discussion. In this group, I discuss with them about strategies to prevent a relapse of symptoms and to improve client's quality of life [P23, 48 yrs, CMHN].

Discussion

The main purpose of this study was to explore Thai nurses' perception on the concept of recovery from schizophrenia and nursing practices that they used to promote client's recovery. Information drawn from the responses of nurse participants in this study reflects not only nurses' understanding and nursing practices related to the concept of recovery from schizophrenia but also

the beliefs underneath Thai mental health nursing.

Recovery from schizophrenia is a complex phenomenon because the term recovery is variously defined as a process, a construct, and an outcome (Mueser et al., 2002; Provencher, 2007; Ramon et al., 2007; Townsend & Glasser, 2003) and it is a multidimensional concept which is involved clinical, psychological and social dimensions (Gillam, 2006). Thus, it appears to be differently defined by different persons (Till, 2007).

When discussing the meaning of recovery from schizophrenia, participating nurses defined the term recovery from schizophrenia as the endpoint of recovering or the state where there were a remission of psychotic symptoms and a regained functioning. They commented that the meaning of recovery from schizophrenia involved two states: a controllable state and a returnable state. While the first state means a state of symptom reduction, the second means a state of regained functioning. Andresen et al. (2003) explain that a medical model considers recovery as a return to a former state of health and a rehabilitation model considers a return to a semblance of the life clients had before the illness. The meaning of recovery from schizophrenia defined by participating nurses is consistent with several authors (Liberman & Kopelowicz, 2002; Ochoka et al., 2005) who suggest that a definition of recovery from schizophrenia should cover not only a symptom remission but also improved psychosocial functioning. However, some authors (Clement, 1997; Davidson et al., 2005) argue that recovery in mental health context, especially of chronic illness, should be defined as a dynamic process in which individuals with chronic mental illness move beyond a chronicity of mental illness.

Regarding to the recovery concept

introduced by Anthony (1993), recovery from schizophrenia is not simply defined as an endpoint of a remission of symptoms or a restoration of functioning (Ellis & King, 2003; Kilbride & Pitt, 2006; Resnick et al., 2005). It is an active process, by which individuals with schizophrenia experience and actively manage their illness to reclaim their meaningful and purposeful life beyond the illness (Adam et al., 1997). Provencher (2007) suggests that it is the transcendence of symptoms, functional limitations and social handicaps attached to schizophrenia. Conclusively, the meaning of recovery defined by participating nurses is inconsistent with the new concept of recovery by Anthony (1993).

The meaning of recovery from schizophrenia defined by participating nurses reflects an influence of a traditional medical model. Traditionally, the term recovery had been dominantly defined by the medical model that considered recovery as a return to a pre-ill state (Andresen et al., 2003; Davidson et al., 2005; Kelly & Gamble, 2005). Thus, Thai mental health nurses are influenced by the dominance of the biomedical paradigm. While Rydon (2005) comments that nurses are often work within the dominance of biomedical model, Bishop and Ford-Bruins (2003) argue that the medical model remains dominant because a nursing model in particular circumstance is under developed.

Not only have nursing practices to promote client's recovery process been dominated by a traditional model so has their understanding of recovery from schizophrenia. When asking about the nursing practices used to promote recovery from schizophrenia, most participating nurses commented that their nursing practices reflected an influence of the medical model. They

highlighted the nursing practices related to symptom stabilization and relapse prevention. This finding is supported by several studies. For example, a study by Cleary (2003) reveals that symptom stabilisation appears to be a central role of mental health nursing, especially in inpatient setting. McGihon (1999) explains that the nursing practices with an emphasis of symptoms stabilisation are resulted from the change in mental health care such as a shorten hospital stay and a promotion of living in the community. This change also occurs within Thai mental health system (WHO, 2006).

From the findings, there is a notice that despite a wide range of nursing practices in the Thai mental health system and an acknowledgement of mental health nurses as 'the backbone' of mental health services (Till, 2007), Thai mental health nurses failed to perform advanced nursing practices, especially psychosocial interventions to promote client's recovery processes. Although over a half of participating nurses were trained in advanced psychiatric nursing, they performed their roles with less expansion than that expected from nurses with a specialty of psychiatric nursing. Daly and Carnwell (2003) explain that advanced practitioner nurses should do a 'role expansion', a special role added by additional skills and responsibilities that gives the nurses greater autonomy and accountability while maintaining the core element of nursing practices. The finding is consistent with a study by Allen (1998), suggesting that nurses undertake roles defined as a normal practice including assessment, providing education, assisting clients to manage symptoms, improving medication adherence, and emotional support. While Barker (2000) suggests that this situation is associated with an attitudinal problem,

Warlow and Edward (2007) place blame on a contextual problem as a factor limiting the roles of mental health nurses. However, Rydon (2005) asserts that a dominant of biomedical model, which structures and organises the mental health systems, has influenced nursing practices.

It is noted from the analysis of the data, Thai mental health nurses failed to address the issues of inspiring hope, client's involvement and client's empowerment which are the key elements in a promotion of recovery processes (Andresen et al., 2003; Davidson et al., 2005; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Resnick et al., 2005). This can be supported in that due to a limited length of hospital stay and an acuity of illness, psychosocial interventions to address these issues need to be adapted to brief techniques; whereas, nurses are lacking in the knowledge and skills to work with such psychosocial interventions (Baker, 2000). Shanley and colleagues (2003) argue that the use of the traditional medical model in mental health nursing contributes to the gap between the nurses and the clients, and discourages the acknowledgement of client's strengths, resulting in depersonalised nursing practices and disempowerment of the clients. Both arguments can be applied to the situation of Thai mental health nurses who deal with a brief treatment plan due to a deinstitutionalisation policy in the Thai health care system (Department of Mental Health, 2003).

As a qualitative study, there are some limitations. It is impossible to claim that 24 participating nurses are representative of Thai nurses who provide nursing care for individuals with schizophrenia. This is compounded further by the fact that the data were collected in only three mental health care settings. However, the value of

a qualitative research is not a competence of generalisation but a power to provide information or evidence related to a situation interesting the reader (Happell et al., 2002).

Conclusion

In this study, it was determined that the nurses' understanding about the concept of recovery from schizophrenia is inconsistent with a new concept of recovery, whereby the term recovery is defined as a lifelong personal process of defining new possibilities and finding a new meaningful and purposeful life beyond mental illness (Adam et al., 2002; Anthony, 1993). Indeed, it is dominated by a medical model, which considers recovery as a symptom remission and a restoration of functioning (Davidson et al., 2005). In addition, the nursing practices of Thai mental health nurses are dominated by a medical approach that generally offers clients the best available treatments to eliminate client's suffering (Smith & Bartholomew, 2006). The findings suggest that mental health nurses should move their nursing paradigm beyond the medical model toward the concept of recovery. With a narrow lens of a medical model, they cannot view a recovery from schizophrenia as a process that drives individuals with this illness to rediscover strengths and abilities for developing a sense of self and moving beyond the illness to have a meaningful life. Mental health nurses should incorporate the principle of the recovery approach into their nursing practices. In addition, they should improve their knowledge and skills that help them to work collaboratively with clients and family in order to promote client's recovery processes.

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