Management Development Institute of Singapore (MDIS)

# RECOVERY STRATEGIES OF THE FORMERLY DEPRESSED – A STUDY OF WHAT HELP

Diploma in Psychology

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## Table of Contents

**Abstract**

Anyone can be stricken by mental illness. As a nation with a fast pace of living and high-stress environment, the nature and prevalence of mental illnesses in Singapore is comparable with other developed nations. As Singapore moves towards having an emotionally resilient and mentally healthy community, it is important that Singapore pays attention to the challenges faced by the mentally ill. Out of the mental illnesses that afflict Singaporeans, depression is the most common and affects approximately 170,000 of them. Increasingly though, the Institute of Mental Health, Singapore and the United States has moved towards a more enlightened view towards mental illnesses, that is, it is recoverable and can be treated. A central theme that recurs in the review of literature was that each individual has their own unique definition of recovery. Hence, there can be "no one size fits all" treatment plan. However, as a patient moves through the process of recovery, he/she has to build in coping strategies. There is a gap between the drive towards mental wellness and the understanding of practical coping strategies. Hence, this study examines 30 individuals who have recovered from depression and consolidates the most common recovery strategies. Simply put, this report lays out the best practices of what helps depressed individuals in the recovery process.

# Recovery Strategies of the Formerly Depressed

Anyone, young or old can be stricken by mental illness at least once in their lifetime. However, only one third of those stricken will seek help. This suggests that the prevalence of stigma remains deeply rooted. However, aversion to treatment does not mean that there is no possibility of recovery. With increasing access to information, many people are seeking self-help to improve their way of living. Similarly, people who may be experiencing depressive symptoms can help themselves if they are committed to employing effective strategies. Given that depression is one of the most common mental illnesses in Singapore, this study focuses specifically on depression. The study aims to identify common symptoms and establish the most effective strategies by looking at the demographic of the formerly depressed. This study is written with a solution-centric mindset. It is also written with four groups of people in mind, the mental health professionals, caregivers, those currently diagnosed with depression and those who experiencing symptoms but are unwilling to seek professional help.

Approximately 450 million individuals worldwide will suffer from some form of neuropsychiatric disorders in their lifetime (WHO, 2001). Given that more than one in 10 Singaporeans will suffer from mental illness at least once in their life (Chang, 2011), the topic of mental illness has relevance to a huge demography. Singapore announced its vision in the 1st National Mental Health Blueprint 2007 - 2012 (IMH, 2010) to have an "*emotionally resilient and mentally healthy community*". In a society that places high emphasis on excellence and meritocracy, Singaporeans are conditioned to work for rewards at a young age. This high level of stress has taken its toll on Singaporeans as an increasing reduction of the onset of median age continues to occur. The top three most common mental illnesses are depression, alcohol abuse and obsessive compulsive disorder (Chang, 2011). Of which, depression is the most common mental illness. It plagues approximately 170,000 of the adults, more women than men (Chang, 2011).

The statistic for the lifetime prevalence rate of depression has grown from 5.6% in 2003 to 6.3% in 2010. The National Mental Health Study (NMHS) conducted in 2003 revealed that adults aged 20 to 59 years old living in Singapore, reported lifetime prevalence of depression to be 5.6% (Chua et. al., 2004). The Singapore Mental Health Study (SMHS) conducted in 2010 revealed that this rate has since rose to 6.3%, with the median age of onset set at 25 (Siow, et. al., 2012). This statistic is consistent among the youths, as one in 14 young people have been reported to have major depressive disorder (Wee, 2012).

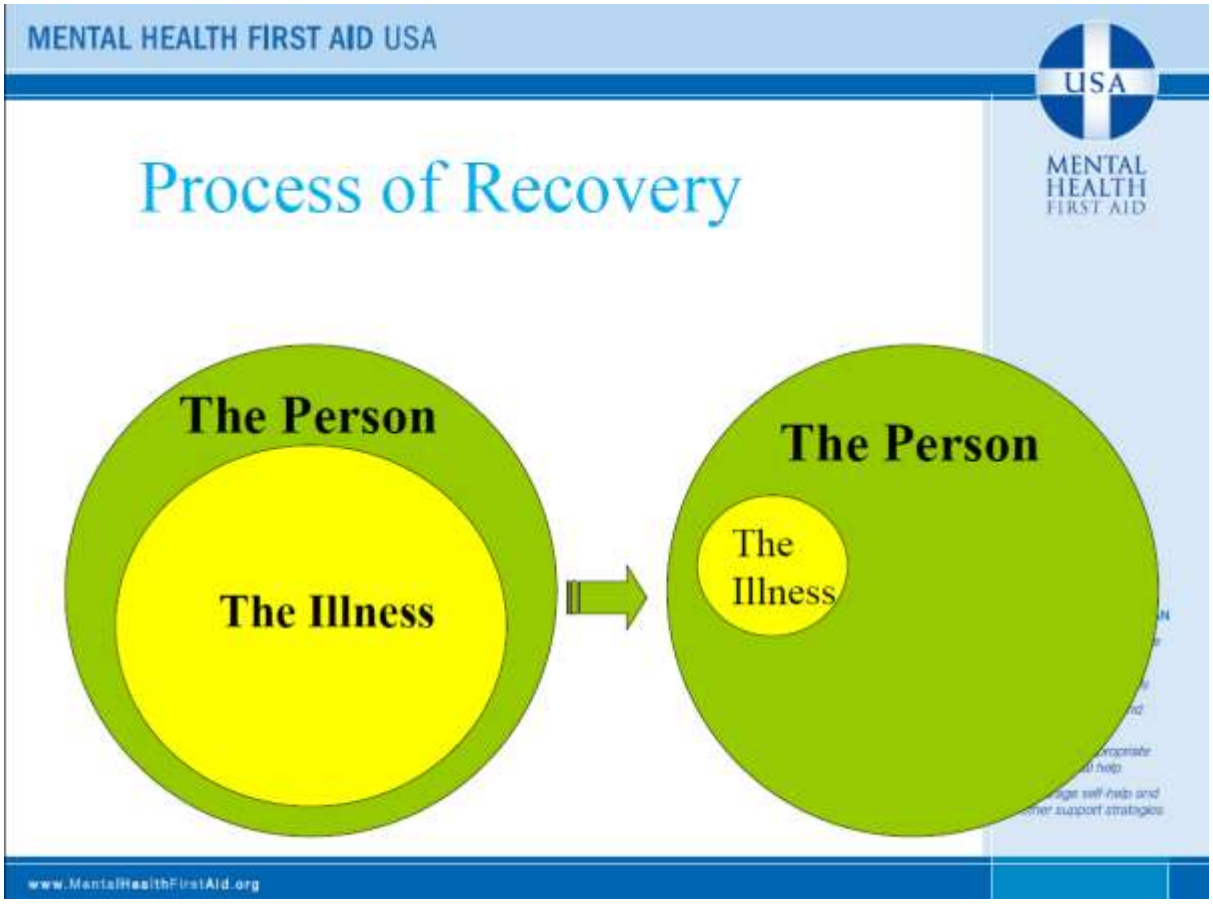
Major depressive disorder (MDD) is classified as a mood disorder in the revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychiatric Association, 2000). The depressive episode can be a singular episode or recurrent. The World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) defines three typical depressive symptoms (WHO, 1992). They are depressed mood, anhedonia and reduced energy. Two of the three should be present before a depressive disorder diagnosis can be made. According to DSM-IV-TR, the two main depressive symptoms are depressed mood and anhedonia, and at least one must be present before a diagnosis of MDD can be made.

The fact that anyone, young or old, can be affected heightens the relevance of mental wellness in today's world. However, misconceptions about people suffering from mental illness still run deep in the society. More than half of the population in Singapore believes that the public should be protected from people with mental illnesses, with more than one in three believing that the latter are violent and dangerous (Chang, 2007). In my opinion, these

misconceptions give rise to stigma and subsequently affect the people with mental illnesses in more personal ways than can be seen. For example, research has shown that half of those with MDD took up to four years before they seek treatment (Wee, 2012). Even still, approximately only one in three will seek help. This is corroborated by the SMHS conducted in 2010, where it revealed that 59.6% of those who suffer from MDD will not seek help. Out of those who seek help, one in two will keep their illness a secret (Chang, 2007). One reason causing this aversion to active seeking of treatment can be attributed to stigma (Chong, 2013).

In the SMHS, the treatment gap for those with MDD comes in an alarming 59.6%. The SMHS revealed that the median number of years of delay in help-seeking amounts to four years (Chong, 2013). Delaying or avoiding treatment can have huge implications on the person and people around him/her. Dr. Jasmine Pang, a senior clinical psychologist at Changi General Hospital (CGH) explained that, "*The illness can affect their ability to make friends, find a partner or job. It can also affect their ability to contribute to society*" (Wee, 2012). Especially for the young, delaying or avoiding treatment may mean that they can never have a head start in life.

However, a delay in treatment does not mean that recovery is not possible. With an active knowledge of the recovery process and commitment to change, there is a good possibility that the depressed individual will recover, over time. What then does recovery mean? Over the course of research, numerous definitions of recovery surfaced. In this report, three such definitions shall be discussed. From Webster's Dictionary, recovery is defined as "*a process of regaining one's life to a usable form; reclaiming one's personal power from one's illness*." In another definition, recovery refers to "*the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms*" (The Carter Centre, 2003). Further still, there are some who defined recovery as "*a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential*" (SAMHSA, 2012). As it can be seen from the above definitions, there is no standard agreement of what recovery means. Hence, it can be said that recovery is different for everyone and recovery ultimately depends on the individual's definition. In principle though, recovery can be broadly defined as one where the mental illness is not dominant. It does not have to be absent but it must not disturb the functioning of the individual. The figure below illustrates the concept of recovery where the illness no longer becomes dominant in the patient's life (Reinhard, 2013).




In the training manual for peer specialists (a vocation where people who have recovered from mental illness help another who have recently been diagnosed), recovery is defined as the "process of gaining control over one's life" and the direction where they want that life to go (Appalachian Consulting Group, 2011). The disabling power of the mental illness was discussed and five stages in the recovery process were identified.

The researchers identified a common pattern in the recovery process where the depressed individual moves from being overwhelmed by the impact of the illness to the recognition that life is limited. At this second stage, he has given in, to the disabling power of the illness. He is unwilling to make a commitment to change. Gradually as he starts to question the disabling power of the illness, he starts to see that change is possible (third stage). As he moves on to challenge the illness in the fourth stage, he grows committed to change and requires resources and support. As the individual gradually regains control of his life, he looks towards moving beyond the disabling power of the mental illness. A pictorial illustration can be found in the Appendices (I) and (II) (Appalachian Consulting Group, 2011).

Given that each individual has their own definition of recovery and there is a movement in the direction of embracing better mental health and wellness, it is the researcher's interest to establish the most effective strategies across those who recognized themselves as having recovered from depression, so as to plug the gap resulting from the lack of a consolidation of practical strategies.

# Method

## Participants

The study focused on people of all ages who had brushes with depression. Data was collected from 30 participants. The sample comprised of a wide demographic from students to working professionals. The survey was supported with participants from Sunshine Path, a support group managed by Singapore Association of Mental Health for those with depression or anxiety disorders.

## Design

A quantitative method was employed in this study. Surveys were preferred over qualitative interviews as this offer an opportunity to collect statistical data of the behavioural and emotional responses. This method was also chosen after considering the fact that it may not be easy for participants to divulge information, as private as a recount of their emotions during their first encounter with depression, in a face-to-face setting with a stranger. Collecting data via surveys also facilitates easy comparison of the strategies participants employ in the journey to recovery.

## Measures

A variety of techniques were employed in the crafting of the survey questions. Most of the questions consist of a variety of choices, from which, participants can choose from. Questions with a choice of a yes or no were also used to measure the participant's responses. In addition, multiple choice questions were also administered to offer participants the variety of choice. Last but not least, open-ended questions were infused sparingly to allow for qualitative expression by the participants. A copy of the informed consent form and survey questions can be found in Appendices (III) and (IV).

## Procedure

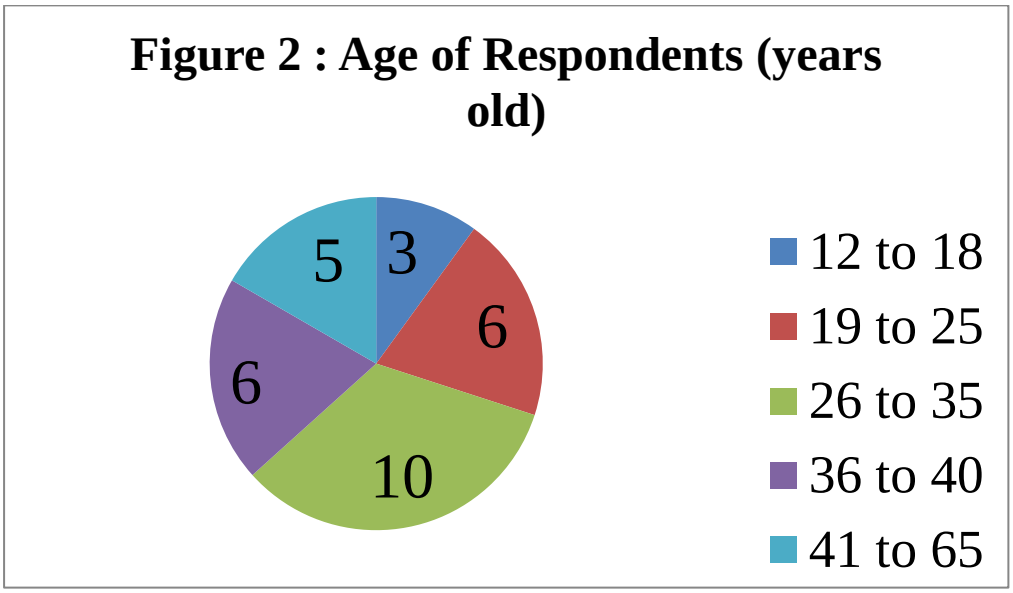
Before the survey was administered, the respondents were shown the informed consent form to help them better understand the objectives of the study. Following which, the surveys were administered in two manners. While most of the responses were collected via the online medium, 6 physical copies of the surveys were administered to people in the support group. In a bid to maintain confidentiality, no identification of the participants was made accessible. This is done to keep the data free from any personal bias. 27 participants responded to the online survey. As three of the online respondents declared that they were not diagnosed clinically, their responses were removed to avoid tampering. As a result, the number of participants whose responses were considered for this study came up to a number of 30. This meets the initial target sample size.

# Results

The purpose of this study is to establish the most common recovery strategies of the formerly depressed to plug the gap between the drive to recovery and a lack of practical strategies. In this section of the report, analysis of the recovery strategies will be done according to the bio-psycho-social model of health. A copy of the results can be found in Appendix (V).

30 participants were surveyed and it was a proportionate study among the genders with a total of 16 females and 14 males. The participants surveyed spanned a wide age range.

The youngest respondent was 17 years old while the oldest is 58 years old. The pie chart below shows the distribution of the ages of the respondents.




Consistent with the Singapore Mental Health Study in 2010, where the median age of the onset of major depressive disorder was 26, a majority of respondents (14 out of 30) reported their first onset to be between 19 – 25 years old.

It appears almost consistent that all the depressed participants who have recovered sought professional help at one point in their illness. 28 out of 30 respondents indicated that they had sought professional help. Out of these, 26 took medication. This suggests that at least 26 had sought help from a psychiatrist. On a similar note, 23 respondents also reported seeking counselling services to help them in their recovery.

Adopting a biological approach towards recovery, medication-assisted recovery addresses the chemical imbalance in the brain of the depressed and uses medication to alleviate the depressive symptoms such that the depressed are able to cope with the underlying issues. However, psychiatrists have established in their research on the placebo effect that the belief in the medication rather than the medication has a significant part to play in recovery. Hence, the participants in this study were asked questions relating to medication to determine their attitude towards medication. Of the 26 who take medication, 25 indicated that they believe that medication supports them in their recovery. This means that only one respondent taking medication does not believe that it helps him/her in recovering. While it is heartening that the overwhelming majority believe that medication supports their recovery, the singular negative response is of concern too, since the attitude towards medication often determines its therapeutic effect.

Moving on to psychosocial rehabilitation, the study turns its focus to the use of counselling services. Of the 23 who sought counselling services, opinions were collected to determine their attitude towards seeking talk therapy and the corresponding effectiveness. 20 of the 23 elaborated in the same vein that talking to a counsellor helps them to air their concerns but they recognized that ultimately they hold the key to change. The respondents revealed an appreciation of the counsellor's effectiveness in helping them gain insights into their illness, challenge and change their negative thinking patterns. The sharing of coping strategies and the recognition of a need to relate to someone who can understand them who does not judge them, were consistent themes that recur in the responses. On the other hand,

four respondents demonstrated negative attitudes towards counselling, expressing that the counsellor tends to go out of tangent and do not help them much.

On a corresponding note, respondents were surveyed on the use of counselling hotlines. The convenience and anonymity of counselling hotlines appeared to be unpopular among respondents as only 13 out of 30 respondents reported using them. The reasons that account for the unpopularity will be explored in the discussion section.

In the recovery from depression and route to wellness, social support plays an important role. Social support, whether physically or emotionally helps patients in their recovery. As such, a few of the survey questions were dedicated to learning more about who are the common pillars of support. The table below provides a statistical overview of the popular sources of support.

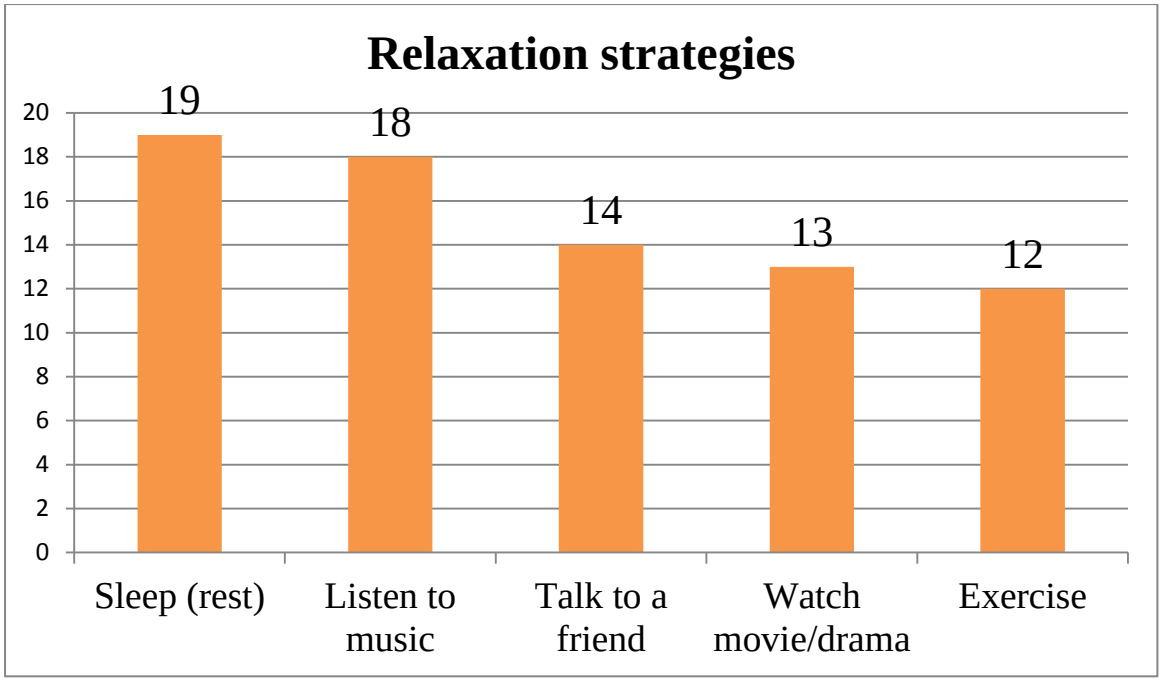
| Immediate Family | Spouse | Friends | Support group | Mentors | None |
|---|---|---|---|---|---|
| 12 | 2 | 9 | 2 | 3 | 2 |

The survey identified that the depressed tend to turn to family and friends for emotional and social support. A clearer breakdown revealed that the top three sources of support come in the form of friends (9), mother (5) and siblings (5). The impact of this finding highlights the most common caregivers in the lives of the depressed.

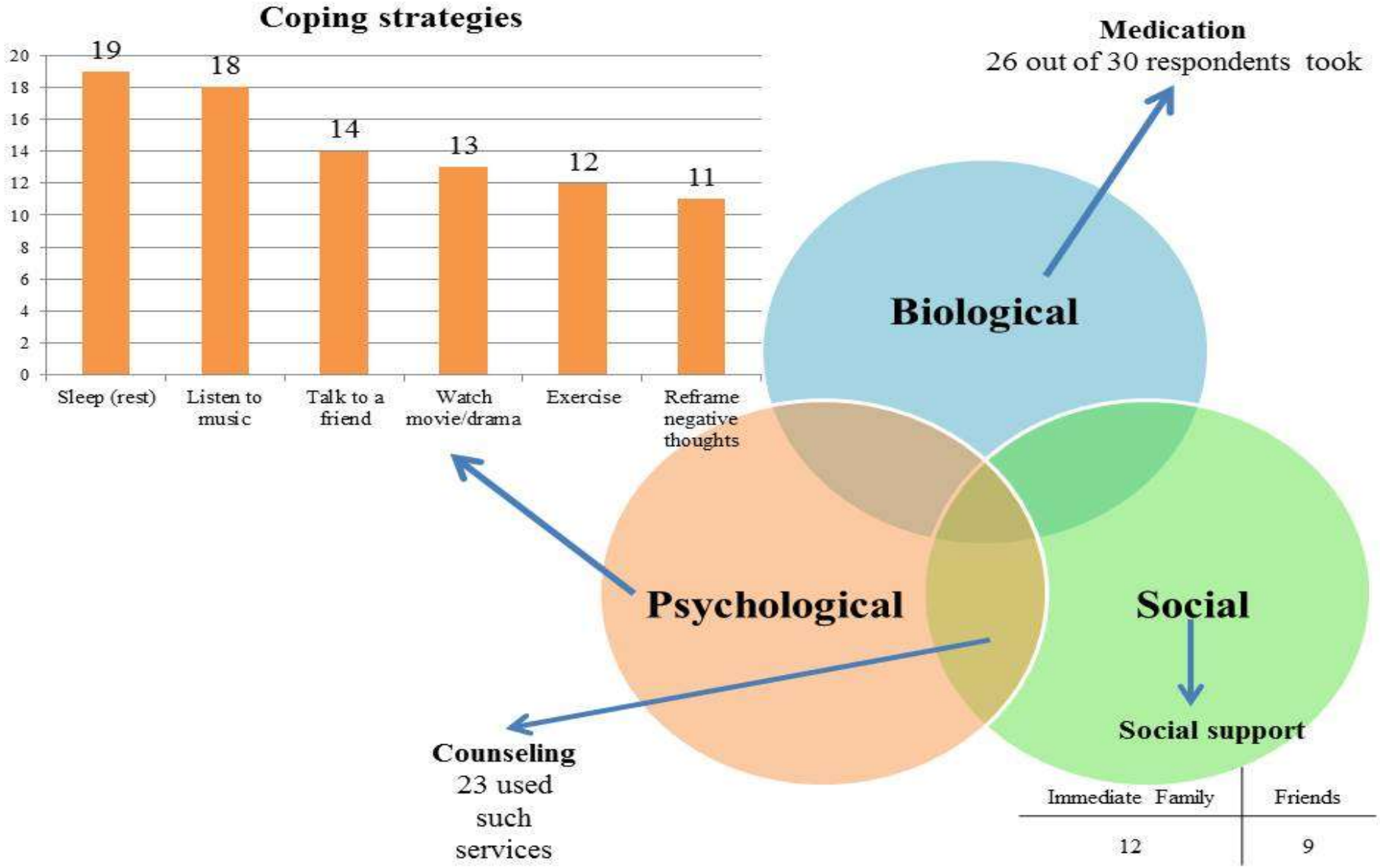
The survey took a qualitative stand towards identifying coping strategies. The responses are grouped in common categories in the table below, as participants were asked, "What did you do to feel better (when you were diagnosed with depression)?"

| Reframe thoughts (think positive) | Seek help (doctor and counsellor) | Talk to someone (social support) | Exercise | Did nothing |
|---|---|---|---|---|
| 11 | 9 | 6 | 6 | 6 |
| Spiritual | Eat good food | Rest (stay in bed) | Self-help | |
| 4 | 3 | 3 | 2 | |
| Keep occupied | Shop (retail therapy) | Listen to music | Pets | Self-mutilate |
| 2 | 2 | 2 | 2 | 2 |
| Smoke | Drugs | Drink (seek solace in alcohol) | Cry | Creative activity (song-writing, art) |
| 1 | 1 | 1 | 1 | 1 |

A follow-up question, "What do you do to relax and unwind", was asked to determine the consistency of the coping strategies of the participants surveyed. The top five relaxation choices used by the participants are shown in the bar graph below.




Adopting the bio-psycho-social model towards health (Engel, 1977), the most effective strategies identified by respondents is summarized in the following diagram.


Coping strategies
20
18
16
14
12
10
8
6
4
2
0
19
18
14
13
12
11
Sleep (rest)
Listen to music
Talk to a friend
Watch movie/drama
Exercise
Reframe negative thoughts
Medication
26 out of 30 respondents took
Biological
Psychological
Social
Social support
Immediate Family
Friends
12
9
Counseling
23 used such services

## Discussion

To begin with, as each individual has their unique definition of recovery, an immediate thought that surfaces may be that the recovery strategies suggested in this study will not work for everyone, and hence will be irrelevant. However, the relevance of the study is not in question. This study serves purely as a consolidation of the most effective recovery strategies of the formerly depressed. The objectives of this study is to contribute suggestions and make recommendations to interested parties who wish to find out more about the common strategies that work for those who recover from depression. It is in no way meant to be a prescriptive study.

Earlier, it was discussed that the counselling hotlines appear to be unpopular as an intervention since only 13 out of the 30 participants surveyed reported using them. The relative unpopularity could stem from a variety of reasons, one of which could be because people usually resort to phone counselling services when they encounter a crisis. Hence, it may not be that commonly used as a channel for expression by the depressed. Another reason could be due to the low publicity given to these counselling services. While it can be understood that the organizations or government may not want to encourage the public to abuse these services or come across as endorsing people with mental illnesses, this poses a problem. As the popular adage goes, "out of sight, out of mind", if these services are not expressively made known via publicity, how can the public be expected to be aware of such services? A list of the general and mental health related helplines can be found in the Appendix VI (NCSS, 2010).

In the recovery from depression and route to wellness, social support plays an important role. Given that the survey helped to identify the top three sources of support for the depressed, additional psycho-education resources can be targeted or at least made available to these parties to equip them as they support the depressed in their journey of recovery. The factors identified may help guide resource allocation, policy formulation, programme development and training for caregivers.

While it is not unusual that friends are commonly sought for support, there was an interesting finding that those who sought solace in their spouses was in contrast much lesser. The expectation that the spouse should be the closest and hence most natural support was proven to be wrong. However, this could be due to the fact that most respondents reported their first onset to be between 19 to 25 years old. In contrast, the median marriage age in Singapore is 26 years old (Singapore Department of Statistics, et. al., 2012). Hence, the respondents may not have a spouse at the time of the onset of the illness and could not have received any foreseeable support. In hindsight, a question on the marital status of the participants may help in accounting for the reason behind why few people, who were clinically depressed, look to their spouse for immediate support in times of emotional crises.

While on the same page of additional fields, questions on the participants' race and religion could have been asked so as to obtain data that allows the study to establish a more comprehensive demographic. A comparison between the more popular coping strategies across the demographic of different races can be done to investigate the cultural influences in recovery of the depressed. Likewise, religious beliefs may influence the coping strategies of the depressed and these could be investigated by grouping people with similar religious beliefs and comparing their preferred recovery strategies.

On another note, some of the questions could have included clarifications of terminologies used, so as to make the survey more accessible to the layman. Some of these terminologies include affect, form of thoughts, self-contemptuous, word salad and nihilistic.

Another issue which warrants consideration involves the validity of the study. The prevalence of chronic illnesses might cause patients to develop depression. In the SMHS, it was found that 14.3% of those with chronic physical illness have at least one mental disorder (Chong, 2013). Given that there are other illnesses frequently associated with depression, this study neglected to look at other conditions which might be relevant to the root cause of depression for the participants. At the same time, there are various forms of depression. These include dysthymia, bipolar depression and major depressive disorder. The latter is what the study is concerned with. A lack of differentiation of the diagnosis of the participants in the study may blemish the validity and accuracy of the results of the study.

At the same time, the survey findings may not be representative of the depressed individuals in the Singapore population. No weightage of the data was done to adjust for oversampling and post-stratify by age and ethnicity distributions between the survey sample and the Singapore resident population in 2013.

Armed with hindsight, it will help to communicate clearly to participants that this study focuses on those who have suffered major depressive disorder rather than dysthymia or bipolar. The data collected should be adjusted for oversampling and stratify by age and ethnicity distributions so as to produce a more representative study.

Over the course of the study, it occurred that program environments that promote recovery can play an important role in the recovery process. Further studies can also consider the influence of environments on the process of recovery. Questions like what are the conditions that will facilitate recovery, relaxation and rehabilitation can be explored. On a similar note, the impact of stigmatization affects the depressed in their journey to recovery. An evaluation of the extent of the impact as well as the attitude the depressed hold towards the stigma will help to shine light on its impact. The impact of stigmatization may influence the coping strategies that the formerly depressed employ.

## Conclusion

It is not the intention of the study to provide a prescriptive summation of recovery strategies that should be adopted, for each person has his/her own unique definition of recovery. To plug the hole caused by the lack of practical strategies even as Singapore strives towards mental wellness and recovery for the mentally ill, this study merely aimed to establish the most common and effective recovery strategies from the perspective of those who recovered from depression. The strategies identified are suggestions for those who are depressed whether diagnosed or not. Likewise, these recommendations are merely suggestions for the mental health professionals and caregivers, in their work to support those who are depressed.

Adopting the bio-psycho-social model towards health, a summary of the most effective strategies identified by respondents is provided through a diagram that can be found under the results section on page 14. The journey of recovery does not stop once a person recovers from the depressive symptoms. In the fifth stage of the recovery process, as a person "*moves beyond*" the disabling power of the illness, maintenance takes over. The individuals now look forward towards maintaining their health, preventing relapses and maximizing their capability for achievement (to be the best they can be). Taking a macro

view, it will be interesting to do a comparative study between the bio-psycho-social model of recovery identified in this study and the bio-psycho-social model of optimal health.

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