Psychiatry Research 269 (2018) 354–360

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Development and validation of a scale for self-efficacy for personal recovery in persisting mental illness

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ABSTRACT

The personal recovery movement in mental health has emphasised consumers' individual responsibility and autonomy in defining and directing their own recovery journey. Self-efficacy, or an individual's belief that they can achieve their desired outcomes, is likely to be a key predictor of recovery success. However, there is no established measure of self-efficacy for personal recovery. The Self-Efficacy for Personal Recovery Scale was developed and its psychometric properties evaluated as part of a broader research program investigating a recovery-focused digital intervention in psychosis. Scale reliability and validity were investigated in a sample of 178 adults with persisting psychosis, and test-retest reliability was evaluated in a subset of 32 participants. The scale showed high internal consistency, test-retest reliability, and convergent validity, including correlating positively with hope, personal recovery, and generalised self-efficacy, whilst showing independence from social desirability, insight, and positive symptoms. This measure may be useful for research into the processes underlying recovery, and for understanding how self-efficacy for personal recovery may be enhanced in people with severe mental illness.

1. Introduction

1.1. Personal recovery

Supporting personal recovery is increasingly viewed as an important focus for service provision in persisting mental illness (e.g. Australian Health Ministers' Advisory Council, 2013). 'Recovery' in this sense is considered "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness" (Anthony, 1993; p. 527). Personal recovery-oriented services focus on enhancing individuals' abilities to recognise and take charge of their own mental health and well-being, by drawing on strengths rather than simply treating symptoms, and actively involving the mental health service consumer in determining their goals and desired treatment outcomes (Farkas et al., 2005). Assistance may include peer support and shared decision-making, vocational engagement, and housing support (Silverstein and Bellack, 2008).

While the definition of personal recovery is subjective, and may vary according to a person's unique experiences and values, descriptions frequently include learning to self-manage mental health care and symptoms, gaining an awareness of one's capabilities, setting and achieving goals, and developing an integrated narrative of one's life to make meaning from one's experiences (de Wet et al., 2015; Green, 2004; Leonhardt et al., 2017; Lysaker et al., 2010; Yarborough et al., 2016). Studies have repeatedly shown that gaining a sense of competence and agency is essential for achieving these aspects of personal recovery (Drake and Whitley, 2014; Law and Morrison, 2014; Ochocka et al., 2005; Schon et al., 2009). From the extensive body of research on personal recovery, five key aspects of recovery have been identified and summarised in a model dubbed the 'CHIME' framework: development and maintenance of supportive relationships (Connectedness), motivation and belief in one's ability to achieve change (Hope), building a positive sense of self and overcoming stigma (Identity), living a

Abbreviations: CHIME, Connectedness-Hope-Identity-Meaning-Empowerment; DASS-21, Depression Anxiety Stress Scale; DSM-IV-TR, Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision; GSE, Generalised Self-Efficacy Scale; ISMIS, Internalised Stigma of Mental Illness Scale; MCSDS, Marlowe-Crowne Social Desirability Scale; PANSS, Positive and Negative Syndrome Scale; PGI-I, Patient Global Impression – Improvement; QPR, Questionnaire about the Process of Recovery; SCID, Structured Clinical Interview for DSM-IV-TR Axis I Disorders; SEPRS, Self-Efficacy for Personal Recovery Scale; SHS, Schizophrenia Hope Scale; SMART, Self-Management and Recovery Technology; WTAR, Wechsler Test of Adult Reading

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https://doi.org/10.1016/j.psychres.2018.08.093
Received 14 December 2017; Received in revised form 5 July 2018; Accepted 24 August 2018
Available online 25 August 2018
0165-1781/

meaningful life with goals and fulfilling activities (Meaning), and taking responsibility and control over one's life (Empowerment; Leamy et al., 2011).

These findings highlight the active role that individuals play in their own recovery journey, through having autonomy to define what recovery means to them, responsibility for self-managing changes, and determination to persist through difficulties (Andresen et al., 2003; Young and Ensing, 1999). However, this active role in shaping personal recovery may be hindered by external processes, such as exposure to disempowering treatment experiences (Hughes et al., 2009; Tew et al., 2012), and by intrapersonal factors, such as internalised stigma, low self-esteem, and low self-efficacy (Andresen et al., 2003; Buckley-Walker et al., 2010; Jones et al., 2013; Mancini, 2007).

1.2. Self-efficacy

Bandura's social cognitive theory emphasises the importance of an individual's self-efficacy, meaning their confidence in their ability to perform certain behaviours or make certain changes, in determining whether the behaviours or changes occur (Bandura, 1977). According to this theory, self-efficacy may be conceptualised as generalised or specific to a task or domain, and may be strengthened by factors including past success, social support and encouragement, and vicarious learning through observation of successful peers (Bandura, 1986).

Self-efficacy forms the foundation of human agency, wherein the belief that one is capable of success is essential for motivation and impetus to act (Bandura, 1989), enabling individuals to become active agents in their own personal recovery (Bellack and Drapalski, 2012; Lysaker and Leonhardt, 2013). Higher levels of self-efficacy engender greater self-esteem, positive goal-setting, and persistence in the face of difficulties, while low levels of self-efficacy may lead to a sense of helplessness and failure, and a lack of motivation to attempt or persist with tasks (Bandura, 1977, 2006; E. C. Thomas et al., 2016).

1.3. Self-efficacy for personal recovery

It has been suggested that social support and recovery-oriented treatment directly enhance self-efficacy, leading to the subjective experience of personal recovery (Bellack and Drapalski, 2012; Cook et al., 2012; Mancini, 2007; E. C. Thomas et al., 2016). For example, contact with positive peer models may buffer disempowering treatment experiences (Hughes et al., 2009) and provide a vicarious experience of recovery, offering a "road map for how to navigate their recovery journeys" (Mancini, 2007, p. 62), thereby providing a sense of confidence that such an outcome is possible for themselves. Similarly, encouragement from supportive professionals and achievement in supported employment inspires increasing confidence of consumers in their own abilities to manage their wellbeing and reach desired outcomes (de Wet et al., 2015; Mancini, 2007; Szczebak, 2012).

The increasing focus on personal recovery, characterised as self-defined and self-managed by consumers, demands greater understanding of how self-efficacy relates to recovery outcomes, as well as personal and clinical characteristics, and how self-efficacy may specifically be targeted to facilitate the subjective and self-directed experience of personal recovery (Leonhardt et al., 2017; Mancini, 2007; Silverstein and Bellack, 2008). While scales exist for measuring self-efficacy for the broad concept of personal recovery (e.g. Drapalski et al., 2012) and for specific aspects of recovery, including social connectedness (e.g. Smith and Betz, 2000; Stephen et al., 2013), empowerment, and self-management (e.g. Carpinello et al., 2000; Clarke et al., 2014; Drapalski et al., 2012), no established measure taps self-efficacy across multiple, specific domains of personal recovery and self-management of persisting mental illness. This article describes the development and evaluation of such a measure in adults with persisting psychosis.

2. Methods

2.1. Context

Data for this study were collected as part of the Self-Management and Recovery Technology (SMART) research program in Victoria, Australia, which has involved the development and research of digital resources targeting personal recovery and self-management in people with persisting psychosis. The development phase included a series of focus groups conducted with mental health service consumers, workers, and other stakeholders, who identified important elements to be targeted in an intervention for personal recovery and self-management (Thomas et al., 2016a; Williams et al., in press). Findings from this consultation process informed the development of a content framework for a web program, which consisted of seven interactive modules: Recovery, Managing Stress, Health, Me, Relationships, Empowerment, and Life. The web program is described in detail in Thomas et al. (2016a). Two intervention studies were then conducted using the web program: a randomised controlled trial (SMART-Therapy; protocol in Thomas et al., 2016b), and a study of adoption and use in routine practice (SMART-Service). Results of these trials will be reported elsewhere.

2.2. Scale development

The **Self-Efficacy for Personal Recovery Scale (SEPRS)** was developed by the researchers during the consultation and resource development process. Items were derived from the content framework for the SMART web program that had been developed from stakeholder consultation, and were designed to reflect the CHIME processes (Leamy et al., 2011). Items were reviewed for relevance and acceptability of wording by three members of the research team and by an established lived experience reference group formed from four consumers of mental health services working as part of the team's broader research program.

In this 14-item, self-report scale, respondents rate their confidence in their own ability to enact specific behaviours relating to personal recovery from severe mental illness. Items are rated on a continuous scale from 0 (not confident I can do this at all) to 100 (highly confident I can do this), in accordance with Bandura's guidelines for self-efficacy measurement (Bandura, 2006). Items are averaged to produce the overall SEPRS score (range 0–100).

The complete scale is shown in Table 1. Two introductory items relate to the broad concepts of personal recovery (e.g. "How confident are you that in the future you will be able to live a satisfying life alongside any mental health problems you may have?") and self-management (e.g. "How confident are you that you can do things to manage any future mental health difficulties?"), with 12 subsequent items tapping specific domains. Items address all but one CHIME dimension, Hope. Self-efficacy in relation to Hope did not lend itself to clear operationalisation, as hope is, in itself, an expectancy, rather than a behaviour or quality one may have efficacy in enacting.

A fifteenth item relating to confidence for clinical recovery, "How confident are you that in the future you will no longer experience mental health symptoms?" is also included in the scale, but does not contribute to the overall SEPRS score. This item was included as a measure of divergent validity, as the definition of personal recovery does not require the absence of symptoms. It was expected that the clinical recovery item would be positively, but relatively weakly, correlated with the other 14 items and the overall SEPRS score.

2.3. Scale evaluation

The current study used pooled baseline data collected from the SMART-Therapy and SMART-Service intervention studies to evaluate the internal consistency, construct validity, and factor structure of the