# Development of a Structured Interview Schedule to assess Stage of Psychological Recovery from Enduring Mental Illness

<table>
<thead>
<tr>
<th>Journal:</th>
<th><em>International Journal of Psychiatry in Clinical Practice</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Manuscript ID:</td>
<td>MPCP-2009-0046.R1</td>
</tr>
<tr>
<td>Manuscript Type:</td>
<td>Original Article</td>
</tr>
<tr>
<td>Date Submitted by the Author:</td>
<td>24-Jan-2010</td>
</tr>
</tbody>
</table>
| Complete List of Authors: | Wolstencroft, Keren; University of Wollongong, School of Psychology  
Oades, Lindsay; University of Wollongong, School of Psychology  
Caputi, Peter; University of Wollongong, School of Psychology  
Andresen, Retta; Illawarra Institute for Mental Health |
| Keywords: | enduring mental illness, psychological recovery, community-based support, assessment |
Development of a Structured Interview Schedule to assess Stage of Psychological Recovery from Enduring Mental Illness

Authors:

Keren Wolstencroft: (BPscy) Hons

Lindsay Oades: BA(Hons) PhD, MBA with Distinction.

Peter Caputi: BA (Hons), Dip Math, PhD

Retta Andresen: BSc (Hons), PhD

Institution: University of Wollongong, NSW 2522 Australia

Correspondence about this manuscript should be addressed to:

Dr Lindsay Oades

B41.130 Faculty of Health and Behavioural Sciences

University of Wollongong

Wollongong NSW 2522

P: +61 2 4221 3694

E: loades@uow.edu.au
Objective: To develop a brief interview-based assessment tool, feasible for routine use in mental health service settings to measure an individual’s stage of psychological recovery from an enduring mental illness.

Method: Key indicators for each stage of psychological recovery were formulated according to the stages of psychological conceptual framework and an analysis of transcribed data wherein seventeen consumer participants described their illness and recovery experiences. Upon development of the measure, Short Interview to assess Stages of Recovery (SIST-R), the instrument was evaluated by practitioners and consumers to examine its feasibility for use in mental health service settings. A pilot test with eighteen mental health consumer participants compared results obtained by the SIST-R with those from an existing self-report stages of psychological recovery measure (STORI), a measure of psychological distress (K-10), and a measure of recovery (RAS).

Results: Concordance between the SIST-R and the STORI was substantial (Somers’ $D = .61$, $p = .004$). The mean scores from other recovery measures correspond with what could be theoretically expected across individual stages of recovery.

Conclusion: This study contributes towards the strengthening of a recovery-oriented approach within clinical/mental health service settings with the development of an assessment tool that demonstrates potential clinical utility. There is a need to validate further the preliminary findings of this study.
Introduction

Empirical research relative to recovery has generally tended to follow the medical model of recovery as assessed by outcomes with measures of symptoms, hospitalisation and functioning. Recently, a psychosocial approach has extended assessment by using a greater number of outcome measures such as employment status or social functioning (1). However, for those seeking support, what is valued as an outcome may vary widely between individuals (2).

Recovery from an enduring mental illness is often described by consumers as a journey or a process. Furthermore, consumer accounts demonstrate that a person “need not delay resuming a full life while waiting for their symptoms, deficits, or illness to disappear or become manageable” (3, p. 20). Largely shaped by consumer’s descriptions the term ‘psychological recovery’ has evolved to refer to the “progressive establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self determination” (4, p. 588).

In an extensive review and analysis of consumer’s personal recovery accounts, Andresen, et. al. (2003) found that consumers frequently referred to four key components as being significant to their recovery journey: i) finding and maintaining hope; ii) taking responsibility for life and wellness iii) redefining self and identity; and iv) finding meaning and purpose in life (4). In order to conceptualise the progressive nature of psychological recovery depicted by consumers, Andresen et. al. (4) reviewed a number of qualitative studies describing recovery in terms of phases or stages and proposed a model of psychological recovery involving five sequential stages:

1. **Moratorium:** Characterised by the absence of: hope, self identity, responsibility for well being, and purpose and meaning in life.

2. **Awareness:** The individual has a dawning realisation that recovery is possible and that there is the potential of a more fulfilling life aside from being ‘mentally ill’.
3. Preparation: In this stage the individual begins to lay the groundwork for recovery. This groundwork may take the form of introspective preparation wherein the individual explores what may be possible as well as taking practical steps towards utilising whatever resources are available.

4. Rebuilding: In the Rebuilding stage the individual takes the necessary steps to work towards his or her personally valued goals. This involves practising health-maintaining behaviours and taking control of one’s life.

5. Growth: Individuals in this final stage radiate confidence, an aura of control, an established and positive sense of self, and eagerness towards the future. The person may not be free of symptoms completely but knows how to manage the illness, stay well, and is resilient in the face of setbacks with faith in their ability to pull through and maintain a positive outlook.

To validate the construct of a five-stage process of psychological recovery Andresen, et. al., (5) developed a 50 item, self-report stages of psychological recovery instrument (STORI). The STORI was tested by comparing it to a number of other recovery-related measures. Results indicated that the STORI correlated with other psychological health variables in such a way as to demonstrate its validity as a measure of patient-oriented recovery (5). In addition, there was a distinctive pattern of correlations between the five subscales and the comparison measures, confirming the validity of a stage like process (5).

The identification of well-defined stages within the process of psychological recovery provides a useful heuristic of the complex psychological transformations that underpin much of what is examined in traditional outcome measures (6). Within mental health service settings the ability to chart the process by which an individual moves towards recovery may enhance a positive expectancy for both practitioners and consumers (6, 7, 8). Importantly, by understanding an individual’s current stage of psychological readiness to engage in recovery-oriented challenges practitioners can potentially match support practices to an individual’s current stage, thus, facilitating movement along such a continuum (6, 8, 9).
psychological recovery model has already proven useful in clinical training (10) and in guiding
the development of a recovery programme based on collaborative goal setting with consumers
(11, 12). In order to further empirical research related to the stages of psychological model there
is a need for an instrument that can be utilised on a routine basis within mental health service
settings.

This study builds on an already extensive body of work currently being undertaken to
conceptualise a framework of recovery based on the lived experiences of individuals who have
journeyed from illness to wellness (4, 5, 10, 11, 12, 13, 14, 15). In this paper we describe the
development and preliminary feasibility and validity testing of an instrument designed for
routine use in community mental health service settings to identify an individual’s stage of
psychological recovery. Consistent with the philosophy of the recovery movement, research for
this study drew on both the perspective and collaboration of consumers. Research for this study
was conducted in three parts.

**Study One:** The aim of study one (a) was to develop a short interview-based schedule
that would reflect the experiences and language of consumer’s recovery accounts (16). In the
second part of this study (b) clinical feasibility of the instrument would be evaluated from the
perspective of consumers and practitioners. In mental health services, feasibility “indicates the
extent to which it is suitable for use on a routine, sustainable and meaningful basis in typical
clinical settings, when used in a specified manner and for a specified purpose” (17, p. 244).

**Study Two:** The aim of the second study was to conduct a pilot analysis of the validity
of the SIST-R as a stage-based measure of psychological recovery. It was expected that a
comparison between participant’s stage of recovery as identified by the SIST-R and that of an
existing self-report measure (STORI) would demonstrate a significant convergence.
Furthermore, as the stages of psychological recovery model demonstrates the presence of
qualitatively distinct stages it was expected that participants’ scores on other recovery and well-
being measures would correspond with what could be theoretically expected for each stage of psychological recovery.

Study 1(a). Development of the Short Interview to Assess Stage of Recovery.

METHOD

Data

The data used in this inquiry were consumer’s responses to a semi-structured interview, from a previous study investigating the role of narrative on recovery, wherein consumer narrators described their illness and recovery experiences. The interviews were structured according to four themes originally identified by Andresen et. al. (4) as recurring themes in the experience of recovery, namely; experiences of hope, self-identity, sense of meaningfulness in life, and taking responsibility for well-being. Interviews were audio recorded digitally and transcribed verbatim. Documented transcripts of each participant’s interview were accessed for this study for analysis.

Participants

Participants consisted of 11 males and 6 females aged between 28 and 61 (M = 42.12, SD = 9.8) with a clinical diagnosis involving psychotic disorder (e.g. Schizophrenia, Depression, Borderline and Post Traumatic Stress Disorder). Thirteen participants had experienced at least one hospitalisation during their period of illness and 9 participants indicated that they were presently undergoing prescribed medication treatment.

Data Analysis Procedure

1. Creating a Coding Frame Based on the Stages of Psychological Recovery Model – Based on literature pertaining to the stages of psychological recovery model (4, 5) a coding frame was
developed in order to categorise how each of the component processes; hope, self-identity, meaning and taking responsibility are proposed to occur within each of the five stages of psychological recovery.

2. Content Analysis – The content of each interview was analysed in order to examine whether participants descriptions of experiences mapped onto the stages of psychological recovery coding frame. For each participant, phrases that were related to particular component processes and differentiated as belonging to particular stages according to the categories identified by the coding frame were extracted and applied to a template in order to determine the stage of psychological recovery of each participant. Reliability of identified stage of recovery was affirmed by examining the agreement between two independent researcher observations for ten participants (Somers’ D = .83, p = .00, Cohens kappa = .66, p = .004).

3. Establishing Key Indicators for each Stage of Psychological Recovery – After extracting phrases from the data applicable to each stage of psychological recovery (as above) the data was analysed to determine key indicators for each stage of recovery. For the purpose of this study, key indicators are items that summarise the most salient, discriminatory and theoretically valid concepts relative to each stage of psychological recovery.

RESULTS

The interviews analysed in Study 1 demonstrated the progressive manner in which movement towards recovery can be differentiated according to qualitatively distinct stages (4, 5). Participant’s phrases associated with each stage of psychological recovery revealed some common themes that can be represented as key indicators for each stage (see Table 1). For example, participants in the Moratorium stage frequently conveyed their feelings of:

1) Hopelessness e.g. “I thought my life would be hell forever”.

2) Powerlessness e.g. “I felt controlled by the illness and others lack of understanding”.
3) Apathy e.g. “I didn’t care whether I’d see the light of day or not”.

4) Withdrawal e.g. “All I wanted to do was die”.

Insert Table 1.

Study 1(b). Pilot testing and refinement of the Short Interview to assess Stage of Recovery.

Method

Participants

Participants were nine mental health workers and seven consumers recruited through the support of Neami. Neami is a non-government community mental health rehabilitation support provider for individuals suffering from a serious mental illness. Mental health workers were seven females and two males aged between 23 and 48 (M = 28, SD = 8.13) with between 1 and 15 years experience working in mental health support positions. Consumers were three females and four males who had experienced the effects of a serious mental illness and were currently receiving rehabilitation support from Neami. Consumer participants were, at time of research, also members of a consumer advisory group aimed at informing service provision to Neami. In respect to these participants, demographics in relation to age and type of diagnosis were not obtained.

Materials

1) Information Sheet and Consent Form.

2) Interview-based Measure – Draft version of SIST-R.

3) Feasibility Survey – An evaluation tool designed to assess consumer and mental health workers opinions on the interview-based schedule, the feasibility survey requires participants to rate whether they 1) Strongly Agree through to 5) Strongly Disagree with ten statements related
to the feasibility of the measure. This tool was based on the criteria for feasibility as outlined by Slade et. al. (17).

Procedure

The researcher met with the participants at the Neami service site on two separate occasions. Firstly with the mental health workers as part of a weekly team meeting between staff and managers and then, secondly, with the consumers as part of a monthly consumer advisory group meeting. After discussing the purpose of the study and providing materials and time for participants to read and complete, each focus group was opened up for discussion. Participants completed the feasibility surveys individually and then each area of feasibility was discussed within the group. The researcher took additional notes of each participant’s comments.

Results

Pilot testing indicated that the measure was brief, simple to use, relevant in concepts and language, and was foreseeable as providing value to recovery-oriented services. However, in an attempt to keep the instrument brief, multiple concepts had been incorporated within each question of the draft measure. Participants indicated that the compound nature of the questions may prove difficult with consumers whose concentration is often limited by cognitive deficits. Based on the feasibility evaluation, amendments to the measure were made to accommodate the comments and suggestions of focus group participants. Finally, to represent both the design and purpose of the interview-based schedule the instrument was named as the Short Interview to assess Stage of Recovery (SIST-R).

Study 2. Validity of the SIST-R as a measure of stage-based psychological recovery

METHOD
Participants

Participants were twelve females and six males aged between 21 and 60 (M = 46.50, SD = 11.07). Participants gave their diagnosis as Schizophrenia (2), Bipolar Disorder (3), Depression (13), Posttraumatic Stress Disorder (3), Obsessive Compulsive Disorder (1), Anxiety (1), Schizoaffective Disorder (2), and Dissociative Disorder (1). The duration of illness from first diagnosis ranged from 3 to 40 years (M = 13.00, SD = 9.82). Thirteen participants indicated that they were receiving mental health support from a psychiatrist (8), psychologist (4), or counsellor (1). Length of support ranged from 4 months to 39 years (M = 10.52, SD = 11.82).

Measures and Procedure

Data were obtained from participants involved in a pilot evaluation of a recovery-oriented self-help program for people with long-term mental illness – Flourish (15). At the completion of the program participants met with consumer facilitators and completed a number of recovery-related outcome measures. Participants were also interviewed at this time using the SIST-R. Approval for this research was obtained from the University of Wollongong Human Research Ethics Committee. The following measures were administered to participants:

1. Structured Interview for Stages of Recovery (SIST-R) – Interview-based measure developed in Study 1. The measure utilises five primary questions to identify an individuals’ stage of recovery, with probe questions to validate an affirmative answer to a primary question. For example the first primary question asks respondents: When you think about your future… do you think that recovery or having a better life is impossible for you? If a respondent answers ‘yes’ the interviewer then utilises some probe questions based on the indicators associated with the Moratorium stage to make a decision rule as to whether the respondent is in the Moratorium stage. If the respondent answers ‘no’ or does not demonstrate being in the Moratorium stage based on the key indicators, the interviewer goes on to ask the second primary question based on the next stage of psychological recovery.
2. **Stages of Recovery Instrument (STORI)** – A self-report measure with 50 items yielding five subscale scores of the five stages of recovery: Moratorium, Awareness, Preparation, Rebuilding and Growth. Participants are required to rate each item for ‘how much each statement is true of you now’ on a six-point scale ranging from ‘0’ = ‘Not true at all now’ to ‘5’ = ‘Completely true now’. Each of the subscales have been found to be internally consistent (from $\alpha = 0.88$ to $\alpha = 0.94$) (5).

3. **Kessler-10 (K10)** – A 10 item self-report measure of psychological distress associated with symptoms of depression and anxiety (18). The measure asks participants how often in the past 4 weeks they have experienced psychological distress such as feelings of hopelessness, depression and nervousness and uses a five point response option for each question. Reliability of the K-10 is moderate with weighted kappa scores ranging from 0.42 to 0.74.

4. **Recovery Assessment Scale (RAS)** – For this study a shortened version of the original 41 item measure was utilised (19). The short version is a 23 item self-report measure of psychosocial functioning and symptoms with five subscales. (20). The subscales for Personal Confidence & Hope, Willingness to ask for Help, Goal and Success and Not Dominated by Symptoms were utilised in this study.

**Analysis**

In the first analysis we tested for a convergence (Somers $D$) between participants’ stage of psychological recovery as identified by the SIST-R with that as identified by the STORI. Participants’ stage of psychological recovery as identified by the SIST-R was established according to participants’ affirmatory responses to the key indicators associated with each stage of recovery. Stage of psychological recovery as identified by the STORI was determined based on each participant’s highest mean score on the five subscales (Moratorium, Awareness, Preparation, Rebuilding and Growth). STORI data for one participant was missing. Therefore, a comparison between the STORI and SIST-R was conducted with 17 participants.
For the second analysis, we firstly correlated (Spearman \( r \)) each of the recovery related measures (K-10, RAS overall and RAS subscales) and stage of psychological recovery as identified by the SIST-R (see Table 2) to provide a preliminary test of the construct validity of the SIST-R. However, given that testing for a significant correlation between participant’s scores and stage of psychological recovery may mask the variability between each stage of recovery, a graphical analytical strategy was utilised. Through the use of control charts, a modified method of Statistical process control (SPC) was employed as a means of graphing the variation in participant’s mean scores across each stage of psychological recovery (21). In study one, it was demonstrated that there are specific recovery-related indicators that are salient to each particular stage of psychological recovery. Thus it is to be expected that the pattern of means for continuous measures of recovery-related processes would fluctuate across stages according to the specific process being measured.

A limitation of this study is the small number of participants involved in the validity testing phase of study. An analysis of variance was not conducted to test for a significant difference between the mean scores on recovery and well-being measures across stages of psychological recovery as identified by the SIST-R. This has limited both the interpretation (in terms of significance) and generalisability of the results.

**RESULTS & DISCUSSION**

*Convergence between the Stages of Psychological Recovery measures.*

In total, nine out of 17 participants were identified as being in the same stage of recovery by both measures. For the remaining eight participants the difference did not exceed one stage i.e. participants were identified as being in adjacent stages. The probability of concordance ranges between 0.5 and 1, with Somers’ \( D \) values closer to 1 indicating increased predictive ability. The concordance between participants stage of recovery as identified by the
interview-based measure (SIST-R) and stage of recovery as identified by the self-report measure (STORI) as indicated by Somers’ $D$ was .61, $p = .004$. These results indicate that the concordance between the two measures is substantial, thus providing preliminary support for the validity of the SIST-R as a measure of an individual’s stage of psychological recovery.

**Construct Validity of the SIST-R as a stage-based measure of psychological recovery.**

Table 2 shows the correlations between participant’s scores on the SIST-R and those of the K-10 and RAS (including subscales). Although the RAS overall measure of recovery and goal orientation subscales demonstrate a significant positive linear relationship all other scores do not. Theoretically non-linearity in individual psychological processes can be expected across stages. However, given the small sample size there is a need to examine these results on a larger scale.

Insert Table 2.

**Stage of Psychological Recovery and Psychological Distress**

The pattern in Figure 1 provides preliminary validation of the SIST-R to identify an individual’s stage of recovery in accordance to what can be theoretically expected in relation to psychological distress (depression and anxiety) across each stage of psychological recovery. An individual in the Moratorium stage is more likely to feel hopeless about the future and the possibility of recovery. In the Awareness stage an individual has become aware of the possibility of recovery and is contemplating a better future but as yet is not engaged in the work of recovery. Relative to the challenges that are faced when one begins to engage in the work of recovery participants in the Preparation stage are more likely to show an increase in anxiety. In the Rebuilding and Growth stages an individual is likely to be experiencing decreasing levels
conceptually consistent with the increasing levels of optimism, goal achievement, and contentment associated with the latter stages of recovery.

**Insert Figure 1.**

*Stage of Psychological Recovery and Goal and Success Orientation.*

Figure 2 demonstrates how participant’s scores on the goal and success orientation subscale remain fairly stable between the Moratorium and Awareness stage and then begin to increase as an individual moves from the Awareness stage through to the Preparation stage. This pattern is consistent with what can be theoretically expected. Goal orientation begins in the Preparation stage. Progression towards goals and success in the pursuit of goals increases motivation towards autonomously chosen goals which an individual in the Rebuilding stage begins to formulate and act upon based on their perceived efficacy to do so. For the individual in the Growth stage, goals are autonomously chosen in relation to the person’s values and belief in their personal competence to carry them out.

**Insert Figure 2.**

*Confidence and Hope.*

The pattern of means presented in Figure 3 depicts an increase in confidence and hope between the Moratorium and Awareness stages. In the movement from Moratorium to Awareness an individual goes from feeling hopeless about the future to considering that recovery or having a better life may be possible. Engagement in the work of recovery can bring a sense of success or achievement which in turn can promote personal confidence and hope.
towards future goals (22). An individual in the Rebuilding stage is readily able to describe particular activities that they are engaged in, roles they are undertaking, and goals that they have achieved or are on the way to achieving. In particular, activities and attainments are described in such a way that demonstrates how positively these can enhance an individual’s sense of self and hope for the future. The person in the growth stage has developed faith in their ability to persevere with setbacks and achieve goals. As such, individuals in the Growth stage look forward to the future with hope and express this in terms of confident expectation.

Insert Figure 3.

Willingness to Ask for Help.

The pattern of means presented in Figure 5 demonstrates that individuals in the Preparation stage are more willing to ask for help. This pattern is theoretically consistent with what could be expected. Engaged in exploring what might be personally possible, individuals in this stage are more likely to seek out supporting resources which can assist them in their recovery process. Harnessing support and relying on others is an integral function of laying the groundwork for recovery that takes place in the Preparation stage.

Insert Figure 4.

Not Dominated by Symptoms.

Not being dominated by symptoms relates to the degree in which individuals not only manage their symptoms but the amount to which they perceive the symptoms of their illness as being a threat to their recovery. The pattern of means presented in Figure 6 demonstrates a
positive linear increase from Moratorium to Preparation, a decrease in the Rebuilding stage and then another increase in the Growth stage. In the Rebuilding stage is when an individual makes the greatest leap towards autonomously chosen goals i.e. engagement in life without others support. Theoretically the primary difference between participants in the Rebuilding stage and those in the Growth stage is their perceived control over their illness.

Insert Figure 5.

Summary

Overall, the results of these analyses provide preliminary evidence for the construct validity of the SIST-R. Processes that are conceptually convergent or discriminatory to each stage of psychological recovery demonstrated a pattern of relations that were consistent with what is theoretically expected for each stage. However, given the small sample size utilised in this study the interpretation and generalisability of these results are limited.

Implications and Further Research

In the drive for recovery-oriented mental health services the need for assessment and outcome measures that not only guide support practices but are practical to use within such settings is apparent (23). This study builds on an already extensive body of work currently being undertaken to conceptualise a framework of recovery based on the lived experiences of individuals who have journeyed from illness to wellness.

A larger sample size would allow for a significant interpretation of distinctly measurable associations between psychological growth and recovery constructs and that of psychological recovery as a stage-based process. Moreover, a comparison between stages of psychological recovery and instruments designed to measure aspects of hope, self-determination and self-efficacy could enhance the validity of the measure and provide evidence for the
interplay between constructs associated with psychological growth and the stages of psychological recovery model.

Acknowledgements

Research for this study was supported by a grant from Australian Rotary Health.

References


13. Clarke S, Oades LG, Dean FP, Caputi P. The role of symptom distress and goal attainment in assisting the psychological recovery in consumers with enduring mental illness. *Journal of Mental Health*. in press.


Tables 1 & 2

*Table 1. Key Indicators associated with each Stage of Psychological Recovery*

<table>
<thead>
<tr>
<th>Moratorium</th>
<th>Awareness</th>
<th>Preparation</th>
<th>Rebuilding</th>
<th>Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hopelessness</td>
<td>Taking Notice</td>
<td>Tentative Goal Forma</td>
<td>Achieving Goals</td>
<td>Optimism</td>
</tr>
<tr>
<td>Apathy</td>
<td>Considering Alternatives</td>
<td>Developing Resource Networks</td>
<td>Sense of Productivity</td>
<td>Strong Sense of Self-Worth</td>
</tr>
<tr>
<td>Powerlessness</td>
<td>Aspiration without Direction</td>
<td>Reliance on Others</td>
<td>Building Resilience</td>
<td>Autonomy</td>
</tr>
<tr>
<td>Withdrawal</td>
<td></td>
<td></td>
<td></td>
<td>Contentment</td>
</tr>
</tbody>
</table>

*Table 2. Correlations between SIST-R and psychological distress and recovery*

<table>
<thead>
<tr>
<th></th>
<th>SIST-R</th>
</tr>
</thead>
<tbody>
<tr>
<td>K-10 Measure of Psychological Distress</td>
<td>-0.13</td>
</tr>
<tr>
<td>RAS Measure of Recovery</td>
<td>0.50*</td>
</tr>
</tbody>
</table>
RAS (Subscale) Goal Orientation 0.67**
RAS (Subscale) Confidence and Hope 0.37
RAS (Subscale) Willingness to Ask for Help 0.20
RAS (Subscale) Not Dominated by Symptoms 0.41

*Correlation is significant at the 0.05 level (2-tailed); **Correlation is significant at the 0.01 level (2-tailed).

Figures 1 - 5

Figure 1. Control chart: pattern of means for psychological distress across stages of psychological recovery as identified by the SIST-R.
Figure 2. Control chart: pattern of means for Goal Orientation across stages of psychological recovery as identified by the SIST-R.

Figure 3. Control chart: pattern of means for Confidence and Hope across stages of psychological recovery as identified by the SIST-R.
Figure 4. Control chart: pattern of means for Willingness to Ask for Help across stages of psychological recovery as identified by the SIST-R.

Figure 5. Control chart: pattern of means for Not Dominated by Symptoms across stages of psychological recovery as identified by the SIST-R.