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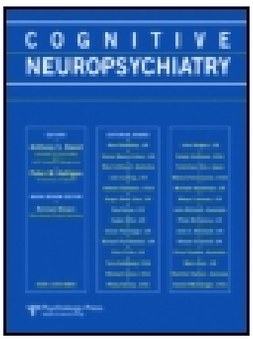

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Recovery style and stigma in psychosis: the healing power of integrating

Regina Espinosa[a,b], Carmen Valiente[a], Alina Rigabert[c,d] and Hanna Song[e]

[a]School of Psychology, Universidad Complutense de Madrid, Madrid, Spain; [b]Deparment of Psychology, Universidad Camilo José Cela, Madrid, Spain; [c]Unidad de Investigación del Distrito Sanitario de Atención Primaria Málaga-Guadalhorce, Málaga, Spain; [d]Department of Psychology, Universidad Loyola Andalucía, Sevilla, Spain; [e]The Wright Institute, Berkeley, CA, USA

ABSTRACT

Introduction. Persecutory delusions are a very common symptom in psychotic disorders and represent a considerable cost for both patients and for society. The way in which a person faces their psychotic disorder (i.e., recovery style) has impact on their recovery. The impact of coping style as a moderator in the course of their illness has not been studied sufficiently in persecutory delusions. In addition, internalised stigma is a common process in psychosis that not only might affect emotional distress, but might also shape recovery style. The goal of this study was to examine the moderator role of recovery style between internalised stigma and emotional distress in people with persecutory delusions. *Methods*. All 50 people with persecutory beliefs were assessed by the Recovery Style Questionnaire, the Beck Anxiety Inventory, Beck Depression Inventory, Second Edition, and Internalised Stigma of Mental Illness. *Results*. Moderation analysis showed that participants with a sealing-over recovery style had high levels of depression when they experienced internalised stigma and low levels of depression only when internalised stigma was low. However, participants with an integration recovery style presented similar levels of depression regardless of the level of their internalised stigma. *Conclusions*. Findings suggest the moderator role of recovery style between internalised stigma and depression in people with persecutory delusions.

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Schizophrenia; psychosis; recovery style; internalised stigma

1. Introduction

Data generated by schizophrenia epidemiology are gradually helping to overcome Kraepelin's (1919/1971) pessimistic and resilient view of mental illness as a chronic and untreatable condition. Over the last decades, it has been shown that recovery is possible for some patients with schizophrenia spectrum disorders (Menezes, Arenovich, & Zipursky, 2006). Even meta-analyses have shown that a significant proportion of individuals with schizophrenia meet recovery standards (Jääskeläinen et al., 2012). Thus, it is important to examine mechanisms related to the recovery of mental illness and provide a challenge

CONTACT Regina Espinosa r.espinosa@psi.ucm.es

for the research community to develop more effective and widely available treatments for those with schizophrenia.

There is a new wave of optimism that focuses on the concept of recovery as an organising principle of mental health delivery systems and clinical care (Braslow, 2013). Paradoxically, although there is a large body of research exploring the onset of psychosis, there has been much less attention focused on researching recovery style (McGrath, 2008).

Recovery style has been identified as an important factor that can predict remission (Staring, Van der Gaag, & Mulder, 2011). Some studies have shown that the recovery style adopted by individuals after an episode of psychosis can impact their outcomes (Staring et al., 2011; Tait, Birchwood, & Trower, 2003, 2004). Two contrasting styles of recovery have been observed in people with psychiatric disorders; integration style and sealing-over style (McGlashan, Docherty, & Siris, 1976; McGlashan & Levy, 1977). A patient with an integration style is characterised by an awareness of self before, during, and after the psychotic experience because they see these experiences as a part of them, in which they are responsible for and which can be used as a source of useful information (McGlashan et al., 1976). However, a patient with a sealing-over style tends to distance himself or herself from his or her psychotic experience because they see the experience as just a negative disruption in their life (McGlashan et al., 1976). There is some evidence that indicates that people who seal-over have a more negative self-evaluation and insecure identity than people with an integration style (Drayton, Birchwood, & Trower, 1998; Tait et al., 2004). Iqbal, Birchwood, Chadwick, and Trower (2000) have suggested that sealing-over people might be defending his or her self from negative emotions by rejecting or avoiding negative expectations and experiences, which could be shameful. These two opposing recovery styles represent the extremes on a continuum. However, many people can present a mixture of the two coping styles (Staring et al., 2011).

There is a clear link between psychotic experiences and negative emotional states (e.g., anxiety and depression). The presence of this emotional distress is likely to contribute to the recurrence of psychotic symptoms (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001). Moreover, emotional distress is not only a maintenance factor of psychosis, but also an important consequence of the illness associated with worse outcomes. For instance, the experience of chronic mental illness as stigmatising and humiliating, which are appraisals that may influence the development of depression (Birchwood & Iqbal, 1998) and hopelessness, may be a predictor of poor prognosis (Aguilar et al., 1997).

Schizophrenia has many negative beliefs associated with its chronic and deteriorating nature (Angermeyer, Matschinger, & Corrigan, 2004). These negative expectations can be threatening and distressing to those who are given the diagnosis, and this is likely to contribute high levels of distress (Mulholland & Cooper, 2000). Internalised stigma (IS), or self-stigma, can be understood as a process where people, who are diagnosed, identify with the stereotypes associated with mental illness, anticipate social rejection, consider stereotypes to be relevant to one's self, and believe themselves to be inferior to others (Corrigan & Watson, 2002). Consequently, there is evidence that indicates that IS is likely to condition the process of the recovery, which leads to negative outcomes (Yanos, Roe, Markus, & Lysaker, 2008).

Research indicates that IS in people with mental illness have been associated with higher depressive and negative symptoms (Ritsher & Phelan, 2004; Yanos et al., 2008);

lower hope, more avoidant coping (Yanos et al., 2008); and weaker empowerment and recovery orientation (Ritsher, Otilingam, & Grajales, 2003).

In sum, IS seems to be a source of emotional distress and a barrier to recovery that is likely to be conditioned by how individuals comprehend and react to their illness (i.e., their recovery style). The primary goal of this study was to examine and explore the strength of the relationship between recovery style, IS and emotional distress (anxiety and depression levels). We specifically formulated two hypotheses. First, in line with findings reported by Tait et al. (2004) and Iqbal et al. (2000), we expected a negative significant relationship between integration style and IS levels, and depression and anxiety symptoms. Our second hypothesis was that recovery style would moderate the relationship between IS and emotional distress: (1) People with higher IS would experience more distress if they had a sealing-over style rather than an integration recovery style and (2) People with lower IS would report similar levels of emotional distress regardless of their recovery style.

2. Material and methods

2.1. Participants and procedure

The inclusion criteria for all participants included a signed informed consent and participants' ages ranged from 18 to 65. All participants were from the same geographical area.

The sample consisted of 50 participants who were admitted to a psychiatric inpatient hospital, who met the research diagnostic criteria of Psychotic Disorders, according to the *DSM-IV* criteria (American Psychiatric Association [APA], 2000) and who suffered from persecutory beliefs assessed by the Present State Examination (PSE-10, SCAN, item 12 or item 13 of the Section 19; World Health Organization, 1992) and had a score of ≥4 (i.e., level of severity) on the suspiciousness item of the Positive and Negative Syndrome Scale (Kay, Fiszbein, & Opler, 1987). None of the people had brain disorders. People were selected through hospital records and diagnoses were confirmed with a clinical structured interview (MINIPLUS, Sheehan & Lecrubier, 2002). According to the *DSM-IV* criteria (APA, 2000), people met diagnostics for the following categories: Paranoid schizophrenia ($n = 15$), delusional disorder ($n = 9$), schizophreniform disorder ($n = 5$), schizoaffective disorder ($n = 4$), brief psychotic disorder ($n = 16$), and non-specific psychotic disorder ($n = 1$). All people were receiving antipsychotic medication at the time of participation in the study. The mean age was 32.5 years (SD = 9.6; Table 1). The mean age of illness onset was 27.8 years (SD = 6.9). Table 1 showed demographic and psychological characteristics of sample.

2.2. Measures

All participants were evaluated using the following measures:

Recovery Style Questionnaire (RSQ; Drayton et al., 1998) is a 39-item self-report measure consisting of 13 subscales (McGlashan As Reviewer 1 rightly pointed out & Levy, 1977). Scoring of the RSQ allowed the classification of recovery styles, where lower scores represent sealing-over and higher scores represent integration. The RSQ has been shown to have excellent psychometric properties and was validated against the

Table 1. Demographics and psychological characteristics of participants.

Characteristics	Participants (50)
Sex: women, *n* (%)	20 (39.2)
Age: mean (SD)	32.5 (9.6)
Marital status *n* (%):	
Married	11 (21.6)
Single	34 (68.6)
Separated	5 (9.8)
Education *n* (%):	
Primary school	22 (44)
Secondary school	22 (44)
College education	6 (12)
Employment, *n* (%):	
Never employed	15 (30)
Unemployment > 1 year	8 (16)
Unemployment < 1 year	9 (18)
Employed	18 (36)
Integrating recovery style (RSQ): mean (SD)	0.57 (0.18)
Internalised stigma scales (ISMI), mean (SD):	
IS total	64.6 (9.42)
Alienation	13.1 (2.52)
Stereotype endorsement	14.44 (3.46)
Discrimination experience	11.06 (2.56)
Social withdrawal	13.65 (2.99)
Stigma resistance	12.04 (2.56)
Depression (BDI-II)	16 (10.35)
Anxiety (BAI)	14.32 (16.33)

interview version (Drayton et al., 1998). The reliability of the version used in this study was moderate (α = 0.65).

Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988). The BAI is a 21-item self-report with an inventory format designed to assess the severity of clinical anxiety symptomatology. Each BAI item reflects an anxiety symptom. The internal consistency of the total scale was α of 0.94

Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer, & Brown, 1996). This is a 21-item self-report questionnaire to assess the severity of cognitive, affective and somatic symptoms of depression. The reliability of the version used in this study was high (α = 0.90)

IS of mental illness (ISMI; Ritsher et al., 2003). This is an instrument to assess the subjective experience of stigma. It consists of 29 items with a 4-point rating scale and 5 subscales: *Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal*, and *Stigma Resistance*. The internal consistency of the total scale was α of 0.84, with α of 0.64 in the Alienation subscale, α of 0.75 in the Stereotype Endorsement subscale, α of 0.74 in the Perceived Discrimination subscale, α of 0.75 in the Social Withdrawal subscale, and α of 0.67 in the Stigma Resistance subscale.

2.3. Data analyses

First, Pearson product-moment correlation coefficient (*r*) was conducted to explore the relationship between recovery style and all dimensions of IS and emotional distress (see Table 2). Second, we used a moderation analysis by PROCESS procedure for SPSS for simple moderation analysis (Hayes, 2013) to estimate by requesting model= 1 if IS (the

Table 2. Correlations between integrating recovery style levels, internalised stigma, depression and anxiety symptoms.

	1	2	3	4	5	6	7	8	9
Integrating recovery style	1								
IS total	−0.46**	1							
IS subscales									
Alienation	−0.32*	0.72**	1						
Stereotype endorsement	−0.39**	0.82**	0.55**	1					
Discrimination experience	−0.40**	0.81**	0.42**	0.70**	1				
Social withdrawal	−0.34*	0.83**	0.53**	0.68**	0.63**	1			
Stigma resistance	−0.11	0.16	0.08	−0.23	−0.04	−0.11	1		
Depression (BDI-II)	−0.30*	0.33*	0.34*	0.13	0.21	0.42**	−0.22	1	
Anxiety (BAI)	−0.09	0.97	0.25	0.08	0.08	0.33*	−0.43**	0.70**	1

*$p < .05$.
**$p < .001$.

independent variable) affected emotional distress outcome (the dependent variable) and whether the strength of the relationship was dependent on a third variable (recovery style). In the case of statistically significant interactions, we conducted tests of the simple slopes of IS conditioned at each of the two levels of recovery style (sealing-over versus integration; Aiken, West, & Reno, 1991). Simple slopes or a spotlight analysis is the most popular approach to probing of interactions (e.g., Aiken et al., 1991). Following this procedure, we will select a value M, calculating the conditional effect of X on Y ($\theta X \rightarrow Y$) at that value, and conducting an inferential test (see, Aiken et al., 1991).

3. Results

3.1. Correlations between integrating recovery style levels, IS, depression and anxiety symptoms

Correlations between the variables assessed in the study are shown in Table 2. Integrating recovery style levels and IS total ($r = -0.46$, $p < .001$), Alienation subscale ($r = -0.32$, $p = .02$), Stereotype endorsement subscale ($r = -0.40$, $p = .005$), Discrimination experience subscale ($r = -0.40$, $p = .005$) and Social Withdrawal subscale ($r = -0.34$, $p = .016$) were significantly and negatively related. However, it was not significantly correlated to Stigma Resistance subscale ($r = -0.11$, $p = .43$).

Pearson correlations between integrating recovery style and emotional distress variables, indicated that integrating recovery style levels was only significantly correlated to depression ($r = -0.30$, $p = .035$) (see Table 2).

3.2. Moderation analyses

To assess whether recovery style moderated the association between IS and emotional distress outcomes (i.e., depression and anxiety) (see Table 3), we used the PROCESS procedure for SPSS for two simple moderation analysis (Hayes, 2013). The interaction of recovery style and IS was only significant when depression was the dependent variable ($\beta = -2.13$, $p < .01$) explaining an additional 15% of the variance. Figure 1 depicts the interaction of recovery style and IS. A simple slopes analysis (Aiken et al., 1991) showed that when people had a sealing-over recovery style, the relationship between IS

Table 3. Regression analysis to assess how recovery style, IS and their interaction predict emotional distress.

Dependent variable: depression (BDI-II)					
	R^2	ΔR^2	*t* (each predictor)	β	*p*
	0.28	0.15*			
Integration recovery style (RSQ)			−1.06	−0.16	.29
Internalised stigma (ISMI)			1.53	0.42	.13
RSQ * ISMI			−2.79	−2.13	.01*
Dependent variable: anxiety (BAI)					
	0.16	0.14			
Integration recovery style (RSQ)			−0.02	−0.28	.71
Internalised stigma (ISMI)			0.29	0.09	.68
RSQ * ISMI			−1.86	−3.63	.07

*$p < .05$.

and depression was positive and marginally significant ($\beta = 0.74$, $t = 2.20$, $p = .09$). However, when people had an integration recovery style, the relationship between IS and depression was non-significant ($\beta = -0.12$, $t = -0.36$, $p = .72$). In conclusion, as shown in Figure 1, there was an approached significance tendency, indicating that participants with sealing-over recovery style and high IS had the highest levels of depression. When anxiety was the outcome variable, the interaction between integration recovery style and IS was non-significant (see Table 3).

4. Discussion

In the current study, we examined the association between recovery style, IS and emotional distress (i.e., depression and anxiety). We tested if recovery style could be moderating the relationship between IS and emotional distress. Results showed that recovery style seems to be associated with IS and depression levels in people with persecutory delusions and is a moderator between IS and depression.

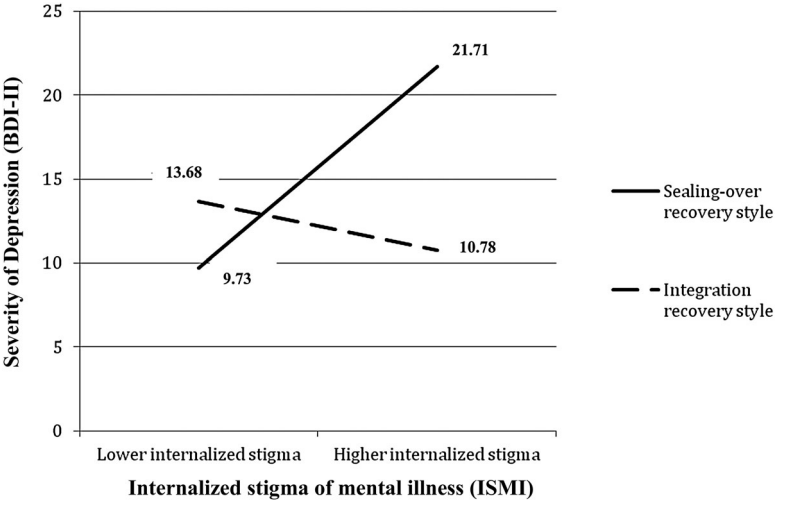

Figure 1. RSQ as a moderator of the relationship between internalised stigma as measured by the ISMI and severity of depression as measured by the BDI-II.

The assessment of relationships between integrating recovery style and IS and paranoid people's emotional distress only partially confirmed our first hypothesis. Our findings are consistent with other studies that have found that sealing-over recovery style is associated with more negative outcomes (e.g., Tait et al., 2003). In line with Iqbal et al. (2000) results, we found that low integrating recovery levels had significantly higher levels of IS. In particular, our results indicate that people with sealing-over recovery styles suffered more from subjective alienation, felt less than a full member of society, and felt more linked to negative stereotypes related to mental illness, which lead to a trend of these people experiencing more discrimination and isolation from others than those with an integration recovery style. Brohan et al. (2010) have noted that these latter elements of self-stigma (alienation, stereotype endorsement and discrimination) are some of the most challenging in schizophrenia and merit further consideration. In addition, our findings are consistent with previous studies, which found that sealing-over recovery style tends to be associated with poorer social functioning, poorer quality of life and higher levels of depression (Drayton et al., 1998; McGlashan, 1987; Thompson, McGorry, & Harrigan, 2003). Our results showed that low integrating recovery style levels were significantly associated with higher levels of depression. However, our results seemed to indicate that there was not an association between recovery style and anxiety.

Consistent with our second hypothesis, we found evidence of recovery style as a moderator only in relationship between IS and depression. Our results showed that when people had a sealing-over recovery style, the relationship between IS and depression was positive and almost marginally significant. Thus, these results could indicate that individuals with a combination of sealing-over recovery style and high IS could be at a higher risk of depression, but those with integration recovery styles, even if stigmatised, tend to be more resilient to depression. When participants had an integration recovery style, the relationship between the presence of IS and depression seemed to be absent. A possible explanation for this is that stigmatised paranoid individuals with a sealing-over recovery style are avoiding emotional material that need to be processed and accepted. However, by doing so, it interferes negatively and delays the normal process of recovery. However, people that use integration are characterised by a flexible thinking style, since they incorporate psychosis into their wider life experience. These latter people use the psychotic experience as a learning experience rather than something that needs to be avoided. In contrast, people who tend to seal-over isolate their psychotic episode and treat it as an inconvenient disruption. It has been suggested that individuals who seal-over are psychologically more vulnerable, with little resilience to life changes (Drayton et al., 1998).

These findings draw attention to the importance of designing interventions to monitor and reduce avoidant recovery styles in order to detect those at risk for depression and reduce feelings of vulnerability and suffering. There are several treatment approaches for people with mental disorders to reduce self-stigma, alter stigmatising beliefs and attitudes of the individual, and enhance skills for coping with self-stigma through improvements in self-esteem, empowerment and help-seeking behaviour (see Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012). This also promotes integrative psychotherapy to emphasise interpersonal attachment, personal narrative and metacognitive processes (i.e., Hamm, Hasson-Ohayon, Kukla, & Lysaker, 2013; Lysaker, Roe, Ringer, Gilmore, & Yanos, 2012). Furthermore, recovery from psychosis might be enhanced by working

actively on the individual's experiential avoidance, which has been advocated by ACT approaches (Bach, Gaudiano, Pankey, Herbert & Hayes, 2006). Moreover, third generation behavioural mindfulness interventions might also help individuals with psychosis to become more aware of their experiences and symptoms without having to rely on psychological avoidance. Sealing-over has been associated with more adverse childhood experiences (Drayton et al., 1998; Tait et al., 2004), suggesting that recovery style may arise out of an individual's life context rather than out of their psychotic experience. It could be implied that a nurturing and accepting community milieu could be an essential breeding ground to allow for the development of a healthy recovery style.

The present study provides interesting results, but is limited in several ways. First, our results are based on cross-sectional data and we cannot draw conclusions about causality. The study design does not allow for studying the dynamic changes of the variables in the study over time and these variables rely exclusively on self-report questionnaires. In addition, since our sample is a homogenous sample of people with persecutory delusions, results might not be representative of a more heterogeneous population. The results must also be used with caution since this study is mainly based on findings obtained by self-report questionnaires, which can elicit sociably desirable answers.

Disclosure statement

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