European Psychiatry 52 (2018) 54–60

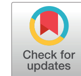
Contents lists available at ScienceDirect

European Psychiatry

journal homepage: http://www.europsy-journal.com

Original article

Resilience trajectories to full recovery in first-episode schizophrenia



Anne-Kari Torgalsbøen[a,*], Susie Fu[a,b], Nikolai Czajkowski[a]

[a] Department of Psychology, University of Oslo, Norway
[b] Vestre Viken Hospital Trust, Norway

ARTICLE INFO

Article history:
Received 16 March 2018
Received in revised form 26 April 2018
Accepted 27 April 2018
Available online xxx

Keywords:
Course
Longitudinal
Recovery
Medication free
Psychosis
Functional outcome

ABSTRACT

Background: Resilience is successful adaptation despite adversity. This personality trait has the potential to add new knowledge to how to achieve a successful outcome, but resilience has been understudied in schizophrenia. The objective of the present study is to investigate if there are significant differences in resilience development among fully recovered and non-recovered patients with first episode schizophrenia (FES).
Methods: In the ongoing Oslo Schizophrenia Recovery Study spanning 10 years, 28 first-episode patients are interviewed and assessed yearly with comprehensive criteria of full recovery, a measure of social and role functioning and resilience, the Connor-Davidson Resilience Scale. The present study includes data from six follow-ups over four years. Working or studying, having symptoms that are stably mild or absent for two years or more, having contact with friends and/or dating, participating in leisure activities and living independently define full recovery.
Results: At the four-year follow-up, 55% were sustained full/partly recovered. Ten percent of those fully recovered were no longer in treatment. Choosing the overall best linear mixed model, we found a significantly larger increase in resilience score among the fully recovered than among those not recovered.
Conclusions: Based on the theoretical rationale that resilience is activated differently in persons who experience adversity, the significant increase in resilience in the fully recovered group indicates that this psychological trait is present to a higher degree in fully recovered. These results highlight resilience as a factor associated with increased recovery in FES adding to the small literature on improvement among these patients and thus have important clinical implications.
© 2018 Elsevier Masson SAS. All rights reserved.

1. Introduction

As early as 1970, Garmezy [1] reported on two kinds of patients with schizophrenia: process and reactive. Chronic courses characterized the process patients, whereas reactive patients had courses with a return to a functional life after their psychotic breakdown, thereby illustrating a positive adaptation to the illness. Resilience was not part of the descriptive picture of these atypical cases, but the psychosocial development of these patients was an early example of signs of premorbid resilience indicators [2]. The subset of patients who evidenced recovery and adaptive patterns have been considered to be somewhat atypical, and have been afforded little attention. With some exceptions [3–8] there has been a lack of positively framed research in schizophrenia, and very little research has been conducted into how a person with schizophrenia arrives at a successful outcome. In this perspective, one might argue that it is a limitation of research, rather than limitations on the ability of individuals, that recovery has not been more widely explored and acknowledged. Recovery in schizophrenia is considered an outcome measure, a process and a definition [9] leading to conceptions of recovery giving equal weight and importance to clinical and personal recovery for the assessment of the final functional outcome.

Although recovery rates for people with first-episode schizophrenia (FES) are still somewhat uncertain due to a wide variety of outcome definitions used [10] as well as lack of consensus on the definition of recovery, a recent meta-analysis of long-term outcome studies concluded that remission and recovery rates in this group may be more favourable than previously thought [11]. The pooled prevalence of recovery among 9642 individuals with first-episode psychosis was 38% (35 studies, mean follow-up 7.2 years) [11]. To increase the knowledge of how persons facing such a profound adversity as schizophrenia successfully recover, we must turn to the field of developmental psychopathology [12]. The recognition of the diversity of developmental outcomes and the

* Corresponding author at: Department of Psychology, University of Oslo, P.O. Box 1094 Blindern NO-0317 Oslo, Norway.
E-mail address: a.k.torgalsboen@psykologi.uio.no (A.-K. Torgalsbøen).

http://dx.doi.org/10.1016/j.eurpsy.2018.04.007
0924-9338/© 2018 Elsevier Masson SAS. All rights reserved.

complexity of developmental pathways has given impetus to the growing interest regarding the presence of successful adaptation despite adversity, the construct of resilience [13]. Resilience is somewhat different than other personality traits because it manifests in response to adversity [11] and according to Bonanno, events are not traumatic until we experience them as traumatic. [14]. Previous follow-up studies on full recovery in schizophrenia using operational consensus-based criteria show that resilience plays a significant role in sustained full recovery [4,8]. Some long-term studies have used resilience as describing personal resources, though without defining the concept [15,16]. Lately some cross-sectional studies has addressed resilience in schizophrenia patients [17,18]. At present there is limited knowledge about how successful outcomes in first-episode schizophrenia (FES) are achieved as well as which factors contribute to recovery.

To fill this knowledge gap we have to investigate the development of resilience in persons who are fully recovered. Secondly, we have to define resilience according to how it is conceptualized in the field of developmental psychopathology where resilience embodies the personality traits that enable one to thrive in the face of adversity, to bounce back from difficult experiences [19]. The instrument that in our opinion measures resilience according to this definition is a scale developed by Connor and Davidson [20], the Connor and Davidson Resilience Scale (CD-RISC). This instrument also measures optimism and hope, which are individual traits characterizing resilient individuals [21,22].

To the best of our knowledge, the Oslo Schizophrenia Recovery study is the first prospective study using the most comprehensive and strict definition of full recovery ([23] in a year-by-year -assessment as part of a modern longitudinal research design to investigate the rate of full recovery in FES. Moreover, we identify the time point during the follow-up period when individuals meet criteria for remission and full recovery, as well as tracking the development of resilience. The aim of the present study is to investigate the relationship between resilience defined as a personality trait and full recovery in FES, and more specifically, if there are significantly different resilience developments among fully recovered and non-recovered groups.

2. Methods and measures

2.1. Design

The Oslo schizophrenia recovery study [24–26] has a prospective longitudinal design, with 12 follow-up points spanning a period of 10 years. This design makes it possible to assess full and sustained recovery, as well as studying resilience over time in a sample not confined to the relapsing patients most often seen in hospital/inpatient settings. It also allows for a testing of causal relationships. The study is ongoing, and here we present the results from the four-year follow-up. During this time, all participants were assessed at six time points, enabling us to capture both the fluctuations and stability in recovery and resilience.

2.2. Participants

Over a period of four years (2007–2011), 31 patients with first-episode schizophrenia were referred to the study. They were recruited from mental health service institutions in the Oslo area, and shortly after admittance, their treating clinicians referred them to the project. Twenty-eight out of 31 patients fulfilled the following inclusion criteria: age $\geq$18 years, the first episode of mental illness was within the spectrum of schizophrenia and psychosis according to DSM-IV [27] and referral within five months of their first contact with the mental health service institutions. Exclusion criteria were affective disorders, IQ $<$ 70 and head trauma, and that all patients could read and write fluent Norwegian. The mean age of the included subjects at baseline was 21.0 years (S.D.2.6) with a mean of 12.7 years of education. 21.4% was diagnosed with schizoaffective disorder, the majority with schizophrenia. The total symptom level was 80.8 (SD 16.5) on the Positive and Negative Syndrome Scale (PANNS) [28], while the positive symptom level was 18.5 (SD 5.6) and the negative symptom score was 21.5 (SD 3.8). Regarding illegal substances, 64.3% had previously used cannabis and amphetamines, but at the time of inclusion, only 3.6% had substance abuse (mainly recreational drugs). Moreover, 57% were hospitalized and 43% were outpatients at baseline.

In the follow-up period, the majority of patients was provided with treatment by their local mental health service institution, through antipsychotic medication, primarily second-generation antipsychotics, in addition to psychoeducation and/or CBT and case management. The retention rate at 4-year follow- up is high (78.6%). All patients were retained during the first three follow-ups, while three patients left the study during the 2-year follow up and an additional three participants dropped out during the 3-year follow-up.

The reasons for dropout were mainly refusal to participate due to anxiety, a lack of insight into having a mental illness, finding participation in research not useful and non-response to attempt at contact. On every measurement occasion, the patients completed the assessments described below. After carefully describing the study and the procedures involved, written informed consent was obtained from all participants, and the Regional Committee for Research Ethics (REK) approved the study.

2.3. Clinical instruments

The clinical interviews and tests of the participants were done within the first five months of their admission to hospitals or outpatient clinics, and were carried out by an experienced clinical psychologist. Diagnoses were established using the Structural Clinical Instrument of Diagnosis for DSM-IV Axis I disorders (SCID-I), modules A-D. The degree of symptoms and psychopathology was measured with the Positive and Negative Syndrome Scale (PANSS) [28]. Furthermore, a semi-structured interview was used, and based on this information level of social and role functioning, was measured by the Global Functioning: Social (GF: Social) and the Global Functioning: Role (GF: Role) [29]. These two measures of social and role functioning disentangle social- from role-functioning domains, detect changes in functioning over time, and provide brief and easy-to-use clinician ratings, while taking age and phase of illness into account.

In this instrument, the social scale assesses the quantity and quality of peer relationships, level of peer conflict, age-appropriate intimate relationships and involvement with family members. The role scale refers to performance in school, at work or as a homemaker. We consider these measures as suitable for prospectively following first-episode individuals.

To assess resilience, the Connor-Davidson Resilience Scale (CD-RISC) was chosen. This scale was translated into Norwegian and demonstrated sound psychometric properties, and also distinguishes between persons with a greater and lesser resilience [20]. The scale is comprised of 25 items, each rated on a 5-point Likert scale (0–4), with higher scores reflecting a greater resilience. It includes items such as for example: “I tend to bounce back after illness or hardship” and “I have close and secure relationships”.

2.3.1. Symptom remission

The symptom remission criteria for schizophrenia (24) are based on an evaluation of eight groups of symptoms of the PANSS: P1

Download English Version:

https://daneshyari.com/en/article/8814783

Download Persian Version:

https://daneshyari.com/article/8814783

Daneshyari.com