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Impact of the Wellness Recovery Action Plan (WRAP) on the Psychiatric Patient with Symptoms of Psychosis

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Abstract

The purpose of the present research was to determine the effectiveness of the Wellness Recovery Action Plan (WRAP) on the psychiatric patients as group therapy intervention. A total of 8 adult patients including 4 females and 4 males (aged 26-55) were selected through purposive sampling from the outpatient's department of a psychiatric rehabilitation facility in Karachi. Patients participated in group therapy intervention for (12 sessions/ bi-weekly) for a period of six weeks. The intervention therapy was based on quasi experimental design with pre and post assessment. The Symptom Checklist 90-R was administered to assess pre and post assessment of symptoms frequency and intensity of the patients. Paired t-test for the pretest-posttest analysis was carried out to statistically analyze the impact of the intervention on the patients. Results indicated that there was a statistically significant reduction ($M=0.65$, $SD= .29$) ($t= 6.26$, $p<.05$) in the overall global symptoms severity of the participants. The study has implications as a structured group therapy program on a small group of patients with severe mental illnesses. Wellness Recovery Action Plan is applicable for the management in psychiatric rehabilitation as evidence based practice for future research.

Keywords: Wellness Recovery Action Plan; psychiatric rehabilitation; patients with psychosis

1. Introduction

Wellness Recovery Action Plan was developed in the USA by a user of mental health services, Mary Ellen Copeland, and is a recovery approach based on self-management in order to improve mental health and well-being (Copeland, 2002). It is a system for monitoring, reducing and eliminating the uncomfortable symptoms and emotional distress (Copeland, 2001).

Pratt (2007) defines "Wellness Recovery Action Plan (WRAP)" as a self-management strategy which provides consumers with a tool to identify strengths and coping strategies that can be used to monitor triggers or early warning signs of the symptom exacerbation and to develop a personal crisis plan to help them prevent relapses and foster personal wellness". The program approach helps people to: 1) decrease and prevent intrusive or troubling feelings and behaviors; 2) increase personal empowerment; 3) improve quality of life; and 4) achieve their own life goals and dreams" (Copeland, 2012).

The program itself is structured and comes with a step by step guideline to make individualized plans. It explores the 5 key values including hope, personal responsibility, education, self-advocacy and support. Through the self-management process the individual is eventually able to identify the triggers that contribute to their psychological distress and also establish some tools to manage those triggers. The process also involved the establishment of a crisis plan (Pratt, 2013).

World Health Organization (2015) defines disability as "an inability to participate or perform at a socially desirable level in such activities as self-care, social relationships, work and situationally appropriate behavior. Most often there is no single treatment sufficient for schizophrenia and other psychotic disorders. Pharmacotherapy alone does not help with lack of coping skills or self-management of the associated negative symptoms of psychiatric disorders. This is why a combination of a range of individual and group psychotherapies are used for helping patients with psychosis (Lockwood, 2004). In addition, with respect to Pakistan, the psychiatrists available to the community are one to one million ratios (Afridi, 2015), which makes it even harder to make the facilities available to population. Community based care can play a vital role in management of symptoms and prevention of relapse (Tharani, 2012).

Many studies have been conducted so far in order to assess the effectiveness of the program however there are not many during the past few years.

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Cook (2016) assessed the effectiveness of the program in a randomized control trial with severe and persistent mental issues. The results showed a significant reduction in the psychiatric symptoms, increase in the hopefulness and an improved quality of life. The WRAP group showed significant effects on the significant recovery areas of life, quality of life and psychiatric symptoms. It has also shown to improve the self-esteem and reduce the addictive behavior (O'Keeffee, 2015). Effectiveness of the wellness recovery action plan in a matched control trial. The participants showed a significant improvement in their perceived social support (Mak, 2016).

Fukui (2011) examined the effects of WRAP participation on psychiatric symptoms, hope, and recovery outcomes for people with severe and persistent mental illness, revealed statistically significant effects for the psychiatric symptoms and hope of the participants. Cook (2010) researched the effectiveness of WRAP in reducing depression and anxiety and increasing the self-perception of recovery. It also increased their self-confidence and the orientation towards the goals. There was also an interesting fining of this research that the impact of the sessions increased with a greater number of sessions.

In another research, the relevance and impact of WRAP was evaluated in the group setting for individuals with mental-health problems. Focus groups and interviews were conducted. The findings reported a positive impact on the well-being of the participants. The significant contributor to the well-being was learning about the recovery process, self-awareness and also the application of WRAP in daily lives (Pratt, 2012). All these research studies highlight the effectiveness of the program in various parts of the world and on a varying degree of populations. The present research explored the impact within the Pakistani community.

2. Materials and Methods

Quasi experiment pre and post intervention design was used for the research because the same group of patients were assessed before and after the completion of intervention groups. The assessments were carried out by the researcher individually with each single patient in with structured questions formats of demographic information form and questionnaire of assessment Patients were informed about the purpose of the research, after willingness and voluntary signing the consent form and the Symptom Checklist-90-revised version was administered for pre and post assessment.

2.1 Participants

A total of 8 patients including 4 females and 4 males were selected using purposive sampling for this intervention group, as limited sample was available with commitment to participate in this study from out patient's facility of psychiatric rehabilitation center. All the patients were able to read and write in English. The selected patients were, taking medication from the center, with history of illness since last 3-4 years.

Inclusion criteria. Patients who were diagnosed from a psychiatric disorder based on DSM-5 criteria were included in the research, participants between 26-55 years of age were included in the research. The reason for this age group was that the WRAP program has been used in this age group previously and have been found to be effective. Patients referred by the psychiatrist, with stable symptoms were included.

Exclusion criteria. Patients outside the age bracket of 26-55 were excluded. Patients who were actively experiencing hallucinations were excluded from the group for the sake of suitability of the group activities.

2.2 Instruments

Informed consent. Informed consent was signed by each patient prior to the intervention when they agreed to attend the intervention groups for a period of 6 weeks.

Demographic Information form. A demographic information form was filled out by the researcher related to the basic information included their name (optional), age, gender, education, occupation and marital status and history of illness.

Symptom Checklist 90-R (SCL-90-R). The symptom checklist-90-revised version (Derogatis and Unger, 2010) was used as an outcome measure for the study to assess the psychiatric symptoms of the patients.

2.3 Procedure

The current research was conducted in the outpatient department of a psychiatric rehabilitation facility in Karachi, Pakistan. The evaluations were carried out in a pre and post intervention format. For this research, a total of 12 intervention sessions were conducted; two sessions per week over a period of 6 weeks. After the successful completion of the intervention for 12 sessions (1.5 hours each), patients were re-assessed for post assessment. Follow up sessions were conducted for the patients with the aim of helping them carry out the self-help plans that they have made and also to provide them free of cost intervention services.

2.4 Wellness Recovery Action Plan Program

Copeland (2012) defines WRAP program as following; "WRAP is a personalized wellness and recovery system born out of and rooted in the principle of self-determination. It is a wellness and recovery approach that helps people to: 1) decrease and prevent intrusive or troubling feelings and behaviors; 2) empower the individuals; 3) helping

individuals' quality of life improvement; and 4) achieve their own life goals and dreams".

WRAP provides a structured step by step process to make individualized plans. It explores the 5 key values including hope, personal responsibility, education, self-advocacy and support. The individualized plans help in the identification of the triggers and tools that contribute to the mental health. It proposes ways to monitor oneself and then develop action plans to manage the symptoms. Triggers are the events/situations that provoke the difficult feelings and behaviors. The action plans include strategies that are needed in the crisis when they observe that the things are breaking down (Pratt, 2013). It is a manualized group intervention for adults with mental illness. WRAP guides patients through the process of identifying and understanding their personal wellness resources "wellness tools" and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness.

WRAP has the following goals:

- Helping patients learn to utilize the recovery concepts of optimism, take responsibility, advocate for oneself and support each other. They learn to apply them in their daily lives.
- Patients will learn to develop some recovery tools which includes a set of activities and hobbies that they used to do in order to make them feel better. These activities serve as self-help tools that need to be utilized in face of any difficulties.
- Patients will learn to create guidelines for how they want their families and other members of the support groups to be involved in their treatment in case when they themselves are not well enough to make decisions for themselves.
- Patients will learn to develop a plan for the time when the crisis is over. This plan mainly serves as a way to promote the wellness.

2.5 Intervention Plan

Before the intervention sessions began, group guidelines and rules were introduced. Patients were already familiar with each other however confidentially of the information was assured and anonymity was maintained on written records. Each participant received a copy of their own WRAP plans for future reference so that they can continue with it even after the intervention groups had ended. The participants had the right to withdraw from the groups. The participants were also provided with a few debriefing sessions post the completion of intervention. In addition to de-briefing, some of the participants were also provided with the counselling sessions.

Sessions began with an introduction of the group in which patients were oriented with the key concepts of recovery by distinguishing the wellness and illness model. The key concepts include hope, personal responsibility, education, self-advocacy and support. Later sessions were based on educating the patients about the various dimensions of wellness including physical, intellectual, emotional, psychological, occupational and spiritual. They identified their goals in each dimension and established a wellness toolbox. Later, individualized daily maintenance plans were developed based on the individual triggers specific to each individual's illness. In the next step warning signs for the onset of symptoms and their management plans were developed. On the basis of the previous steps actions plans were developed as to when and how certain action steps were to be followed in face of a crisis.

3. Result

Data was recorded, transcribed and analyzed on Statistical Package for Social Science (SPSS) version 21. Descriptive statistics were used to analyze the demographical information. Paired sample t-test for the pretest-posttest analysis of the intervention was run to analyze the effectiveness of the program after the completion of 12 sessions. A significance level of .05 was used for all the analyses. Data was analyzed to assess the differences in the Symptom Checklist 90-R scores of the patient's before and after the interventions sessions.

Table 1 show the total number of participants for the group, male and female, and Table 2 shows the means and standard deviation of the demographic variables of the sample. There was equal representation of males and females in the sample and the mean age of the participants was 38 years.

Table 1. *Demographic variables for patients (n=8)*

Gender	N
Males	4
Females	4

Table 2. *Means and standard deviations of the demographic variables*

Variables	Mean	Standard Deviation
Age	38.37	10.58

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Table 3. *Means and standard deviations of the global symptom indexes of the SCL-90-R*

Variables	Pre-test		Post-test	
	M	SD	M	SD
Global Symptom Index	*1.11*	.34	.65	.29
Positive Symptom Total	44.75	10.51	28.88	11.37
Positive symptom distress Index	2.20	.31	2.05	.49

Table 3 shows the differences in the means and standard deviations of the symptom checklist-90-revised scores before and after the WRAP program. Symptoms checklist provides three indexes that are global symptom index, positive symptom total and positive symptom distress index. Table shows a difference in the mean scores of the before and after the test results.

Table 4. S*tatistic differences in the global symptom index, positive symptom total and positive symptom distress index*

Variables	M	SD	T	P
Global Symptom Index	*.45*	.20	6.26*	.000
Positive Symptom Total	15.87	10.60	4.25	.004*
Positive symptom distress Index	.15	.38	1.16	.28

* p <.05

The analysis of the above-mentioned results in Table 3 and 4 reveals that the there is a statistically significant difference in the global symptom index before (M=1.11) and after the intervention groups (M=0.65) as indicated by t= 6.26, p<.05. It shows that there was a reduction in the global symptoms index after the intervention groups.

Similarly, the results of table 3 and 4 also indicate that the positive symptom total has also reduced after the WRAP intervention (M=28.8) as indicated by the t= 4.25, p<.05. This index shows that the total number of experiences symptoms has reduced. However, there was no statistically significant difference found in the positive symptom distress index. These results indicate the verification of the research hypothesis that there will be a reduction in psychiatric symptoms as the global symptom index has reduced post intervention (p<.05).

4. Discussion

The present research was based on the objective to increase focus on a therapeutic wellness model instead of an illness model. The fundamental objective was to introduce evidence-based practices to the patients of psychiatric rehabilitation services in Pakistan. Research conducted by Fukui et al. (2011) demonstrated statistically significant group intervention effects on the symptoms of illness and the hope and recovery of the individuals. Similarly, Cook et al. (2012) also found out positive impact on the depression anxiety and recovery of the participants. The present research findings confirmed the results from some of the previous researches. Although throughout the group therapy sessions the fidelity of the program was maintained. Almost all the participants expressed that the exploration of their goals while discussing the various dimensions of wellness was the most helpful in their direction of life (O'Keeffe, 2016). There were some areas that are relatively pervasive constructs which requires a long time before it starts to reflect itself in a person's life or an individual starts experiencing it subjectively. Such as it would take more time to observe and record changes in the social life or psychological aspects of one's life quality than the physical aspect (Petros et al. 2020). Since the program was a time bound activity, a long-term efficacy couldn't be assessed.

Other studies particularly found out a strong relationship between negative symptoms and quality of life for individuals in the early course of the illness (Eack, 2007). In another study, Starnino et al. (2010) evaluated the impact of WRAP on the recovery outcomes of the patients after a period of 12 weeks of WRAP sessions and he found a significant impact on the hope and recovery outcomes of the patients. O'Dwyer (2014) evaluated the effectiveness of WRAP on the groups of individuals with mental health problems and acquired brain injury groups. Results indicated significant positive changes in both groups. The findings of this research has supported by other researchers from different countries.

5. Conclusion, Limitation and Implication

The present study highlighted the impact of an evidence-based practice wellness recovery action plan on the psychiatric patients with a diagnosis of a severe mental illness. The result findings suggested that it has been effective in reducing the severity as well frequency of the experience of psychiatric symptoms. Nevertheless, more studies with different population and bigger samples, more appropriately with a control

group design are necessary for reaching further conclusions on efficacy of the program.

A low sample size is one of the limitations of the present research. However, one of the reasons for a low sample size in the present study was that you can only take 8-10 participants in a single group at a time hence the pre and posttest analysis was conducted on a single group. However, for a greater generalizability of the research findings more groups could be conducted and also in different populations. In Pakistan the psychiatric rehabilitation facilities is still developing, in addition there is very little support from the government sector organizations particularly for psychiatric healthcare hence making it really hard to support patients in the rehabilitation process as it takes a long time.

This research can be used as a foundation to help individuals with psychiatric disabilities to promote a sense of wellbeing and help put them back into community by keeping a focus on the community living skills. Future researchers can carry this method to assess the extent of the independence living skills developed and maintained over the period of time in the management of psychiatric rehabilitation with Wellness Action Recovery Plan.

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