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The Importance of Context in Identifying the Recovery Needs of Women With Psychosis

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A recent article published in the *Journal* by Dubreucq and colleagues¹ examined both objective and subjective aspects of recovery among 1,055 clinically stable outpatients (785 men and 270 women) with schizophrenia spectrum disorders (SSD) recruited from a network of 9 psychiatric rehabilitation centers in France. The authors found that, compared to men with psychosis, women with psychosis had more socially valued roles, but poorer subjective recovery-related outcomes including greater self-stigma, lower self-reported quality of life, lower satisfaction with interpersonal relationships, and more unmet needs with respect to interpersonal relationships. Women were also more likely to take antidepressants and to have a history of suicide. There were no differences between men and women in insight or in functional level as measured by the Global Assessment of Functioning scale (GAF).

The seeming contradiction between the article's findings regarding objective and subjective outcomes highlights the highly subjective nature of recovery. The authors asked about 4 major socially valued roles—being a student or employed, living independently, being a parent, and “living in relationship” (which we interpreted to mean cohabiting with a partner or significant other)—and found that women were more likely to have 2 or more socially valued roles. Specifically, 28.5% of women versus 14.7% of men had 2 or more socially valued roles. We can gather from Table 1 of the article that approximately twice as many women as men were married or in a couple (19% vs 9%) and that twice as many women as men were parents (21% vs 10%), with both of these differences being statistically significant. On the other hand, there was no gender difference in occupational status; the numbers were equally grim for men and women, with only 9% of the sample working. The majority (69%) were unemployed and receiving disability benefits, and another 22% reported no income at all.

On the surface, one might think that women having more socially valued roles, as Dubreucq and colleagues found,

might be a marker of a more favorable recovery course compared to men. This idea is consistent with many studies that have pointed to better outcomes in women compared to men with SSD. For example, though the prevalence of SSD is similar in men and women,² onset of illness in women is 3–4 years later than in men³ (though women also have a secondary peak onset after age 45 years⁴). Women are also less affected by cognitive⁵ and negative symptoms,^{6–8} which are symptom domains that are less responsive to treatments and that are most strongly associated with long-term disability. Women's later onset and relatively less severe course is largely thought to be due to the protections conferred by female sex hormones, especially 17 β -estradiol, both during brain development^{7,9–11} and throughout a woman's reproductive years.⁷ Thus, women might seem to be at an advantage when it comes to SSD.

However, recovery in psychosis is increasingly recognized as a journey toward the attainment of meaningful goals and full human potential,^{12–14} in which meaningful goals are individually defined. In an individual's journey toward recovery and meaning-making, context matters; the larger context in which a role exists can substantially influence individuals' subjective experience and meaning of that role. As Seeman¹⁵ has emphasized, outcomes have both good and bad facets; whether an outcome is good or bad ultimately depends on one's perspective. For example, being married or in a couple has been associated with better prognosis for individuals with SSD in some studies.¹⁶ But married women with SSD are also more vulnerable to abuse by domestic partners.¹⁷ Twice as many women as men with psychosis are parents.¹⁸ However, many parents with SSD frequently encounter more judgment about their parenting skills and the threat of losing custody of their children.¹⁹ Thus, even if a role is valued by society, context matters in determining whether the role is also valued by the individual with SSD.

Critically, in discussions of context, it seems important to better understand how different roles intersect among the individuals reporting 2 or more roles. A situation is likely to give rise to more challenges if 2 roles are not well aligned with respect to goals or values or if 2 roles compete for time and attention. In this framework, it would be interesting to know the following: Are more women than men with psychosis simultaneously parenting while working or going to school? Are more women parenting while living independently versus parenting with the help of other family members? Finally, how do individuals view these roles? And how do these roles interact with individuals' illness and process of recovery? Though the article by Dubreucq and colleagues

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did not explore these role interactions, these are important areas for further research.

A second issue related to context that Dubreucq and colleagues' article highlights is the specific age-related recovery needs of women with SSD. When the authors divided their sample of women into those under 40 years old and those 40 and older, they observed greater gender differences in recovery in the older sample of women. This finding is consistent with the work of Seeman and Gupta,²⁰ which has shown that the needs of older women with SSD are different from the needs of those who are younger. An important question to consider in further developing this line of work is how the age-related needs of women with SSD are impacted by the stage of illness and recovery. Are the needs of a woman in her 20s who is experiencing her first psychotic episode the same as those of a woman of the same age who has experienced symptoms for years? Conversely, focusing on stage, are the needs of a woman in her early 20s who is a college student and experiencing her first episode the same as those of a woman in her 30s who is experiencing her first episode after having her second baby? The authors' analysis was not specific to illness or recovery stage; therefore, more work is needed to specifically examine the intersection of age, illness stage, and process of recovery.

A third point that the article draws attention to is the relative lack of women receiving treatment in specialized clinics. Women made up only 26% of the SSD patients who were recruited from psychiatric rehabilitation centers geared toward providing recovery-oriented interventions for individuals with serious mental illness. According to Dubreucq and colleagues, patients are referred to the psychiatric rehabilitation centers by their general practitioner or psychiatrist or are self-referred. The underrepresentation of women among individuals receiving specialized psychosis services is not unique to this study.²¹ These statistics beg several questions. Where are women with psychosis receiving their care, if in fact they are getting care? Why are women with psychosis less likely to be referred or to self-refer to specialized care settings? If women are less likely to be referred, what are the clinical and demographic characteristics of the women whom we are missing? One small qualitative study²² suggests that women with psychosis do seek care, at least in early psychosis, but that family members and clinicians may underestimate their symptoms, overestimate their functioning, and dismiss their calls for help. Additional barriers include lack of child care services,²³ barriers related to race and ethnicity,²⁴ the narrow inclusion of only nonaffective psychotic disorders among some specialized psychosis programs,²⁵ and the restrictive age range of first-episode psychosis programs, which is often more appropriate for men than women.²⁵

A final point relevant to context relates to the fact that we are currently in the midst of a global public health crisis. During the 10 months that have passed since the World Health Organization declared COVID-19 to be a pandemic, it has become clear that the pandemic has had a disproportionate impact on women.^{26,27} Though the study

by Dubreucq and colleagues was conducted from January 2016 to November 2019, just preceding the pandemic, we can infer that any role conflicts experienced by women with psychosis are likely to be exacerbated during periods of crisis. Since the start of the pandemic, not only have women lost the most jobs, but they also bear the brunt of cooking, cleaning, childcare, and other caregiving.²⁸ The reality is such that many women who both work and are parents are having to "face brutally hard choices about whether to stay home if they haven't already been laid off."²⁹ Thus, even in the general population, the pandemic is adding significant pressure on women who hold 2 or more socially valued roles, with more women forced to choose between competing roles. In addition, incidents of domestic violence have risen at an alarming rate during this pandemic,³⁰⁻³² as stay-at-home orders force victims and survivors to isolate at home with their abusers. All of this is bad news for women, in general. But what about women who must deal with the compounded challenges of both the pandemic and serious mental illness? How are they navigating employment and/or job loss, parenting, spousal relationships, social isolation, and possibly trauma during this unprecedented time? What can psychiatric services do to help women with SSD navigate these challenges during and after the pandemic? Finally, we have already mentioned that women with psychosis are less likely to receive specialized services. In what ways is the pandemic creating additional barriers for women, and what can be done to help increase access for women? There is clearly a need to better understand the pandemic's gendered impacts, especially among women with psychiatric disabilities, including SSD.

What are the clinical implications that stem from considering context when working with women with psychosis? Dubreucq and colleagues' finding of poorer subjective recovery-related outcomes among women with SSD despite their holding a greater number of socially valued roles than their male counterparts suggests the need for interventions that help women navigate social roles in ways that align with their individual, context-specific values. Research has shown acceptance and commitment therapy (ACT),³³ which has its philosophical basis in functional contextualism, to be effective in individuals with psychosis.^{34,35} In ACT, emphasis is placed on the whole event and the role of context in understanding the nature and function of an event.³⁶ ACT encourages individuals to live according to their values, attending to the contextually established function and meaning of an event, rather than try to determine what is literally or objectively true.³⁶ While ACT is certainly not the only effective psychotherapeutic treatment for SSD, the goals of ACT are particularly well aligned with the concept of recovery, and women in psychosis recovery may especially benefit from ACT's goal of helping patients identify their values and navigate goal and value conflicts.

What are some ways we could address context-specific issues related to both stage of illness and stage in life among women with psychosis? Given the effectiveness of group

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interventions for individuals with SSD,³⁷ the development and implementation of women's groups that are specific to age could provide a venue to support age-related needs. Interacting with others in groups could simultaneously provide an expanded social network to address Dubreucq and colleagues' findings that women with SSD have lower satisfaction and greater unmet needs in the domain of interpersonal relationships. It will also be important to investigate the possible benefits of group services that are facilitated by women peer-specialists and open to women of all ages. Peer support services have been shown to improve self-perceived recovery, hopefulness, self-efficacy, quality of life, and social support,^{38,39} and including women of all ages could provide opportunities for cross-generational mentorship and relationships.

Another area that would benefit from age-related adaptation is family therapy. Family interventions are often an integral part of treatment for individuals with SSD⁴⁰; however, little attention has been placed on the unique needs of women with SSD within the family and how those needs are impacted by the women's age and role in the family (eg, expecting mother, new mother, mother of older children, wife, daughter, sister, grandmother, incomer-earner,

caretaker). Typically, family interventions for SSD have primarily focused on helping parents provide support for a young adult patient with recent-onset SSD or at risk of developing SSD.⁴¹ Family interventions that incorporate the age-related needs of women with SSD provide an opportunity to support women's recovery across the different (and likely multiple) roles they may hold in a family and in society.

In sum, though female biology may confer some protection against psychosis early in life, the effects of gender catch up and disadvantage women in a number of ways, especially over time.⁴² Illness and recovery do not occur in a vacuum. Rather, the effects of genes and hormones manifest themselves in a broader context that involves social roles, expectations, and values that may change over the course of a lifespan. Dubreucq and colleagues' study provides important insights about the differing recovery needs of men and women with SSD. At the same time, more work is needed in the field to better understand the contextual factors that influence outcomes. Context is inarguably an important issue for all individuals in recovery, including men. However, considerations of context are particularly critical for research, service delivery, and policy that address the needs of women with psychosis in their recovery.

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