

Validity and Reliability Study of Mental Health Recovery Measure's Turkish Version



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ABSTRACT

Objective: The present study aims to translate into Turkish and investigate the validity and reliability of the Mental Health Recovery Measure (MHRM).

Method: The sample consisted of 343 outpatients - and in-patients under treatment for a variety of psychiatric diagnoses at a state hospital and a university research hospital. The MHRM along with the Subjective Recovery Assessment Scale (SRAS), Psychological Well Being Scale (PWBS), Emotional Eating Scale (EES), and The Internalized Stigma of Mental Illness Scale (ISMI).

Results: The mean MHRM total score was estimated at 31.66 (sd=10.02). Exploratory factor analysis revealed one single robust factor explaining 64% of the variance of the total scores. Alpha internal consistency coefficient was calculated as 0.94 and corrected item-total correlation coefficients were entirely above 0.60. The MHRM scores showed positive and strong correlations with the PWBS ($r=0.695$; $p<0.001$) and SRAS ($r=0.732$; $p<0.001$), negative and strong correlation with the ISMI ($r=-0.696$; $p<0.001$) and no correlation with the EES scores ($r=-0.021$; $p=0.703$).

Conclusion: Our data provides initial evidence supporting the validity and reliability of the Turkish MHRM in evaluating the tendency for recovery of mental health consumers for clinical and research purposes. Further studies addressing psychometric properties of the scale are warranted.

Keywords: Mental Health Recovery Measure, validity, reliability.

INTRODUCTION

Mental health is defined as a state of well-being in which each individual is aware of their own potential, can cope with the usual challenges of life, work productively and efficiently, and contribute to their environment (RSKT 2017). Healing, on the other hand, is defined as a highly personal and unique process of change in one's attitudes, values, feelings, goals, skills, and/or roles, in its broadest definition, and includes developing new meaning and purpose that grows beyond the destructive effects of mental illness (Anthony 1993, Şenocak et al. 2019, Yüksel and Arslantaş 2021). Leamy et al. (2011) discussed the recovery process under five categories, namely, connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. 'Recovery' is the process of learning how to live with a persistent psychotic disorder rather than an outcome in which symptom relief and

improvement in functionality are defined by clinical criteria (Davidson 2010). The concept of mental health brings with it the distinction between clinical recovery and personal recovery. While clinical improvement is defined by mental health professionals as the reduction or cessation of symptoms and the recovery of social functioning, personal recovery refers to an ongoing holistic process that is determined by the individual receiving treatment and includes personal development, recovery, and self-determination (Stuart 2013, Güler 2017, Şenocak et al. 2019, Yüksel and Arslantaş 2021).

It is argued that the recovery movement first emerged in the United States of America (Meehan et al. 2008). It is difficult to say exactly when the movement emerged, but it is reported to have originated from self-help groups that were part of the wider sphere of addictions and that it was, as a concept, guided by approaches such as the 12-step approach of Alcoholics Anonymous founded in the 1930s.

Received: 09.03.2021, **Accepted:** 19.11.2021, **Available Online Date:** 08.11.2022

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Today, recovery is related to the concept of personal recovery (Sowers 2005). Social movements that emerged in the 1960s and 1970s contributed to the development of the concept of recovery. The human rights movement and the consumer rights movement, which oppose the beliefs and values that oppress and limit social groups, the anti-discrimination and anti-stigmatization movements, and the anti-psychiatry movement, which questions the tendency of psychiatrists to detain and treat individuals with mental disorders by force and to solve all kinds of health problems by using drugs, are shown as examples of these movements. Advances in psychopharmacology also offer opportunities for people with psychiatric illnesses to keep their symptoms under control. Thanks to these movements and developments, people who benefit from mental health services have been able to participate more in the planning, delivery, and evaluation processes of mental health services, in addition to the protection of their individual rights. Thus, the necessary groundwork has been prepared for the transition from hospital-based services to community-based services and the development of psychiatric rehabilitation (Noordsy et al. 2000, Van Tosh et al. 2000, Berlim et al. 2003, Dixon and Goldman 2003, Sowers 2005, Ramon et al. 2007, Field and Reed 2016). With a better understanding of the recovery process, its importance and value for people struggling to overcome their problems and the mental health systems that serve them have increased. Thus, the need for the transformation of service systems has become more apparent. Recovery attracted considerable attention with the publication of the President's New Freedom Commission Report on Mental Health (2003), which was the first national report emphasizing recovery. The report recognizes that there are widespread barriers to recovery in the existing mental health system for individuals with mental illnesses and aims to transform the mental health system into a recovery-oriented system. According to the report, mental health care in the transformation to recovery process should be shaped according to people who receive mental health services and their families. The focus should be on tackling life challenges for clients, building resilience, and collaborating with clients in decision-making at all stages of care. Care that focuses only on symptom-management will be inadequate (President's New Freedom Commission on Mental Health 2003, Sowers 2005, Caldwell et al. 2010). Some guidelines based on the recovery-oriented approach (Sowers 2005, Mental Health Commission of Canada 2015) and various models related to recovery have been developed. These models include the Strengths Model (Tse et al. 2016), Recovery Alliance Theory (RAT) (Shanley and Jubb-Shanley 2007), Conceptual Recovery Model (Jacobson and Greenley 2001), Collaborative Recovery Model (Oades et al. 2005), and Tidal Model (Barker 2001, Barker 2004, Buchanan-Barker and Barker 2008, Barker and Buchanan-Barker 2010).

Although a large number of tools have been developed to measure mental health recovery and to evaluate recovery-oriented services and professionals, there are a limited number of scales in Turkish, whose validity and reliability have been examined (Telef 2013, Yıldız et al. 2017, Yalçiner et al. 2019, Guler and Gurkan 2019). Indeed, it is extremely important to develop and use practical, reliable, useful, and multifunctional screening tools to provide an effective health service. This study was conducted to analyze the validity and reliability of the Mental Health Recovery Measure (MHRM), which facilitates such an assessment, by translating it into Turkish.

It is important to consider subjective recovery in planning health education interventions for mental illness recovery. For this reason, it is highly important to introduce a scale in our language, which has little number of items (questions), is easy to understand, and which can be easily applicable in routine-care environments. In this study, the aim was to translate the MHRM into Turkish and to examine its validity and reliability in a sample of individuals with chronic mental illnesses. More precisely, the aim, again, was to collect different types of evidence regarding the validity of MHRM scores. In line with these objectives, the following research questions were determined.

1. Is the internal consistency of the Mental Health Recovery Measure acceptable (Cronbach's $\alpha=0.70-0.79$) or adequate ($\alpha \geq 0.80$ for studies; $\alpha \geq 0.90$ for individual clinical assessment) (Nunnally et al. 1994) (construct validity)?
2. Is the factor structure of the Mental Health Recovery Measure similar to the factor structure of the original scale (Young and Bullock 2003) (factorial validity)?
3. Is there a correlation between the scores of individuals who have recovered from the Mental Health Recovery Measure and the scores obtained from the Psychological Well-Being Scale (PWBS), the Subjective Recovery Assessment Scale (SRAS), the Internalized Stigma of Mental Illness Scale (ISMI), and the Emotional Eating Scale (EAS)?

METHOD

The Translation Process

First, necessary permissions were obtained from the first author of the original development study of the MHRM (Young and Bullock 2003). Then, the back-translation method was used to minimize the conceptualization and expression differences in the language adaptation of the scale. The scale was translated into Turkish by three psychiatric nurses, who were blinded to each other's translations. These translations were checked by the research team and translated into English by a psychiatrist and a clinical psychologist who

did not participate in the initial translation process. This text, which was translated back into English, was compared with the original Mental Health Recovery Measure, and it was sent to the first author who developed the scale and their approval was obtained. It was decided that the latest version of the Turkish translation was appropriate. During the adaptation process of the scale to our language, no changes were made in the scale items during the translation and retranslation, and the items that were the same with those in the original scale were accepted.

The Sample

The study was carried out with 343 patients who were treated in Aydın Adnan Menderes University Research and Application Hospital Psychiatry Service and Psychiatry Outpatient Clinic, Torbalı State Hospital Psychiatry Service, and Community Mental Health Center and were diagnosed with a psychiatric disorder according to DSM 5. It is stated that a sample size of 100 to 200 individuals or 10 times the number of total items on the scale would be enough for factor analysis to be used in scale development (DeVellis 2003). For this reason, the calculation of the sample size was based on the number of questions on the scale (30 items) in the beginning, which required 300 (10x30) participants for the validity and reliability study of the scale. Considering possible data losses, 20% extra sample size was added and the sample size was calculated as 360. However, the sample consisted of 343 people because some patients did not want to continue filling out the questionnaires. The inclusion criteria of the study for the patients included with a previous diagnosis of a psychiatric disorder according to DSM 5 and volunteering to participate in the study, while the exclusion criteria were determined as the presence of a secondary mental disorder and/or alcohol and substance addiction. Data for the study was collected by the researchers (RY, MK, and SI) in one year through face-to-face interviews. No adverse events were experienced during data collection.

The participants were evaluated cross-sectionally by using some scales. Of the participants, 61.2% (n=210) were female, 55.7% (n=190) were single, mean age was 37.41 ± 19.70 years, 40.1% (n=137) of the participants had a secondary school education, 55.4% (n=190) were unemployed, and 48.7% (n=164) considered their income level as less than their income. Also, 47.5% (n=162) of the participants lived in the city (province). The mean age when participants were diagnosed with a mental illness was 27.31 ± 11.61 years, and the mean number of hospitalizations was 2.63 ± 3.02 . Considering the psychiatric diagnoses of the participants according to DSM 5, 19.5% (n=67) had schizophrenia spectrum and other disorders accompanying psychosis, 19.0% (n=65) had bipolar and related disorders, 13.7% (n= 47) had obsessive-compulsive disorder and related disorders, 13.1% (n=45) had anxiety

disorder, 30.9% (n=106) had depression disorder, and 3.8% (n=13) had other psychiatric diagnoses.

Ethics Committee Approval

The study was approved by the Aydın Adnan Menderes University Faculty of Nursing Non-Invasive Clinical Research Ethics Committee (12/11/2019-E.70083). Participants were informed about the research, and their verbal and written consent was obtained before starting the study.

Data Collection Tools

Data for the study was collected by using the Mental Health Recovery Measure (MHRM), whose validity and reliability studies were conducted in this study, the Psychological Well-Being Scale (PWBS), the Subjective Recovery Assessment Scale (SRAS), the Emotional Eating Scale (EAS), and the Internalized Stigma of Mental Illness Scale (ISMI).

The Mental Health Recovery Measure (MHRM): This scale was developed by Young et al. in 1999 to evaluate recovery from mental illnesses and was revised in 2003 by Young and Bullock (2003). The item content of the MHRM and its conceptual domains is based on a specific model of mental health recovery based on the experiences of people with psychiatric disabilities (Young and Ensing 1999). The MHRM consists of 30 items and the questions are answered on a 5-point Likert-type scale with options ('0' Strongly Disagree, '1' Disagree, '2' Undecided, '3' Agree, '4' Strongly Agree). The validity and reliability study was conducted on the 30-item form. However, Cronbach's alpha of the scale was found as 0.98, which suggested that the item contents might be close to one another. Thus, exploratory factor analysis was performed to examine the factor structure of the MHRM and to select the ten most appropriate items for a short measurement. Factor analysis revealed an interpretable single-factor structure. The MHRM-10 was formed by choosing the ten items with the highest factor loadings. The researchers found that these ten items were the same as the items which Armstrong et al (2014) obtained as a result of their validity and reliability study in which total items were reduced to 10 (Armstrong et al. 2014). There were no reverse-scored items on the scale. The scores that can be obtained on the scale range between 0 and 40. High scores indicate increased mental illness recovery.

The Psychological Well-Being Scale (PWBS): This scale was developed by Diener et al. (2010) to measure socio-psychological well-being as an 8-item, 7-point Likert-type (1-Strongly disagree; 7-Strongly agree) tool. The scores on the scale range between 8 and 56. Telef (2013), who examined the validity and reliability of the Turkish version of the scale, reported Cronbach's alpha internal consistency coefficient as 0.80. Higher scores indicate that the person has many

psychological resources and resilience. The alpha coefficient of the scale was calculated as 0.93 in our study sample.

The Subjective Recovery Assessment Scale (SRAS): This is a self-report scale that was developed by Yıldız et al. (2017) to evaluate subjective recovery in patients with schizophrenia. It has 17 items and is responded to on a 5-point Likert-type scale (1- Doesn't define me at all, 5- Defines me fully). The scores on the scale range between 17 and 85 points. Yıldız et al. (2017) reported Cronbach's alpha coefficient as 0.98. High scores obtained from the scale indicate the perception of a better recovery. The alpha coefficient of the scale was calculated as 0.95 in our study sample.

The Emotional Eating Scale (EES): This scale was developed to evaluate the emotional eating behaviors of obese and overweight people (Garaulet et al. 2012). It consists of 10 items and three sub-dimensions (disinhibition, type of food, and guilt). The items are evaluated on a 4-point Likert-type scale with options ('0' Never, '1' Sometimes, '2' Usually, and '3' Always). The scores on the scale range between 0 and 30. There are no reverse items on the scale. High scores indicate a high level of emotional eating behavior. The validity and reliability study in our country was conducted by Arslantaş et al. (2020). It was found that the Turkish version, similar to the original scale, also had a three-factor structure, namely, disinhibition, type of food, and guilt. The corrected item-total score correlation coefficients of the scale items were greater than 0.34, and the internal consistency coefficient of the total score was 0.84. In line with the recommendations of the authors, the total score of the scale was used in this study (Arslantaş et al. 2020) and Cronbach's Alpha coefficient was calculated as 0.85.

The Internalized Stigma of Mental Illness Scale (ISMI): This self-report scale was developed by Ritsher et al. (2003) to evaluate internal stigma, and its Turkish validity and reliability study was conducted by Ersoy and Varan (2007). It has 29 items and a 4-point Likert type scale (1-I strongly disagree, 4-I strongly agree). The scale has five sub-dimensions, namely, alienation (6 items), stereotype endorsement (7 items), discrimination experience (5 items), social withdrawal (6 items), and stigma resistance (5 items). Items of the 'stigma resistance' subscale are reverse-scored. The total ISMI score obtained by summing up the scores of the five subscales varies between 4 and 91 points. High scores on the ISMI mean that the person's internalized stigma is more severe negatively. Cronbach's alpha internal consistency coefficient of the scale was calculated as 0.91 in our study sample.

Statistical Analysis

As a result of the preliminary analysis, it was understood that all scale scores conformed to the normal distribution. To examine the reliability of the Mental Health Recovery Measure, Cronbach's alpha internal consistency coefficient

of the scale and corrected item-total score correlations were calculated. The Mental Health Recovery Measure was factor-analyzed to determine the content of the items. In the validity examination, the level of agreement between the MHRM total score and the score of the other scales used in the research were examined. In the evaluation of the correlation coefficients, the values were accepted as low between 0.10 and 0.29, moderate between 0.30 and 0.49, and a high degree of correlation above 0.50 (Cohen 1988). All statistical analyses were conducted on the IBM SPSS version 22.0 software package.

RESULTS

Factor Structure of the Mental Health Recovery Measure

The suitability of the data for factor analysis was tested by using the Kaiser-Meyer-Olkin (KMO) and Barlett's tests. In the preliminary analysis, KMO was 0.94, and Barlett's test was found to be significant ($p < 0.001$). Accordingly, these values indicated that our data were suitable for factor analysis. As a result of the principal components factor analysis, it was seen that the eigenvalue of the first component was 6.85 and that the eigenvalues of all the other components were less than 1. Upon examination of both these values and the scree plot (Figure 1), it was concluded that the scale had a single factor structure. The ten items of the scale explained 64.35% of the variance in the total score. Since the scale items were collected under a single factor, no rotation was applied. The factor loads of the scale items are explained in Table 1. The factor loadings of the items between 0.66 and 0.87 suggested that all items were highly correlated with this factor.

The Internal Consistency of the Mental Health Recovery Measure

Cronbach's Alpha internal consistency coefficient of the scale was calculated as 0.94 [0.93–0.95]. When Table 1, which contains the corrected item-total correlations calculated for the evaluation of the psychometric properties of individual scale items, was examined, it was seen that all items showed correlations over 0.60 with the total score. These data suggest that each item contributed adequately to the total score. Studies interpret alpha coefficients of 0.70 for group-level measurements indicate an acceptable reliability of the scale, and alpha coefficients of 0.80 are considered to indicate adequate reliability (Nunnally and Bernstein 1994, Erdoğan et al. 2015).

The Distribution of the Total Score of the Mental Health Recovery Measure

The mean score of the patients on the Mental Health Recovery Measure was found to be 31.66 ± 10.02 (25th $p = 22$; 50th $p = 33$, 75th $p = 39$).

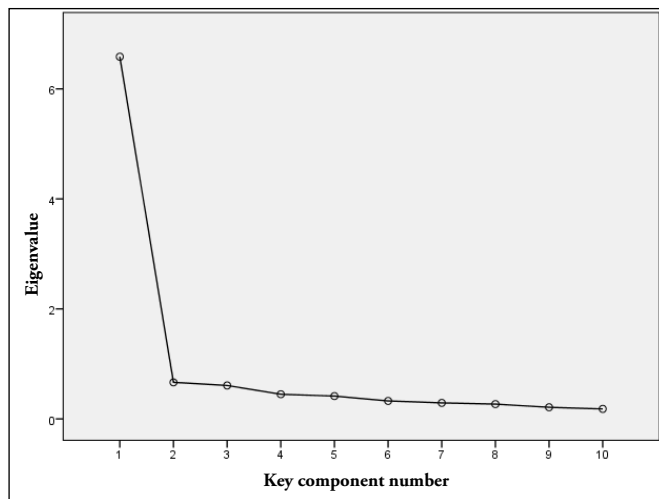


Figure 1. Scree Plot

Concordance between the Total Scores of the Mental Health Recovery Measure and the Scores of the Other Scales

The distribution properties of the total score of the Mental Health Recovery Measure are given in Table 2. The calculations indicated that the 95% confidence interval of the mean score was between 30.6 and 32.7 and that the 99%

confidence interval of the mean score was between 30.2 and 33.0. Correlations between the MHRM and other scale scores were calculated to obtain evidence of validity for the MHRM total score. Accordingly, the MHRM showed a highly positive correlation with the PWBS ($r=0.695$; $p=0.001$), a highly positive correlation with the SRAS ($r=0.732$; $p=0.001$), and a highly negative correlation with the ISMI ($r=-0.696$; $p=0.001$). It did not show any correlation with the EAS ($r=-0.021$; $p=0.703$) (Table 2).

DISCUSSION

Recovery is a process where an individual learns to lead a meaningful and satisfying life despite a permanent mental disorder as well as to live with this disorder. It is highly important to be able to subjectively evaluate and monitor the improvement of individuals throughout the psychiatric treatment process. In this way, it can be ensured that the individual gains skills required for the self-management of the disease by being included in the treatment. In this study, data supporting the reliability and validity of the Turkish form of the MHRM, which will help to evaluate mental recovery in a short and precise way, were obtained.

Table 1. Reliability Data of Mental Health Recovery Measure, Factor Structure, and Factor Loads of the Items (N=343)

Items of the Mental Health Recovery Measure		Item-total Correlation Coefficients	Factor Loads
1.	I believe in myself.	0.71	0.77
2.	Despite having mental problems, I keep changing and making progress in the right direction.	0.67	0.73
3.	Even if I still have problems, I value myself as I deserve to be valued.	0.81	0.85
4.	I feel good about myself.	0.79	0.83
5.	My way of handling events in my mind helps me reach my goals.	0.81	0.85
6.	I feel at peace with myself.	0.83	0.87
7.	I am in a positive attitude over the last weeks.	0.78	0.82
8.	I do something productive each morning.	0.69	0.75
9.	I make progress toward my goals.	0.82	0.86
10.	I get involved in tasks or activities that are enriching for me and my world.	0.60	0.66
Explained Variance		64.35%	

Table 2. Distribution Parameters of the Scale Scores of Participants and the Correlation of Mental Health Improvement Measure Scores with Other Scales

Scale	n	Minimum	Maximum	Mean	SD	r	p
The Mental Health Recovery Measure	343	11.00	50.00	31.65	10.02	-	-
The Psychological Well-Being Scale	343	8.00	56.00	34.42	12.34	0.695	0.001
The Subjective Recovery Assessment Scale	343	17.00	85.00	51.35	17.09	0.732	0.001
The Emotional Eating Scale	343	10.00	40.00	20.14	6.16	-0.021	0.703
The Internalized Stigma of Mental Illness Scale	343	33.00	113.00	71.62	16.76	-0.696**	0.001

The Factor Structure of the Mental Health Recovery Measure

The exploratory factor analysis method was used to examine the factor structures of the Mental Health Recovery Measure (MHRM). Gorsuch (1997) stated that exploratory factor analysis could be used instead of confirmatory factor analysis in cases where the same factors could be obtained from previous analyses (Gorsuch 1997). In the light of literature, it was concluded that there was no need for confirmatory factor analysis since exploratory factor analysis showed that the factor structures of both measurement tools were the same as the factor structures of their original forms. Analysis results showed that the items on the scale were collected under a single factor and that this factor explained 64.35% of the total variance of the scale score. This result was consistent with the single-factor structure (with an explained variance rate of 56%) reported by Armstrong et al. (2014).

Reliability of the Mental Health Recovery Measure

The alpha internal consistency coefficient of the scale was calculated as 0.94 (95% CI:0.94 [0.93-0.95]). A calculated reliability coefficient of 0.70 or higher indicates that the reliability of the measurement tool is sufficient for use in research (Tavşancıl 2002, Büyüköztürk 2007). The results showed that the reliability level of the MHRM was quite high. Both the internal consistency coefficient and the item-total score correlation coefficients observed in our study were quite high. In our study, all items showed a strong positive ($r>0.60$) correlation with the total score. Considering all the results, it can be said that the MHRM reliably measures the recovery status of individuals diagnosed with mental illnesses. Studies conducted in other countries regarding the scale also showed that the alpha coefficient of the scale varied between 0.91 and 0.95 (Bullock 2009, Chang et al. 2013, Nieuwenhuizen et al. 2014, Armstrong et al. 2014, Abraham et al. 2016). The fact that the internal consistency coefficient of the scale is so high indicates that the scale can be applied safely in routine care settings.

The Distribution of the Total Score of the Mental Health Recovery Measure

The mean score of the patients on the Mental Health Recovery Measure was determined as 31.66 ± 10.02 (25th $p=22$; 50th $p=33$; 75th $p=39$). Similarly, Armstrong et al. (2014) reported that a mean MHRM score of 26.60 ± 7.30 . Considering that the maximum score that can be obtained from the scale is 40, it can be said that the recovery score of individuals in the sample was above the average. This result can be explained by cultural factors. This finding may have stemmed from the fact that our country has a collectivist rather than individualistic social structure (Kağıtçıbaşı 2007).

Concordance between the Total Scores of the Mental Health Recovery Measure and the Scores of the Other Scales

In the correlation analyses applied to examine the agreement validity, high correlations were observed between the MHRM score and those of other scales measuring the same and different domains. Accordingly, the MHRM was highly positively correlated with the PWBS ($r=0.695$; $p<0.001$), highly positively correlated with the SRAS ($r=0.732$; $p<0.001$), and highly negatively correlated with the ISMI ($r=-0.696$; $p<0.001$). It did not show any correlation with the EAS ($r=-0.021$; $p=0.703$). These results can be interpreted as follows: As psychological well-being and subjective well-being increase in individuals with a psychiatric diagnosis, recovery tends to increase. A high level of negative correlation was found between recovery and stigma. In other words, as internalized stigma increases, recovery decreases. In the study of Bilge and Çam (2010), it was reported that stigma reduced recovery. The finding that recovery increases as psychological and subjective well-being increases and that it decreases as stigma increases, may contribute to the planning of mental health and rehabilitation services. No correlation was found between recovery and emotional eating. This is a finding that was already expected by the authors. No results that supported our findings were found in literature. Studies reported that emotional eating was mostly related to negative emotions, such as anxiety, depression, fury, anger, and worry (Laitinen et al. 2002, Macht 2008, İnalkaç and Arslantaş 2018, Arslantaş et al. 2021).

Strengths and Limitations of the Research

The strongest aspect of this study is that it was conducted with a large sample of patients who had a psychiatric diagnosis from two different hospitals. The large sample size enables the narrowing of the confidence interval of the alpha values, that is, it ensures that the true alpha value in the population can be estimated very precisely and accurately. In addition, the research was carried out in about a year, and the researchers themselves filled out the questionnaires one-to-one with the participants, which is a good indicator for the results and reliability of the research. In addition, the MHRM had a high positive correlation with the PWBS, the SRAS, and the ISMI, which showed the MHRM had a high capacity to predict recovery status. The scale was applied to individuals who had a psychiatric diagnosis according to DSM 5, which shows that the scale can be used in all mental illnesses. The recovery scale was not conducted on a specific mental disorder (schizophrenia, depression, etc.), which can be considered as a limitation of the study. In addition, limited resources were used in the discussion due to the inadequate number of studies using the same/similar scales in the world and our country, which was another limitation of the study.

Conclusion and Recommendations

The high internal consistency of the Turkish version of the Mental Health Recovery Measure in this study was a finding that supported both the reliability and the validity of the construct of the scale. Our data provided evidence supporting the validity of the Turkish version of the MHRM for assessing the mental health improvement tendencies of the patients. All of the items on the scale contributed appropriately to the total score, Cronbach's alpha value calculated for the total score (0.94) indicated adequate internal consistency despite the relatively low number of items on the scale, and factors similar to the original factor structure of the scale were obtained in the factor analysis, which suggested that the Turkish translation of the Mental Health Recovery Measure was a valid and reliable measurement tool. With these features, the MHRM is appropriate for use in research.

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Mental Health Recovery Scale (MHRS)
(Young & Bullock, 2003)*

Name-Surname: Date:

This questionnaire aims to collect information regarding your assessment of your own recovery process. Mental recovery is a complicated process which is unique for each individual. Hence, no right or wrong answers. Please read carefully and rate each item to indicate the extent to which it applies to your recovery process.

		Absolutely disagree	Disagree	Neither agree nor disagree	Agree	Absolutely agree
1.	I believe in myself.	☐	☐	☐	☐	☐
2.	Despite having mental problems, I keep changing and making progress in the right direction.	☐	☐	☐	☐	☐
3.	Even if I still have problems, I value myself as I deserve to be valued.	☐	☐	☐	☐	☐
4.	I feel good about myself.	☐	☐	☐	☐	☐
5.	My way of handling events in my mind helps me reach my goals.	☐	☐	☐	☐	☐
6.	I feel at peace with myself.	☐	☐	☐	☐	☐
7.	I am in a positive attitude over the last weeks.	☐	☐	☐	☐	☐
8.	I do something productive each morning.	☐	☐	☐	☐	☐
9.	I make progress toward my goals.	☐	☐	☐	☐	☐
10.	I get involved in tasks or activities that are enriching for me and my world.	☐	☐	☐	☐	☐

Thank you for rating all the items.

*The MHRM© was developed with the help of mental health consumers by researchers at the University of Toledo, Department of Psychology. This research was supported through a grant from the Ohio Department of Mental Health, Office of Program Evaluation and Research. For further information, please contact Wesley A. Bullock, Ph.D. at (419) 530-2721 or email: wesley.bullock@utoledo.edu.

*Young SL, Bullock WA (2003) The mental health recovery measure. University of Toledo, Department of Psychology.