Predictors of mental health care stigma and its association with the therapeutic alliance during the initial intake session

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Predictors of mental health care stigma and its association with the therapeutic alliance during the initial intake session

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Abstract
Objective: We investigated the association between socio-demographic and clinical variables with mental health care stigma, and the impact of the latter on the quality of the therapeutic alliance measured at intake. Method: Consecutive clients (N = 236) filled questionnaires upon accessing services for a new episode of care. Immediately following the intake, a randomly selected sample of clients and their corresponding therapists (n = 102) completed the Working Alliance Inventory – Bond Scale. Results: Lower mean years of education and higher emotional distress (both partial r = .17) were significantly associated with higher stigma. Higher care stigma negatively correlated with therapists’ ratings of the therapeutic alliance during the intake (partial r = -.22), but not with those of clients. Conclusions: Care stigma is present among service-users and may affect outcomes of the intake.

Keywords: intake; mental health; stigma; working alliance; access to care

Introduction
Treatment gap (i.e., the proportion of individuals with a diagnosable mental disorder who do not receive treatment) remains large, despite the existence of effective interventions (National Institute of Health and Clinical Excellence (NICE), 2012; World Health Organization, 2012). Approximately two-thirds of people with psychiatric disorders never seek care (Kohn, Saxena, Levav, & Saraceno, 2004; Wang, Aguilar-Gaxiola, et al., 2007; Wang, Angermeyer, et al., 2007) and many others who begin treatment fail to pursue it as prescribed (Collins, Westra, Dozois, & Burns, 2004). Similarly, the treatment lag (i.e., time from onset of disorder to treatment) is wide (Levinson, Lerner, Zilber, Grinspoon, & Levav, 2007; Nakash et al., ahead of print).

Stigma, which refers to severe social disapproval of personal characteristics, beliefs or behaviors that are perceived to be deviant from cultural norms (Hinshaw & Stier, 2008), has been cited as a primary subjective barrier with regard to care (Andrews, 2005; Corrigan, 2004). It may delay or impede consultation, hinder the course of treatment and it may interfere with rehabilitation and social inclusion (Angermeyer & Matschinger, 2003; Corrigan, 2004; Hinshaw & Stier, 2008; Institute of Medicine, 2002; Lasalvia et al., 2012; Tal, Roe, & Corrigan, 2007; Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009). Importantly as well, stigma has the potential for internalization of the degraded status by those who are stigmatized—i.e., self-stigma (Brohan, Elgie, Sartorius, & Thornicroft, 2010; Corrigan, Watson, & Barr, 2006; Lysaker, Tsai, Yanos, & Roe, 2008; Struch et al., 2008). The World Health Organization referred to stigma as the hidden burden of mental disorders (World Health Organization, 2001) whilst the US Surgeon General (1999) documented it as an obstacle to the receipt of care (US Surgeon General, 1999). Most research to date has focused on the effect of stigma on access to care among community respondents. Little is known about the effect of stigma on the course of therapy, particularly during the initial phases of treatment. In the current study we investigated the effect of mental health care stigma on the quality of the therapeutic alliance among clients during the intake sessions in...
public mental health clinics that offer services to a diverse adult population.

Stigma can target different mental health issues such as the individuals with mental health disorders (i.e., public stigma) or the mental health services (i.e., stigma towards mental health care) (Corrigan, 2004). Research that examined the socio-demographic variables that are associated with public stigma primarily in community studies in the US documented that younger age (Mojtabai, 2007; Ojeda & Bergstresser, 2008), male gender (Mojtabai, 2007), fewer mean years of formal education, lower socio-economic status (Golberstein, Eisenberg, & Gollust, 2008), and more observant religious background (Eisenberg, Downs, Golberstein, & Zivin, 2009) were associated with increased public stigma. Some research also documented that immigrant status, though representing diverse cultural groups, was associated with increased public stigma among community residents (Eisenberg et al., 2009).

Stigma associated with mental health care arises from the perception that a person who seeks it is undesirable or socially unacceptable (Vogel, Wade, & Haake, 2006). In a telephone survey conducted among 1000 randomly selected adults in the USA, the American Psychological Association documented that 20% of Americans chose not to seek help from a mental health professional because of the stigma associated with therapy, while 30% said they would be concerned should other people would know they sought treatment (Buetler, 2007). Another community-based study in the USA found that one in four individuals who perceived a need for help did not seek services, in part due to concerns about what others might think (Kessler et al., 2001).

Research on care stigma among clients with regard to treatment is scanty (Corrigan, 2004; Wahl, 1999). In this study we examined stigma among clients entering a new episode of care and its association with socio-demographic and clinical variables (i.e., psychopathology, treatment history). The higher dropout from treatment particularly following intake (Collins et al., 2004; Reneses, Muñoz, & López-Ibor, 2009; Samstag, Batchelder, Muran, Safran, & Winston, 1998) justifies further exploration. Although the factors associated with premature termination from treatment are still largely unknown, approximately 70% of those who drop out of treatment do that after the intake visit (Olfson, Mojtabai, Sampson, Hwang, & Kessler, 2009).

Intake is often the first point of contact between clients and their therapists. Providers’ observations during intake directly impact clients’ treatment retention (Samstag et al., 1998) and guide therapists’ decisions regarding treatment planning and strategies to facilitate the establishment of therapeutic alliance (Nakash, Dargouth, Oddo, Gao, & Alegria, 2009; Nakash, Rosen, & Alegria, 2009; Rosen, Miller, Nakash, Halperin, & Alegria, 2012). The quality of the therapeutic alliance is the single best predictor of positive clinical outcomes of psychotherapy (Horvath, 2001; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Zuroff & Blatt, 2006). Recent research suggests that therapists tend to use implicit processes that are primarily based on non-verbal cues and affective communication in appraising the quality of working alliance with their clients (Nakash & Alegria, 2013). Therefore, understanding the role stigma may play in this process is vital to improve therapists’ ability to establish the alliance that would support the initial exploration of painful issues.

Objectives

To investigate: (i) the association between stigma towards mental health care and socio-demographic (i.e., age, gender, religiosity, country of birth) and clinical variables (i.e., emotional distress, treatment history) among clients upon accessing care in public mental health clinics; and (ii) the effect of the clients’ stigma towards mental health care on the therapists’ and clients’ appraisals of the quality of the therapeutic alliance immediately following the intake session.

Methods

Settings

All four participating public mental health clinics offer free services to an ethnically and socio-economically diverse adult client population. Access to care does not necessitate medical referral (Levav & Grinshpoon, 2004). The primary goal of the intake session at all participating clinics was to gather information about the presenting problem and psycho-social history of the client to inform diagnosis and treatment plan. None of the participating clinics used a structured intake protocol. At each of the clinics, clients were consecutively allocated to therapists. Thirty-seven therapists participated in the study, 86.1% of whom were females. Mean age of providers was 45 years (SD = 10.8). Two-thirds of them, 66.7%, were licensed staff clinicians and 33.3% were trainees. Mean years of clinical experience was 14.3 (SD = 11.0). Participating therapists had diverse disciplinary background: 47.2% were social workers, 36.1% psychologists and 16.7% psychiatrists.
Sample and Procedure

Clients (N = 236), who presented consecutively for a first-ever or a repeated new episode of care in four adult outpatient clinics in two large Israeli cities (June 2011–April 2012), completed questionnaires in their native language (Hebrew or Russian) upon contacting the clinic. The questionnaires included measures of stigma towards mental health care, emotional distress, demographic information, and treatment history (see below). Immediately following intake, which was conducted 7–10 days following the initial contact with the clinic, a randomly selected sample of the clients (n = 118, 50% of the original sample) was invited to participate in the second part of the study, which included a completion of the Working Alliance Inventory – Bond Scale, client long version (Horvath & Greenberg, 1989), while their corresponding therapists (N = 37) completed the respective version of the measure. In addition, clients and therapists completed the short versions of the Working Alliance Inventory – Goal and Task Scales. Eight clients, declined participation; six cancelled their intake session; and two clients did not show for their intake session. One hundred and two clients (43% of original sample) participated in the second stage of the study.

The study was approved by the Institutional Ethics Committee, and data collection was in compliance with human subject protocols at all participating clinics.

Measures

Demographic and treatment history. The questionnaire included information on age, gender, years of formal education, country of birth, self-defined level of religiosity (secular, traditional, religious) and previous mental health treatment. Therapists’ demographic questionnaire included age, gender, professional background and experience.

The General Health Questionnaire (GHQ-12) (Goldberg, 1972). This 12-item scale is a well-documented screening measure for common psychiatric disorders and assesses symptoms in the last month. It has been subject of tests in many countries (Kessler & Ustun, 2008), including Israel (Levav et al., 2007). Items are rated on a 4-point Likert scale. Final score was computed as the summary for all items, where higher scores indicate increased emotional distress. The overall internal consistency reliability for the scale was good (Cronbach’s α = .88).

Stigma towards mental health care. This is a nine-item modified version (Struch et al., 2007) of the commonly used Orientations to Seeking Professional Help Scale (Fischer & Turner, 1970). The specific items employed were selected from two studies which validated the modified version of the measure for Israeli participants (Struch et al., 2007, 2008). Items included statements about explicit willingness to seek mental health treatment (e.g., “I will feel uncomfortable going to mental health treatment because of what people would think of me”), attitudes toward mental health treatment (e.g., “I would prefer to turn to a friend than to mental health treatment, even for an emotional problem”), and perception of the benefits of treatment (e.g., “someone who has a healthy logic does not need mental health treatment”). Participants were asked to rate the degree to which they thought that the statement is true or false on a 5-point scale, ranging from very true (5) to not true at all (1). Final score included mean score for all items. The internal consistency of the scale was good (Cronbach’s α = .76)

Working Alliance Inventory – Bond Scale (WAI-Bond Scale therapist and client versions) (Horvath & Greenberg, 1989). This 12-item self-report scale is part of the Working Alliance Inventory, a measure that has been widely used in studies on therapeutic outcomes in many countries, including Israel (Shelef, Diamond, Diamond, & Liddle, 2005), to assess therapeutic alliance in treatment and during a single therapy session. The measure has corresponding versions for clients and therapists and both versions have shown good reliability and validity (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Of the three original scales we used the Bond Scale, since it was the most relevant for our purpose. This scale contains items relating to trust, empathy and other constructs that contribute to the therapeutic bond (e.g., “[name of therapist/client] and I trust each other,” “I believe [name of therapist/client] likes me”). Each item is rated on 7-point Likert scale. Final score included mean score for all items, with higher score reflecting better therapeutic alliance. Internal consistency for therapist and client Bond scale was good (Cronbach’s α = .84 and .71, respectively).

Statistical Analysis

Analyses were performed using the SPSS version 20.0 (SPSS Inc., Chicago, IL). Hierarchical linear regression was computed to examine the contribution of clinical variables above the effects of socio-demographic variables on stigma. Stigma was
entered as the dependent variable, while independent variables included socio-demographic variables (gender, age, years of education, religiosity, and country of birth) in the first block, and clinical variables (emotional distress, mental health treatment history) in the second block.

Two multiple linear regression analyses were computed to examine the effect of mental health care stigma on the therapeutic alliance while adjusting for clients’ socio-demographic confounders. Working Alliance Inventory – Bond Scale for therapists or clients was entered as the dependent variable, while independent variables included clients’ gender, age, years of education, religiosity, and mental health care stigma.

Results

Socio-Demographic and Clinical Characteristics of the Sample

The majority of the 236 consecutive clients who participated in the first part of the study were Israel-born Jewish secular females (Table I). The 102 clients who participated in the second part of the study did not significantly differ from those who did not participate (n = 134) on any of the socio-demographic variables except for gender (Table I). Similarly, there were no significant differences in the report of emotional distress and history of mental health treatment between these two sub-samples (Table I).

Variables Associated with Stigma towards Mental Health Care

Participants’ mean level of stigma was at the midpoint of the scale (M = 2.4, SD = .8). No significant differences in care stigma were observed between the clients who participated in the second part of the study and those who did not (Table I), or between clients who returned to care and novel clients (M = 2.4, SD = .8; M = 2.5, SD = .9, respectively, t(236) = .96, n.s.).

The hierarchical linear regression analysis using stigma as the outcome measure and socio-demographic variables in the first block and clinical variables in the second block as predictors was significant, predicting 10% of the variance. Mean years of formal education was significantly and inversely related to stigma (partial r = −.17, p < .05). Higher emotional distress was associated with increased stigma (partial r = .17, p < .01; see Table II).

The Effect of Clients’ Stigma on Appraisal of the Quality of the Therapeutic Alliance

Multiple linear regression analysis using therapists’ Working Alliance Inventory – Bond Scale as the outcome measure, and clients’ gender, age, years of education, religiosity, and mental health care stigma as predictors was significant, predicting 13% of the variance. Stigma was significantly and inversely related to therapists’ Working Alliance Bond Scale, such that higher reports of stigma towards care were associated with decreased therapists’ Working Alliance Bond Scale mean score (partial r = −.23, p < .05). Of the clients’ demographic characteristics, higher religiosity was negatively associated with decreased therapists’ Working Alliance Bond Scale mean score (partial r = −.26, p = .01; see Table III).

Linear regression analysis using clients’ Working Alliance Bond Scale as the outcome measure, and gender, age, years of education, religiosity and mental health stigma as predictors was not significant F(5, 97) = 1.94, n.s.

Table I. The socio-demographic and clinical characteristics of the samples.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total sample (N = 236)</th>
<th>Subsample in pre-intake stage (n = 134)</th>
<th>Subsample pre- and post-intake stages (n = 102)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td>X²(1) = 4.542, p &lt; .05</td>
</tr>
<tr>
<td>Female</td>
<td>62.6%</td>
<td>56.7%</td>
<td>70.2%</td>
<td></td>
</tr>
<tr>
<td>Age Mean years (SD)</td>
<td>39.9 (14.6)</td>
<td>38.3 (13.4)</td>
<td>41.9 (15.9)</td>
<td>t(234) = −1.833, n.s.</td>
</tr>
<tr>
<td>Years of education, Mean (SD)</td>
<td>13.0 (3.1)</td>
<td>13.3 (3.0)</td>
<td>12.6 (3.1)</td>
<td>t(234) = 1.931, n.s.</td>
</tr>
<tr>
<td>Religiosity</td>
<td></td>
<td></td>
<td></td>
<td>X²(2) = .729, n.s.</td>
</tr>
<tr>
<td>Secular</td>
<td>41.6%</td>
<td>41.8%</td>
<td>41.3%</td>
<td></td>
</tr>
<tr>
<td>Traditional</td>
<td>34.0%</td>
<td>32.1%</td>
<td>36.5%</td>
<td></td>
</tr>
<tr>
<td>Religious</td>
<td>24.4%</td>
<td>26.1%</td>
<td>22.1%</td>
<td></td>
</tr>
<tr>
<td>Nativity</td>
<td></td>
<td></td>
<td></td>
<td>X²(1) = .255, n.s.</td>
</tr>
<tr>
<td>Israel-born</td>
<td>74.6%</td>
<td>76.9%</td>
<td>74.0%</td>
<td></td>
</tr>
<tr>
<td>GHQ, mean (SD)</td>
<td>30.5 (7.8)</td>
<td>29.9 (7.8)</td>
<td>31.2 (7.8)</td>
<td>t(234) = −1.280, n.s.</td>
</tr>
<tr>
<td>Mental health stigma, mean (SD)</td>
<td>2.4 (0.8)</td>
<td>2.4 (0.8)</td>
<td>2.4 (0.7)</td>
<td>t(234) = .147, n.s.</td>
</tr>
<tr>
<td>Mental health treatment history</td>
<td>73.4%</td>
<td>69.4%</td>
<td>78.6%</td>
<td>X²(1) = 2.546, n.s.</td>
</tr>
</tbody>
</table>
Table II. Hierarchical multiple regression analysis examining socio-demographic and clinical predictors of mental health care stigma among clients (N = 236).

<table>
<thead>
<tr>
<th>Model</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>Partial r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td>2.86</td>
<td>.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>−1.18</td>
<td>.11</td>
<td>−11</td>
<td>−11</td>
</tr>
<tr>
<td>Age</td>
<td>.00</td>
<td>.00</td>
<td>.05</td>
<td>.04</td>
</tr>
<tr>
<td>Years of education</td>
<td>−.04</td>
<td>.02</td>
<td>−.17*</td>
<td>−.17</td>
</tr>
<tr>
<td>Religiosity (secular, traditional, religious)</td>
<td>.08</td>
<td>.06</td>
<td>.09</td>
<td>.09</td>
</tr>
<tr>
<td>Israel-born*</td>
<td>.14</td>
<td>.12</td>
<td>.08</td>
<td>.07</td>
</tr>
<tr>
<td>Block 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional distress</td>
<td>.02</td>
<td>.01</td>
<td>.17**</td>
<td>.18</td>
</tr>
<tr>
<td>Mental health treatment history*</td>
<td>.21</td>
<td>.11</td>
<td>.12</td>
<td>.12</td>
</tr>
</tbody>
</table>

Note. $R^2 = .10$, $F(7,228) = 3.59**$.  
*Born in Israel=0, immigrant=1.  
*Past mental health treatment=0, no past mental health treatment=1.  
* $p < .05$; ** $p < .01$.

Discussion

This study investigated the socio-demographic and clinical predictors of stigma towards mental health care among clients upon accessing care and the association of stigma with the appraisal of the therapeutic alliance. Our findings showed that mental health care stigma was present among those who seek treatment. Consistent with other community studies (Golberstein et al., 2008), our findings show that education may serve as a buffer against stigma, possibly through exposure to knowledge about mental health care (Leaf, Bruce, Tischler, & Holzer, 1987). Our findings extend this finding to those who sought treatment.

Furthermore, our findings showed that higher emotional distress was also associated with stigma towards mental health care (Corrigan, 2004; Garg, Sidana, & Chavan, 2011), possibly a consequence of events taking place during the extended treatment lag (Nakash et al., ahead of print), or a proxy of severity of mental health diagnosis (see also Moritz, Schröder, Meyer, & Hauschildt, 2012). Stigma towards mental health care may delay entry into treatment, thus causing further clinical deterioration (Corrigan, 2004).

Notably, our findings show that stigma towards mental health care is associated with more negative therapists’ appraisal of the quality of the therapeutic alliance. Surprisingly, and contrary to our hypotheses, stigma was not associated with clients’ ratings of the therapeutic alliance. This is possibly due to the large proportion of returned clients (approximately 73%) in the sample. Although the high rate of repeated clients is representative of the client population in the public mental health clinics that participated in the study, it may have masked differences that are more characteristic of novel clients.

Our findings may suggest a role for implicit processes that may take place during the clinical interaction and affect the quality of the therapeutic alliance. Recent research showed that therapists tended to use implicit processes when making judgments about the quality of the working alliance and the client’s trustworthiness (Nakash & Alegría, 2013). Therapists tended to integrate the information the client verbally reported and their observations of how he or she reported it in assessing the quality of the rapport with their clients during the intake session. They primarily relied on affective-relational aspects (e.g., affective reaction, tone of voice, eye contact, body posture), rather than on the content of the information reported (see also Hilsenroth & Cromer, 2007; Westen, 1997).

Processing a vast amount of information delivered through multiple communication channels during the intake is challenging. When faced with such challenges, therapists might use cognitive shortcuts that can prove economical under the time pressure. Although it can be time efficient, such shortcuts might rely on assumptions that are not necessarily accurate (Nakash & Alegría, 2013). Our findings may suggest that stigma towards mental health care may play a role in the implicit appraisal of the quality of the therapeutic alliance by therapists. Recent research suggests that clients’ concern about a poor alliance with the therapist, skepticism about psychotherapy, and self-stigma serve as important subjective barriers to access care (Moritz et al., 2012). Future research that includes in-depth interviews with clients following the intake and longitudinal research that will follow the development of the impact of stigma on the therapeutic alliance may shed further light on these findings.

The study has several limitations. First, measuring the emotional bond following the intake session,
though has been practiced in other research in the past (Horvath, 2001), may be limited. It is possible that with the development of treatment and working alliance the effects of stigma may be more accurately measured. Nonetheless, given the importance of the intake session (Nakash et al., 2009) to the progression of treatment it is informative to assess the impact of stigma during this stage of treatment. Second, although there were no significant differences in the socio-demographic characteristics of the randomly selected sample who completed the measures following the intake compared with the initial consecutive client sample (except for gender), it is possible that some selection bias occurred. Third, although we included a consecutive client sample in the current naturalistic study, the relatively high percentage of repeated users may have resulted in a conservative estimation of the effect of stigma on the working alliance. It is plausible that among new users this association would be different. In addition, it is plausible that measuring stigma among repeated users reflects in part actual previous experiences with the care system. Future study that includes only novel clients can shed light on these questions. Future studies should also examine other variables that may be associated with perceived stigma such as personality traits (e.g., self-criticism; Link & Phelan, 2001), as well as investigate the downstream effects of care stigma, and the client’s and therapist’s alliance as well as the discrepancy between them, on therapeutic outcomes such as survival-in-treatment.

Despite the importance of reducing care stigma, the focus of mental health interventions has traditionally been on the person’s psychopathology. More rarely, except for psychosocial rehabilitation programs, therapeutic efforts are geared towards providing relief from the stigma associated with the mental disorder and mental health care. Our findings highlight the importance of continued efforts to rebut the effects of stigma towards mental health care throughout the course of treatment. In clinical practice, attention should be directed to explicit discussion of care stigma and efforts should be directed to reduce it through client education and empowerment.

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