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The impact of recovery-oriented day clinic treatment on internalized stigma: Preliminary report

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ABSTRACT

Internalized stigma is a complicating feature in the treatment of schizophrenia spectrum disorders and considerably hinders the recovery process. The empowerment and recovery-oriented program of our day clinic might contribute to a reduction in internalized stigma. The aim of the study was to explore the influence of this day clinic program on internalized stigma and other subjectively important outcome measures such as quality of life and psychopathology. Data from two groups of patients had been collected twice, at baseline and after 5 weeks. The experimental group attended the day clinic treatment ($N=40$) and the control group waited for the day clinic treatment ($N=40$). The following significant differences between the two groups were found: Patients in day clinic treatment showed a reduction in internalized stigma while the control group showed a minimal increase (Cohen's $d=0.446$). The experimental group as compared with the control group also showed a greater improvement in the quality of life domain psychological health (Cohen's $d=0.6$) and in overall psychopathology (Cohen's $d=0.452$). Interestingly, changes in internalized stigma and psychological quality of life were not associated with changes in psychopathology. Results are encouraging but have to be confirmed in a randomized design.

1. Introduction

Stigmatizing attitudes associated with mental illness and toward people diagnosed with a schizophrenia spectrum disorder in particular continue to persist despite public anti-stigma-campaigns and improvements in psychopharmacological and psychosocial therapies (Angermeyer and Matschinger, 2005; Thornicroft, 2006; Schulze, 2007; Gaebel et al., 2008; Norman et al., 2008; Pescosolido et al., 2010). People with a diagnosis of a schizophrenia spectrum disorder are widely considered by both lay and professional people to be incomprehensible, unreliable, unpredictable, unreasonable, incompetent and dangerous, and their condition is often regarded as untreatable and incurable (Crisp et al., 2000; Stuart and Arboleda-Florez, 2001; Angermeyer and Matschinger, 2004; Klin and Lemish, 2008). A detrimental consequence of such beliefs for people identified as mentally ill is the internalization of stigma. That is, the inner subjective experience of stigma resulting from applying negative stereotypes and stigmatizing attitudes to oneself (Ritsher et al., 2003). Internalized stigma may contribute to self-devaluation, shame, secrecy and social withdrawal. It makes it difficult to overcome existing barriers to enter and sustain positive relationships, employment and housing (Stuart, 2008; Yanos et al., 2010). Internalized stigma may impact negatively on quality of life (Vauth et al., 2007; Norman et al., 2011; Sibitz et al., 2011b), lead to hospitalization (Rüsch et al., 2009), contribute to poor adherence to treatment (Fung et al., 2008; Tsang et al., 2009) and hinder the recovery process (Ritsher and Phelan, 2004; Amering and Schmolke, 2009; Munoz et al., 2011).

Counteracting internalized stigma and promoting a positive self-image are essential therapeutic goals. Day clinic treatment has shown to be effective in reducing psychiatric symptoms (Oka et al., 1999; Cichocki, 2008; Handa et al., 2009) and readmission rates (Yoshimasu et al., 2002), and can lead to improved quality of life (Handa et al., 2009). It might also contribute to a reduction in internalized stigma, especially if the program is orientated toward recovery and empowerment. The day clinic program at the Medical University of Vienna, Department of Psychiatry and Psychotherapy focuses on people's strengths and promotes self-

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awareness, self-efficacy, self-esteem, choice, autonomy, hope and recovery. The intent is to counteract self-devaluation and to advance the idea that people with mental illness can lead meaningful and satisfying lives with or without the persistence of psychiatric symptoms, and thereby reduce internalized stigma. The program also emphasizes the development of social skills and the management of stigma in social situations. The philosophy of the program is congruent with recovery practices and principles such as promoting partnerships with patients, emphasizing patients' choice, focusing on patients strengths and instilling hope (Farkas et al., 2005; Salyers et al., 2007; Amering and Schmolke, 2009). However, the impact of this kind of day clinic treatment on internalized stigma has not been studied. This study examines the effect of recovery-oriented day clinic treatment on internalized stigma and other subjectively important outcome measures such as quality of life and psychopathology over a period of 5 weeks.

2. Methods

2.1. Study design

An exploratory pilot study comparing day clinic patients with waiting list controls was conducted. The study hypothesis was that the intensive, recovery-oriented day clinic program would contribute to a reduction in internalized stigma. In addition, we expected a positive effect of the program on quality of life and psychiatric symptoms. The protocol and consent form were approved by the Ethics Committee of the Medical University of Vienna. Participants were recruited once a week at the specialized outpatient clinic for integrative treatment of psychosis of the Department of Psychiatry and Psychotherapy of the Medical University of Vienna. Consecutive patients with a referral to the recovery-oriented day clinic program were screened by a clinical psychiatrist for possible study participation. Inclusion criteria included being aged between 18 and 65 years with a diagnosis of an ICD-10 schizophrenia spectrum disorder, and being motivated to attend the day clinic. Exclusion criteria included not being proficient in German or being unable to provide informed consent. Those meeting study inclusion criteria were approached by the researchers (K.P. and M.L.). After detailed explanation of the study, participants provided written informed consent for participation in the study.

Participants were allocated to one of the two groups, the day clinic group (the experimental group) or the waiting list group (the control group). Allocation to groups depended on the expected waiting period until the next possible start of the day clinic treatment. The mean waiting time until day clinic treatment is about 5 weeks. If the start of the day clinic treatment was possible within the next 5 weeks, participants were allocated to the day clinic group. Otherwise they were allocated to the waiting list control group.

Data were collected at baseline (at the beginning of day clinic treatment or the waiting list period) and again after 5 weeks. This short follow-up period was chosen because the mean waiting time until day clinic treatment is 5 weeks. Thus, with a follow-up period of 5 weeks many patients could be included without artificially extending the waiting time in the control group. Two researchers who were not part of the clinical team (K.P. and M.L.) but who were not blind to group assignment carried out the assessments.

2.2. Day clinic program

The day clinic at the Department of Psychiatry and Psychotherapy of the Medical University of Vienna routinely offers patients with a diagnosis of a schizophrenia spectrum disorder the opportunity to participate in a recovery-oriented treatment program over a period of 2 months. A group of nine patients starts and ends the program together. Patients attend groups and activities from 8:00 am until 3:30 pm, Monday to Friday, following a structured weekly schedule. The therapeutic program comprises the full spectrum of therapeutic interventions. Therapies are offered by a multidisciplinary team (psychiatrist, nurse, psychotherapist, occupational therapist, physiotherapist, social worker, psychologist, and nutritionist) and most are performed in groups e.g. psychoeducation, daily living skills and social skills training, physiotherapy, cognitive training, and occupational therapy. In addition, individualized therapy sessions are provided by psychiatrists, psychotherapists, nurses and social worker offering a range of psychopharmacological and psychosocial interventions as appropriate. Relatives' groups take place monthly and individual family interventions are conducted as needed. Group sessions follow an empowerment and recovery-oriented psychoeducational approach. The content and process is based on the manual "Knowing–enjoying–living better. A seminar for people with experience in psychosis" (Amering et al., 2002) and covers illness as well as quality of life related topics. The four illness-related topics are "concept of illness", "symptoms and early warning signs", "medication" and "prejudices and discrimination". The four quality of life related topics are "well-being", "healthy diet and fitness", "cultivating friendships" and "active daily life organization". Group work is conducted following the principle of "Theme Centered Interaction (TCI)" (Richards et al., 1990) and participants are instructed to discover their own knowledge, a technique called "Guided Discovery"(Mayer, 2004). Professional knowledge is conveyed by facilitators and via written material (flip-charts and handouts). For instance within the sessions covering "prejudices and discrimination" participants discuss and are provided handouts about (1) the empirical correction of myths about schizophrenia, (2) the problem of concealing the diagnosis or being open about it and (3) examples of consumer experiences with prejudices and how to confront them. General and individual strategies to confront prejudices, to deal with discrimination and to counteract internalized stigma are developed, e.g. establishing contact with self-help and trialogue groups (Amering et al., 2012) and developing stigma resistance (Sibitz et al., 2011a). Evaluation of this program among outpatients demonstrated positive effects on knowledge, empowerment, attitudes towards medication and overall quality of life (Sibitz et al., 2007a). Results from a qualitative study also indicated a positive impact on internalized stigma (Sibitz et al., 2007b).

Another important aspect which might be effective against internalized stigma relates to the attitude and mindset of the members of the multidisciplinary therapeutic team. Regular supervision and continuing education about empowerment and recovery in mental health including the consumer perspective help professionals to convey a belief that people can get better, that recovery is possible and to act as "holders of hope" in times of crisis (Glove, 2002). The belief in patients' potential for development and growth, a focus on their strengths and capacities and encouragement in activities that challenge them to develop and gain confidence help to empower individuals and facilitate self-efficacy and self-acceptance. The therapeutic relationships are non-hierarchical, partner-like and respectful, and convey an appreciation of the experiences and views of participants. Participants are encouraged to identify and explore individually helpful therapies and activities. This therapeutic approach with an emphasis on patients' autonomy and empowerment contributes to self-acceptance and fosters a hopeful attitude. Experiencing oneself as a capable individual, whose experience and viewpoints are valued by others is likely to counteract internalized stigma and promote well-being and recovery.

2.3. Waiting list control group

Participants in the waiting list control group continued to receive their usual mental health services (treatment as usual). All participants received medication and saw their psychiatrist at least once during the waiting time. Other therapies (e.g. psychotherapy, case management and occupational therapy) were used by less than 50% of the participants. These therapies may also contribute to empowerment and recovery, but were not administered regularly and systematically. Almost all waiting list participants received less than 2 h of professional contact per week.

2.4. Measures

Demographic and clinical variables including age, gender, education, work situation, housing, social network, age of onset of mental illness, age at the first hospitalization and number of hospitalizations were recorded on the initial self-report questionnaire.

At baseline and 5 weeks later patients were interviewed by trained researchers using the Positive and Negative Syndrome Scale (PANSS) to assess psychopathology. The PANSS is a 30-item scale that uses a seven-point Likert scale to evaluate current severity level on each symptom in patients with psychosis. The PANSS has subscales for positive symptoms (seven items), negative symptoms (seven items) and general pathology (16 items). The PANSS has demonstrated high internal reliability and good construct validity both in its English (Kay et al., 1987) and German version (Müller et al., 1998).

In addition, the following self-report questionnaires were administered at baseline and at 5 week follow-up:

(a) The Internalized Stigma of Mental Illness (ISMI) scale, developed by Ritsher et al. (2003) in collaboration with people with the experience of mental illnesses, is a 29-item instrument for self-rated assessment of the subjective experience of stigma. The ISMI consists of five subscales: alienation (e.g. "I feel out of place in the world because I have a mental illness"), stereotype endorsement (e.g. "Mentally ill people tend to be violent"), discrimination experience (e.g. "People discriminate against me because I have a mental illness"), social withdrawal (e.g. "I avoid getting close to people who don't have a mental illness to avoid rejection") and stigma resistance (e.g. "I can have a good, fulfilling life, despite my mental illness"). Each item is rated on a