



More Optimistic Recovery Attitudes Are Associated with Less Stigmatization of People with Mental Illness among Healthcare Professionals Working on Acute and Semi-Acute Psychiatric Wards

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Abstract

Stigmatization towards individuals with mental illness is common among mental healthcare professionals, yet poses a key concern regarding the provision of effective support and therapy for those undergoing psychiatric treatment. In this study, we examined to what extent recovery attitudes among mental healthcare professionals are associated with stigmatization. We conducted a survey among staff members ($n = 110$) of a large psychiatric hospital working on acute or semi-acute wards one year following a multi-professional training session, which included the promotion of recovery orientation as a therapeutic approach. The survey included measures such as gender, age, professional background, years of working experience, ward setting (mostly open or closed doors), recovery attitudes (RAQ-7), and stigmatization of individuals with mental illness (OMS-HC scale). Mental healthcare professionals who attended training in recovery orientation significantly more frequently stated to know the concept of recovery compared to those who did not receive training. In addition, recovery attitudes were more optimistic and significantly associated with levels of stigmatization among professionals who were familiar with the concept of recovery. Despite the cross-sectional study design that did not test causal links, these findings suggest that enhancing recovery attitudes through training may lead to less stigmatization among mental healthcare professionals.

Keywords Stigmatization · Recovery attitudes · Mental illness · Healthcare professionals · Psychiatric services · Multiprofessional training

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Introduction

Users experience discrimination in about 16% to 44% of mental healthcare settings, such as being treated like a child or lack of respect and/or honesty from professionals [1]. Stigma in mental healthcare not only affects the users' feelings and confidence, but also poses a key concern regarding the provision of effective support and therapy for individuals receiving psychiatric treatment [2]. It is, therefore, clearly necessary to take action to reduce stigma in mental healthcare settings and to identify factors which contribute to better attitudes.

In contrast to many existing anti-stigma interventions and among general healthcare professionals, very little is known as to what is effective in the mental healthcare setting [3]. Nevertheless, it has been demonstrated that negative attitudes and treatment expectations of mental healthcare professionals can result in discriminating behaviours that include practicing greater control and tighter restrictions [1, 4]. This is significant, as a study in Switzerland revealed that psychiatrists have even stronger stigmatizing attitudes than does the general population [5]. In contrast, mental healthcare professionals with positive attitudes and confidence towards patients' recovery were perceived as more supportive and collaborative in addressing the individual patients' needs [6].

Recovery orientation, the belief that recovery from mental illness is possible, has been proposed as an important factor in anti-stigma interventions among general healthcare professionals [7]. Regarding mental healthcare, the term is understood as a multi-dimensional construct including the perspective of both caregivers and service users; although, a unified definition has yet to be determined [8]. From the service users' perspectives, personal recovery stands for "a subjective experience to find a way of living a satisfied life despite the limitations caused by the mental illness" [9]. More precisely, four key recovery processes have been identified such as finding hope, re-establishing identity, finding meaning in life, and taking responsibility for recovery [10]. From the caregivers' perspective, recovery orientation means adopting positive attitudes and hopefulness regarding one's recovery from mental illness as well as delivering person-oriented and individual treatments, setting goals collaboratively and promoting hope and empowerment [11]. Previous studies could show that mental healthcare professionals' recovery attitudes can be enhanced through formal recovery training sessions [12, 13].

In March 2016, a one-day, formal, voluntary, multi-professional training session for all clinical staff members of the University Hospital of Psychiatry Zurich took place, organized by the Center of Acute Psychiatric Disorders. The goal was to introduce the concept of recovery orientation as a therapeutic approach and to discuss the implementation of recovery-oriented practices, as tested in a previous pilot study [14], in acute and semi-acute wards. For this purpose, the training session included talks from international experts as well as practical workshops. In line with the hospital's overall strategy, the concept of recovery was also an aspect of other training courses.

Aims of the Study

In this study, we were interested in the relationship between recovery attitudes and mental healthcare professionals' stigmatization towards individuals with mental illness following their multi-professional recovery training along with other activities that promote recovery orientation. For this purpose, we conducted a cross-sectional survey study in 2017. First, we examined whether the concept of recovery orientation is more familiar among mental healthcare professionals who participated in the multi-professional recovery training compared

to those who did not. Second, in line with previous studies, we hypothesized and tested whether the recovery attitudes were more optimistic in mental healthcare professionals who stated to know the concept of recovery compared to those who did not know it. Third, based on the previous findings reported above, we further assumed that more optimistic attitudes in recovery orientation were associated with reduced stigmatization among mental healthcare professionals towards individuals with mental illness.

Methods

Study Sample and Data Collection

We conducted a cross-sectional survey among clinical staff members of 15 wards for adult psychiatry at the Department for Psychiatry, Psychotherapy and Psychosomatics of the Psychiatric University Hospital Zurich in September and October 2017. Nine of the included wards were specialized for acute psychiatric disorders of all diagnostic categories, four were specialized in multimodal treatment of depression and anxiety, and two in treating substance use disorders. All data were collected anonymously, thus, ethical approval from an IRB was not required. In total, 113 health professionals of all 15 different wards completed the questionnaire with a response rate of 36.0%. Three respondents were excluded from further analyses (one person because of fast response time, one person because of suspect response pattern and one person because of missing values in all personal variables). The final sample size was $n = 110$ persons.

Measures

The whole survey included measures about personal variables and different scales related to attitudes of personal recovery, stigmatization towards people with mental illness, attitudes towards coercion and recovery orientation of services. This is the first study using these data while focusing on the first two scales measuring attitudes of recovery and stigmatization.

Personal Variables

We assessed the following personal variables: Gender (female/male), age classified into five categories (16–25, 26–35, 36–45, 46–55, 56–65), years of working experience classified into four categories (< 1, 1–5, 6–10, >10) and professional background (physician, nurses, psychologist, social worker and other therapists such as occupational therapists). As there were only three psychologists with similar job descriptions as assistant physicians, they were summarized into one group. We also asked the participants whether they work on mostly open or closed wards and whether they can indicate the name of their wards.

Recovery Orientation

We asked the participants whether they know the concept of recovery. In a following separate question, we further asked them whether they had participated in the multi-professional recovery training session, which was organized by the Center of Acute Psychiatric Disorders.

Attitudes towards recovery from serious mental illness were examined using the RAQ-7 scale [15]. The RAQ-7 included seven items of a 5-point Likert scale ranging from 1 (strongly

disagree) to 5 (strongly agree) that have been validated for different groups of people such as health professionals, patients or the general population [15, 16].

In this study, the RAQ-7 total score was nearly normally distributed ($M = 4.17$, $SD = 0.46$, $\text{Min-Max} = 3.3\text{--}5$, $\text{Kurtosis} = -0.77$ and $\text{Skewness} = -0.14$) and sufficient reliable (Cronbach's $\alpha = 0.69$). The two subscales were "recovery is possible and needs faith" (Cronbach's $\alpha = 0.61$) and "recovery is difficult and differs among people" (Cronbach's $\alpha = 0.54$).

Stigmatization

The OMS-HC was explicitly developed for measuring stigmatizing attitudes and behavioral intentions in healthcare providers such as physicians and nurses and has been proved to be successful in detecting stigmatization towards people with mental illness [17]. We used a German-translated version (Zuaboni, G., Ventling, S., & Rüschi, N., 2014, not yet published) of the validated 15-items scale. Participants responded to statements on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

In this study, the OMS-HC total score was nearly normally distributed ($M = 2.00$, $SD = 0.39$, $\text{Min-Max} = 1.1\text{--}3$, $\text{Kurtosis} = -0.21$ and $\text{Skewness} = -0.32$) and sufficient reliable (Cronbach's $\alpha = 0.75$). The OMS-HC included the three subscales "negative attitudes toward people with mental illness" (Cronbach's $\alpha = 0.60$), "willingness to disclose and seek for help" (Cronbach's $\alpha = 0.48$), and "preference for social distance" (Cronbach's $\alpha = 0.78$).

Statistical Analyses

Relationships between the variables of interest were determined by Pearson or Spearman correlation coefficients. We used a chi-squared test to examine the relationship between the participation in the recovery training session and the knowledge of the concept of recovery. To examine differences in recovery attitudes and stigmatization between participants who were familiar with the concept of recovery and those who were not familiar with it, we used independent samples t-tests. We performed a regression analysis to investigate the association between participants' recovery attitudes and stigmatization controlling for personal factors such as gender, age and professional background based on previous studies [17, 18]. Before conducting the regression analysis, we calculated the intraclass coefficient (ICC) based on all participants who indicated their wards and included all wards with at least two participants ($n = 84$; 13 wards). The ICC explained only 3.36% and was not statistically significant ($p = 0.708$). We, therefore, concluded that adjusting for ward settings was not necessary. All statistical tests were performed using IBM SPSS, version 23 for Windows (IBM Corp. 2015). Statistical significance was set at the 5% level.

Results

Sample Characteristics

The study sample included 60% females and covered the full range of age. More than one third of the participants had working experience over 10 years. Years of working experience was strongly correlated with age ($r_s = 0.79$, $p < 0.001$) and, thus, not included in further analysis.

Most of the participants were nurses, one fifth were psychiatrists and psychologists and one fourth were social worker and other therapists. Half of the participants worked on mostly open and the other half on mostly closed wards. For details see Table 1.

Recovery Orientation

Of all participants, 36.4% stated to have participated in the multi-professional training session concerning recovery orientation. Of these participants, 95% indicated to know the concept of recovery in contrast to 70% of those who did not participate in the training session (see Table 2). Recovery attitudes were generally high with a mean of 4.17 ($SD = 0.46$) on a possible range from 1 to 5. Table 2 shows that attitudes on the first subscale “recovery is possible and needs faith” were significantly more optimistic in participants who stated to know the concept of recovery compared to those not knowing it. Contrastingly, attitudes on the second subscale “recovery is difficult and differs among people” were not associated with knowing the concept of recovery. Personal factors such as gender, age and professional background as well as ward setting (mostly open or closed) were not significantly associated with recovery attitudes in this sample.

Stigmatization

The overall OMS-HC score was $M = 2.00$ ($SD = 0.39$) on a possible range from 1 to 5. Table 2 shows that negative attitudes towards people with mental illness and preference for social distance, assessed by the first and third OMS-HC subscales, were lower for participants who stated to know the concept of recovery compared to those who did not know it. Contrastingly, the second subscale showed no difference between these two groups. The latter subscale concerning disclosure and seeking for help, however, was associated with age ($r = -0.30$, $p =$

Table 1 Sample characteristics

	n	%
Total n	110	100.0
Gender, female	66	60.0
Age		
16–25	10	9.1
26–35	42	38.2
36–45	23	20.9
46–55	21	19.1
56–65	14	12.7
Years of working experience		
< 1	12	10.9
1–5	39	35.5
6–10	17	15.5
> 10	42	38.2
Profession		
psychiatrists and psychologists	21	19.1
nurses	62	56.4
social workers and other therapists	27	24.5
Ward setting		
mostly open	56	50.9
mostly closed	54	49.1

Table 2 Relationship between recovery training, recovery attitudes and stigmatization among healthcare professionals ($n = 110$)

Participated in recovery training	Knowing the concept of recovery		Chi-squared value (df)	p
	yes	no		
yes	38 (95%)	2 (5%)	9.62 (1)	0.001
no	49 (70%)	21 (30%)		
Recovery attitudes	M (sd)	M (sd)	T-value (df)	p
RAQ total score	4.21 (0.45)	4.00 (0.45)	1.98	0.050
RAQ subscale 1 “recovery is possible and needs faith”	4.13 (0.56)	3.78 (0.55)	2.67	0.009
RAQ subscale 2 “recovery is difficult and differs among people”	4.31 (0.50)	4.29 (0.52)	0.17	0.862
Stigmatization				
OMS-HC total score	1.96 (0.39)	2.13 (0.38)	1.78	0.078
OMS-HC subscale 1 “negative attitudes toward people with mental illness”	1.76 (0.45)	1.95 (0.39)	1.88	0.063
OMS-HC subscale 2 “willingness to disclose and seek for help”	2.43 (0.61)	2.38 (0.65)	0.37	0.713
OMS-HC subscale 3 “preference for social distance”	1.83 (0.60)	2.13 (0.61)	2.13	0.035

Recovery attitudes were measured on the RAQ-7 total score and subscales ranging from 1 to 5 while higher values indicate more agreement; Stigmatization was measured on the OMS-HC total score and subscales ranging from 1 to 5 including all three subscales

0.002) and the professional background: Social worker and other therapists had significantly lower scores ($M = 2.11$, $SD = 0.61$) than psychiatrists and psychologists ($M = 2.58$, $SD = 0.69$, $p = 0.022$) and nurses ($M = 2.50$, $SD = 0.56$, $p = 0.015$). Gender and ward setting (mostly open or closed) were not significantly related to stigmatization in this sample. Table 3 shows the results of the regression analysis. Controlled for personal variables, better recovery attitudes were significantly associated with lower stigmatization in mental healthcare providers.

Discussion

The adoption of positive attitudes and hopefulness towards recovery from mental illness is proposed as a main ingredient of effective anti-stigma efforts [7]. However, in the mental healthcare setting, supporters and inhibitors of stigmatization are less frequently studied [3]. With this study, to the best of our knowledge, we were the first researchers to examine the relationship between improved recovery attitudes and stigmatization among mental healthcare professionals working on acute and semi-acute wards of a large psychiatric hospital. Our results support previous findings indicating that recovery-based training can enhance recovery attitudes. Furthermore, we could show that more optimistic recovery attitudes were associated with less stigmatization towards people with mental illness.

Overall, most participants (79.1%) were familiar with the concept of recovery, thus reflecting its currency in the psychiatric field. Forty participants (36.4%) had participated in the multi-professional recovery training. One year later, almost all of them, and significantly more compared to those without the formal training, claimed to know the concept of recovery. This might indicate a positive training effect despite the concept of recovery was widely known. In addition, knowing the concept of recovery was significantly associated with more

Table 3 Health professionals' recovery attitudes predict their stigmatization towards people with mental disorders (n = 110)

	B	SE	beta	p
Intercept	3.76	0.33		p < 0.001
Gender (male = 0, female = 1)	0.05	0.07	0.07	0.447
Age, years (categories 1–5)	0.00	0.03	0.01	0.902
Social workers and other therapists versus psychiatrists, psychologists and nurses	−0.21	0.08	−0.24	0.007
Recovery attitudes	−0.43	0.07	−0.50	p < 0.001
Adjusted R^2		0.28		p < 0.001
F (df)		11.33 (4)		p < 0.001

Recovery attitudes were measured on the RAQ-7 total score ranging from 1 to 5 while higher values indicate more agreement; Stigmatization was measured on the OMS-HC total score ranging from 1 to 5 including all three subscales; R^2 change for recovery attitudes = 24%, $p < 0.001$

optimistic recovery attitudes. The result of our cross-sectional study is in line with previous findings of interventional studies that include recovery training sessions' pre- and post-measurements [12, 13]. However, a closer look revealed that there was only a significant difference in the first RAQ-7 subscale "recovery is possible and needs faith" whereas there was no difference in the second RAQ subscale "recovery is difficult and differs among people". The latter subscale might be less suitable to independent use due to insufficient reliability and ceiling effects [16]. Furthermore, recovery attitudes were not associated with sociodemographic factors - a result that corresponds with a previous study conducted among patients [16]. Aside from more optimistic recovery attitudes, participants who stated they knew the concept of recovery also revealed fewer stigmatizing attitudes towards individuals with mental illness as well as less preference for social distance. However, behavioural intentions related to oneself as assessed by "the willingness to disclose and seek for help" were only affected by personal characteristics such as age and professional background. Social workers possessed less stigmatization in regard to disclosure and help-seeking than did nurses, psychiatrists, and psychologists, which has already been reported in previous studies [17]. Controlling for personal factors, recovery attitudes explained 24% in the variation of stigmatization towards individuals with mental illness among mental healthcare professionals. In contrast, different ward settings accounted for less than 3.5% in the variation, indicating that stigma seems to affect all groups of patients in mental healthcare. Thus, a general change of attitudes towards more recovery orientation seems to be required for stigma reduction in mental healthcare.

The strengths of the current study are the provision of first data of the relationship between recovery attitudes and stigmatization towards individuals with mental illness among mental healthcare professionals, the questioning of different professional groups, and the one-year timespan between the survey and the recovery training session. Due to the cross-sectional study design, we cannot draw causal conclusions. Our results, however, might be a good starting point for further interventional studies to clarify the impact of recovery orientation on reducing stigmatization towards people with mental illness. Another limitation is that the sample may be considered biased due to the low response rate of 36%. In addition, to some extent, it might also be that participants with weaker pre-stigmatizing attitudes were more interested in recovery orientation and were, thus, more likely to either participate in the recovery training or respond more positively. Nevertheless, the sample covered all professional

groups as well as the full range of working experience, thus, reflecting real-life conditions. Despite the mentioned limitations, our results clearly showed that recovery attitudes may be improved through training and are closely linked to stigmatization among mental healthcare professionals. Based on these findings, we conclude that recovery orientation seems to be an additionally important ingredient in the anti-stigma efforts in the mental healthcare setting.

Compliance with Ethical Standards

Ethical Approval All data were collected anonymously, thus, ethical approval from an IRB was not required. Informed consent was given by the participants' replies to the anonymous online-survey.

Conflict of Interest The authors report no conflicts of interest.

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