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Hope, meaning and responsibility across stages of recovery for individuals living with an enduring mental illness

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Hope, meaning and responsibility across stages of recovery for individuals living with an enduring mental illness

Abstract

This study reports on the relationship between stage of recovery and hope, meaning and responsibility for individuals diagnosed with severe mental illness. Methods: Seventy-seven people with a diagnosis of a psychotic disorder of at least 6 months' duration participated in the study. Participants completed the Self-Identified Stage of Recovery (SISR) scale, measures of component processes of recovery (Hope Scale; Positive Interpretation of Disease, SpREUK; Active Involvement, Personal Health Management Questionnaire (PHMQ) and the Recovery Assessment Scale-short (RAS). Results: Hope, meaning, Personal Confidence and Hope and Not Being Dominated by Symptoms varied significantly across stages of recovery; however, neither in a parallel nor linear fashion. Hopefulness and sense of meaning in relation to the experience of mental illness increase before personal confidence and resilience in the face of setbacks. Conclusions and implications: Symptoms appear to take less prominence in individuals' lives in later stages of recovery. Greater insight into the relationship between stage of recovery and component processes may allow for more targeted recovery-oriented support for individuals at different stages of recovery. Keywords: psychological recovery, stages of recovery, hope, meaning.

Keywords

meaning, hope, recovery, individuals, stages, living, mental, across, illness, enduring, responsibility

Disciplines

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Running Head: HOPE AND IMPROVEMENTS IN MENTAL HEALTH

Hope and Improvements in Mental Health Service Providers' Recovery Attitudes Following Training

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Hope and Improvements in Mental Health Service Providers' Recovery Attitudes Following Training

Abstract

Background: Service providers' attitudes towards recovery can improve with formal training. However, it is unclear whether improvements depend on dispositional hope. Aims: To determine whether attitudinal improvements following formal recovery training vary depending on participants' dispositional hope. Method: One hundred and three providers attended formal recovery training and completed measures of recovery knowledge, attitudes, hopefulness and optimism. Results: Training improved providers' recovery knowledge, attitudes, hopefulness and optimism. Providers with both high and low dispositional hope achieved similar gains. Conclusions: Attitudinal improvements following formal recovery training were not dependent on baseline levels of dispositional hope. Institutions committed to recovery-oriented care should consider utilising formal training. Declaration of Interest: This research was partly funded by the Australian National Health Medical Research Council (NHMRC, #219327), through the Health Partnership Grant Scheme.

Keywords: Recovery, hope, mental illness, mental health.

Introduction

Consumer leaders consider hope to be a cornerstone of recovery for people with severe and persistent mental illness, however they argue traditional definitions of recovery involving symptom elimination and return to premorbid functioning insufficiently emphasise hope (Halpern, Trachtman & Duckworth, 2009). Contemporary definitions of recovery incorporate consumer perspectives and a review identifies four key processes: finding hope, identity and meaning in life, and taking responsibility (Andresen, Oades & Caputi, 2003). Further, service providers who identify themselves as having had personal experience with mental illness, or 'survivor/providers', endorse that 'recovery is about hope' (Storey, Shute & Thompson, 2008, p. 3).

Hope has been defined as a person's perception that goals can be met (Snyder et al., 1991). A state-trait theory of hope proposes dispositional hope as a general cognitive set applying across a range of situations and relatively stable across time, whereas state hope varies according to particular times and situations. People with higher dispositional hope should endorse higher state hope as they confront situations compared to persons with low dispositional hope (Snyder et al., 1996).

It has been argued provider hope transfers to consumers (Oades et al., 2009) and can be a powerful motivator for positive change in consumers (Byrne et al., 1994). Peterson and Byron (2008) present data from four studies indicating workers with higher dispositional hope demonstrate improved problem-solving and job performance. It is argued more hopeful providers are likely to overcome obstacles and deliver better services to consumers, as well as inspire greater hope and motivation for recovery.

Interventions capable of improving provider hope represent an important step towards enhancing consumers' recovery prospects. Three published studies have examined standardised recovery training programs using validated measures. A randomised controlled

trial found improvements in recovery knowledge and attitudes among inpatient staff following training, yielding medium effect sizes (Pollard, Gelbard, Levy & Gelkopf, 2008). A second study found three days of training delivered significant gains in understanding, as measured by the Recovery Knowledge Inventory (RKI; Bedregal, O'Connell & Davidson, 2006) and these gains were maintained 6 months later (Meehan & Glover, 2009). However, only one study has included a measure explicitly targeted at capturing changes in hope (Crowe, Deane, Oades, Caputi & Morland, 2006).

Crowe et al. (2006) adapted items from the dispositional Hope Scale (HS; Snyder et al., 1991) to construct a situationally-specific measure of hope, reflecting providers' hopefulness regarding consumer recovery prospects. This measure was integrated as a subscale within the Staff Attitudes to Recovery Scale (STARS), which also included items measuring more general recovery attitudes. Two hundred and forty eight community mental health workers showed improvements in recovery attitudes and hopefulness as measured by the STARS following the 'Collaborative Recovery Training Program' (CRTP) (Oades et al., 2005), with medium effect sizes reported (Government η^2 = .48; non-Government η^2 = .38). Specifically, trainees showed greater hopefulness regarding the ability of individuals with serious mental illness to set and achieve goals.

The present study aims to replicate this earlier work by assessing changes in providers' recovery knowledge, attitudes and hopefulness following completion of the CRTP. Additionally, a measure of provider optimism has been included, the Therapeutic Optimism Scale (TOS; Byrne, Sullivan & Elsom, 2006). Optimism is a person's belief good things will happen; and although hope and optimism are related, research indicates the two constructs are distinct and can be discriminated from each other (Peterson & Byron, 2008). Studies suggest optimism may predict persistence in service provision and reduce the incidence of burnout (Byrne et al., 2006).

It was hypothesised mental health workers would show improvements in recovery knowledge, attitudes, hopefulness, and optimism following training. Further, consistent with state-trait theory, it was hypothesised providers with higher levels of dispositional hope would display greater improvements following training, compared to providers with lower dispositional hope, in their recovery knowledge, attitudes, hopefulness and optimism.

Method

Participants

One hundred and three mental health workers from Government and non-Government organisations in eastern Australia completed the CRTP. All organisations offered ongoing support for people with severe and persistent mental illnesses, such as schizophrenia. Of the 103 participants attending training, 100 provided pre-training data (97% participation rate) and 75 provided both pre- and post- training data on the RAQ-7, STARS and TOS. The RKI was introduced at a later date after several groups had already been trained and a much smaller subsample of 27 participants provided both pre and post-training data on this measure. Pre-training HS scores were available for all participants with complete pre-post data.

There was minimal missing data for some demographic and descriptive characteristics of the full sample (<13%) so, valid percentages are reported. Most of the sample was female (65.5%). The mean age of participants was 38.30 years (SD = 11.54) and ranged in age from 20 to 63 years. The mean number of years in the mental health profession was 7.58 years (SD = 8.45) ranging from 1 month to 31 years. The most commonly endorsed professional affiliation was ‘Other’ (n = 39, 45.3%), which frequently involved identification as a support worker, followed by nurse (n = 14, 16.3%), social worker (n = 13, 15.1%), psychologist (n = 8, 9.3%), occupational therapist (n = 7, 8.1%) and welfare worker (n = 5, 5.8%). Educational backgrounds were heterogeneous, with n = 35 (42.7%) identifying undergraduate training as

their highest level of education, n = 22 (26.8%) postgraduate, n = 21 (25.6%) Technical and Further Education, n = 2 (2.4%) Higher School Certificate, and n = 2 School Certificate.

Measures

Participants were administered the following measures, all of which were measured on a 5-point Likert-type scale ranging from 1, strongly disagree, to 5, strongly agree, unless otherwise stated. Cronbach's alpha coefficients for the present study were derived from pre-training scores.

The Recovery Attitudes Questionnaire (RAQ) consists of seven items measuring attitudes towards the recovery concept (e.g., 'People in recovery sometimes have setbacks'). Higher scores indicate better recovery attitudes. The developers report an alpha coefficient of .704 (Borkin et al., 2000). The current study had a Cronbach alpha of .72 for the full scale.

The dispositional Hope Scale (HS; Snyder et al., 1991) conceptualises hope as a general cognitive disposition, or trait, that applies across a range of settings and is relatively stable across time (e.g., 'I meet the goals I set for myself'). The HS has eight items, rated on a 4-point scale ranging from 1, definitely false, to 4, definitely true. The developers report alpha coefficients ranging from .74 to .84. Cronbach's alpha for the present study was .78.

The Staff Attitudes to Recovery Scale (STARS; Crowe et al., 2006) assesses hopeful attitudes regarding consumers' recovery possibilities. Three items address general hopefulness (e.g., 'All of these clients are capable of positive change'). Eight items were adapted from the HS to be more specifically relevant to the work with clients (e.g., 'There are lots of ways around any problem' became 'There are lots of ways to deal with any problems these clients have'). The Cronbach's alpha reported by Crowe et al. (2006) was .81 and in the current study the alpha was .80.

The Therapeutic Optimism Scale (TOS; Byrne et al., 2006) consists of 10 items measuring providers' optimism. It assesses general and personal treatment expectancies (e.g.,

'With my assistance most people with mental disorders will recover'), and pessimism. The developers of the scale report acceptable internal reliability (Cronbach's $\alpha = .68$). The TOS shows convergent validity with the Clinician Optimism Scale ($r = .54$, $p < .01$), and moderately correlates with the HS ($r = .44$, $p < .01$), consistent with hope and optimism literature (Byrne et al., 2006). Cronbach's alpha in the present study was .57

The Recovery Knowledge Inventory (RKI; Bedregal et al., 2006) comprises 20 items assessing providers' knowledge and attitudes regarding recovery-oriented practices (e.g., 'It is the responsibility of professionals to protect their clients against possible failures'). Cronbach's alpha has been reported as .83 (Meehan & Glover, 2009). The current study alpha was .79.

Procedures

The CRTP involved 2 days of training in recovery concepts and skills supporting consumers' abilities to set, pursue and attain personal goals. A detailed description of the training components has been published (Oades et al., 2005). Pre-training measures were collected on the first day before training commenced. Post- training measures were collected following completion of the second day of training.

Results

To test the hypothesis that providers with higher dispositional hope would show comparably greater attitudinal improvements following CRTP, two groups (high dispositional hope versus low) were created by dividing pre-training HS scores at the 50th percentile. The STARS and TOS met assumptions for multivariate analysis of variance (MANOVA) and were analysed together to control for Type 1 error. However, the distribution of RAQ scores violated normality and transformations were unsuccessful so this data was analysed nonparametrically. Finally, the RKI met assumptions for parametric analysis but a separate analysis of variance (ANOVA) was conducted due to the reduced sample size.

A 2 (pre/post training) x 2 (high/low hope) within and between groups MANOVA was used to investigate whether participants with higher dispositional hope showed comparably greater improvement on the STARS and TOS following training. The MANOVA indicated a main effect across both measures showing that recovery attitudes and optimism significantly improved over the course of training, $F(2, 72) = 58.10$, $p < .001$, $\eta^2 = .617$. No interaction with dispositional hope was observed, $F(2, 72) = .41$, $p > .05$. Both univariate ANOVAs showed main effects, at $p < .001$ (STARS $d = .872$; TOS $d = .783$).

Since there is not a nonparametric equivalent to test for interaction, a series of nonparametric tests were conducted on RAQ scores. A Wilcoxon Signed Ranks test for the entire sample of 75 showed significant improvements from pre-test (*Mdn* = 4.29) to post-test (*Mdn* = 4.43), $z = -3.35$, $p < .001$, $d = .284$. If there is an interaction between dispositional hope and improvements over time, then it is likely that there would be differential changes for those in the low and high hope groups over time. Thus, Wilcoxon Signed Ranks tests were conducted on the low-hope and high-hope groups separately. Both groups showed pre-post improvements (low hope $z = -2.61$, $p < .01$; high hope $z = -2.11$, $p < .05$). To further explore the potential of an interaction, a Mann Whitney test of pre-post scores for the low-hope versus the high-hope group was conducted. The low hope group achieved significantly lower scores than the high hope group at pre-test (low hope *Mdn* = 4.14 versus high hope *Mdn* = 4.43, U=481.50, $p < .01$) and post- test (low hope *Mdn* = 4.36 versus high hope *Mdn* = 4.71, U=473.00, $p < .01$). Given both low and high hope groups improved over the course of training, and retained their relative positions, it is unlikely there was a differential effect of training between groups.

A 2 (pre/post training) x 2 (high/low hope) within and between groups analysis of variance (ANOVA) was conducted on the subsample of 27 participants who completed the

RKI. A main effect for improvements in recovery knowledge following training was evident, $F(1, 25) = 6.59$, $p < .05$, $d = .414$. There was no interaction with hope, $F(1, 25) = .64$, $p > .05$.

Given there was no interaction between dispositional hope and training outcomes, only means for the full sample are provided in Table 1.

Insert Table 1 about here

Discussion

This study found improvements following recovery training did not depend on dispositional hope. That is, regardless of providers' levels of dispositional hope coming into training, they showed similar improvements in their understanding and attitudes regarding consumer recovery prospects. This finding suggests the moderating effect of dispositional hope on state hope theorised by Snyder et al. (1996) does not impact improvements on recovery knowledge and attitudes following training.

This study replicated and extended the results of an earlier investigation into the effectiveness of CRTP, finding improvements in providers' knowledge, attitudes, hopefulness and optimism regarding recovery. Effect sizes ranged from small ($d = .28$, RAQ-7) to large ($d = .87$, STARS). The recovery knowledge improvements attained are important given there have been suggestions providers' lack of knowledge about recovery may be a critical barrier to the implementation of recovery-oriented services (Young et al., 2005); and many staff want further training to better understand recovery processes (Cleary & Dowling, 2009). The large effect size achieved on the measure of attitudes and hopefulness regarding consumer recovery (STARS) is especially significant given a documented link between hope and improved problem-solving and job performance, as well as the potential for provider hope to transfer to consumers. The large effect size improvements on provider optimism regarding recovery are noteworthy since optimism may predict persistence in service provision and reduce burnout (see Byrne et al., 2006).

There were several limitations to this study. The lack of a control group means other uncontrolled variables cannot be ruled out as the cause of improvements. The smaller effect sizes on some measures, particularly the RAQ-7, may reflect ceiling effects. Outcome measures did not examine other important recovery-orientation domains like provider behaviour, or link observed provider changes to consumer outcomes. In addition, the surveys used involve self-report bias, including a potential for social desirability effects.

Future research directions could supplement provider knowledge and attitude outcomes with measures of provider behaviour change; linking provider outcomes with measures of consumer recovery processes; and conducting follow-up measurements of training changes. When considered alongside a growing evidence-base of the effectiveness of formal recovery training as well as evidence many providers both need and want further training, these results indicate organisations seeking to promote high quality recovery-oriented care among their staff should seriously consider implementing formal training programs.

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Table 1

Pre- and Post- Training Means and Standard Deviations

	Pre-Training		Post-Training		Effect Size [b]
Variable	M	SD	M	SD	
RAQ-7	4.29	.40	4.41	.45	.28
STARS	3.95	.41	4.28	.35	.87
TOS	3.98	.37	4.26	.35	.78
RKI[a]	3.51	.39	3.69	.49	.41

Note. RAQ-7 = Recovery Attitudes Questionnaire, STARS = Staff Attitudes to Recovery Scale, TOS = Therapeutic Optimism Scale; RKI = Recovery Knowledge Inventory.

[a] N = 75 for all measures apart from the RKI subsample of n = 27.

[b]Effect sizes are Cohen's *d* and indicate pre-post training effects.