Journal of Affective Disorders 181 (2015) 41–49

Contents lists available at ScienceDirect

Journal of Affective Disorders

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

Research report

Mental health self-management questionnaire: Development and psychometric properties

Simon Coulombe [a], Stephanie Radziszewski [a], Sarah-Geneviève Trépanier [a], Hélène Provencher [b], Pasquale Roberge [c], Catherine Hudon [c], Sophie Meunier [a], Martin D. Provencher [d], Janie Houle [a,*]

[a] Département de psychologie, Université du Québec à Montréal, Canada
[b] Faculté des sciences infirmières, Université Laval, Canada
[c] Département de médecine de famille et de médecine d'urgence, Université de Sherbrooke, Canada
[d] École de psychologie, Université Laval, Canada

ARTICLE INFO

Article history:
Received 26 March 2015
Accepted 2 April 2015
Available online 11 April 2015

Keywords:
Self-management
Questionnaire
Common mental disorder
Personal recovery
Symptom severity
Well-being

ABSTRACT

Background: Through self-management, people living with depression, anxiety or bipolar disorders can play an active role in their recovery. However, absence of a validated questionnaire limits empirical research on self-management. The study aimed to develop a French instrument, the Mental Health Self-Management Questionnaire (MHSQ), and to investigate its psychometric properties

Methods: A pool of 86 items was created based on a qualitative study with 50 people in recovery from depression, anxiety or bipolar disorders. The 64 most pertinent items were identified following ratings from 14 experts. A sample of 149 people in recovery completed these items and criterion-related measures (specific aspects of self-management, clinical and personal recovery, social desirability), and 93 participants also completed MHSQ two weeks later

Results: Exploratory and confirmatory factor analyses show that MHSQ is composed of three subscales: Clinical (getting help and using resources), Empowerment (building upon strengths and positive self-concept to gain control) and Vitality (active and healthy lifestyle). These subscales had satisfying consistency and test–retest reliability, and were mostly unrelated to social desirability. Correlations with criterion variables support convergent and concurrent validity, especially for Empowerment and Vitality. Comparison of structural models provides evidence of the distinct nature of MHSQ in comparison to the constructs of clinical and personal recovery

Limitations: Longitudinal studies with larger samples are needed to explore the validity of MHSQ for predicting recovery over time

Conclusion: MHSQ is a psychometrically-sound instrument, useful for establishing the role of self-management in recovery and monitoring the efficacy of self-management support programs.

1. Introduction

Mood (depression and bipolar) and anxiety disorders are highly prevalent and associated with disability and premature deaths (World Health Organization, 2014). Pharmacological and psychotherapeutic interventions are not readily accessible to all, as barriers hinder people from benefiting from such services (Kohn et al., 2004; Peachey et al., 2013). The efficacy of pharmacological treatments for these disorders is moderate (Hidalgo et al., 2007; Pigott et al., 2010; Van Lieshout and MacQueen, 2010). Even with efficient treatment relapses are likely to occur. For example, major depression disorder presents a cumulative recurrence rate of 20-40% in the year following recovery and 60% in a five-year period (Hardeveld et al., 2010). Anxiety disorders have a recurrence rate of 24% in the two-year period following an episode (Scholten et al., 2013). Building on the active role of people in their recovery process (Deegan, 1997; Slade, 2009), guidelines recommend supporting self-management as a complementary approach to optimize recovery from depression, bipolar and anxiety disorders (National Institute for Health and Care Excellence, 2014; Patten et al., 2009; Swinson et al., 2006).

Self-management encompasses all the actions a person takes on a daily basis to manage symptoms, avoid relapse and optimize well-being (Lorig and Holman, 2003). Research has demonstrated the value of self-management for people living with a chronic

* Correspondence to: Département de psychologie, Université du Québec à Montréal, P.O. Box 8888, Station Centre-Ville, Montreal, Canada H3C 3P8. E-mail address: houle.janie@uqam.ca (J. Houle).
E-mail address: houle.janie@uqam.ca (J. Houle).

http://dx.doi.org/10.1016/j.jad.2015.04.007
0165-0327/

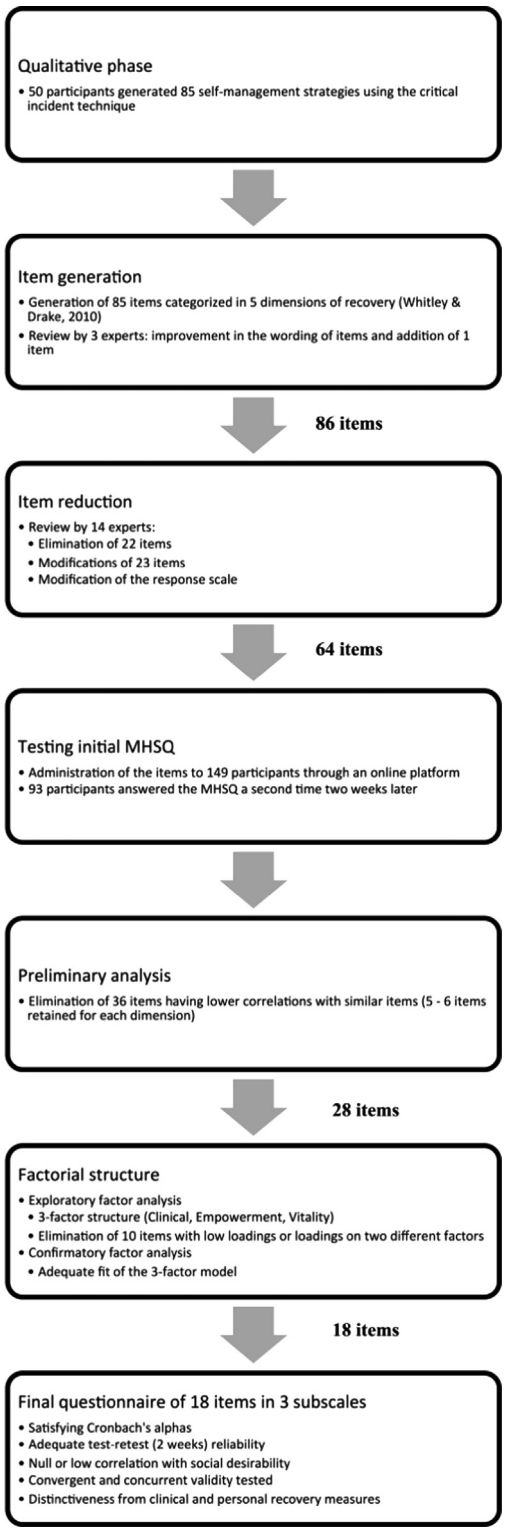

Fig. 1. Overview of the derivation and validation of MHSQ.

physical illness (Barlow et al., 2002; Lorig and Holman, 2003). A few recent studies highlighted the potential benefits of self-management for people living with mental health disorders (Lorig et al., 2014; Ritter et al., 2014). However, a systematic review underscored the scarcity of empirical evidence (Houle et al., 2013), partly due to the absence of a validated questionnaire to measure self-management in the mental health domain. This study aimed to develop and validate a short but comprehensive questionnaire, the Mental Health Self-Management Questionnaire (MHSQ), to measure the use of self-management strategies in patients recovering from mood and anxiety disorders.

To our knowledge, no theoretical model exists concerning the classification of mental health self-management strategies that could have guided the development of MHSQ. Recovery is a related concept that has received further attention. Complete recovery implies more than a clinical aspect focused on symptom reduction; it also involves a personal aspect, experienced through a self-transformation process leading to increased emotional, psychological and social well-being (Drake and Whitley, 2014; Provencher and Keyes, 2011). Empowerment, achieved through self-management, is described as essential to recovery (Slade, 2009; Young and Ensing, 1999). Whitley and Drake's (2010) model highlights five dimensions of recovery: Clinical (e.g., symptoms, therapy), Functional (e.g., employment, housing), Physical (e.g., diet, exercise), Social (e.g., family, social activities) and Existential (e.g., agency, spirituality). This model was chosen as the basis for MHSQ because it integrates clinical and personal aspects in a manageable number of conceptual dimensions. This paper reviews the multiphasic development of MHSQ (see Fig. 1).

2. Method

2.1. Item generation and reduction

In a qualitative phase, 85 self-management strategies (see Villagi et al., 2015) emerged from interviews with 50 adults recovering from a depression, anxiety or bipolar disorder. Three researchers subsequently reviewed the strategies, eliminating nine considered specific to a disorder or circumscribed to a particular timeframe (e.g. *I search for the appropriate diagnosis*). Strategies including more than one component were subdivided. Items were written in French for every strategy, and classified using the five dimensions of Whitley and Drake's (2010) model: 1) Clinical: e.g., *I consult with a professional concerning my mental health disorder*; 2) Functional: e.g., *I do activities I like to maintain an active lifestyle*; 3) Physical: e.g., *I have healthy eating habits*; 4) Social: e.g., *I find comfort, I feel listened by people around me*; 5) Existential: e.g., *I learn to distinguish my mental health disorder from myself as a person*. At that stage, MHSQ comprised 86 declarative items.

A group of 14 experts (persons in recovery, decision-makers of mental health organizations, mental health professionals and researchers) reviewed the 86 items and scored each one on a 4-point scale ("Poor" to "Very good") regarding their clarity and pertinence. They could also add qualitative comments. A total of 22 items were eliminated because they obtained a score lower than .78 on Lynn's (1986) Content Validity Index (CVI) for the pertinence criterion. For each item, CVI represents the proportion of raters that scored 3 or 4 (Polit and Tatano Beck, 2006), with scores higher than .78 considered evidence of good content validity (Polit et al., 2007). A similar index was generated for the clarity criterion. Items were reformulated when they obtained a low score on the clarity index ($<.78$), but a decent score on the pertinence index, which meant that the experts thought these items were valuable yet difficult to comprehend. A total of 23 items were modified, taking into account the experts' suggestions for wording improvement. Also based on the experts' advice, MHSQ's response scale was configured as a five-point scale: "Never" (0), "Very rarely" (1), "Rarely" (2), "Often" (3), and "Very often" (4).

2.2. Psychometric investigation

The version of the questionnaire for psychometric investigation contained 64 items. It was used in the present empirical study,