



Psychological recovery and its correlates in adults seeking outpatient psychiatric services: An exploratory study from an Indian tertiary care setting



Aditi Gandotra^a, Seema Mehrotra^{a,*}, Srikala Bharath^b

^a Department of Clinical Psychology, NIMHANS, Bangalore, India

^b Department of Psychiatry, NIMHANS, Bangalore, India

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ABSTRACT

The study was designed to explore psychological recovery and its correlates in adults receiving outpatient mental health services for psychiatric disorders. It specifically aimed at examining the association of psychological recovery with symptomatic and functional recovery and with selected illness and treatment variables. The relationship of psychological recovery with perceived social support was also the focus of inquiry. The study utilized a cross sectional survey design with a sample of 90 participants diagnosed with severe and common mental illness who had been seeking outpatient psychiatric follow up services. The data was collected with the help of both clinician rated and self-rated measures. The study findings suggested that symptomatic, functional and psychological recovery are significantly correlated but not completely overlapping constructs. Nearly 40% of the sampled participants were at the lower stages of psychological recovery, despite the fact that a majority of them were rated by clinicians as having mild or lower severity of symptoms. With respect to socio-demographic variables, a significant association was found between higher levels of education and psychological recovery. The participants with common mental illness were significantly lower on self-reported improvement and higher on moratorium subscale of psychological recovery (as compared to those with severe mental illness), indicating their struggle in dealing with a sense of loss and despair. Findings also suggested that higher levels of overall perceived social support is likely to facilitate psychological recovery.

1. Introduction

The concept of recovery in the field of mental illness has undergone significant changes in the last two decades from a dominant focus on symptom alleviation to inclusion of functional recovery as well. Several studies, including large-scale surveys across nations, have highlighted that remission of psychiatric symptoms is not necessarily associated with full restoration of health-related quality of life (Robio et al., 2013). Researchers have argued as to how focusing on symptoms and pathology results in oversimplification of the complex experiences of persons with mental illness due to insufficient attention to the adaptive processes (Resnick et al., 2005). Studies in the last two decades have shown that individuals diagnosed with psychiatric illness can lead a productive and fulfilling life and their recovery can be facilitated when clinicians broaden their focus to understand the difficulties faced by them in dealing with their illness (Davidson et al., 2005). These observations have resulted in enhanced understanding of recovery from a consumer oriented recovery paradigm. This paradigm views recovery

both as an outcome and as a process that involves four broad phases: i) overwhelmed by disability, ii) struggling with disability, iii) living with disability and iv) living beyond disability (Spaniol et al., 2002). Recovery is seen as a highly active and an individualized process that can be facilitated by understanding it from the consumers' perspective (Tooth et al., 2003). A systematic review of research and utilization of a narrative synthesis approach led by Leamy et al., (2011) illustrated that recovery processes are colored by themes of connectedness to others, hope and optimism about future, rebuilding of identity, meaning in life and a sense of empowerment.

While the term functional recovery is often used to denote restoring of one's social and occupational functioning, recovery as a psychological construct involves the development of new meanings and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993). It entails an experience of hopefulness and meaningfulness in life, regardless of symptom status and involves an experiential shift from despair to hope, alienation to purpose, isolation to connectedness, withdrawal to engagement and from passive adjust-

* Corresponding author.

E-mail address: drmehrotra_seema@yahoo.com (S. Mehrotra).

ment to active coping (Ridgway, 2001). Several variables such as age, gender, nature of illness, insight, social support and experience of stigma have been explored as factors influencing the recovery process (e.g. Brierer and Strauss, 1984; Lloyd et al., 2010, Fowler et al., 2015). A number of recovery models have been developed. The stage model of psychological recovery by Andresen et al. (2006), perhaps one of the most popular models, is based on thematic analysis of narratives of patients diagnosed with mental illness. This model proposes five stages of recovery as briefly described below: a) moratorium: a time of withdrawal characterized by a profound sense of loss and hopelessness, b) awareness: realization that all is not lost, and that a fulfilling life is possible, c) preparation: taking stock of strengths and weaknesses regarding recovery, and starting to work on developing recovery skills, d) rebuilding: actively working toward a positive identity, setting meaningful goals and taking control of one's life and e) growth: living a full and meaningful life, characterized by self-management of illness, resilience and a positive sense of self.

On the whole, there is an emergent recognition of the need for shift in emphasis from purely objective or clinical indicators to subjective measures of recovery, in evaluation of global recovery for people with mental illness (Lloyd et al., 2010). However, the relationship between traditional clinical outcomes and recovery outcomes have not been sufficiently examined (Donnelly et al., 2011).

1.1. Rationale for the study

Understanding the process of recovery can help mental health professionals gain a better understanding of the complexities of living with mental illness and offer supportive services that facilitate personal growth and recovery in a holistic sense.

There is a dearth of studies on the extent of psychological recovery in individuals diagnosed with varied psychiatric conditions and receiving treatment for the same. Several studies have narrowly focused on only a few psychiatric diagnoses, especially serious mental disorders, despite growing evidence that common mental disorders also result in significant burden, poor quality of life and demand an active participation of the individuals in their recovery process. Moreover, there are relatively fewer studies on psychological recovery in non-western contexts like India. The current status of research in this field indicates the need for studies that examine psychological recovery and its correlates in heterogeneous psychiatric conditions in different socio cultural contexts.

Theorizations as well as some empirical research suggest that symptomatic recovery, functional recovery and psychological recovery do not overlap completely. However, the extent of their associations has not been sufficiently examined. Similarly, socio demographic variables, role of perceived social support as well as illness and treatment related variables (such as duration of illness, nature of interventions received) are likely to influence the process and extent of recovery. But only a few studies have examined these relationships.

In the above context, this study was undertaken to address some of the gaps in the existing literature with the following objectives in view: a) to examine the extent of psychological recovery in a sample of individuals seeking psychiatric outpatient services, b) to examine the association of symptomatic and functional recovery with psychological recovery, c) to examine the relationship of psychological recovery with illness and treatment variables and d) to examine the relationship of psychological recovery with perceived social support.

2. Materials and methods

2.1. Design and sampling

The study used a single group, cross sectional survey design. It was conducted after the proposal was reviewed for its methodological aspects and cleared for its ethical aspects by the protocol review

committee of the authors' department. Purposive sampling was used and the participants were recruited from a tertiary care institute in South India using the following inclusion criteria: (a) Diagnosis of a psychiatric disorder as established through detailed clinical assessment based on ICD-10, (b) 20–60 years old clients/consumer seeking outpatient psychiatric follow up services who were fluent in either Hindi or English and (c) Those undergoing treatment for at least 6 months duration and showing a fair treatment compliance as judged by the treating clinician, Those meeting criteria for post-traumatic stress disorder, personality disorder, mental retardation, having major neurological illness, substance dependence with active use in the last three months and those not amenable for assessment using questionnaires were excluded. Though psychological recovery is a relevant concept in varied disorders including posttraumatic stress disorder, an attempt was made to reduce heterogeneity by excluding certain disorders, due to the time-bound nature of this study and consequent sample size limitations. The participants who met the sample selection criteria were approached for informed consent. Ninety participants who provided the written informed consent during the study period (August 2015–March 2016) were administered the tools on a one to one basis for data collection.

Different measures were used in the present study to capture different conceptualizations of recovery because research findings have demonstrated that clinical measures do not assess important aspects of recovery such as personal growth and well-being (Andresen et al., 2010). The standardized measures used in this study were as follows: Clinical Global Improvement Scale (CGI) developed by Guy (2000). CGI has following subscales: Severity of Illness item assesses the treating clinician's impression of the patient's current illness state whereas Global Improvement item assesses the patient's improvement or worsening from baseline. Scores on the Severity of Illness subscale range from 1 = 'not at all ill' to 7 = 'among the most extremely ill'. The Global Improvement item involves ratings from 1 = 'very much improved' to 7 = 'very much worse'. Lower scores on these items reflect less severity of illness and higher levels of improvement respectively. CGI improvement ratings were provided by the member of the concerned psychiatric unit who was interviewing the patient at follow up. These improvements ratings were arrived at based on the current clinical picture and the information provided in the hospital records at previous follow up visits. Apart from clinician ratings, the participants also rated their own perceptions of level of improvement in symptoms on a scale from 0 to 100%. These were used as indices of symptomatic recovery. Functional recovery was assessed through Work and Social Adjustment Scale developed by Mundt et al. (2002). The scale consists of five items that determine self-perceived impairment in the following domains: (1) work; (2) home management; (3) social leisure activities; (4) private leisure activities; and (5) relationships with others. Higher scores reflect higher impairment in functioning on this measure. Psychological recovery was assessed through the Stages of Recovery Instrument (STORI-30) developed by Andresen et al. (2010). It is a self-report measure consisting of 30 items, presented in six groups of five each. The items are rated by the respondent on a 0–5 scale ('not at all true' to 'completely true'). Individual items within each group represent a particular stage of recovery as described earlier in the model of recovery proposed by Andresen et al. (2006). The highest subscale score is used to indicate the stage of recovery that the person is experiencing. In addition, total scores on the various subscales can be seen as continuous measures of the respective stages of psychological recovery with higher scores on awareness, preparation, rebuilding and growth subscales reflecting higher levels of awareness, preparation, rebuilding efforts and perceived growth, respectively. On the other hand, higher scores on moratorium subscale indicate higher experience of loss and hopelessness. Perceived social support was assessed using social support scale developed by Pillay and Rao (2002). The scale comprises of three parts. Part A measures the availability and utilization of social support, Part B measures perceived availability of three

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