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Article

Evidence of Validity and Reliability for the Spanish Version of the Self-Identified Stage of Recovery

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ABSTRACT

Background: The Self-Identified Stage of Recovery (SISR) (Andresen, 2007) is a scale used to assess both the stage of recovery (SISR-A) and the components of the process of personal recovery (SISR-B). This study aimed to develop the Spanish version of the SISR and obtain evidence of validity and reliability in a sample of 230 users of community mental health services. **Method:** The Spanish version of the SISR was developed following the translation–back translation procedure, with the support of a committee of experienced experts. The SISR was examined in terms of dimensional structure, internal consistency, relationships with other variables (i.e., the Maryland Recovery Assessment Scale [MARS-12] and the Dispositional Hope Scale [DHS]), and temporal stability (n = 66). Differential item functioning (DIF) by gender was analysed. **Results:** The study confirmed the unidimensionality of the SISR-B and suitable internal consistency of its scores (ω = .83, α = .83). Scores from both SISR-A and SISR-B showed good temporal stability and the SISR-B displayed strong correlations with the MARS-12 (r_s = .78) and the DHS (r_s = .67). No DIF was found. **Conclusions:** This study supports the validity and reliability of the scores of the Spanish version of the SISR.

Evidencia de la Validez y Fiabilidad de la Versión en Español de la Etapa de Recuperación Autoidentificada

Palabras clave:
Recuperación personal
Salud mental
Evidencia de validez
Evaluación de escala de recuperación

RESUMEN

Antecedentes: La Self-Identified Stage of Recovery (SISR) (Andresen, 2007) es una escala que evalúa tanto la etapa de recuperación (SISR-A) como los componentes del proceso de recuperación personal (SISR-B). El objetivo del estudio fue desarrollar la versión en español de la SISR y obtener evidencias de validez y fiabilidad en una muestra de 230 usuarios de servicios comunitarios de salud mental. **Método:** La versión en español se desarrolló siguiendo el procedimiento de traducción-retrotraducción, con el apoyo de un comité de expertos por experiencia. Se examinó la estructura dimensional, consistencia interna, relaciones con otras variables (Escala de Evaluación de la Recuperación de Maryland [MARS-12] y Escala de Esperanza Disposicional [DHS]) y estabilidad temporal (n = 66). Se analizó el funcionamiento diferencial del ítem (DIF) por género. **Resultados:** El estudio confirmó la unidimensionalidad de la SISR-B y una adecuada consistencia interna de sus puntuaciones (ω = .83, α = .83). Las puntuaciones de la SISR-A y la SISR-B presentaron estabilidad temporal y la SISR-B mostró correlaciones elevadas con la MARS-12 (r_s = .78) y la DHS (r_s = .67). No se encontró DIF. **Conclusiones:** Este estudio apoya la validez y fiabilidad de las puntuaciones de la versión española de la SISR.

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Following the paradigm shift begun over two decades ago in English-speaking countries (Leamy et al., 2011), the WHO, via its Quality Rights Initiative, has highlighted the need for mental health services to be recovery-oriented (Funk & Drew Bold, 2020; World Health Organization, 2012, 2021). According to this approach, public mental health policies should no longer prioritize symptom remission and the restoration of previous levels of functioning (Andresen et al., 2003; Schrank & Slade, 2007). Instead, in the recovery-oriented approach the support, treatment, and care of people with psychosocial disabilities should aim to enhance their overall life satisfaction, foster hope, and help them make meaningful contributions to society, irrespective of the presence or absence of symptoms (Anthony, 1993; Copeland, 2004; Shepherd et al., 2008).

This approach is referred to as psychological recovery (Andresen et al., 2011) or personal recovery (Leamy et al., 2011; Slade et al., 2012), to distinguish it from clinical recovery. The personal recovery approach has also been called the user-based definition of recovery (Alyahya et al., 2022; Schrank & Slade, 2007) because this conception emerged from the demands and expectations of users and survivors of psychiatry (Jacob et al., 2017; Schrank & Slade, 2007). In fact, during the final two decades of the twentieth century, numerous users and survivors shared personal accounts of their recovery experiences (Chamberlin, 1990; Deegan, 1988; Mead & Copeland, 2000), providing evidence that recovering was not only something achievable but also usual, albeit with a different meaning than symptom remission or functional adaptation to society. In this sense, the literature has repeatedly pointed out that clinical recovery and personal recovery are different constructs and, as such, they should be evaluated separately (Macpherson et al., 2015; Roe et al., 2011; van Eck et al., 2018).

Moreover, the narrative of these lived experiences showed that personal recovery not only implies a gradual improvement in different dimensions or factors but also occurs through a series of stages that involve qualitative changes in the recovery process. Numerous studies have highlighted that there are different stages within the recovery process (Andresen et al., 2003; Baxter & Diehl, 1998; Pettie & Triolo, 1999; Spaniol et al., 2002; Young & Ensing, 1999). However, there is variation among these studies regarding the number of stages proposed. For instance, Pettie and Triolo (1999) identified two stages, Young and Ensing (1999) proposed three, Spaniol et al. (2002) outlined four, and according to the model presented by Andresen et al. (2003), there are five stages, as follows:

(a) Moratorium: The initial stage is characterized by a negative sense of identity, confusion, hopelessness, disempowerment, and self-protective withdrawal.
(b) Awareness: In the second stage, individuals begin to harbour hope for a better life, recognizing the possibility of recovery and the potential to transcend the confines of the sick role.
(c) Preparation: The third stage entails the person drawing upon their intact self, encompassing their values, strengths, and weaknesses. They acquire recovery skills, establish connections with peers, and cultivate confidence.
(d) Rebuilding: As the fourth stage unfolds, individuals forge a positive identity, assume control over their own lives, re-evaluate past goals and values, take risks, and persevere in the face of setbacks.
(e) Growth: The final stage signifies the attainment of a positive sense of self. Individuals lead fulfilling and purposeful lives, embrace the future with hope, and strive for continuous personal growth.

With the inclusion of recovery-oriented care as the main approach of mental health public policies, the need to measure personal recovery has arisen in order to evaluate programmes and interventions aimed at promoting it. Nowadays, measuring recovery is considered a prerequisite for the development of recovery-oriented services (Andresen et al., 2011). Moreover, recognizing that the recovery process in mental health takes place in distinct phases or stages, and identifying in which stage of the process a person is currently, are fundamental aspects of recovery-oriented care. The support needs and therapeutic objectives vary considerably between each stage and identifying them could aid in the development of targeted treatment approaches (Andresen et al., 2010) and fostering the provision of person-centred care (Funk & Drew Bold, 2020).

Few scales have been designed to evaluate both the quantitative level of the recovery process and the stages of recovery in mental health. A recent literature review (Penas et al., 2019) identified four instruments: The Self-Identified Stage of Recovery (SISR) (Andresen, 2007), the Stages of Recovery Instrument (STORI) (Andresen et al., 2006), the Stages of Recovery Scale (SRS) (Song & Hsu, 2011), and the Recovery Assessment Scale – Domains and Stages (RAS-DS) (Hancock et al., 2015). All of them were created based on users' perspectives of recovery (Penas et al., 2019). Only the STORI has a published Spanish version (Lemos-Giráldez et al., 2015). However, the STORI was implemented in the Spanish cultural context (Eiroa-Orosa et al., 2022), and it was revealed that the scale is perceived as grammatically complex by many users, necessitating individual administration and additional support to ensure comprehension of its instructions and items. In contrast, the SISR is advantageous due to its brevity and simplicity, as it comprises only five items.

Researchers have used the SISR scale in different cultural contexts for two primary purposes: (a) in conceptual research on personal recovery and its relationship with other variables, such as identity (Buckley-Walker et al., 2010), or hope, meaning, and responsibility (Copic et al., 2011); and (b) to evaluate the effectiveness of programmes aimed at promoting personal recovery in hospital settings (Mitsunaga-Ohmuro & Ohmuro, 2021), community settings (Chiba et al., 2014), and job placements (Rüsch et al., 2019). The above-mentioned studies were conducted in different countries and cultures (e.g., Australia, Japan, and Germany).

Nowadays, recovery-oriented care is being introduced in Spanish-speaking countries, such as in Spain's strategic mental health plans (Ministerio de Sanidad, 2022) and in Mexico's mental health law (Secretaría de Gobernación, 2022), and it is expected that more Spanish-speaking countries will follow this paradigm shift, as promoted by the Pan American Health Organization (Organización Panamericana de la Salud, 2021). The current study thus aimed to develop the Spanish version of the SISR and gather evidence of validity and reliability among users of mental health services, to provide a brief instrument that allows the self-perceived stage and the level of recovery to be evaluated in a Spanish cultural context.

Method

Participants

Participants were adult users of community rehabilitation services (CRS). Initially, 236 users agreed to participate and signed the informed consent. However, six participants were excluded due to missing data, resulting in a final sample size of 230 participants. Their mean age was 47.9 years (*SD* = 9.5; range 20–69). Most of the participants (56.5%, *n* = 130) were male. 'Single' was the most prevalent marital status among participants (47.4%, *n* = 109). In terms of educational level, a secondary level of education had been completed by most participants (42.2%, *n* = 97), followed by a primary level of education (35.2%, *n* = 81). The most common living arrangements reported by the participants were living with their original family (41.3%, *n* = 95) or with their own family (32.6%, *n* = 75). Regarding employment status, the majority of participants were receiving a pension due to disability (67%, *n* = 154). The most frequently reported diagnoses were depression (31.7%, *n* = 73), bipolar disorder (18.7%, *n* = 43), schizophrenia (18.7%, *n* = 43), and personality disorder (13.9%, *n* = 32). More details of the socio-demographic characteristics of the sample are shown in Table 1.

Furthermore, out of the 230 participants, a total of 66 agreed to take part in the retest. Their mean age was 48.3 years (*SD* = 9,0; range 27–66). Half of the participants were female (50%, *n* = 33). The most prevalent marital status among them was 'single' (53%%, *n* = 35), and the most frequently reported diagnoses were depression (42.4%, *n* = 28), bipolar disorder (16.7%, *n* = 11), and personality disorder (15.2%, *n* = 10).

Instruments

The SISR (Andresen, 2007) is a two-part scale designed to measure both the stage of recovery and the level of the components of the recovery process. The first part (SISR-A) is a single-item forced-choice measure, with five statements (from A to E), each representing one of the five stages of the recovery process (i.e., A: moratorium, B: awareness, C: preparation, D: rebuilding, and E: growth). The second part (SISR-B) is a 4-item scale, assessing four key component processes of recovery: finding hope (Item 1. Hope), re-establishment of identity (Item 2. Identity), finding meaning (Item 3. Meaning) and taking responsibility (Item 4. Responsibility). Responses are measured using a 6-point Likert scale, ranging from 1 (*Disagree strongly*) to 6 (*Agree strongly*). The total score of SISR-B is calculated by summing up all the responses, which range from 4 to 24. A higher score on the scale indicates a higher level in the recovery process. The SISR-B has been shown to be highly positive and significantly correlated with other instruments measuring personal recovery, such as the Recovery Assessment Scale (RAS) (r = .70, p < .01) and the Mental Health Recovery Measure (MHRM) (r = .80, p < .01) (Andresen et al., 2010).

The Maryland Assessment of Recovery Scale (MARS-12) (Drapalski et al., 2012; 2016; Medoff, 2015) is a 12-item scale designed to assess six components of personal recovery: self-direction/empowerment, holistic, non-linear, strengths-based, responsibility, and hope. MARS-12 uses a 5-point Likert scale (1 = *Not at all*; 5 = *Very much*). The total score is obtained from the sum of all the answers, resulting in a range from 12 to 60. A higher score on the scale indicates a higher level of recovery. The Spanish version of the MARS-12 has recently been validated, showing adequate psychometric properties (Balluerka et al., 2024). In the present sample, this instrument exhibited excellent internal consistency (McDonald's ω = .94; Cronbach's α = .94), with a total score ranging between 12 and 60 (M = 34.9; SD = 11.2).

Table 1
Sample Sociodemographic Characteristics (N = 230)

	n (%)
Gender,	
Male	130 (56.5)
Female	99 (43.0)
Not answered	1 (0.5)
Diagnosis*1	
Depression	73 (31.7)
Bipolar disorder	43 (18.7)
Schizophrenia	43 (18.7)
Personality disorder	32 (13.9)
Anxiety disorder	22 (9.6)
Schizoaffective disorder	18 (7.8)
Obsessive-compulsive disorder	13 (5.7)
Other psychotic disorders (f21-f29, CIE-10)	12 (5.2)
Others (ADHD, ASD, ED, PTSD)*2	15 (6.5)
Don't know/Not answered	29 (12.6)
Marital status	
Married	64 (27.8)
Single	109 (47.4)
Separated/Divorced	52 (22.6)
Widower	5 (2.2)
Educational level	
Primary education not completed	5 (2.2)
Primary education	81 (35.2)
Secondary education	97 (42.2)
Higher education	47 (20.4)
Living arrangement	
Original family	95 (41.3)
Own family	75 (32.6)
Alone	37 (16.1)
Shared flat	17 (7.4)
Institutional centre	3 (1.3)
Other	3 (1.3)
Employment status*1	
Working	6 (2.6)
Unemployed (with benefits)	33 (14.4)
Disabled (receiving a pension)	154 (67)
Looking for a job (without benefits)	8 (3.5)
Studying	8 (3.5)
Retired	7 (3)
Taking care of his/her home and family	25 (10.9)
Other	11 (4.8)

Note. *[1] The categories are not mutually exclusive; people can choose more than one option. *[2] ADHD: Attention Deficit Hyperactivity Disorder; ASD: Autism Spectrum Disorder; ED: Eating Disorder; PTSD: Post-Traumatic Stress Disorder.

The Dispositional Hope Scale (DHS) (Snyder et al., 1991) is a 12-item scale comprising two subdomains: pathway and agency. Four items measure the pathways subdomain, four measure the agency subdomain, and the remaining four serve as filler items. The DHS uses a 4-point Likert scale, from 1 (*Definitely false*) to 4 (*Definitely true*). The total score is calculated by adding up the scores of the pathway and agency items, ranging from 8 to 32. A higher score on the scale indicates a higher level of hope. The Spanish version of the DHS has been validated, providing evidence of its appropriate psychometric properties, in terms of both validity and reliability (Galiana et al., 2015). In our sample, the DHS showed a high level of internal consistency (McDonald's ω = .94; Cronbach's α = .94), with a total score ranging between 8 and 32 (M = 20.3, SD = 6.3).

Procedure

The SISR was translated into Spanish following the International Test Commission guidelines (Hernández et al., 2020; International Test Commission, 2018) for translating and adapting scales. Specifically, the following steps were carried out: (a) the original English version of the SISR was translated into Spanish using the parallel translation procedure, i.e., four independent bilingual psychologists whose mother tongue was Spanish (with a range of 1.5 to 20 years of experience translating and adapting scales) translated the scale from the original language into Spanish; (b) all the translations were compared, and a consensus version was created to ensure that the meaning of the original scale was preserved; (c) a committee of experts with lived experience (seven women and four men, with a mean age of 50.2 years [SD = 7.9, range 37–61], and the most common diagnosis of bipolar disorder [45.5%]), who spoke Spanish as their native language, independently assessed the clarity, wording, and cultural appropriateness of each item using a 4-point Likert scale (where 1 represented a lack of understanding and 4 indicated perfect comprehension); (d) a multidisciplinary committee (i.e., mental health professionals and users of mental health services) reviewed the results and agreed a consensus version; (e) a Spanish linguist refined and polished the syntax, grammar and terminology of the instructions and items; and (f) finally, a professional translation service carried out the back-translation of the scale, which was rated by the original instrument's authors for agreement with the original version of the SISR.

Participants were recruited by convenience sampling in 14 community rehabilitation services (CRS) across Catalonia. All users of these CRS over 18 years old, with no relevant cognitive impairment or comprehension difficulties, and without severe or decompensated somatic disease, were invited to participate. Participation was voluntary, and all eligible participants were informed about the nature and objectives of the study. No financial compensation was offered to participants. The study was conducted in accordance with the ethical standards of the Helsinki Declaration and its later amendments and was approved by the Bioethics Committee of the University of Barcelona (CBUB; Institutional Review Board Number: IRB00003099).

Data collection spanned from January 24 to October 7, 2022, and was carried out by one of the research team members accompanied by one or two professionals from each CRS. The participants were summoned in small groups to answer the protocol of tests, which included questions assessing participants' sociodemographic status (i.e., age, gender, marital status, coexistence unit, education level, working status, and diagnosis) and the three scales.

All participants were invited to complete the SISR a second time one or two weeks after the initial assessment. A total of 66 participants agreed to complete the second round.

Data Analysis

To estimate the distribution of the data at the item level, we examined the frequency of responses for each category on both the SISR-A and SISR-B. In addition, we evaluated the distribution of total scores on the SISR-B by calculating the mean, standard deviation, and Shapiro-Wilk normality test. Multivariate normality was assessed using the Mardia test. In order to provide validity evidence based on the internal structure of the SISR-B, we performed a confirmatory factor analysis (CFA) using the weighted least square mean and variance adjusted (WLSMV) estimator. The model fit was assessed using the chi-square test, the comparative fit index (CFI), the Tucker-Lewis index (TLI), the root mean squared error of approximation (RMSEA), and the standardized root mean squared residual (SRMR). Following the recommended guidelines proposed by Hu and Bentler (1999), the chi-square/degrees of freedom ratio (χ^2/df) was expected to be less than 2; CFI values $\geq$ .95, RMSEA values $\leq$ .08, and SRMR $\leq$ .06 were considered indicative of an adequate fit.

Furthermore, we analysed the presence of differential item functioning (DIF) by gender in the SISR-B using the ordinal logistic regression (OLR) method (Choi et al., 2011). We compared three different models (i.e., total DIF effect, uniform DIF, and non-uniform DIF) using a significance level of .05.

To obtain evidence of the validity based on the relation to other variables of the SISR-A and the SISR-B, we used Spearman's correlation coefficient. Both were correlated with each other and with the MARS-12 and DHS.

Following the recommendations of Doval et al. (2023), the SISR-B internal consistency was assessed using McDonald's omega (ω) and Cronbach's alpha (α). Temporal stability was evaluated by calculating the intraclass correlation coefficient (ICC) for the total score of the SISR-A and SISR-B.

Statistical analyses were conducted using JASP (Version 0.16.4), except in the case of the CFA, DIF detection, and Mardia test, which were calculated using RStudio (RStudio Team, 2020).

Results

Spanish Version

After the forward, consensual, and reconciled translation, one member of the committee of experts with lived experience (i.e., users of mental health services) scored less than 4 points on the pre-item instructions of the SISR-A. One of the participants pointed out that in Spanish there is no distinction between disease/illness/sickness, and suggested replacing the concept of "illness" with that of "disorder" or "health problem". The second option was incorporated into the instructions. Another participant of this committee scored less than 4 points on item 4 of the SISR-B "I am completely responsible for my own life and well-being", highlighting that the word 'completely' could be confusing because there is always a social/community dimension in the responsibility for our lives and well-being. After

careful consideration, the research team decided to keep the original phrasing so as not to change the meaning of the item. The final Spanish version of the SISR is shown in Table 2.

Item Analysis

Based on the distribution of the SISR-A, we found that participants most frequently endorsed the second stage (Awareness; n = 65, 28.3%) and the third stage (Preparation; n = 62, 27%), followed by the first (Moratorium; n = 47, 20.4%) and fourth (Rebuilding; n = 42, 18.2%), while the last stage was less frequently endorsed (Growth; n = 14, 6.1%).

In turn, participants' responses on the SISR-B predominantly fell into the *Agree slightly* or *Agree somewhat* categories, with very few selecting the first category (*Disagree strongly*). The skewness coefficient for the four items and SISR-B total score showed a left-skewed distribution, especially for items about Identity and Responsibility, where almost 70% of participants responded with the highest categories (*Agree slightly, Agree somewhat*, and *Agree strongly*). For further details see Table 3. The Shapiro-Wilk normality test revealed that the SISR-B total score distribution significantly deviated from normality (W = .98, p < .001; M = 15.8, SD = 4.4) and the multivariate normality, as measured by the Mardia test, showed that the data were non-normally distributed (Skewness = 62.42, p < .001; Kurtosis = 5.24, p < .001).

Evidence Based on the Internal Structure

On one hand, the results of the CFA supported the one-factor structure of the SISR-B ($\chi^2(2)$ = 3.54, p = .170, χ^2/df = 1.77, CFI = .999, TLI = .996, SRMR = .015, RMSEA = .058, CI 90% [.000, .155]). As depicted in Figure 1, the standardized factor loadings for the SISR-B items ranged from .62 (Responsibility) to .88 (Meaning), with standard errors ranging from .000 (Hope) to .050 (Responsibility), with all loadings being significant at p < .001.

On the other hand, the ordinal logistic regression method did not identify any items exhibiting DIF based on gender in the SISR-B. The differences between the models were not statistically significant, as indicated by the p-values ranging from .051 to .933 (see Table 4).

Table 2
Spanish Version of the SISR

ETAPA DE RECUPERACIÓN AUTOIDENTIFICADA [SELF-IDENTIFIED STAGE OF RECOVERY]

Parte A. [Part A.]

Las personas diagnosticadas de un problema de salud grave pueden variar su manera de sentir lo que es vivir con esa condición en diferentes momentos. A continuación, se muestran cinco afirmaciones que describen cómo las personas a veces pueden sentirse cuando viven con un problema de salud mental. [People who are told they have a serious illness can feel differently about life with the illness at different times. Below are five statements describing how people may feel at times when living with a mental illness.]

Por favor, **lee las cinco afirmaciones** (A-E) antes de responder a las siguientes preguntas. [Please **read all five statements** (A-E) before answering the question that follows.]

A) "No creo que las personas puedan recuperarse de un problema de salud mental. Siento que he perdido el control de mi vida y que no hay nada que pueda hacer para ayudarme a mí mismo/a." ["I don't think people can recover from mental illness. I feel that my life is out of my control, and there is nothing I can do to help myself."]

B) "*Recientemente* me he dado cuenta de que las personas pueden recuperarse de un problema de salud mental grave. Estoy comenzando a pensar que quizá sea posible ayudarme a mí mismo/a." ["I have *just recently* realised that people can recover from serious mental illness. I am just *starting* to think it may be possible for me to help myself."]

C) "Estoy empezando a aprender cómo puedo superar mi problema de salud mental. He decidido que voy a seguir adelante con mi vida." ["I am *starting* to learn how I can overcome the illness. I've decided I'm going to start getting on with my life."]

D) "*Actualmente* puedo manejar mis problemas de salud mental razonablemente bien. Lo estoy haciendo bien y me siento bastante optimista respecto al futuro." ["I can manage the illness reasonably well now. I am doing OK, and feel fairly positive about the future."]

E) "Siento que *actualmente* tengo el control de mi salud y de mi vida. Lo estoy haciendo muy bien y el futuro parece prometedor." ["I feel I am in control of my health and my life now. I am doing very well and the future looks bright."]

De las cinco afirmaciones anteriores, ¿cuál dirías que describe ***mejor*** cómo te has sentido en el **último mes** en relación a vivir con tu problema de salud mental? Marca la casilla correspondiente a esa afirmación. [Of the five statements above, which one would you say ***most closely*** describes how you have been feeling over the **past month** about life with the illness? Tick the box next to that statement.]

Parte B. [Part B.]

A continuación, se presentan cuatro afirmaciones sobre cómo pueden sentirse las personas en relación a ciertos aspectos de su vida. [Below are four statements about how people can feel about aspects of their lives.]

Durante el **último mes,** ¿cuál es tu grado de acuerdo con cada afirmación? Marca el número correspondiente. [For the past month, how much would you agree with each statement? Please circle the appropriate number.]

1) Estoy seguro de que encontraré formas de lograr mis metas en la vida. [I am confident that I will find ways to attain my goals in life.]

2) Sé quién soy como persona y qué cosas de la vida son importantes para mí. [I know who I am as a person, and what things in life are important to me.]

3) Las cosas que hago en mi vida tienen sentido y valor. [The things I do in my life are meaningful and valuable.]

4) Soy completamente responsable de mi propia vida y bienestar. [I am completely responsible for my own life and wellbeing.]

Table 3
Score Distribution on the SISR-B

Item	Frequency of item endorsement [n (%)]						*M (SD)*	*S*	*K*
	1	2	3	4	5	6			
Hope	18 (7.8)	25 (10.9)	34 (14.8)	90 (39.1)	38 (16.5)	25 (10.8)	3.8 (1.4)	-.36	-.37
Identity	14 (6.1)	13 (5.7)	24 (10.4)	71 (30.9)	73 (31.7)	35 (15.2)	4.2 (1.3)	-.80	.21
Meaning	10 (4.3)	32 (13.9)	36 (15.7)	64 (27.8)	65 (28.3)	23 (10)	3.9 (1.3)	-.39	-.65
Responsibility	17 (7.4)	24 (10.4)	35 (15.2)	66 (28.7)	63 (27.4)	25 (10.9)	3.9 (1.4)	-.49	-.52
Total							15.8 (4.4)	-.44	.04

Note. S: Skewness, *K:* Kurtosis.

Figure 1
Path Diagram of the Confirmatory Factor Analysis (CFA) of the SISR-B

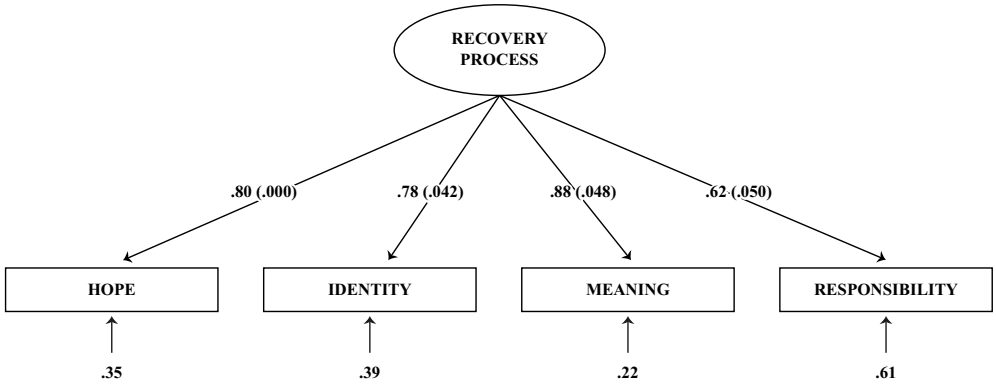

Table 4
Differential Item Functioning (DIF) Detection on the SISR-B Items

Item	Total DIF		Uniform DIF		Non-uniform DIF	
	p	ΔR^2	*p*	ΔR^2	*p*	ΔR^2
Hope	.548	.0016	.848	0	.280	.0016
Identity	.141	.0054	.713	.0002	.051	.0052
Meaning	.527	.0018	.738	.0002	.279	.0017
Responsibility	.933	.0002	.889	0	.730	.0002

Internal Consistency and Temporal Stability

Scores on both the SISR-A and SISR-B were stable over a period of one or two weeks, demonstrating that self-identification of the stage of the recovery process and the level of recovery have temporal stability (ICC_{SISR-A} = .87, CI 95% [.84, .90]; ICC_{SISR-B} = .86, CI 95% [.82, .89]).

Regarding internal consistency of the SISR-B score, we found that the four items demonstrated a high level of consistency (ω = .83, CI 95% [.79, .87]; α = .83, CI 95% [.79, .86]).

Evidence Based on Relations to Other Variables

The SISR-B showed a highly positive correlation with the MARS-12 (r_s = .78, p < .001) and the DHS (r_s = .67, p < .001). These results provide, respectively, excellent convergent evidence of the scale and a strong correlation with hope, a construct of high relevance for recovery. Furthermore, the SISR-A showed a high correlation with the SISR-B (r_s = .64, p < .001) and the MARS-12 (r_s = .66, p < .001), but the correlation with the DHS was slightly lower (r_s = .58, p < .001).

Discussion

The present study sought to adapt the SISR into Spanish and conduct a psychometric validation to determine the applicability of the SISR in assessing the stage of recovery (SISR-A) and the level reached in the process of recovery (SISR-B) in the Spanish context. The English version of the SISR was translated and adapted into Spanish according to current international standards (International Test Commission, 2018), and its psychometric properties were explored in a sample of users of community mental health services in Catalonia.

Concerning the adaptation process, following an observation made by the committee of experts with lived experience of this study, we decided to translate the expression "mental illness" as "mental health problems", to avoid the connotations of biological disease that the word *"enfermedad"* has in Spanish. Indeed, the recovery-oriented approach was born as an alternative to the biomedical model (Slade et al., 2012). This approach aligns with the current strategy adopted for the Spanish adaptation of materials within this field, such as the Spanish version published by the Spanish Association of Mental Health Nursing (AEESME) of the Illness Management and Recovery manual created by the Substance Abuse and Mental Health Administration of the United States (SAMHSA, 2020).

The results of the present study illustrate for the first time the factorial structure of the SISR-B, which was not examined or reported in the original English version (Andresen, 2007) or the Japanese version (Chiba et al., 2010) of the instrument. The confirmation of the unidimensionality of the SISR-B, as demonstrated by the high and statistically significant standardized factor loadings, has important implications. First, these findings indicate that all the items within the test are effectively measuring a single underlying construct: the level of recovery. Second, the high factor loadings suggest that each item is strongly related to the overall concept of recovery and contributes meaningfully to its measurement. Finally, this one-factor structure of the SISR-B allows for a simplified interpretation and utilization of the test scores. Since all the items are measuring the same construct, the total score derived from the test provides a representation of the individual's level of recovery. On their side, the DIF results indicated that the items in the SISR-B are invariant across genders and, therefore, the items and the scale score can be effectively compared between men and women.

The results of the reliability analysis demonstrated that the test score of the Spanish SISR, including both parts A and B, exhibits high temporal stability after one or two weeks, and that the SISR-B has a high level of internal consistency. The high temporal stability observed in the present study for both parts of the SISR contrasts with the results of the validation of the Japanese version, in which the test–retest reliability for the SISR-A was just fair after one or two weeks (Chiba et al., 2010). This difference could be attributed to cultural factors or the size of the test-retest subsample (n = 66 in the Spanish version, and n = 32 in the Japanese version), as well

as differences in the sampling process. For example, the sample in our study was drawn exclusively from community rehabilitation services, which enhances the uniformity of the sample context. In contrast, in the study by Chiba et al. (2010), 51.6% of the sample was drawn from community services and 48.4% from an inpatient setting, that is, a context in which most people may not have clinical stability.

The present study also provides evidence of validity based on relations with other variables for the Spanish version of the SISR. As expected, the SISR-B showed a highly positive correlation with the MARS-12 (Medoff, 2015), another short, one-dimensional scale that measures the level of personal recovery. Additionally, the SISR-B exhibited a strong positive correlation with the DHS (Snyder et al., 1991), revealing that people who perceive having a higher level of recovery also perceive greater dispositional hope. This observation supports the idea that hope is one of the key components of personal recovery (Andresen et al., 2003). Similarly, we found a moderate correlation between both parts of the SISR, demonstrating that an improvement in the level of the components is usually accompanied by a step forward in the stages of recovery (Andresen, 2007).

Some limitations should be noted in this study. First, the recruitment of participants from community rehabilitation services was based on convenience sampling, which may limit the generalizability of our results. This is a specific type of mental health service that caters to individuals who, although not in a state of clinical decompensation, require professional assistance to promote their autonomy, social functioning, and/or community inclusion. Their representativeness of the broader population of mental health users cannot be assumed. Second, although a statistically significant difference was observed in the gender distribution of our sample, with women comprising 44% and men accounting for 56%, similar percentages were identified in prior investigations conducted in other community rehabilitation services in Spain (Navarro & Carrasco, 2011; Prat et al., 2018), which reflects the slight gender difference attending this type of service in our cultural context.

Despite these limitations, the evidence of validity and reliability found in the scores of the Spanish version of the SISR supports its use within the Spanish-speaking community. Notably, among the scales available for assessing the stage of the recovery process, the STORI (Andresen et al., 2006) was previously the only scale adapted into Spanish (Lemos-Giráldez et al., 2015). However, whereas the STORI is a 50-item scale whose Spanish version is grammatically complex and often requires assistance for comprehension and completion, the SISR stands out for its simplicity and brevity, making it highly recommended for use. In sum, the availability of the Spanish version of the SISR provides professionals, researchers, and users with a self-administered and brief scale that facilitates the assessment of programmes, interventions, and psychological treatments, since it enables an understanding of the individual's stage in the recovery process and their level of recovery.

Author Contributions

Hernán María Sampietro: Conceptualization, Data Curation, Formal Analysis, Investigation, Resources, Validation, Visualization, Writing – Original Draft, Writing – Reviewing & Editing. **Maite Barrios:** Conceptualization, Methodology, Supervision, Visualization, Writing – Original Draft, Writing – Reviewing & Editing. **Ángela I. Berrío:** Data Curation, Formal Analysis, Software, Validation, Visualization, Writing – Original Draft. **J. Emilio Rojo:** Conceptualization, Methodology, Project Administration, Resources, Writing – Reviewing & Editing. **Georgina Guilera:** Conceptualization, Funding Acquisition, Methodology, Supervision, Writing – Original Draft, Writing – Reviewing & Editing. **Juana Gómez-Benito:** Conceptualization, Funding Acquisition, Project Administration, Supervision, Writing – Reviewing & Editing.

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Declaration of Interests

The authors declare that there is no conflict of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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