



Therapeutic alliance in schizophrenia: The role of recovery orientation, self-stigma, and insight



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ABSTRACT

The present study examined variables related to the quality of the therapeutic alliance in out-patients with schizophrenia. We expected recovery orientation and insight to be positively, and self-stigma to be negatively associated with a good therapeutic alliance. We expected these associations to be independent from age, clinical symptoms (i.e. positive and negative symptoms, depression), and more general aspects of relationship building like avoidant attachment style and the duration of treatment by the current therapist. The study included 156 participants with DSM-IV diagnoses of schizophrenia or schizoaffective disorder in the maintenance phase of treatment. Therapeutic alliance, recovery orientation, self-stigma, insight, adult attachment style, and depression were assessed by self-report. Symptoms were rated by interviewers. Hierarchical multiple regressions revealed that more recovery orientation, less self-stigma, and more insight independently were associated with a better quality of the therapeutic alliance. Clinical symptoms, adult attachment style, age, and the duration of treatment by current therapist were unrelated to the quality of the therapeutic alliance. Low recovery orientation and increased self-stigma might undermine the therapeutic alliance in schizophrenia beyond the detrimental effect of poor insight. Therefore in clinical settings, besides enhancing insight, recovery orientation, and self-stigma should be addressed.

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1. Introduction

Therapeutic alliance is defined as the affective and collaborative bond existing between a therapist and his patient (Svensson and Hansson, 1999). It has also been referred to as the therapeutic bond, working alliance or helping alliance. The theoretical definitions of the alliance have three elements in common: (1) the collaborative nature of relationship, (2) the affective bond between patient and therapist, and (3) the patient's and therapist's ability to agree on treatment goals and tasks (Bordin, 1979). The quality of the therapeutic alliance is a key predictor of adherence (Lecomte et al., 2008) and was also found to be associated with higher psychosocial functioning, reduced symptom severity and better quality of life (Frank and Gunderson, 1990; Gehrs and Goering, 1994; Svensson and Hansson, 1999). Because of the consistent association between therapeutic alliance and service engagement it is important to identify variables that predict a good therapeutic alliance (Gibbons et al., 2003). But building a strong therapeutic alliance in schizophrenia may be a challenging endeavor due to the nature of the clinical presentation of the illness (Frank and

Gunderson, 1990; Evans-Jones et al., 2009). For example, patients may distrust or hold delusional beliefs about their therapist, and therapists may find it difficult to empathize with patients' unusual experience (Evans-Jones et al., 2009). Given these difficulties it is important to understand factors which improve or undermine building therapeutic alliance.

Because agreement between therapist and patient on treatment goals was found to be important for the development of a strong therapeutic alliance (Martin et al., 2000; Webb et al., 2011) variables undermining goal orientation of the patient may be important to address. Besides impeding effects of depression (Webb et al., 2011) and negative symptoms (Lysaker et al., 2011) on goal orientation of the patients also self-stigma was identified to undermine goal orientation in therapy as well (Corrigan et al., 2009). In contrast, motivational aspects like a strong recovery orientation were identified to facilitate goal orientation in therapy (Waldheter et al., 2008; Corrigan et al., 2004a).

Self-stigmatizing means applying negative stereotypes of mental illness to oneself (Corrigan and Watson, 2002) and it is followed by feelings of shame and by coping strategies like secrecy and withdrawal (Rüşch et al., 2006; Vauth et al., 2007). Further, self-stigma undermines help seeking behavior (Vogel et al., 2006), adherence to psychosocial treatment (Livingston and Boyd, 2010), more generally social relationships (Yanos et al., 2008), and is a risk factor for

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psychiatric hospitalization (Rüsch et al., 2009). Because continuing feelings of unworthiness and incompetency were found to be associated with self-stigma as well as a demoralization in engagement in therapy (the 'why try'-effect; Corrigan et al., 2009), all these consequences underline that self-stigma may undermine engagement in therapy (Livingston and Boyd, 2010) and the building of a strong therapeutic alliance in schizophrenia, respectively.

Recovery as a motivational process (for a review see Cavelti et al., 2011) may promote engagement in therapeutic alliance as it is supposed to facilitate the patients' striving for the attainment of individual life goals by successful therapy. Recovery orientation refers to regaining a self-determined and meaningful life in spite of mental illness. It might be achieved by finding hope that important life goals can be attained, re-establishing a positive identity, developing meaning in life, taking control of one's life through individual responsibility, spirituality, empowerment, and having supporting relationships (Chiu et al., 2009).

Variables already found to be associated with quality of therapeutic alliance in individuals with schizophrenia and other forms of severe mental illness (SMI) were patient-related factors including older age (Draine and Solomon, 1996), avoidant attachment style (Dozier et al., 2001; Berry et al., 2008; Kvrđic et al., 2011) and more prior service contact (Klinkenberg et al., 1998) as well as illness-related factors like less severe symptoms (Frank and Gunderson, 1990; McCabe and Priebe, 2003; Lysaker et al., 2011) or higher insight into illness (Johnson et al., 2008; Wittorf et al., 2009; Barrowclough et al., 2010). Actually, insight in patients with schizophrenia is the only variable which consistently was associated with patient-rated therapeutic alliance in most studies (Dunn et al., 2006; Wittorf et al., 2009; Barrowclough et al., 2010; Lysaker et al., 2011). Insight is a multidimensional construct and it is defined as the awareness of having a mental disorder, of specific symptoms, and their attribution to the disorder, the awareness of social consequences and of need for treatment (Mintz et al., 2003). Low insight was also found to be linked to difficulties to form sustaining bonds with others (Lysaker et al., 1998; Francis and Penn, 2001). Low levels of insight are a risk factor for nonadherence to treatment, which is associated with poor clinical outcome (Lincoln et al., 2007), but on the other hand, high levels of insight have been linked to depression, hopelessness, suicidal tendency as well as to lowered self-esteem (Drake et al., 2004; Hasson-Ohayon et al., 2009; Restifo et al., 2009). Self-stigma as a moderating variable can be decisive whether more insight leads to better or worse outcome. On the other hand, self-stigma can act as a mediator between insight and outcomes (Lysaker et al., 2007; Staring et al., 2009; Cavelti et al., 2012). Finally, insight is suggested to be positively associated with recovery orientation (Mohamed et al., 2009).

Based on these studies, we expected lower self-stigma and higher recovery orientation to uniquely contribute to the variance of better quality of therapeutic alliance above and beyond of possible confounding variables such as younger age, clinical symptoms, avoidant attachment style, and duration of treatment by the current therapist. Second, because of the consistent findings of an association of insight and therapeutic alliance, we hypothesize that insight contributes additional explanatory power to the model of therapeutic alliance, independently from recovery orientation and self-stigma.

2. Methods

2.1. Participants and procedure

The recruitment took place in Community Mental Health Centers (CHMC) in the region of Basel, Switzerland, between February 2009 and March 2010. Patients between 18 years and 65 years of age and diagnosed with schizophrenia or schizoaffective disorder in the maintenance phase of their treatment (i.e. defined as an absence of an acute psychotic episode including a first episode of

schizophrenia and no change of medication in the last 6 weeks) were asked for study participation. Diagnoses were confirmed by the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders-IV Axis I Disorders (Wittchen et al., 1997). After the procedure was fully explained, written informed consent was obtained from all participants. Patients were informed that their therapists were blind to their answers. Exclusion criteria were a primary diagnosis of alcohol or substance dependency, an organic syndrome or a learning disability, inadequate command of German to engage in therapy with a German-speaking therapist, and/or unstable residential arrangements. The information of the exclusion criteria were obtained from prior reports and prior interviews with the therapists. For all interviewer-based rating scales, three research psychologists (MA), who were blind to the results of self-ratings and the assessments of the attending clinicians, were previously trained until a concordance of Cohen's kappa=0.80 was achieved (Shrout and Fleiss, 1979). Participants received a financial compensation of 40CHF (approximately 42 USD) in order to minimize selection bias by a high refuser rate. Therapists were psychiatric trained nurses, psychiatrists, and psychologists. To be able to suggest a more stable state of the therapeutic relationship only patient-therapist pairs were included, which have worked together more than 3 months or a longer time. The study was approved by the local ethics committee.

2.2. Treatment

Treatment was not standardized but leaned on the suggestions of Dickerson and Lehman's (2011) supportive therapy. According to these authors, supportive counseling in our clinical units includes providing reassurance, offering explanations and clarification, and giving advices and suggestions. Treatment was done within a multiprofessional team of in problem solving and behavioral skills training trained nurses, social workers, psychiatrists and psychologists, depending on changing treatment needs in the course of illness. The therapists focus on current problems in everyday life functioning and persistent symptoms, assessed pharmacological needs and concerns raised by having a persistent schizophrenia or schizoaffective disorder. The mean case load of therapists was about 40 patients.

2.3. Measurements

All measures employed have shown to be valid and reliable in samples of patients with schizophrenia or other severe mental illnesses in prior studies (Kay et al., 1987; Birchwood et al., 1994; Hall, 1995; Beck et al., 1996; Corrigan et al., 1999; Corrigan et al., 2006; McGuire-Snieckus et al., 2007; Kvrđic et al., 2011). Measures were applied once during the ongoing therapy.

Therapeutic alliance was measured using the German version of the Scale to Assess the Therapeutic Relationship-Patients Version (STAR-P; McGuire-Snieckus et al., 2007). The STAR is based on the pantheoretical model of therapeutic alliance (Catty et al., 2007) and it is a self-rating instrument with 12 items comprising three subscales: Positive Collaboration, Positive Clinician Input, and Non-Supportive Clinician Input. Items were rated on a 5-point Likert scale, with 0='never' to 4='always'. Before scoring, scores for the Non-Supportive Clinician Input subscale were reversed. A total score can be obtained by summing up the relevant subscale scores. Higher scores denote a better alliance. In the current study Cronbach's alpha for the total score was 0.71. We only applied the patients' version of STAR, as a higher predictive impact on therapy outcome was demonstrated for patient rated alliance than it was shown for therapist rated alliance in people with schizophrenia (Horvath and Symonds, 1991; Bentall et al., 2002).

Recovery orientation was assessed with the Recovery Assessment Scale (RAS; Corrigan et al., 1999) which is a self-rating 5-point Likert scale with response categories from 1='strongly disagree' to 5='strongly agree'. A factor analysis resulted in five factors, namely Personal Confidence, Willingness to Ask for Help, Goal and Success Orientation, Reliance on Others, and Not Dominated by Symptoms totaling 24 items (Corrigan et al., 2004b). A total score can be calculated by summing up all items. In the present study, Cronbach's alpha was=0.78.

We measured *self-stigma* using the 10-item Self-Esteem Decrement Due to Self-Stigma subscale of Corrigan's Self-stigma in Mental Illness Scale (Corrigan et al., 2006; Rüsch et al., 2006). The measure included statements such as 'I currently respect myself less because I cannot be trusted' and 'I currently respect myself less because I am unpredictable'. Research participants were asked to respond to each item using a 9-point agreement scale (9='strongly agree'). In the current study, Cronbach's alpha for the Self-Esteem Decrement Due to Self-Stigma subscale was 0.84.

Insight was measured with the 8-item Birchwood Insight Scale (BIS; Birchwood et al., 1994), including the subscales Perceived Need for Treatment, Awareness of Illness, and Relabeling of Symptoms as Pathological. Items are rated from 0='not right' to 2='right', higher sum scores indicating more insight. Cronbach's alpha for the total score was 0.60.

Positive and negative symptoms were assessed by the Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987), a semi-structured interview composed by 30 items, which assesses positive symptoms, negative symptoms, and general psychopathology. High scores indicate high levels of symptoms. In the present

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