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The complex relationship between self-reported 'personal recovery' and clinical recovery in schizophrenia

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ABSTRACT

Self-reported 'personal recovery' and clinical recovery in schizophrenia (SRPR and CR, respectively) reflect different perspectives in schizophrenia outcome, not necessarily concordant with each other and usually representing the consumer's or the therapist's point of view.

By means of a cluster analysis on SRPR-related variables, we identified three clusters. The first and third cluster included subjects with the best and the poorest clinical outcome respectively. The second cluster was characterized by better insight, higher levels of depression and stigma, lowest self-esteem and personal strength, and highest emotional coping. The first cluster showed positive features of recovery, while the third cluster showed negative features. The second cluster, with the most positive insight, showed a more complex pattern, a somewhat 'paradoxical' mixture of positive and negative personal and clinical features of recovery.

The present results suggest the need for a characterization of persons with schizophrenia along SRPR and CR dimensions to design individualized and integrated treatment programs aimed to improve insight and coping strategies, reduce stigma, and shape recovery styles.

1. Introduction

Recovery from schizophrenia is a recent concept that antagonize the well-rooted belief of the impossibility to heal from a mental illness

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(Liberman and Kopelowicz, 2002; Torgalsbøen, 2005). Although this concept gained acceptance as an important domain in health care, a lack of consensus in its definition has lead to some confusion in the literature with several conceptualizations of recovery dimensions being proposed, e.g. service-based, clinical or objective recovery vs. user-based, personal vs. objective recovery.

The main hypotheses driving the study of recovery derive from two different perspectives: the clinical and the subjective one.

From the clinical perspective, recovery is an objective element, with return to a previous condition of health. Outcomes include symptomatology/hospitalization reduction and medication use, with particular regard to the pharmacotherapy adherence.

From the subjective perspective, recovery is driven by people's lives, peer support and subjective experiences of mental illness and recovery. The subjective perspective challenges the notion of enduring mental illness. Treatment can be considered as putatively helpful, but not an absolute requirement (Bellack, 2006). It defines self-appraised sense of wellness (i.e. self-reported 'personal recovery'), representing a consumer's point of view of outcome not necessarily being concordant with the classical medical model (Ahmed et al., 2011; Roe et al., 2011; Hofer et al., 2016; Bellack, 2006). This view has been contrasted with a clinical recovery, mainly based on the severity of symptoms that practitioners consider as indicative of change.

In spite of their differences, the two perspectives have lead to conceptions of recovery that should be complementary rather than opposite (Bellack, 2006), and should be considered of equal weight and importance for the assessment of the final functional outcome (Torgalsbøen, 2005).

Subjective or personal resources have been observed to mediate the impact of symptoms and cognitive impairment on real-life functioning in subjects with schizophrenia and their first-degree relatives (Galderisi et al., 2014, 2016; Rossi et al., 2016), suggesting that the two domains of recovery are complementary rather than incompatible (Roe et al., 2011).

In fact, real-life functioning of people with schizophrenia depends on a number of variables, some related to the disorder, to personal resources, or to the context in which the person lives (Galderisi et al., 2014). Several studies reported that persons with comparable severity of psychopathology may differ in their real-life functioning because of differences in personal resources (Hultman et al., 1997; Macdonald et al., 1998; Ritsner and Ratner, 2006).

Hence, a call for a unifying definition of recovery, and its underlying factors has been proposed. As a matter of facts there is no single definition for recovery although there is an emerging temptation of a "reductionist approach" in creating a concise definition and evaluation. In fact, more than definitions, a further study of the issues underlying recovery and what they would mean in practice is essential (Shepherd et al., 2008).

Resilience, coping abilities, recovery style, strategies used to interact with services and therapists, as well as stigma, are constructs encompassing several aspects of personal resources that have been associated with a positive outcome in schizophrenia (Torgalsbøen, 2012; Hofer et al., 2016; Xu et al., 2013).

Research concerning the relationship between self-reported 'personal recovery' (SRPR) and clinical recovery (CR) reported inconsistent findings. Different studies found a significant correlation between personal recovery and severity of symptoms (Corrigan et al., 2004; Resnick et al., 2004; Jørgensen et al., 2015), although such finding has not been replicated elsewhere (Roe et al., 2011).

A further analysis of the relationship between self-reported 'personal recovery' and clinical recovery may help to identify the variables that influence outcome.

In this report, we investigate how SRPR identify different groups of persons with schizophrenia and which clinical variables characterize these groups. We predicted that clustering participants in three groups on the basis of SRPR would identify specific patterns of associations. The three group solution was retained as the modal value on the basis of studies using clustering methods to stratify schizophrenia (Marquand et al., 2016). Furthermore, we planned to compare the identified clusters according to CR.

2. Methods

2.1. Subjects

In the study of the Italian Network for Research on Psychoses, participants were recruited from people living in the community and consecutively seen at the outpatient units of 26 Italian university psychiatric clinics and/or mental health departments (Galderisi et al., 2014). Inclusion criteria were; (a) diagnosis of schizophrenia according to DSM-IV using the Structured Clinical Interview for DSM-IV—Patient version (SCID-I-P); (b) age between 18 and 66 years. Exclusion criteria were: (a) a history of head trauma with loss of consciousness; (b) moderate to severe mental retardation or of neurological diseases; (c) alcohol and/or substance abuse in the last 6 months; (d) current pregnancy or lactation; (e) inability to provide an informed consent; (f) symptom exacerbation, treatment modifications, hospitalization in the last 3 months.

All participants to the study signed a written informed consent to participate after receiving a comprehensive explanation of the study procedures and goals. Approval of the study protocol was obtained from the local ethics committees.

2.2. Procedures

Recruitment took place from March 2012 to September 2013. Data on age of onset, course of the disease and treatments, using all available sources of information were obtained. For research training procedure see Galderisi et al., 2014.

2.3. Study variables

2.3.1. Self-reported 'personal recovery' (SRPR).

(a) Resilience was assessed using the Resilience Scale for Adults (RSA) (Friborg et al., 2003; Capanna et al. 2015). (b) The Self-Esteem Rating Scale (Self-Esteem-RS) (Nugent, 1993) was used to assess self-esteem. (c) Recovery style was measured with the Recovery Style Questionnaire (RSQ; Drayton et al., 1998; Poloni et al., 2010). (d) The Brief Cope was used for the assessment of dispositional as well as situational coping efforts. Problem-focused versus emotion-focused coping strategies were considered (Carver, 1997; Sica et al., 1997). (e) The Internalized Stigma of Mental Illness (ISMI) (Ritsher and Phelan, 2004; Boyd et al., 2014) was used to evaluate the experience of stigma and internalized self-rejection.

2.3.2. Clinical recovery (CR)

(a) Psychotic symptoms were assessed by means of the Positive and Negative Syndrome Scale (PANSS) 30-item rating scale (Kay et al., 1987). (b) Depressive symptoms were evaluated using the Calgary Depression Scale for Schizophrenia (CDSS) (Addington et al., 1993; http://www.ucalgary.ca/cdss/). (c) Psychosocial functioning was measured using the Personal and Social Performance (PSP) scale (Morosini et al., 2000; Nasrallah et al., 2008; Patrick et al., 2009).

All of the clinical evaluations were done by research trained professionals.

2.3.3. Statistical analysis

The total scores of the SRPR and CR assessments have been used in the analysis as in previous companion paper (Rossi et al., 2016).

A cluster analysis, k-means method, was performed using measurements of SER. The absolute measures were z-transformed. Nonhierarchical k-means clustering is a fast and reliable method that partitions

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