

Dynamics of psychosis recovery, stigmatisation, and healthcare professionals' microaggressions in Dutch healthcare

Master thesis

Name	Ploon Defourny
Studentnumber	627056
Coursename	GW4030MV
Supervisor	M. Heerings
First reader	H.M. van de Bovenkamp
Assignment date	08-08-2022
Wordcount	14997 (without referencing parentheses)

Summary

Introduction

Psychosis recovery has undergone a shift from a pure clinical recovery towards an approach in which the importance of personal development has grown. People suffering from psychosis are frequently stigmatized, resulting in discrimination on all levels of society. If patients internalise these expressions, they experience self-stigmatisation as well as a diminished self-esteem and self-efficacy. With the approach that focuses on a patient as a whole, healthcare professionals play a significant role in this process and should assist patients in developing a positive self-perception through partnerships. However, research suggests that healthcare professionals also express stigmatising attitudes, influencing patients and their path to recovery. As a result, the goal of this thesis will be to gather information on the impact of these stigmatising attitudes via microaggressions, as well as the dynamics underlying their effect on recovery.

Methods

The research question has been researched while using an abductive narrative research approach. It included analysis of narratives and narrative analysis, which followed steps as described by Murray & Sools (2014). Analysis was performed with the use of Word (interviews) and Atlas.ti (books). This led to categorisation in themes and the identification of narrative storyline types. In total, two books and nine patient interviews were studied.

Results

Analysis of data resulted in the classification of microaggressions into four themes: dehumanisation of patients; patients being treated as second-class citizens; professionals suggesting that patients lack the ability to know what is good for them; and minimising patients and their experiences. Narrative analysis of patient stories resulted in the identification of four narrative storyline types that explicate the potential effects of microaggressions on psychosis recovery. Hopelessness for the future; loss of direction; self-stigma; and avoidance of care are all possible outcomes.

Conclusion and discussion

This thesis provides an overview of microaggressions experienced by patients suffering from psychosis by Dutch healthcare professionals. This thesis has scientific relevance as research that combines this specific patient population, setting and research method has not been conducted before. It also illustrated the potential consequences of microaggressions on recovery

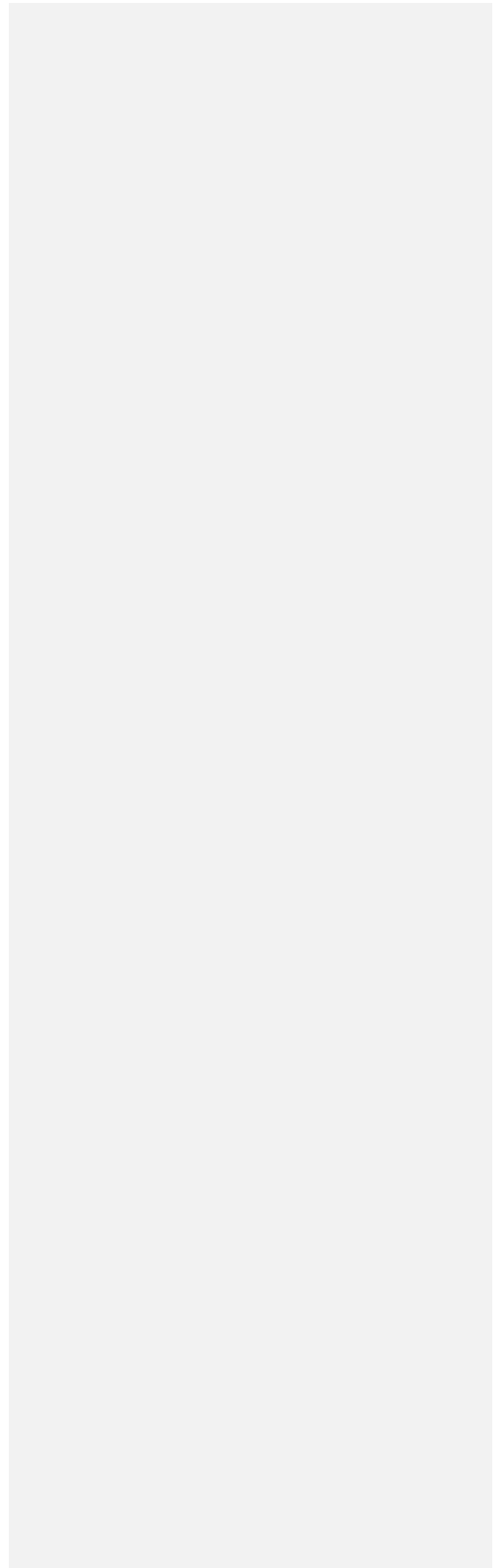
by demonstrating how microaggressions result in hopelessness for the future, lack of direction, care discontinuity, and self-stigma. Furthermore, partnerships seem to get hampered by the expression of microaggressions, and mediate the above mentioned effects. With this knowledge, prevention interventions may be developed, resulting in societal relevance as well.

Table of contents

Summary	2
Chapter 1: Introduction	6
1.1 Scientific and societal relevance	7
1.2 Research question	8
1.3 Reading guide	8
Chapter 2: Theoretical Framework	10
2.1 Recovery	10
2.2 Stigma	11
2.3 Microaggressions	13
Chapter 3: Research methods	16
3.1 Study design	16
3.2 Data extraction	16
3.3 Data analysis	18
3.5 Ethical considerations	21
Chapter 4: Results	22
4.1 Categorisation of microaggressions	22
Microaggressions that dehumanise patients and convey the notion that a patient is a unit or illness that needs to be fixed.	22
Microaggressions that suggest that patients with psychotic disorders are seen as second-class citizens	24
Microaggressions that suggest that patients lack the ability to know what is good for them.	26
Microaggressions that minimise patients	28
4.2 Microaggressions and their effects on recovery	29
Microaggressions that lead to feelings of hopelessness	30
Microaggressions that lead to a loss of direction in life	31
Microaggressions that induce self-stigma	33
Microaggressions that cause discontinuation of care and motivation to get better	35
Chapter 5: Discussion and conclusion	37
5.1 Microaggressions and their effects on recovery	37
5.2 Implications	40
5.3 Limitations and strengths	41
5.4 Conclusion	42
References	44
Appendices	50

Appendix 1: positionality of reflectivity

50



Chapter 1: Introduction

In recent years, the approach to mental illness recovery has shifted (Leamy et al., 2011). Clinicians used to focus on clinical recovery, which was defined as the absence of symptoms and lower rates of relapse and hospitalisation (Law & Morrison, 2014). Patients, on the other hand, see rehabilitation as a unique and individualised process in which hope and the rebuilding of self and life are essential (Law & Morrison, 2014). Consequently, recovery-oriented treatment has evolved into a process in which a relationship based on mutual respect between professional and patient has become central. This perspective on recovery emphasises the importance of patients' self-esteem, feelings of connectedness, hope and optimism for the future, identity rebuilding, finding meaning in life, and empowerment (Leamy et al., 2011).

Psychosis is a mental illness characterised by symptoms that include delusions, hallucinations, disorganised speech and behaviour, and occasionally negative symptoms such as falling, not speaking, or depression (DSM-V). As people are unfamiliar with these symptoms and behaviours, they are frequently labelled and stereotyped as dangerous and unpredictable. This unfamiliarity and labelling results in discrimination in all aspects of life (Corrigan et al., 2009).

When patients internalise these stigmatising attitudes, it may result in self-stigmatisation, low self-esteem, and low self-efficacy. Self-stigmatisation can form a barrier to recovery, as high self-esteem and efficacy are essential components of the recovery processes (Leamy et al., 2011; Pitt et al., 2018). Therefore, it is crucial to increase self-esteem and self-efficacy while decreasing self-stigmatising attitudes during psychosis treatment. As research indicates that familiarity with symptoms and learning about illnesses may reduce stigmatising beliefs, it may appear that healthcare practitioners are well equipped to assist patients, dispel self-stigma, and heighten their self-esteem and self-efficacy (Loch et al., 2013; Rao et al., 2009). Patients, on the other hand, frequently report being patronised, chastised, or humiliated when interacting with healthcare professionals, and they identify healthcare workers as one of the most stigmatising groups (Thornicroft et al., 2007). According to research, healthcare professionals convey their stigmatised attitudes in less overt forms, such as subtle stigmatisation or microaggressions (Young et al., 2019). These microaggressions consist of subtle verbal or behavioural signs that communicate negative messages to people of marginalised groups (Sue et al., 2007). Healthcare professionals frequently express microaggressions that communicate the idea that lived experiences are irrelevant, that there is no hope for the future, and that sharing and discussing professional knowledge is unnecessary (Amsalem et al., 2018).

Research on the effects of these microaggressions is crucial, as the negative effects of

stigma are more visible when they are expressed by those who have a bigger impact on our lives, such as healthcare professionals (Thornicroft et al., 2007). Other research on the effects of microaggressions towards people of colour, LGBTQ and women, suggests that microaggressions can have a negative effect on self-esteem, depression and anxiety related symptoms and can increase self-doubt and feelings of invisibility (Torino et al., 2018). Moreover, research suggests that microaggressions can also have a negative effect on therapeutic alliances and satisfaction of a professional relationship, when they are portrayed by healthcare professionals (Sue et al., 2007). Illustrating that, expressed microaggressions undermine the new foundational concepts of recovery-oriented treatment in the Netherlands, in which partnerships based on mutual respect, increasing self-esteem, and providing patient-centred care are central (GGZ, 2022).

This thesis therefore aims to research the underlying dynamics between microaggressions expressed by healthcare professionals and their effects on psychosis recovery in the Netherlands, so that appropriate interventions to prevent these expressions can be developed and more knowledge on the subject can be gained.

1.1 Scientific and societal relevance

The purpose of this thesis is to investigate the underlying dynamics of microaggression expressed by Dutch healthcare professionals in the context of psychosis recovery through a narrative analysis and analysis of narratives of patient stories derived from books or interviews.

The written narratives of patients are not influenced by others and reflect the feelings and experiences of the author. In addition, the interviews used could be classified as narrative interviews, which were only lightly steered by the introduction of specific themes, allowing patients to describe their experiences in a narrative manner (Sharp et al., 2019). They therefore cover the 'life stories' of patients, which enables the analysis of the internal diversity of patients, just as the books do. Previous research on this topic gathered data via semi-structured interviews or topic-specific prompts, followed by selective questions (Amsalem et al., 2018; Gonzales et al., 2015; Peters et al., 2016). This may have influenced the direction and sincerity of the responses. This thesis' data, however, provides a non-directed and more in-depth account of patient experiences, which may resolve the problems that arose with earlier research (Bovenkamp et al., 2020).

Besides, this thesis will have a focus on the expression of microaggressions experienced by patients that suffer from psychosis in Dutch healthcare and will also focus on the analysis of narratives. Previously performed studies were conducted in other countries and did not include

analysis of narratives. Narrative analysis may aid in unravelling the dynamics that underpin psychosis recovery and the expression of microaggressions by healthcare professionals because it helps to better understand patients' experiences (Sharp et al., 2019). This adds scientific relevance to this research, as it limits the biases of previous research and may aid in unravelling the underlying dynamics between microaggression expression and psychosis recovery.

Furthermore, this thesis aims to extend the knowledge and categorisation of microaggressions proposed by Amsalem and Gothelf (2018), Gonzales et al. (2015), and Peters et al. (2016) by providing more detail through analysis of narrative and narrative analysis. This is necessary because microaggressions manifest in subtle ways that often go unnoticed (Sue et al., 2007). Clear documentation of the types of microaggressions that occur in Dutch healthcare towards people suffering from psychosis is therefore required, as more knowledge and distinct categories make them easier to identify. This in-depth understanding of what these microaggressions entail is also required for the development of interventions that target their expression and effects (Michie et al., 2011). As a result, the findings of this thesis may be used to develop interventions aimed at minimising (the effects) of microaggressions, which can contribute to better healthcare in the future, giving this thesis societal relevance.

1.2 Research question

People suffering from psychosis face stigma in a variety of ways. Healthcare professionals express this stigma in subtle ways and through microaggressions. However, little research has been conducted on the dynamic relationship between recovery, microaggressions, and stigmatisation. The majority of studies rely on data from targeted interviews, which limits data collection. The aim of this study is to further explore the dynamic relationship between stigmatisation and microaggressions from healthcare providers on the recovery of patients who suffered from psychosis through narrative analysis of patient stories. It seeks to better understand the effects and to broaden and specify the categorisations of microaggressions so that they become easier to recognise. As a result, the following research questions emerged:

1. What type of microaggressions do people suffering from psychosis-related disorders experience in Dutch healthcare?
2. How can microaggressions affect a patient's route to recovery, and what role does self-stigmatisation have in this process?

1.3 Reading guide

This thesis consists of five chapters. This first chapter was the introduction, which included background information, the relevance of the research, and the research question. The second

chapter will include a theoretical framework outlining the main concepts through which this research was conducted. This theoretical framework sheds light on stigma, recovery, and microaggressions while also serving as a foundation for data analysis in the result section. In the third, or methodology chapter, the data collection, data analysis, applied validity and reliability processes, and the thesis's ethical considerations will be discussed. The fourth chapter is the results section, which will present relevant data that contributes to answering the research questions. The fifth chapter will contain a discussion of the findings and their limitations; a conclusion on the dynamics of microaggressions and stigmatisation by healthcare professionals; and recommendations for further research.

Chapter 2: Theoretical Framework

2.1 Recovery

Medical practitioners frequently define psychosis recovery as the absence of symptoms, decreasing relapse rates, and a decrease in hospitalisations (Law & Morrison, 2014). Patients, on the other hand, frequently describe recovery as a unique process wherein hope, rebuilding of self, and rebuilding of life are central (Law & Morrison, 2014). These user-oriented studies have revealed that psychosis recovery is unique and varies from person to person (Leamy et al., 2011), indicating that recovery therapies should be patient-centred, with treatment tailored to patients' unique goals and vulnerabilities (GGZ, 2022). This has resulted in a new recovery approach in which the emphasis of recovery from healthcare practitioners has shifted from a strictly clinical to a more holistic one, with an emphasis on personal and societal recovery as well (Leamy et al., 2011).

The clinical part of this recovery approach focuses on measurable results such as symptom remission and functional improvements (Pec, 2020). The primary interventions are psychoeducation and medication (GGZ, 2022; Yeomans et al., 2010). The focus of the personal part of recovery lays on the psychological and social aspects of recovery, such as self-esteem and quality of life, and interventions are support-driven (Law & Morrison, 2014). Personal recovery interventions in the Netherlands consist of Individual Placement and Support (IPS), which focuses on retaining and acquiring work, and activity planning (GGZ, 2022). Furthermore, service users identify a safe place to live and a focus on personal understanding of their problems as recovery building blocks (Law & Morrison, 2014).

Recovery can be seen as a process that consists of several stages. Andresen et al. (2006) define these stages as: moratorium, awareness, preparation, rebuilding, and growth. In other words, the patient initially experiences withdrawal and hopelessness, then discovers that there is hope, identifies their strengths and vulnerabilities, strives for a positive identity, and finally develops a positive sense of self while living a meaningful life (Andresen et al., 2006). However, it should be borne in mind that recovery is a non-linear process marked by setbacks and that stages can be turned back to at any given moment (Jose et al., 2015).

There are several processes that contribute to successful recovery and movement from one stage to the other (Leamy et al., 2011). These processes are described with the CHIME acronym, which stands for: feelings of connectedness, hope and optimism for the future, identity rebuilding, finding meaning in life, and empowerment (Leamy et al., 2011). Therefore, treatments should aim to facilitate these processes. These processes require high self-esteem and high self-efficacy and should be emphasised throughout (Leamy et al., 2011; Pitt et al.,

2018). Self-esteem can be attained through self-awareness, which involves recognising and gaining an understanding of past events, and through empowerment. Empowerment is facilitated through understanding of illness, accepting it, motivation, and peer support, which may demonstrate the possibility of recovery (Pitt et al., 2018). Self-efficacy relates to an active participation in life, which helps with finding a purpose. Motivating patients to participate in voluntary work may contribute to this. Support and overcoming stigma can provide hope for a better future (Pitt et al., 2018).

The stages of recovery and underlying processes are implemented in recovery-oriented treatments and enforced through a partnership between professionals and patients. This partnership also implies that treatment should be altered in accordance with the consumers' needs, aspirations, and lived experiences (GGZ, 2022). Mental health professionals thus play a vital role in patient recovery and should maintain an open and respectful attitude towards patients (Frese et al., 2009; GGZ, 2022). Unfortunately, this is not always the case, as healthcare professionals can have stigmatising attitudes as well (Burke et al., 2016). Stigmatisation of professionals may contribute to a lack of self-esteem, worsening of symptoms, reduced functionality, and withdrawal from treatment. As a result, it can form a barrier to recovery (Burke et al., 2016).

2.2 Stigma

Expressions of stigma 'reduce someone from a complete and usual person, to a devalued, tainted one' (Goffman, 1963, p. 3). Stigma rises through a few synthesising concepts, which consist of labelling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001). The labelling process consists of identification of differences between the minority and the greater mass; these labels are then related to stereotypes, in which the label is connected to specific traits or behaviours; and finally, there is a separation, in which the labelled group is perceived as distinct from the rest. These synthesising concepts finally result in the loss of status and discrimination against the labelled group (Holder et al., 2018; Link & Phelan, 2001).

People with mental illnesses face discrimination as a result of this public stigma, which consists of disapproval of a group of people with certain characteristics by society. The public stigma of mentally ill people include preconceptions of dangerousness and incompetence (Corrigan et al., 2009). This public stigma can result in loss of opportunities (e.g. lower chances of employment or housing), coercion, and segregation from society and can therefore negatively influence the chances of the achievement of their personal goals (Link & Phelan, 2001). Public stigma can lead to self-stigma because people form expectations of others when they encounter

a minority, such as those with mental illnesses, as a result of labelling. This becomes relevant to someone when they themselves develop a mental illness, because it determines how others will interact with them from that point forward. The attitudes of others, as well as the development of a mental illness, have a negative impact on one's self-perception (Valk et al., 2018). These negative effects on self-esteem are mediated by the fact that patients are treated differently after their diagnosis, are ignored, ridiculed, and face social exclusion and marginalisation as a result of these existing stigmas (Corrigan et al., 2009).

The awareness of these stigmatising attitudes, agreeing with them, and their application to themselves results in self-stigma (Corrigan et al., 2009). Self-esteem and a sense of self-efficacy serve as mediating variables in the self-stigmatisation processes (Corrigan et al., 2009). When the above-mentioned attitudes are internalised, it can result in even lower self-efficacy and self-esteem, as patients get fewer opportunities and feel as if they will never be able to achieve their goals, making it a self-reinforcing loop. This eventually causes the "why try effect" as described by Corrigan et al. (2009), in which patients give up and do not actively seek help or engage in society, as they think that failure is inevitable. Illustrating that, stigma can have a negative influence on recovery processes as active participation in life is an important aspect of recovery (Leamy et al., 2011).

Stigma also manifests in institutions, such as healthcare, despite the fact that it is thought that familiarisation and knowledge about illnesses will reduce stigmatising attitudes (Loch et al., 2013, Rao et al., 2009). The stigmatising attitudes of professionals consist of dangerousness, -although less than the general public-, a pessimistic outlook on prognosis, and that people with mental illnesses should not have children or should not marry (Valery & Prouteau, 2020; Wahl & Aroesty-Cohen, 2010). They do, however, have a higher faith in the usefulness of pharmaceutical treatment (Valery & Prouteau, 2020). This results in a paradox in which patients feel both aided and misunderstood by healthcare professionals, which may form an obstacle to recovery as it may lead to patients' unwillingness to elaborate on their self-stigma (Corrigan, 2004; Thornicroft et al., 2007). Furthermore, the negative effects of stigmatisation may become magnified when they are expressed by people who have a bigger impact on patients' life, such as healthcare providers (Thornicroft et al., 2007).

Stigmatised attitudes of professionals are often expressed in less obvious and implicit ways, but this does not mean that they have less negative effects (Young et al., 2019). A way in which healthcare professionals may express these implicit stigmatising attitudes is through microaggressions. Research of patients that perceived microaggressions aimed at their racial and sexual orientation from healthcare professionals reported that these expressions negatively

influenced their therapeutic partnership and overall satisfaction with care (Sue et al., 2007). Besides, it is also known that microaggressions can cause low self-esteem, self-doubt, isolation, and can cause people to feel invisible (Torino et al., 2018). This illustrates that microaggressions can cause similar effects as stigmatisation, although they are expressed in less overt ways.

2.3 Microaggressions

Stigmatisation of professionals manifests itself in subtle ways, such as microaggressions, rather than through exclusion (Amsalem et al., 2018; Gonzales et al., 2015). Microaggressions are subtle verbal or behavioral signs that implicitly and explicitly transmit negative messages to a group of minorities (Sue et al., 2007). Microaggressions can take numerous forms, including microassault, microinsult, and microinvalidation (Sue et al., 2007, p. 275). The most obvious form is microassault, which includes name-calling. Microinsults are more subtle and stem from insensitivity. Microinvalidation is the least obvious form, in which lived experiences are minimised (Sue et al., 2007, p. 275).

Several studies have classified microaggressions that were directed at people suffering from mental illnesses. Gonzales et al. (2015) classified the general public's voiced microaggressions toward those suffering from mental illnesses into five main and eight subthemes. Peters et al. (2016) described four main themes of microaggressions and eight subthemes experienced by individuals with mental health illnesses, and Amsalem et al. (2018) described three themes in which microaggressions from healthcare professionals can be placed. Figure 1 has been made to provide an overview of how the described microaggressions are related. Themes that are related are categorised underneath each other, and microaggressions that share the same meaning are put into a shared box (see figure 1).

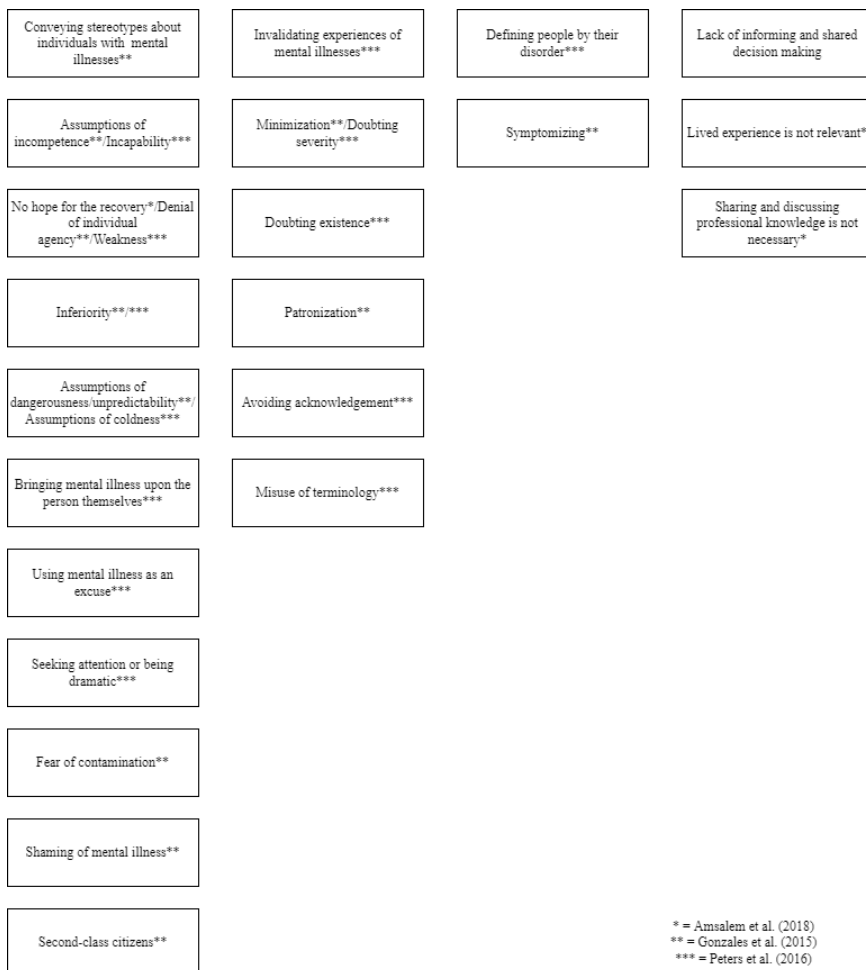


Figure 1: Subordination of microaggressions as described in existing literature.

Figure 1 illustrates that many of the till this date identified microaggressions can be placed under the theme of ‘conveying stereotypes about individuals with Mental illnesses’ as drawn up by Peters et al. (2016). However, lack of informing and shared decision-making, under which ‘lived experience is not relevant’ and ‘sharing and discussing of professional knowledge is not necessary’ may also be placed under the theme ‘inferiority’ or ‘incapability’ that are now placed under the conveying stereotype microaggression. These microaggressions suggest that people

with mental illnesses are incapable of understanding information or keeping up with a discussion, and invalidate the idea that patients know what is good for them (Amsalem et al., 2018). Besides, the microaggressions that suggest that people with mental illnesses are seen as weak, as if they will never be able to recover or are seen as second class citizens, which also illustrates the idea of inferiority. This illustrates that many of the till this date drawn up microaggressions are interlinked. It becomes clear that there are too many categorisations in which microaggressions can be placed and that they are all intertwined when we combine current research. This makes recognition of microaggressions harder, as one statement can be placed into different categories. This thesis aims to recategorise these microaggressions and develop a clear and well-formulated categorisation, so that microaggressions in Dutch hospitals become easier to recognise and target with interventions.

When looking at the microaggressions of figure 1, it becomes clear that there is a conflict between practice and intentions of the new recovery approach. Expressed microaggressions even appear to undermine it. Many of the listed microaggressions signal patients' inferiority and therefore appear to disregard a partnership built on mutual respect between patient and practitioner. Shared decision-making, one of the other building blocks of recovery, gets undermined due to the microaggressions of 'lived experience is not relevant' and 'sharing and discussing of professional knowledge is not necessary'. Finally, there are microaggressions that undermine the final principle of the new recovery approach, which is to build self-esteem and self-efficacy. These principles are undermined by microaggressions that communicate inferiority, weakness, hopelessness for the future, and second-class citizenship, as they may contribute to self-stigma, loss of self-esteem, and decreased hope and optimism for the future.

Chapter 3: Research methods

3.1 Study design

An abductive narrative analysis and analysis of narratives of patient stories were conducted to gain insights into the dynamics underlying psychosis recovery and expression of microaggressions by professionals. Patient stories offer in-depth information on patients' experiences (Bovenkamp et al., 2020). This in-depth information is analysed with the use of narrative analysis, which is a form of qualitative research that assists in understanding the experiences, actions, and motives of people who have faced a significant life challenge. This gives narrative analysis the potential to inform policy changes for marginalised groups (Sharp et al., 2019).

This thesis focused on storyline analysis, which attempts to connect the person, context, and broader social situation of a story (Murray & Sools, 2014). This results in a comprehensive overview of the story, which allows situations to be placed in a theoretical context (Murray & Sools, 2014). Each patient story has been analysed in accordance with the first two steps of the framework as proposed by Murray & Sools (2014). This framework is used to make connections between the analysed stories and theory in the conclusion (Murray & Sools, 2014).

3.2 Data extraction

This thesis' results are derived from written patient stories and anonymised patient interviews. Analysis of written patient stories provides non-influenced insight into all the aspects of living with a disease. As included narratives cover a longer journey, they also provide us with information on internal diversity within stories (Bovenkamp, 2020).

Books were obtained through the patient story database of the library of the Erasmus University Rotterdam. The collection consists of books that describe the sickness experiences of patients or family members. Books were first gathered by Stichting Coleta's Chronische Circus (CCC) and are now part of the Erasmus School of Health Policy & Management (ESHPM). The books have been added to the university library, allowing the information to be accessed by a broader audience (Erasmus University Library, n.d.). The database consisted of 32 books on psychosis in total. However, only two of them were included because they were the only ones that provided comprehensive material on microaggression and experiences with medical personnel.

Patient interviews were collected by the psychiatry story bank of UMC Utrecht and provided additional information on the issue of microaggressions and stigmatisation towards patients with psychosis-related disorders. Stories from this database are utilised to improve care

and aim to gather insight into what factors aided or hindered mental illness recovery (Verhalenbank Psychiatrie, n.d.) Interviews from this bank use no pre-set of questions, resulting in interviews that can be classified as narrative interviews (Anderson & Kickpatrison, 2015). The interviews are thus only lightly steered by the introduction of specific themes, which allows patients to dictate their experiences in a narrative manner (Sharp et al., 2019). They therefore cover 'life stories' of patients, which enables the analysis of the internal diversity of patients (Sharp et al., 2019). Two employees of the psychiatry story bank at UMC Utrecht made a preselection of stories for this study. The selection was based on patients with psychotic disorders and the mention of experiences with mental healthcare professionals, which resulted in the selection of 37 patient stories.

In- and exclusion criteria have been used for data selection. Inclusion criteria were as follows: (1) writer or interviewee has had experiences in the 'GGZ', as this is the main mental healthcare provider in the Netherlands; (2) writer or interviewee has experienced a psychosis or psychosis related disorder, as this is the focus of this thesis; (3) described experiences with care institutions took place between 1998 and 2022, ensuring the applicability of the results to healthcare today; (4) narrative describes or illustrates instances of microaggressions or stigmatisation by healthcare professionals. Exclusion criteria were as follows: (1) writer/interviewee only had experiences with healthcare outside of the Netherlands, as this thesis aims to gather insights into the occurrence of microaggressions and stigmatisation from professionals within the Dutch healthcare system, (2) patient story was too chaotic, as this made narrative analysis and analysis of narrative too difficult.

Furthermore, healthcare practitioners' displays of stigma or microaggressions may be influenced by age, the number of psychotic experiences, and the sorts of disorders. Therefore, no filters based on age, the severity and amount of psychosis, or psychotic-disorder type have been applied. Resulting in a higher variability, and therefore, improved generalisability of found results.

In total, 33 interviews and 2 books that were in accordance with set in-and exclusion criteria have been read. Only 9 interviews have been fully analysed, as other interviews described little to no relevant events (n=10), or as no other (sub)themes were identified (n=12). An overview of included patient stories and books can be found in tables 1 and 2.

Table 1: included books

Title	Writer	Reference	Diagnosis	Age	Gender
'Schizofrenie en bergen beklimmen'	Saskia Bos	R1	Many, eventually Schizophrenia	30-45	Woman
'Herstel na dertien jaar overleven in de psychiatrie'	Meini Westering	R2	Many, Schizophrenia, borderline and autism	30-45	Woman

Table 2: included patients from psychiatry story bank

Patient	Reference	Diagnosis	Age	Gender	Ethnicity
P342019	R3	Schizophrenia	40	Man	Unknown
P352019	R4	Schizophrenia	60	Woman	Unknown
P602019	R5	Schizophrenia	44	Woman	Dutch
P612019	R6	Bipolar disorder	52	Woman	Unknown
P622019	R7	Schizophrenia	22	Woman	Unknown
P802020	R8	Schizoaffective disorder	38	Woman	Dutch/Columbian
P902020	R9	Schizoaffective disorder	48	Woman	Dutch
P1002020	R10	Autism, PTSS, psychosis and mood disorder	26	Woman	Dutch
P1052020	R11	Psychosis	47	Man	Dutch

3.3 Data analysis

With the use of the qualitative research support application Atlas.ti, included books were digitised and analysed. The programme keeps track of remarks and notes, aids in document organisation, and facilitates coding-based analysis (Atlas.ti, 2022). Books have been labelled by identifying the plot characteristics as described by Murray & Sools (2014). Using a transcription tool, patient interviews were converted to digital form and analysed in Word.

The first step was to undertake a narrative analysis of each patient story. This followed the first two steps of Murray & Sools' (2014) storyline analysis framework, which called for the creation of a case title, a case introduction, and analysis of each storyline from the case. Analysis consisted of identification of each storyline element (agent, incident, means/helpers, setting, purpose, and breach), a narrative summary that matches the author's voice, and a conclusion that follows the plot (Murray & Sools, 2014). This enabled the author to summarise each narrative, making patient stories more accessible to a wider audience. This summary also revealed the connections between loosely tied acts and meanings (Murray & Sools, 2014).

Furthermore, storyline analysis enabled analysis of the narratives, as it provided descriptions that helped with the identification and categorisation of themes of microaggressions (Sharp et al., 2019). These common themes aided the replenishment of microaggression theory. Microaggressions were first coded as microaggressions in Word and Atlas.ti, then organised and analysed in Excel, where the researcher looked for commonalities and differences in separate expressions. Final categorisation followed these commonalities, making the analysis of narratives similar to thematic analysis (Braun & Clarke, 2006).

The second question of this thesis asked for a different approach as it aimed to better understand the dynamics underlying microaggression and recovery. In order to effectively demonstrate the consequences and contextual influences of microaggressions, it was necessary to identify similarities and plot types. This has been addressed with the help of comparative analysis, which is the fifth step in the Murray & Sools (2014) framework. As a result, four storyline types were identified that represent the effects of expressed microaggressions on psychosis recovery (Murray & Sools, 2014).

An abductive analysis has been used alongside the analysis of narrative and narrative analysis. Abductive analysis seeks to generate theories based on qualitative data (Tavory & Timmermans, 2014). A theoretical framework has therefore been built prior to the analysis. However, the theoretical framework was modified during research, in order to gain a better understanding of emerging phenomena (Tavory & Timmermans, 2014). During analysis, the researcher discovered that more information on the self-stigmatisation process and the effects of microaggression was required. Later on, new research on microaggressions experienced by people who suffered a mental illness had been found. Both were therefore incorporated into the theoretical framework. As a result, the researcher alternated between observation and theory in order for theory to be produced and refilled based on existing theories (Dubois & Gadde, 2002).

Lastly, it's important to note that Murray and Sools' (2014) narrative analysis originally has two additional steps: an analysis of how storytellers and listeners interact and position themselves; and contextual analysis of wider social, political, and societal contexts. These steps were left out of analysis as the previous steps provided enough information to identify the themes and storyline types.

3.4 Validity, credibility, and generalisation

To achieve good quality, quality measures for qualitative research have been applied. For credibility purposes, a positionality of reflectivity has been drawn up, which can be found in appendix 1. This illustrates how the characteristics and background of the writer might have influenced the interpretation of the data.

In qualitative research, validity refers to the reliability of interpretations (Riessman, 1993). Multiple tools have been applied to heighten the validity of found results. One way to heighten validity is through the providence of thick descriptions, which consist of descriptions that aid with interpretation of the found results (Whittemore et al., 2001). The narrative approach of this study aided the clear context descriptions of each story. Table 1 and 2 added to the thick description by illustrating the age, gender, and clinical characteristics of each patient included. Furthermore, researchers can request access to analysed data, allowing for control, interpretation of meaning and context, and study repetition, all of which improve validity (Whittemore et al., 2001). Another measure that makes interpretation of meaning and context of results easier is by the providence of quotes, as information is presented in the words of the storyteller (Whittemore et al., 2001). In addition, data, theory, and method triangulation have been applied. Data triangulation has been assured by the selection of multiple patient stories, with patients that had different ages, genders, and disorder types, as can be seen in table 1 and 2. Theoretical triangulation has been assured with the use of a theoretical framework, which provided the researcher with multiple theoretical lenses (Mortelmans, 2013). With the inclusion of both written patient stories and interviews, method triangulation has been assured, leading to higher internal validity as it confirms findings (Maso & Smaling, 1998). Besides, negative findings in and between stories were sought for, if none are found, the chances that presented results are true rise, resulting in higher validity (Brink, 1993). When negative findings are found, the results should be evaluated with greater caution. Finally, peer deliberation has been applied. Member checking has been left out in this thesis, as contacting anonymous writers and interviewees is impossible (Reynolds et al., 2011). Regardless of the measures used, the results should be interpreted with caution because the relationship between the interviewer and interviewee, as well as recall bias, may have influenced the narratives examined (Brink, 1993).

Generalisability of qualitative research is an active discussion in sciences (Polit & Beck, 2010; Smith, 2017). However, in this thesis generalisability has been tried to achieve through the use of narrative storyline analysis and thick description. One way to increase generalisability of qualitative research is through analytic generalisation. Analytic generalisation consists of the

conceptualisation of human processes (Polit & Beck, 2010). In this thesis, analytic generalisation has been achieved through the analysis of the narrative patient stories, as this led to a categorisation of their experiences. The used data analysis approach thus contributed to the generalisability of the found results. The abductive approach of this thesis also contributed to its generalisability, as it addresses the credibility of the results by the provision of a theoretical framework, which provides a field of knowledge (Thorne et al., 2009). Furthermore, thick descriptions enabled case-to-case translation or so-called reader generalisability, as they allowed for the application of accumulated knowledge to different circumstances based on recognition of the reader (Firestone, 1993; Misco, 2007). Finally, no filters on age, amount of psychosis and disorder type have been applied. As theme identification was consistent across all groups, it is possible to assume that the findings are context independent and thus generalisable (Firestone, 1993; p. 17).

3.5 Ethical considerations

Used books are freely accessible via the patient experience database, and all stories are published by the authors themselves. However, they might be unaware that their books are in the patient story database, raising the question whether they want their stories to be used in this manner. On the contrary, used books are published under a pseudonym and are untraceable to the actual person, which makes it less of an issue to utilise these names during research. Apart from books, interviews were used for data analysis. The psychiatry story bank interviews used were completely anonymised, including the visited facilities, which makes these respondents untraceable as well. Both of these facts make the use of provided data more ethically appropriate.

Another ethical problem that arises is whether the stories may be appropriated, given that they may be interpreted differently than perhaps intended. In order to respect all storytellers, the researcher tried to prevent this by the providence of detailed and rich descriptions. However, analysis makes their experiences available to a greater audience and may contribute to their goals of possible policy changes, as analysis of narratives resulted in categorisation of microaggressions, and can therefore aid interventions that target this behaviour. As a result, this study may have assisted the storytellers in achieving their goals.

Chapter 4: Results

Analysis of the patient narratives has led to a categorisation of expressed microaggressions. Eventually, four central themes have been identified, which are supplemented by subthemes. Categorisations from earlier research on microaggressions as experienced by patients with mental illnesses and psychosis have been kept in mind during analysis of the data. However, presented categorisations illustrate microaggressions that are experienced by patients who have suffered from psychosis and were treated in the Dutch healthcare system. Moreover, current categorisations were drawn-up to clarify the existing categorisations, so that microaggressions become easier to identify and, therefore, easier to target in interventions. Finally, a narrative analysis of the patient stories has been performed. This resulted in the identification of four story types, which represent the potential consequences of microaggressions expressed by healthcare professionals on psychosis recovery. Both will be presented below.

4.1 Categorisation of microaggressions

Microaggressions that dehumanise patients and convey the notion that a patient is a unit or illness that needs to be fixed.

The microaggressions in this theme express the idea that patients are some kind of unit or illness that needs to be fixed. This microaggression can be expressed in a variety of ways. The first way through which this type of microaggression can be communicated is by the diagnosis trajectory of the GGZ. Treatment follows diagnosis in the GGZ, meaning that the patient first has to be diagnosed before they can start their treatment. Expression of this microaggression illustrates that patients are not seen as a person that is in need of help, but as an illness that requires treatment. This view can also be communicated during the treatment trajectory, which in reality needs to be based on a partnership between the professional and the patient. The expression of microaggressions that communicate the idea that patients are considered as unworthy of attention get in the way of this principle. Microaggressions that belong to this theme imply that professionals consider their patients as unworthy of normal human interaction, support, attention, or therapy. Professionals may start to see patients as an illness that needs to be fixed with pills and not with suitable therapies, which can be communicated through microaggressions that belong to the last subtheme.

Met opmerkingen [HvdB1]: Maar is dit alleen maar een micro aggression> het is ook iets wat iets kan bieden vermoedelijk?

Met opmerkingen [HvdB2]: Maar het is allebei

Patient labelling and working via diagnostic protocols

When patients enter a psychiatric facility, they must frequently be diagnosed before being offered treatment. This microaggression thus lies in the client system of the GGZ. This can make patients feel as if psychiatrists are just "hunting" for a diagnosis. This illustrates that their treatment is diagnosis-centred instead of patient-centred as described by the GGZ (2022). Microaggressions of this theme communicate the idea that patients are merely seen as their disease and not as a patient that needs to be treated as a whole. This leads to situations in which professionals do not know what to do, as they are only specialised in one condition, and can lead patients to feel misunderstood and be sent on run-arounds, as can be seen in the following situation:

'I had to go back to the super psychiatrist for a new diagnosis and only then could I go to the psychotic disorders treatment programme, but on one condition, namely, that I did not show any symptoms of a personality disorder, because then everyone would go crazy. Of course, this whole process was not a matter of minutes, but rather weeks.' (R1)

This quote illustrates that the need for a specific diagnosis and not seeing the patient as a person in need of assistance can lead to the postponement of care. Finally, labelling may also cause tunnel vision of professionals, as one of the symptoms of a patient might have given them the sign that this patient must have illness X or Z. They will subsequently pay greater attention to other symptoms that support these ideas, resulting in an incorrect diagnosis and treatment.

Considering the patient as someone who is unworthy of attention

Another microaggression that can occur is seeing the patients as unworthy of attention. After diagnosis, patients can start treatment. However, some professionals do not give them enough personal attention or personal therapy, as they may see patients as a diagnosis and not as real humans. Professionals that do not actively participate in conversations, only take notes, and give few responses to patients convey this type of microaggression. This can cause patients to feel misunderstood and to suppress information as they feel uncomfortable and not taken seriously. The fact that professionals convey this idea of unworthiness stands in the way of the needed partnership between professionals and patients. Presence of this microaggression illustrates a lack of respect and can make it seem as if professionals do not see patients as worthy of normal human interaction. The effects of these expressions become clear in the following statement:

'I felt as if nobody was going to help me. My family is never going to help me. Not the social workers, because there I was also without a story. I never got anything back. I only told them how frustrated I was. But that person was just writing a bit on a notepad. And that made me so desperate. That I thought, this is not the intention.' (R5).

Another way in which this subtheme gets conveyed is by the lack of services that facilities provide. This can suggest that the providence of therapies is too costly, as if patients are things that should just exist and are unworthy of fun things. This can eventually cause boredom amongst patients.

Considering the patient as something that needs to be "fixed" with the prescription of pills, and reducing them to their illness alone

Patients may thus only receive treatment when they are diagnosed, and professionals can cause them to feel unworthy of attention. However, professionals may go a step further, by expressing the idea that they only see patients as illnesses that are unable to function on their own. They then may take all normal day-to-day activities out of a patient's hands, which conveys the idea that patients are unable to do things because they are sick. They prescribe them medication, and see this as the magical cure for all their problems. The aspect of lack of attention can also be seen when healthcare professionals do not seek to solve or inquire the underlying causes of self-harm or suicide attempts. They either do not deal with these problems at all or try to fix them with drugs or isolation, making it seem like these are the only ways to "fix" a psychosis. While past experiences may have been a cause of patients' conditions, there is little to no room for genuine dialogues about their past, emotional support, or practical advice. A patient describes this as follows:

'It feels as if they advocate for 'take your pills, and shut your mouth.' While there should be more attention for serious conversations, as they almost never do and because they do not help with other problems that contributed to your current situation. 'It felt as if I was not treated as a whole person, as if I did not have a disease, but as if I were my disease.' (R4).

Microaggressions that suggest that patients with psychotic disorders are seen as second-class citizens

This theme's microaggressions convey the idea that schizophrenic patients are less capable and inferior when compared to others. One way through which professionals can convey this idea is through microaggressions that suggest that professionals can hold some kind of power over

patients, which suggests their inferiority to professionals. Professionals may express this through not following dawn-up healthcare rules, threatening patients and forcing patients to comply with what the professional thinks is best. Another way through which this type of microaggression can be expressed is through expressions that imply that patients will never be able to fully recover or to fully participate in society.

Microaggressions that imply superiority of professionals

Microaggressions that belong to this theme convey the idea that professionals hold power over patients and are present when professionals act as if they are inviolable. These comments and actions give the impression that patients are powerless to advocate for themselves, and illustrate a lack of respect for patients. Professionals communicate this microaggression when they do not follow treatment regulations and protocols. Examples are sharing patient information without permission, or pulling patients by their hair. Moreover, this microaggression may also be conveyed through actions that imply intimidation of patients. Professionals may for example hold a hostile or aggressive attitude over patients, as if patients are inferior and as if they can do whatever they want with them. One patient, for example, described that professionals kept holding isolation over her head, so that she would act in ways that the professionals liked.

'My psychiatrist did not agree with the decision of the lawyer and tried to force me to go into IBS again. The psychiatrist said that I need to go to the separation unit again. I said that I did not want to go. He said that I need to go, and if I do not go voluntarily he would apply for a new IBS in a heartbeat. I do not know what to do, risk another IBS and fight against it again in a few days? Or should I do as he pleases and hope that I can go to the normal department soon?'. I do as he pleases, and go back to the separation unit. This time not forced, but in 'free will'. (R1).

One patient also experienced sexual intimidation from one of her psychiatrists. He invited her to his home and attempted to simulate orgasms through hypnosis. This can also be interpreted as viewing the patient as inferior, since it implies that he did not care about professionalism, as he may have assumed that she would regard him as someone that she could not stand up to.

Microaggressions that imply that patients have no hope for a successful future.

This subtheme's microaggressions express the idea that gaining and maintaining a social or working life is difficult for people who have suffered from psychosis. This theme also includes expressions that imply that patients will never fully recover from their disease. These ideas may be expressed explicitly through remarks or implicitly through actions and the way that the

Met opmerkingen [HvdB3]: Is dit allemaal wel zo micro|?

Met opmerkingen [HvdB4]: Again is this micro?

system is organised. Explicit remarks can cause patients to become passive, as they may start to believe these remarks themselves. Microaggressions of this subtheme may also be implicitly expressed by not actively allowing the patient to return to a regular life outside of the GGZ. This can make patients feel as if they have to abandon their goal, as they begin to believe they will never be able to return home again. Finally, this microaggression is also represented through the GGZ client system. Professionals act as if patients' diagnoses are for life, and as if there is no possibility for a future without the prominence of their disease. Patients may therefore lose hope for a successful future.

'It is hard that you have been a client. It is something that you have to deal with. It causes self-stigmatisation and you need confirmation. My tutor tells me that it would be better to say that I had a schizoaffective disorder because I am not suffering from it now. I have not had a psychotic episode in 5 years. It is weird, but they say that if you get a diagnosis, that it is for life. It is unfair when your psychoses fade and you are able to handle them. Why do you still have to say I have a schizoaffective disorder [...] With cancer, they do not say that you will have it for life. But with this diagnosis, they say you will have this for the rest of your life.' (R8).

Microaggressions that suggest that patients lack the ability to know what is good for them.

This theme's microaggressions convey the idea that patients cannot comprehend what their diagnosis of treatment entails; that they cannot contribute to discussions about their treatment; that their suggestions are useless; or that the professional will always know what is best for the patient rather than the patient themselves. Microaggressions belonging to this theme thus illustrate assumptions of incapability. This microaggression can manifest itself in a variety of ways. First of all, this microaggression is conveyed when professionals do not inform patients on their illness or treatment. This implies that professionals might be convinced that the patient is incapable of comprehending what their diagnosis entails. It can also be expressed in situations in which the professional makes decisions for the patient instead of with them. This can result in a misalignment between patient preferences and treatment practice as professionals fail to listen to the suggestions of patients. Microaggressions that express the idea that patients do not know what is good for them can surface in the following situations:

Providing little to no explanation about diagnosis or medication

One way through which this type of microaggression can be communicated is by giving little to no explanation of diagnosis or medication. This conveys the idea that professionals see patients as people who are unable to comprehend the nature of their illness or the potential (side) effects of their treatment. The provision of little to no explanation of what the diagnosis and treatment of a patient entails can cause patients to feel frustrated. As they have no idea what is going on, they feel as if they are left in the dark, and can start to feel hopeless. Similar issues arise when patients do not receive a thorough explanation of why specific medications and therapies are given. This lack of knowledge may lead to lower motivation and, thus, treatment nonadherence. Lack of explanation about why particular therapies are administered can also have detrimental consequences for the partnership of the professional and patient, as one patient remembers feeling as if he was just "put away to get rid of" when placed in isolation cells. Other patients claim that they were not informed on the potential adverse effects of their medication. One patient, for example, gained weight, while she did not know that this could be caused by her medication, it made her very insecure. This demonstrates how a lack of information can lead to patient insecurity and how this can form a barrier to recovery, as a result.

'I was taking Seroquel and at some point the psychiatrist said I know a better drug and then I was given Haldol. Bl. I did not know either, I had no experience. But Haldol turned out to be a heavy drug, I started shaking, eh, it made me stiff, eh, I gained 30 kilos. Um, yes, I really hated it, that medicine. Especially the gaining of weight and the shaking. X: The side effects, yes. Y: They are so, terrible. The psychosis did lessen, I think. But the side effects I thought, yes, then, you do get less psychosis, but the side effects are so unpleasant that you do not feel comfortable.' (R8).

Making decisions for the patient rather than with them

This sub-theme's microaggressions represent the belief that patients are incapable of determining what is good for them. Professionals can express this microaggression when they do not consult patients during the development of their treatment. Furthermore, this microaggression can also be expressed by not acknowledging suggestions that patients have made, by for example, not re-examining patients when they feel like they have received the wrong diagnosis or not looking at certain medications when the patient suggests that the problem may lie elsewhere. This suggests that some professionals hold the belief that patients

do not know what is wrong with them. However, this microaggression can also get conveyed when professionals feel as if they are acting in the best interest of one of their patients. The problem here lies deeper, as this microaggression still gets conveyed due to a lack of communication between the professional and patient. The following passage provides an example of a woman who had children and was kept at home for too long during one of her episodes. This had negative effects, despite the fact that her professionals believed they were acting in her best interests:

'They kept me at home for a long time, while I was psychotic, because I have children. And actually, I find that very stupid, it is irresponsible. Because they left me in the family for an awfully long time, yes, because they thought that I would sink deeper otherwise. Well, I did sink. But I, I, I was just not OK. And I could not eh, could not really see the children anymore. I did not want to.' (R5).

Given examples inhibit shared decision-making, which may result in a hampered partnership between the professionals and patients. This causes suboptimal care and patient dissatisfaction as triggers and other circumstances may not be taken into account. Illustrating that the presence of microaggressions that convey the idea that patients do not know what is good for them can form a barrier to recovery.

Microaggressions that minimise patients

This theme's microaggressions minimise patients. This minimisation of patients can take various forms. First of all, this microaggression can get conveyed when professionals act as if someone's disease or experience is not that severe or act as if patients are overreacting. Secondly, patients can also get minimised by expression of microaggressions that suggest that patients are unworthy or less capable, which can be demonstrated through certain actions and comments of professionals.

Minimising of patients or patient experiences

Microaggressions belonging to this theme communicate the idea that the experiences and illnesses of patients are not that bad or serious. Professionals may, for example, downplay the severity of the sickness at one point, or may imply that if their illness was truly that terrible, patients would have acted on it. Professionals may also disregard patients' comments on things like side effects or requests for aid when patients believe that their sickness is worsening. Professionals ignore these quests for help and act as if their situation is not that awful, they thus

minimise what the patient experiences. Professionals may act as if patients are not deserving of help, that they are overexaggerating, or that others normally do not need help in their situation. This microaggression can also be communicated by expressions of professionals that suggest that the disease of the patient is something that is easily solvable or will get better soon. This can be frustrating for patients as it may cause them to feel as if they are not that sick after all, that it is just in their personality or that they are not taken seriously.

'The psychiatrist at the KIB asked me just a few questions and almost immediately concluded that I did not have schizophrenia. They could teach me to do those things, was more or less the conclusion. But that I was so depressed? Did they not want to see that? [...] These people from the KIB gave me the feeling that I must be a very difficult person.' (R2).

Minimising patients and their capabilities

Microaggressions belonging to this theme communicate a lack of respect for patients. Professionals make fun of patients or make disrespectful remarks about their choices or hobbies. Professionals can make assumptions about patients and communicate these in a disrespectful manner as well. One professional spread rumours, for example, as she told her colleagues that one of their residents was anorexic and called her an alcoholic, while this was not the case. Another way in which this microaggression can be expressed is through over-explaining things and taking things way slower, as professionals think that patients will otherwise not comprehend what is being told or learned. This can make patients feel as if professionals think that they are stupid, incapable, or unintelligent, which can hamper their partnership and the self-esteem of patients.

4.2 Microaggressions and their effects on recovery

Microaggressions from healthcare professionals can influence psychosis recovery in a variety of ways, as they can cause feelings of hopelessness, loss of direction, self-stigma and care avoidance. Furthermore, the opposite also proved to be true, as analysis illustrated that the absence of microaggressions could positively affect psychosis recovery. One patient, for example, reached high levels of recovery when she was in therapy with a supportive healthcare professional. Another patient described how her good relationship with her living assistant had helped her a lot, as she felt supported and cared for. These positive effects will, however, not be elaborated upon further, as this is not part of the focus of this thesis.

This chapter will focus on the impact of microaggressions from healthcare professionals

on psychosis recovery, as this is the main topic of this thesis. Analysis illustrated that microaggressions can affect recovery. They may cause feelings of hopelessness, loss of direction, self-stigma or care avoidance. When microaggressions lead to care avoidance, it can have two possible effects. One is positive, as discontinuity is accompanied by motivation to get better on their own. The other is more negative, as it can cause recovery to deteriorate. These possible effects of microaggressions on recovery of psychosis will now be elaborated on further with the support of plot types that have been identified during data analysis.

Microaggressions that lead to feelings of hopelessness

'What is happening to me, what can I do? Please, just help.'

Narrative summary:

'During my treatment I first suffered from symptoms that I could not place in perspective. I started to hallucinate and noted that I could not comprehend what was happening to me. So, as I was looking for answers, started to look for help. My goal was to get help and to get an explanation on what was happening to me. Eventually I got referred to an institution where I was prescribed medication, but I still did not know what was happening to me and what those pills would do. I was put into isolation cells without proper explanation. Another time my symptoms got worse in an institution and I did not know why I got resigned from this hospital as I was ill. They never explained anything to me, I just had to follow along and I felt confused. They made decisions for me instead of with me, they did not ask me what I would want when my symptoms got worse. When I got hospitalised again I slowly started to get more depressed as well and asked for antidepressants, however they did not go into this request. My professionals only looked into my anti-psychotic drugs as they thought that that would help me. No, ehm, explanation or letting me participate in decision-making during treatment was something that they seemed to never have heard of. It made me feel hopeless as if I could not do anything to better my situation, as if all things were out of my control. Out of desperation I started to attempt suicides, to show them that I was really not doing okay and that something needed to change. My attempts were a cry for help, for help that was better suited and more in line with my preferences.'

Effects on recovery:

This storyline represents the possible effects of the microaggressions that belong to the theme of 'patients do not have the capabilities to know what is good for them'. Patients that describe

this plot are hopeful at first. They believe that medical professionals are there to assist them and that they will offer appropriate diagnoses and treatments. However, the expression of microaggressions that belong to the theme ‘patients do not have the capabilities to know what is good for them’ undermine this sense of hope. Patients may be prescribed medication or may be placed in an isolation cell to help their symptoms. This may, however, have contradictory effects when no proper explanation has been given. It can cause patients to become hesitant to take their medication and can make them feel as if they are put in isolation cells to get rid of them. This plot also illustrates this microaggression by a lack of involvement of patients in shared decision-making, as professionals ignore the suggestion of patients in this plot. Patients are left in the dark and their suggestions are not taken into account. Their treatment plan is therefore not in line with their wants and needs, while this is a vital part of the recovery process as clients describe in literature (GGZ, 2022). Patients may start to gather the idea that their care is not really helping them and may feel as if they are not making any progress during treatment. Moreover, the lack of attention that their suggestions are given may also cause feelings of invisibility, feelings of hopelessness, and eventually, suicide attempts as a cry for help. The plot type illustrates that patients were first hopeful when they were searching for help. However, this hopefulness starts to fade when they experience these microaggressions, which leaves them to feel hopeless and with recovery that is stranded at recovery phase 1 (Leamy et al., 2011). This plot type, therefore, illustrates that the expression of microaggressions that ignore patient involvement and communicate the idea that patients do not know what is good for them can lead to recovery deterioration.

Microaggressions that lead to a loss of direction in life

‘Why does nobody seem to care, how am I even going to manage life if nothing gets their attention?’

Narrative summary:

‘During my hospitalisation I was hopeful to get the care that I so desperately needed. I did not have any structure and I wanted to get supported so that I could rebuild my life again. However, in reality this was not really the case. First I had to wait for a diagnosis, so that I could get therapy, as they did not want to start treatment before I had a label. The amount of offered therapies was limited too, due to cutting of budgets. The ones that I got offered were not suitable for me. I had nothing to do, and I started to get really bored. The only things that I could do were drink coffee and things that I thought of myself. There was a lack of structure while I

desperately sought for this. I just wanted to find a direction, so that I could get back to doing things with my day. I was bored to death and started to do drugs and drink, so that I could pass the time, which actually was harmful for my recovery. It felt as if I was not getting the right treatment and as if I was not really helped. The drugs also flattened my emotions, I started to self-harm again and planned some suicides. I felt hopeless and bored, but this all did not get much attention. They never asked me about the reasoning behind my attempts or tried to support me when things got tough. I received care for my physical wounds, not for my mental ones. They only cared for my pills, and I got them all the time, but for my own wellbeing? No, they did not seem to care for that. I was still not functioning how I should be. It seemed as if they could only see me as my illness, as if they did not see all my other suffering and other human needs. There was little to no attention for my personal life, which was a mess. I did not have a job and I had some financial issues as well. They did not respond to my quest for help on this, and I did not know how I could fix this on my own. My symptoms seem to have lessened, but I still do not know how to handle all the other things. I still do not have the grips on how to work things out. I missed guidance during the trajectory. Now, I still do not have a purpose.'

Effects on recovery:

Storylines that have this type of breach in common influence the road to recovery in negative ways. It becomes clear that professionals lay too much emphasis on clinical recovery and medication and see this as the solution to patients' problems. Professionals also only start treatment when there is a clear cut diagnosis. Patients however, want to receive a more holistic approach as they experience a loss of their self-perception, as they might have lost their job and do not have any structure anymore (Valk et al., 2018). This story type thus illustrates the effects of microaggressions that diminish patients to their illness. Patients get marginalised to their diagnosis, which results in a distance between the patient and professional. This can have negative effects on recovery as research has shown that feelings of connectedness, hope and optimism for the future, rebuilding of identity, finding meaning in life and empowerment are important processes for recovery (Leamy et al., 2011). Patients from this storyline may not feel connected to their professional, as professionals do not actively involve themselves with patients' underlying problems. Another way in which professionals seem to distance themselves from patients is by not asking about the reasoning behind suicide attempts and self-harm practices. This storyline also illustrates the effects of the unavailability of therapies and the lack of support for sorting out their strengths and weaknesses. These processes make building a positive sense of self, gaining understanding of their capabilities, and rebuilding their life

difficult, as they are not provided with the right tools. Microaggressions that dehumanise patients therefore stand against the recovery stages as described by Andresen et al. (2006) which describe preparing, rebuilding, and growth as important stages in mental illness recovery (Andresen et al., 2006). This lack of guidance may cause patients to feel hopeless, as they do not know how they can solve their issues that have risen by – or contributed to – their illness. They feel as if they still have no sense of direction after hospitalisation. When patients of this story type get resigned from the hospital, the presence of their symptoms and illness often rises. This illustrates that patients can relapse soon when no sufficient help on how to direct their life or handle their problems is given, even when recovery had been achieved in the facility by the prescription of pills.

Microaggressions that induce self-stigma

‘Why should I even try?’

Narrative summary:

I have encountered a lot of different professionals during my psychosis treatment, as I have been replaced and diagnosed a couple of times. At first, I was quite scared to open up to my professionals. I did not want to tell them what was going on and left some pieces out of our conversations. It thus took some time before I talked about things with professionals openly, as I was scared. During my stays, I have encountered multiple healthcare professionals who have made me feel horrible about myself. When I was home during my psychosis, I got home care, who helped me with daily activities and my children. I had a hard time and I was tired often, but when I decided to lie in bed, not because I wanted to but simply because I could not handle anything else at the moment, my nurses judged me. They acted as if I was a horrible mother, and I started to believe it. At one point, they decided that I needed to get a new diagnosis, where they just asked me a few questions and told me that my diagnosis was incorrect. They told me that they would help me to get rid of my ‘bad behaviour’. As if they could not see my suffering, it made me feel as if I was faking it and as if I was just a tough person to be around. During my stays, I also encountered a lot of disrespectful behaviours. Professionals sometimes acted as if they had some kind of power over me, made remarks on my behaviour, or tried to hold isolation over my head if I did not listen. One nurse even stated that ‘no one had died of depression’, while dying was the only thing that I wanted. I felt misunderstood and it made me insecure. I also noticed that nurses had lost faith in me. They talked about sheltered living, as if I could not recover, and I started to believe it. Other nurses told me that I should just forget about a future with a job and social circle. This made me passive. They confirmed that I could not do

anything, so I started to act upon it. I stopped putting time into self-development as I thought that it would not matter anymore. Another thing that happened due to these remarks of nurses was that I felt as if I would always be a client. I felt as if my diagnosis was something that I would have for life, I felt as if I would never get better, which also made my recovery harder. I felt as if there was no hope for a life without it.'

Effects on recovery:

This storyline illustrates that professionals that express microaggressions that suggest hopelessness for the future and minimisation of experiences and illnesses may lead to self-stigmatisation and lowered self-esteem as these themes communicate negative attitudes and beliefs. Patients may start to feel as if they are faking it when they are being judged for their coping mechanisms or when professionals act as if they are able to recover quickly. It causes them to feel as if they are overexaggerating and they start to internalise these feelings. Patients may start to feel as if it is not their illness that is causing their behaviour but as if all of their issues are just caused by themselves, resulting in insecurity. The disrespectful remarks of professionals and them acting as if they are superior also contribute to this insecurity, as patients may start to feel as if there is something wrong with them. Patients start to have less faith in themselves, while high self-esteem is essential for recovery as it contributes to processes of hope and optimism for the future, identity rebuilding, and motivation to find meaning in life (Leamy et al., 2011). Patients are thus doubting themselves due to expressions that suggest minimisation and hopelessness for the future. Expressions of this microaggression illustrate that professionals do not always have faith in the recovery and full participation of patients in society, leading to self-stigmatisation of patients when these beliefs are communicated. This might lead to the 'Why try' effect, as described by Corrigan et al. (2009), in which patients stop trying because they think that they will never be able to reach their goals or fully recover, regardless of their efforts. This is harmful for recovery as identity rebuilding, finding meaning and life and empowerment (Leamy et al., 2011) all require efforts from patients. If they do not have the self-esteem that is necessary to go through these processes, they will not be able to recover.

Another instance that is depicted in this storyline type is shame during professional consultation. It might be that patients do not want to open up to their healthcare professionals about their hallucinations as they might feel that they will be judged. This holding back of information can be ascribed to self-stigma, as patients might feel that they are insane or are seen as insane when they inform this professional about their hallucinations. Withholding of this

information may lead to suboptimal care as the right diagnosis and therefore, right treatment cannot be given. Illustrating that, presence of these microaggressions and self-stigma may also have negative effects on the partnership between patient and professional.

Microaggressions that cause discontinuation of care and motivation to get better

'Start treating me like a human, or I will fix it myself.'

Narrative summary

'I felt that I was not doing okay, I felt weird and was acting chaotic, so I decided to look for help. I consulted a psychiatrist and tried to explain everything thing to him, he however, did not take me seriously and I decided to stop seeing him. It went okay for a while, but eventually my symptoms got worse, I really started to lose it all and had to be admitted to a hospital. So, I started care there. I did not really like it as care was organised in a very clinical manner, but I could get some rest, which was nice. After some time passed I actually noticed that my symptoms were not becoming less, but I had stabilized for a bit. I gained some energy and started to look for forms of therapies and explanations on what had happened to me. I wanted to know what i could do myself and actually found some really interesting things that could possibly help me. During consultation I tried to speak to my psychiatrist about this, and suggested that we should look into my past, as I thought that that would help me. He however, did not respond to it well, he said that his therapies were very successful and that I should just oblige to them. Yet again, I felt as if I was not taken seriously. The facility nurses made remarks as well, they did not give me any personal attention and when something went wrong they acted as if I was a horrible or unmanageable person. They also acted as if I was stupid, and as if I could not comprehend easy tasks due to my psychosis. I hated it here and it felt as if this environment was not profitable at all. Maybe I was even doing worse and I wanted to take the matter in my own hands. I knew that I was not stupid and I wanted to show them. If this was how treatment as the GGZ takes place, I did not want to have anything to do with it. It would never be able to help me, so I decided to discontinue my treatment and started to look into therapies and alternative ways of healing that I found myself. It felt as if the professionals of the GGZ were working against me, instead of with me. I wanted to show them that I could do it better on my own, and I wanted to prove that I was able to recover and live a fulfilling life. I wanted to show them that I was intelligent and that I was not dumb as they always implied. I decided to start living on my own again, as I felt that I got bored as the GGZ took every responsibility out of my hands. On the internet I had read about the positive effects of recovery

plans, talking to people about your past and empowerment. I finally started to understand my illness. I also tried to find suitable ways to fill my life, when things went wrong I did not give up, I was motivated and luckily supported by my family and friends, they kept me going.'

Effects on recovery:

From this storyline we can conclude that a suboptimal care pathway induced by the absence of a partnership that is based on mutual respect, patient centeredness, and enhancing self-esteem of patients can form a barrier to recovery. The presence of microaggressions that communicate can lead to discontinuity of care. From this story type, it can be concluded that this discontinuity of care can lead to two possible outcomes. The first possibility is that discontinuity of care due to dissatisfaction can lead to worsening of symptoms. This is usually the case when patients are in a beginning stage of recovery and have not yet gathered the needed information for identity rebuilding. When their care gets continued again they start to experience care that is not in line with their preferences again, and they also experience remarks from nurses alongside this. However, it seems as if these microaggressions of professionals did not influence the self-esteem of patients in this storyline. These patients, in contrast to the patients of other story types, felt as if they could research their illness so that they could know what was best for them. It seemed as if they became confident in their own capabilities and gained knowledge. The fact that professionals did not want to listen to their suggestions did not result in the 'Why try' effect as described by Corrigan et al. (2009). Patients of this story type had high faith in their own capabilities and self after they had gained knowledge on their illness. They therefore decided to take the matter into their own hands, as they felt that they were better off without care from the GGZ. They searched for treatments that were suitable for them and applied them. They also started to take up their day-to-day activities and received support from their families and friends. Patients start to feel better and start to recover with this support and suitable therapies. The fact that they were now supported, and that this was lacking in the GGZ, may have contributed to this. Overtime, patients start to do more things as they are looking for ways to lead a fulfilling life due to an increase in self-esteem as they are not being shamed by healthcare professionals. Illustrating that, healthcare professionals that express microaggressions that suggest inferiority of patients by not letting them partake in treatment and treating them as second class-citizens formed a barrier to their recovery.

Chapter 5: Discussion and conclusion

The analysis of patient stories of patients suffering from psychosis, which describes the experiences and effects of microaggressions by Dutch healthcare professionals, led towards the identification of four microaggression themes. These themes are: dehumanisation of patients; patients are seen as second-class citizens; aggressions implying that patients lack the ability to know what is best for them; and minimisation of patients. This illustrates that Dutch healthcare professionals may transmit stigmatised attitudes and hold stigmatising beliefs without realising it.

Furthermore, a narrative analysis has been performed, which has led to the identification of four plot story types, which describe the effects of microaggressions on recovery from psychosis. These story types illustrate that microaggressions can lead to feelings of hopelessness; loss of direction; self-stigmatisation; and discontinuity of care, which may or may not result in motivation to get better on their own. Feelings of hopelessness may cause patients to give up, as they think that they will not get better and may drive them to inflict self-harm or try to commit suicide. These feelings may also be mediated through self-stigmatisation, as they may start to believe the ideas that the microaggressions as portrayed by professionals convey. Identified themes and plot types will now be connected to microaggressions and consequences as described in literature.

5.1 Microaggressions and their effects on recovery

The identified themes in which microaggression can be placed are comparable to those identified in existing literature. Microaggressions that suggest that patients are seen as second-class citizens have similarities with existing literature, such as the themes of 'inferiority' (Gonzales et al., 2015; Peters et al., 2016), 'second-class citizenship' (Gonzales et al., 2015) and hopelessness for the future (Amsalem et al., 2018). Microaggressions of this theme communicate that patients have no hope for the future and are inferior to professionals. This inferiority also manifests itself in microaggressions which convey that patients lack the abilities to know what is good for them. This type of microaggression excludes patients from shared decision-making and implies that their suggestions are seen as unimportant. Microaggressions of this theme thus show similarities to the microaggressions 'lived experience is not seen as relevant' and 'sharing and discussing of professional knowledge is not necessary' as described by Amsalem et al. (2018). Furthermore, analysis revealed that professionals in Dutch healthcare may convey microaggressions that minimise patients' experiences and illnesses, which communicate the idea that patients are overreacting and are seeking attention. Microaggressions

that minimise patients therefore hold similarities with microaggressions as described by Gonzales et al. (2015) and Peters et al. (2016).

In addition, analysis revealed a new type of microaggression which could be placed under the theme 'dehumanisation of patients'. Expressions of this microaggression marginalise patients to their illnesses. This theme is related to the themes 'defining a person by their disorder' (Peters et al., 2016) and 'symptomizing' (Gonzales et al., 2015). People who express this microaggression describe all characteristics of a person with a mental illness to their disorder. Both microaggressions make patients feel as though they are only being seen as their illness rather than as a person, but how they are expressed varies. This illustrates that people that portray this microaggression ignore the other qualities that people suffering from mental illnesses have. This study also found that other qualities of patients were ignored. However, the prescription of their behaviour to their disorder lacked. The microaggression 'dehumanisation of patients' may go one step further than the microaggression as described by Gonzales et al. (2015) and Peters et al. (2016). These microaggressions convey the idea that patients are simply their disease, as evidenced by the fact that treatment follows diagnosis. Treatment in which this microaggression is present ignores all the other aspects that attributed to the development of their disease. It also communicates that patients are unworthy of normal human attention and interactions, illustrating that patients are merely seen as their diagnosis and not as a person who needs help as a whole. This creates distance between patients and professionals (Jensen et al., 2013). Presence of this microaggression therefore threatens the guidelines of the GGZ (2022), which describe the importance of mutual respect and shared decision-making. Furthermore, treatment should be holistic, focused on clinical as well as personal and societal recovery, and be supportive of personal goals (GGZ, 2022; WHO, 2013). Microaggressions that dehumanise patients stand directly against this, as they leave little to no room for personal attention and illustrate the professionals' focus on medication.

The GGZ describes that the above mentioned principles should be reinforced through a partnership that supports patients who suffer from psychosis in their unique recovery route. Self-esteem and self-efficacy should be heightened through this partnership (Leamy et al., 2011; Pitt et al., 2018). This partnership may also contribute to the development of feelings of connectedness, hope and optimism for the future, identity rebuilding, finding meaning in life and empowerment (Leamy et al., 2011). Furthermore, good partnerships decrease the chances of discontinuity of care (GGZ, 2022). Partnerships are therefore essential for successful psychosis recovery. However, literature and analysis illustrate that the presence of microaggressions can undermine this partnership and its connected recovery processes. The

first way in which the partnership may get hampered is by the presence of microaggressions that belong to the theme 'dehumanisation of patients'. Story type 2 illustrates that this microaggression can lead to a lack of direction and purpose in life, as patients only receive medication. Patients therefore miss the guidance of their professionals and are not offered solutions for their personal problems. This results in less fruitful recovery attempts, as they miss some kind of direction and purpose in life. This may cause their symptoms to quickly resurface when they return to their normal life and emphasises the need for a holistic approach of recovery and purpose in life as described by Leamy et al. (2011).

Partnerships may also be harmed by the expression of microaggressions that minimise patients' experiences and capabilities, or expressions that suggest that people who suffer from psychosis are seen as second-class citizens, as described in story type 3. These expressions are problematic, considering that professionals should empower and support patients (Leamy et al., 2011). Furthermore, they should help patients with acceptance (Leamy et al., 2011) and should demonstrate the possibility of recovery (Pitt et al., 2009). Expressions of this microaggressions reinforce self-stigma, the 'why-try effect' as described by Corrigan et al. (2009), and can inhibit the development of a positive sense of self as positive feedback from professionals is missing, and can cause patients to feel disconnected. Above mentioned may cause patients to become passive and this may cause professionals to express more microaggressions, which eventually leads to a self-reinforcing loop.

Shared decision-making is one of the other key principles in this partnership between professional and patient (GGZ, 2022). It is important to note that shared decision-making can only take place when there are reciprocated feelings of respect, as professionals may otherwise not take suggestions from patients seriously. All identified storyline types illustrate a lack of shared decision-making, and thus, illustrate the effects of presence of microaggressions that suggest that patients lack the capabilities to know what is good for them. This microaggression gets conveyed when patients' suggestions are not taken into account or when they are not fully informed. This is troublesome as recovery is a highly personal experience and should thus be in line with the preferences and desires of patients (GGZ, 2022; Leamy et al., 2011). This absence of shared decision-making may cause patients to take medication that they do not want and can damage trust, self-efficiency, and empowerment. Furthermore, it may cause feelings of hopelessness and may cause patients to feel invisible. This microaggression's effect is thus similar to that found in research on the effects of microaggressions on people of colour, the LGBTQ community, and women (Torino et al., 2018).

Finally, analysis revealed that presence of microaggressions may lead to discontinuity

of care, which is inline with effects as described by Gonzales et al. (2015) and the GGZ (2022). This discontinuity of care may be caused by a combination of misalignment between patient preferences and treatment, and the presence of microaggressions that minimise patients or dehumanise patients by not giving them attention. The effects of this discontinuity of care are discrepant. Some patients relapse, as they do not have sufficient knowledge and self-efficacy to handle their problems on their own. Their discontinuity of care was mainly fed by unsatisfactory feelings. Other patients self-educate on recovery during treatment by professionals, they therefore gained more knowledge on the availability of possible treatments and therapies. They did not find their existing therapies helpful, and felt that they themselves had found better suitable options. As their professionals did not want to listen to their suggestions, they decided to take the matter into their own hands. This illustrates that expression of microaggressions can also have positive effects as it provides these patients with motivation and a purpose to get better on their own.

5.2 Implications

Research implication

Analysis of narratives and narrative analysis resulted in the identification of 4 themes of microaggression and 4 storyline types. Most microaggressions show similarities with those described in existing literature (Amsalem et al., 2018; Gonzales et al., 2015; Peters et al., 2016). However, a new theme of microaggressions ‘dehumanisation of patients’ has emerged during analysis. This microaggression can be conveyed through a lack of personal attention, limiting care to medication and clinical recovery, or the fact that patients are only offered treatment after diagnosis. Expressions of this type of microaggression illustrate that treatment of the GGZ can be diagnosis-centred instead of patient-centred and can cause patients to feel unseen. When it is expressed through a lack of attention, this microaggression may also signify a lack of respect and can make patients feel misunderstood. Finally, it can also get conveyed when professionals solely focus on clinical recovery. Personal problems may not be given attention, and professionals may act as if patients are seen as a unit that needs to be fixed with pills.

Furthermore, the possible effects of microaggressions on recovery of psychosis have been illustrated. Earlier research of Gonzales et al. (2015), included this as well. Their respondents elaborated that microaggressions negatively influenced therapeutic alliances, led to discontinuity of medication, treatment non adherence and internalisation of stigmatised attitudes. Their respondents expressed these effects, but the interplay between microaggressions

and the expressed effects were missing. Gonzales et al. (2015) suggested that further research should look into the impact of microaggressions against people in context of their therapy relationship and implications on treatment outcomes. This thesis has filled this gap with the use of a narrative approach. Narrative analysis aided this replenishment, as it provided the researcher with extensive descriptions of patient experiences and therefore helped to better connect expressions to their effects.

Practical implications

This research illustrated the microaggressions that get portrayed towards patients who suffer from psychosis by professionals in the GGZ. Analysis also illustrated what its possible effects are and how these microaggressions interfere with the intended goals of the GGZ. Presence or of microaggressions may negatively influence the partnership between professional and patient. An hampered partnership may negatively influence the self-esteem of patients and may cause feelings of hopelessness, loss of direction in life, self-stigma and discontinuity of care, and thus recovery. This thesis has provided examples through which these microaggressions may be communicated, and has provided a categorisation in which expressed microaggressions can be placed. Furthermore, it illustrated the presence of microaggressions that could be placed in the new theme of 'dehumanisation of patients', which marginalises patients to their diagnosis alone. As a result, this microaggression directly contradicts the prescribed holistic approach, as the expression of this microaggression conveys that professionals solely focus on clinical recovery.

The gathered knowledge of this thesis may be used to better care, as it may aid the development of interventions that target the effects and expression of microaggressions. These interventions can, for example, focus on debunking self-stigma or partnership restoration. Additionally, it might increase healthcare professionals' awareness of microaggressions because they frequently slip out unintentionally. This awareness could eventually result in fewer microaggressions being expressed.

5.3 Limitations and strengths

This thesis adds knowledge on the expression and effects of microaggressions through narrative analysis and narrative analysis of patient stories of people suffering from psychosis in the Netherlands. Narrative analysis resulted in the creation of overarching story types that reveal the dynamics underlying the effects of microaggressions. However, due to time constraints and the volume of stories included, not all steps of Murray & Sools' (2014) narrative analysis have

been carried out. This thesis does therefore not include the steps that consider the analysis of interaction and context. As a result, the composed story types disregard the influence of context and interactions, resulting in potentially biased results that are less suitable for generalisation. Moreover, it is uncertain how severe the psychosis symptoms and the level of literacy of the interviewees are in comparison to the general psychosis patient population. People with low literacy levels may have not been included in interviews or may not have been able to publish books as they may find it harder to elaborate on their experiences. Furthermore, chaotic stories have been excluded from analysis as well, since this made the narrative analysis difficult to achieve. This has led to the exclusion of people with low literacy and chaotic stories, while they might have had different experiences in healthcare, resulting in bias. A recall bias has also been induced as all storytellers tell a narrative about the past. However, when findings were compared to microaggressions as described in literature similar experiences have been described, resulting in a higher validity of found results. Finally, this thesis has only focused on analysis of microaggressions that the interviewed patients or writers themselves have encountered, while some of them also described microaggressions as experienced by others. The same goes for narratives that describe more structural problems in psychiatry, such as funding issues.

This thesis's strengths can be attributed to its study design. Analysis of written patient stories and non-directed interviews provided a full and minimally influenced overview of how care and microaggression have been experienced by patients. Furthermore, it provided this thesis with the possibility to better connect the events—in this case, microaggressions—to their effects on recovery. However, further research to determine how the expression and found effects of microaggressions on psychosis recovery can be prevented is necessary so that well suited interventions can be developed. It may also be valuable to assess the expression and effects of microaggressions by healthcare professionals on patients who suffer from psychosis during treatment, as this will result in less bias of the found results.

5.4 Conclusion

This thesis aimed to identify the types and effects of microaggressions from healthcare professionals on psychosis recovery in the Netherlands. It provided themes in which microaggressions can be placed (dehumanisation of patients, patients are seen as second-class citizens, patients lack the ability to know what is best for them, minimisation of patients) and illustrated the possible effects on recovery (feelings of hopelessness, loss of direction, self-

stigma, or discontinuity of care) via the identified storyline types. From analysis, it also became clear that the partnership of professionals and patients is an essential part of recovery. Expression of microaggressions negatively influences this partnership and mediates the observed effects of microaggressions. Further research should therefore aim to gain knowledge on how this partnership can be restored. This thesis fills a gap in literature where the dynamics between the expression and effects of microaggressions had been left out. Furthermore, it broadened knowledge on how stigmatisation of patients suffering from psychosis has manifested itself in Dutch healthcare, and may therefore aid policy changes.

References

- Amsalem, D., Hasson-Ohayon, I., Gothelf, D., & Roe, D. (2018). Subtle ways of stigmatisation among professionals: The subjective experience of consumers and their family members. *Psychiatric Rehabilitation Journal*, 41(3), 163–168. <https://doi.org/10.1037/prj0000310>
- Anderson, C., & Kirkpatrick, S. (2015). Narrative interviewing. *International Journal of Clinical Pharmacy*. <https://doi.org/10.1007/s11096-015-0222-0>
- Andresen, R., Caputi, P., & Oades, L. (2006). Stages of Recovery Instrument: Development of a Measure of Recovery from Serious Mental Illness. *Australian & New Zealand Journal of Psychiatry*, 40(11–12), 972–980. <https://doi.org/10.1080/j.1440-1614.2006.01921.x>
- ATLAS.ti Scientific Software Development GmbH. (2022). *ATLAS.ti: The Qualitative Data Analysis & Research Software*. ATLAS.ti. Retrieved January 22, 2022, from <https://atlasti.com/>
- Bovenkamp, H. M., Platenkamp, C., & Bal, R. (2020). Understanding patient experiences: The powerful source of written patient stories. *Health Expectations*, 23(3), 717–718. <https://doi.org/10.1111/hex.13053>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Burke, E., Wood, L., Zabel, E., Clark, A., & Morrison, A. P. (2016). Experiences of stigma in psychosis: A qualitative analysis of service users' perspectives. *Psychosis*, 8(2), 130–142. <https://doi.org/10.1080/17522439.2015.1115541>
- Collectie Patiëntervaringen. (z.d.). Erasmus University Library. Retrieved August 3, 2022, from <https://www.eur.nl/library/collecties/collectie-patientervaringen>
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614–625. <https://doi.org/10.1037/0003-066x.59.7.614>

- Corrigan, P. w., Larson, J.E., & Rüsch, N. (2009). Self-stigma and the “why try” effect: impact on life goals and evidence-based practices. *World Psychiatry*, 8(2), 75–81. <https://doi.org/10.1002/j.2051-5545.2009.tb00218.x>
- De Valk, R., Van Der Drift S. & Korrelboom, K. (2018). Versterken van het zelfbeeld bij mensen met een psychotische kwetsbaarheid.
- Dubois, A., & Gadde, L. E. (2002). Systematic combining: an abductive approach to case research. *Journal of Business Research*, 55(7), 553–560. [https://doi.org/10.1016/s0148-2963\(00\)00195-8](https://doi.org/10.1016/s0148-2963(00)00195-8)
- Firestone, W.A. (1993). Alternative Arguments for Generalizing from Data as Applied to Qualitative Research. *Educational Researcher*, 22(4), 16–23. <https://doi.org/10.3102/0013189x022004016>
- Frese, F. J., Knight, E. L., & Saks, E. (2009). Recovery From Schizophrenia: With Views of Psychiatrists, Psychologists, and Others Diagnosed with This Disorder. *Schizophrenia Bulletin*, 35(2), 370–380. <https://doi.org/10.1093/schbul/sbn175>
- GGZ. (2022, january). *Zorgstandaard psychose*. GGZ Standaarden. <https://www.ggzstandaarden.nl/zorgstandaarden/psychose/introductie>
- Goffman E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall
- Gonzales, L., Davidoff, K. C., Nadal, K. L., & Yanos, P. T. (2015). Microaggressions experienced by persons with mental illnesses: An exploratory study. *Psychiatric Rehabilitation Journal*, 38(3), 234–241. <https://doi.org/10.1037/prj0000096>
- Holder, S. M., Peterson, E. R., Stephens, R., & Crandall, L. A. (2018). Stigma in Mental Health at the Macro and Micro Levels: Implications for Mental Health Consumers and Professionals. *Community Mental Health Journal*, 55(3), 369–374. <https://doi.org/10.1007/s10597-018-0308-y>

- Jensen, M. E., Pease, E. A., Lambert, K., Hickman, D. R., Robinson, O., McCoy, K. T., Barut, J. K., Musker, K. M., Olive, D., Noll, C., Ramirez, J., Cogliser, D., & King, J. K. (2013). Championing Person-First Language. *Journal of the American Psychiatric Nurses Association*, 19(3), 146–151. <https://doi.org/10.1177/1078390313489729>
- Jose, D., Ramachandra, Lalitha, K., Gandhi, S., Desai, G., & Nagarajaiah. (2015). Consumer perspectives on the concept of recovery in schizophrenia: A systematic review. *Asian Journal of Psychiatry*, 14, 13–18. <https://doi.org/10.1016/j.ajp.2015.01.006>
- Law, H., & Morrison, A. P. (2014). Recovery in Psychosis: A Delphi Study With Experts by Experience. *Schizophrenia Bulletin*, 40(6), 1347–1355. <https://doi.org/10.1093/schbul/sbu047>
- Leamy, M., Bird, V., Boutillier, C. L., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, 199(6), 445–452. <https://doi.org/10.1192/bjp.bp.110.083733>
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, 27(1), 363–385. <https://doi.org/10.1146/annurev.soc.27.1.363>
- Loch, A. A., Guarniero, F. B., Lawson, F. L., Hengartner, M. P., Rössler, W., Gattaz, W. F., & Wang, Y. P. (2013). Stigma toward schizophrenia: do all psychiatrists behave the same? Latent profile analysis of a national sample of psychiatrists in Brazil. *BMC Psychiatry*, 13(1). <https://doi.org/10.1186/1471-244x-13-92>
- Maso, I. & Smaling, A. (1998). Kwalitatief onderzoek. Praktijk en theorie. Amsterdam: Boom.
- Michie, S., Van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6(1). <https://doi.org/10.1186/1748-5908-6-42>

- Misco, T., 2007. The frustrations of reader generalisability and grounded theory: alternative considerations for transferability. *Journal of Research Practice* 3, 1–11
- Mortelmans, D. (2013). *Handboek kwalitatieve onderzoeksmethoden* (4de editie). Acco.
- Murray, M., & Sools, A. (2014). Narrative research. *Qualitative Research in Clinical and Health Psychology*. London: Palgrave, 133-154.
- Pec, O. (2020). Stages of recovery in psychosis: Converging qualitative research and psychoanalysis. *Perspectives in Psychiatric Care*, 56(4), 760–767. <https://doi.org/10.1111/ppc.12490>
- Peters, H. J., Schwenk, H. N., Ahlstrom, Z. R., & McIalwain, L. N. (2016). Microaggressions: The experience of individuals with mental illness. *Counselling Psychology Quarterly*, 30(1), 86–112. <https://doi.org/10.1080/09515070.2016.1164666>
- Polit, D. F., & Beck, C. T. (2010). Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, 47(11), 1451–1458. <https://doi.org/10.1016/j.ijnurstu.2010.06.004>
- Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A., & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing*, 16(3), 279–284. <https://doi.org/10.1111/j.1365-2850.2008.01369.x>
- Reynolds, J., Kizito, J., Ezumah, N., Mangesho, P., Allen, E., & Chandler, C. (2011). Quality assurance of qualitative research: a review of the discourse. *Health Research Policy and Systems*, 9(1). <https://doi.org/10.1186/1478-4505-9-43>
- Riessman, C. K. (1993). *Narrative analysis*. London: Sage.
- Sharp, N. L., Bye, R. A., & Cusick, A. (2019). Narrative Analysis. *Handbook of Research Methods in Health Social Sciences*, 861–880. https://doi.org/10.1007/978-981-10-5251-4_106

- Smith, B. (2017). generalisability in qualitative research: misunderstandings, opportunities and recommendations for the sport and exercise sciences. *Qualitative Research in Sport, Exercise and Health*, 10(1), 137–149.
<https://doi.org/10.1080/2159676x.2017.1393221>
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, 62(4), 271–286. <https://doi.org/10.1037/0003-066x.62.4.271>
- Tavory, I., & Timmermans, S. (2014). *Abductive analysis: Theorizing qualitative research*. University of Chicago Press.
- The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; **DSM–5**; American Psychiatric Association, 2013)
- Thorne, S., Armstrong, E. A., Harris, S. R., Hislop, T. G., Kim-Sing, C., Oglov, V., Oliffe, J. L., & Stajduhar, K. I. (2009). Patient Real-Time and 12-Month Retrospective Perceptions of Difficult Communications in the Cancer Diagnostic Period. *Qualitative Health Research*, 19(10), 1383–1394. <https://doi.org/10.1177/1049732309348382>
- Thornicroft G., Rose D., Kassam A. (2007). Discrimination in health care against people with mental illness. *International Review of Psychiatry*, 19, 113–122.
- Torino, G. C., Rivera, D. P., Capodilupo, C. M., Nadal, K. L., & Sue, D. W. (2018). *Microaggression Theory: Influence and Implications* (1ste edition). Wiley.
- Uitgangspunten*. (2019, July 1). Verhalenbank Psychiatrie. Retrieved June 26, 2022, from: <https://psychiatrieverhalenbank.nl/de-herstel-benadering/>
- Valery, K. M., & Prouteau, A. (2020). Schizophrenia stigma in mental health professionals and associated factors: A systematic review. *Psychiatry Research*, 290, 113068. <https://doi.org/10.1016/j.psychres.2020.113068>

- Wahl, O., & Aroesty-Cohen, E. (2010). Attitudes of mental health professionals about mental illness: a review of the recent literature. *Journal of Community Psychology*, 38(1), 49–62. <https://doi.org/10.1002/jcop.20351>
- Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in Qualitative Research. *Qualitative Health Research*, 11(4), 522–537. <https://doi.org/10.1177/104973201129119299>
- Yeomans, D., Taylor, M., Currie, A., Whale, R., Ford, K., Fear, C., Hynes, J., Sullivan, G., Moore, B., Burns, T., 2010. Resolution and remission in schizophrenia: getting well and staying well. *Advances in Psychiatric Treatment* 16, 86–95. <http://dx.doi.org/10.1192/apt.bp.108.006411>
- Young, R. E., Goldberg, J. O., Struthers, C. W., McCann, D., & Phillips, C. E. (2019). The Subtle Side of Stigma: Understanding and Reducing Mental Illness Stigma from a Contemporary Prejudice Perspective. *Journal of Social Issues*, 75(3), 943–971. <https://doi.org/10.1111/josi.12343>

Appendices

Appendix 1: positionality of reflectivity

The researcher of this thesis has a medical background and therefore had prior knowledge of psychosis related disorders. During her study of medicine, she learned that psychosis is a result from both nature and nurture, and that a variety of bio-sociopsychological processes contribute to the development of a psychotic disorder. From practice and education she has learned that recovery is possible, but also that it is a difficult road in which support is important. She entered the research with an open mind, as she was curious how medical staff would act towards psychiatric patients. She also knew that psychotic patients may be difficult to interact with as she has had experience with psychotic patients in her family. She was especially interested to see what type of behaviour from professionals would be beneficial and what would not, as she might want to become a psychiatrist in the future. Besides, a theoretical framework which elaborates the viewing point of the researcher has been provided.