# 5 Stigma and Attitude Towards Personal Recovery from Mental Illness Among Italian Mental Health Professionals

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## 5.1 Introduction

In the area of mental health, "recovery" is characterized by two distinct connotations used to refer to an individual personal "process" and an outcome, particularly following the widespread adoption of "recovery" as a target treatment for people affected by mental illness.

Personal recovery has been defined as "a way of living a satisfying, hopeful, and contributing life even in the presence of limitations caused by illness" [1]. In contrast to *clinical or social recovery*, comprising a reduction or absence of symptoms and a significant improvement in occupational and social functioning, *personal recovery* is a process that individuals go through to live a satisfying life and achieve life goals [2], a process of helping people to live a life "beyond illness"—i.e., to recover a meaningful life, with or without symptoms is the traditional meaning applied to "personal" recovery [3].

Indeed, the recent definition of "personal recovery" [4], *"Recovery is defined by the person themself and not other people's definition of what recovery means,"*

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seems to make it more difficult to scientifically investigate this important construct that has garnered considerable attention over the last two decades. Based on a recent systematic review and meta-analysis of factors associated with personal recovery in people with a psychotic disorder, meaning in life, empowerment, and hope seem to be the main dimensions on which to focus [5].

In Italy, the term "recovery," borrowed from the English language, is present in the everyday language of mental health professionals, and is highly popular in mental health services focused on becoming recovery-oriented. Numerous parallelisms can be identified between the relatively "new," "recovery-orientated" approach and the Italian community psychiatry established by Law 180. Over the last 40 years, following the abolishment of mental hospitals, Italy has seen a progressive consolidation of a community-based system of mental healthcare [6]; indeed, continuity of care provided in the context of the subject's life domain and multi-professional care represent the main approach in the psychiatric care of severe mental disorders in a psychosocial rehabilitation setting [7].

Despite the relevant interregional variability, development of the Individual Treatment Plan (ITP), based on the user's personal goals rather than those imposed by professionals, represents an important step not only from a clinical perspective, but also at a social and functional level in terms of quality of life, care needs, and user satisfaction for the treatments received, in what could be defined as "the recovery process."

Although not particularly frequent in Italy, qualitative research, innovative experiences of peer support, accounts from a "first-person" and "evidence-based hope" perspective have contributed to the understanding of the paradigm of recovery in severe mental illness [8–10].

In an Italian context, further impetus to the recovery process was provided by multicentric research involving several Mental Health Services that confirmed the validity of the Italian version of the Recovery Assessment Scale (RAS) [11], an instrument developed to detect recovery among users [12]. This Italian Study on Recovery demonstrated the ability of RAS to identify users matching the "in recovery" operational criteria and offered an outcome measure on which to base a recovery-oriented transformation [12, 13].

Our work will examine the "state of the art" of barriers and orientation relating to the recovery principles of mental health professionals in an Italian context. In particular, a lack of theoretical clarity over the practical provision of support recovery hampers the implementation of policies aimed at addressing this ambitious goal.

## 5.2 Attitudes and Stigma Displayed by Mental Health Professionals Towards the Mentally Ill: Selected Studies Conducted in Italian Facilities

Stigmas relating to mental illness seem to be widely endorsed by the general public [14], with those affected being challenged by the stereotypes and prejudice resulting from misconceptions of mental disorders.

Negative attitudes, such as discrimination, frustration, and lack of respect, at times displayed even by health professionals, may lead to poor health outcomes in those targeted [15, 16], thus representing a major barrier to consumer and carer participation and overall improvement of health [17].

An inverse relationship has been found between recovery orientation and stigmatizing attitudes, in the sense that recovery-oriented individuals may display less negative attitudes with regard to people affected by mental disorders [18]. Stigma represents a major barrier in preventing patients affected by mental disorders from seeking help or achieving personal recovery [19]. Stigmatizing attitudes may also be detected among mental health professionals, thus exerting negative effects on the quality of healthcare [20]. Several interesting Italian studies investigating the attitudes and stigma displayed by mental health professionals towards the mentally ill will be briefly described.

Attitudes displayed by psychiatric nurses and mental health professionals towards patients affected by mental disorders present in a series of different care settings in an Italian healthcare facility were investigated by Cremonini et al. [21]. The authors of the study used the Italian version [22] of the Community Attitudes Mentally Ill inventory (CAMI-I) [23] to investigate authoritarian attitudes, benevolence, and social restrictiveness, and revealed how healthcare professionals displayed fluctuating levels of sensitivity and positive attitudes towards mental illness. Varying attitudes were found to exist between psychiatric care units: healthcare professionals employed on the psychiatric ward displayed less positive attitudes, whereas staff working in the mental health daycare center held more positive views on mental illness. The authors hypothesized that their findings may have been influenced by resource organization, staff-user interaction, care provider stress levels, and the high complexity of users on an acute psychiatric ward [21].

Another European study used the Community Attitudes Mentally Ill inventory (CAMI-I) to compare attitudes towards mental illness and investigate potential differences based on type of professional category, setting and country across a large sample of professionals (1525) working in a wide range of mental health facilities run by a non-profit mental health organization (Sisters Hospitallers) in Spain, Portugal, and Italy [24]. The study included compilation of the Attribution Questionnaire (AQ-27) [25], validated in Italian by Pingani [26]. The AQ-27 provides a vignette about a man with schizophrenia and comprises 27 items that evaluate respective assertions related to the hypothetical case. The AQ-27 evaluates nine factors: (1) personal responsibility; (2) anger; (3) pity; (4) help (provision of assistance to people with mental illness); (5) dangerousness; (6) fear; (7) avoidance; (8) segregation; and (9) coercion. Psychologists and social therapists displayed the most positive attitudes, while nursing assistants the most negative. Community staff displayed more positive attitudes than hospital-based professionals [24]. Comparison of the three countries at AQ-27 revealed how Spanish professionals had the highest inference of attribution of responsibility for the illness and more coercive approaches, but felt more pity and less fear than the other two groups. On the other hand, Italian

professionals were at the lowest end of the dimensions of pity and help, and ranked highest in avoidant behaviors. Anger, perceived dangerousness, and segregation did not significantly differ throughout the three countries. On the CAMI scale, Spanish professionals showed more positive attitudes towards benevolence and communitarian ideology, the Italians were the least supportive of community treatment and most supportive of social restriction, while the Portuguese ranked highest in authoritarianism.

Given the primary role of community care within the Italian mental health services, these findings are surprising and confirm the data reported by Chambers et al. [27] from a study conducted on a sample of nurses from five European countries. At the CMHI subscale, Portuguese nurses were found to be significantly more positive about community care than Italian nurses [27].

An association between stigma and personality was observed in an Italian study of mental health professionals working across six Community Mental Health Services (CMHS) in North-East Italy [28]. The personality trait of openness to new experiences was seen to determine lower levels of stigma. People scoring higher on openness may be more prone to developing positive contact experiences and proving more willing to try to understand the feelings of individuals affected by mental disorders. They seem to be more prone to a positive and recovery-oriented attitude, which in turn has been associated with lower levels of stigma [29]. The study highlighted how higher levels of burnout were associated with more negative views of patients, in particular those displaying lower emotional stability [28]. A previous study had addressed a possible connection between personality traits, burnout dimensions, and stigmatizing attitudes in mental health professionals [30]. Perception of poor workplace safety was found to produce a significant negative effect on the burnout dimension of personal efficacy, and, indirectly, negative attitudes towards users. The presence of institutional responses at CMHS to risk situations (namely, protocols for the management of aggressive or violent behaviors) was associated with a higher level of personal efficacy. Emotional Stability and Openness to new experiences were inversely correlated with burnout dimensions and avoidant attitudes, respectively [30].

## 5.3 Assessment of Staff Knowledge and Attitudes Towards Recovery Principles

For the purpose of operationalizing recovery and assessing the extent of understanding and implementation of the recovery concept, a series of measures were developed to evaluate the knowledge of mental health professionals and their attitudes towards recovery. Studies conducted using both qualitative and quantitative measurement methods have been reported in the literature. We describe below the widely used quantitative scales, deemed to be evidence-based by a very recently published review [31].

### 5.3.1 Quantitative Methods

A frequently used tool among the quantitative methods is represented by the **Recovery Knowledge Inventory (RKI)**, a questionnaire developed in the United States addressed to evaluating more recovery-oriented health services [32]. The original 36-item scale was reduced to 20 items. The RKI consists of 20 items on a 5-point Likert scale and assesses four different domains of understanding on recovery in mental health: (1) "*Roles and responsibilities in recovery"* (seven items; range score 7–35), relating to risk-taking, decision-making, and the various roles and responsibilities of people in recovery and behavioral health providers, respectively (e.g., people with mental illness should not be burdened with the responsibilities of everyday life); (2) "*Non-linearity of the recovery process"* (six items; range score 6–30), regarding the role of illness and symptom management and the nonlinear nature of recovery (e.g., recovery is characterized by a person making gradual steps forward with no major steps back); (3) *"Roles of self-definition and peers in recovery"* (five items; range score 5–25), focusing on the activities undertaken by an affected individual to define an identity for him/herself and a life that goes beyond that of "mental patient," including the valuable roles that peers can play in this process (e.g., the pursuit of hobbies and leisure activities is important for recovery); and (4) "*Expectations regarding recovery"* (two items; range score 2–10), relating to expectations (e.g., not everyone is capable of actively participating in the recovery process). Fifteen out of 20 items are reverse-coded. The maximum score for the 20 items is 100 (range 20–100). Higher scores represent a greater orientation to the concept of recovery (cutoff scores are not reported in the literature).

The **Recovery Attitude Questionnaire (RAQ-7)** is a self-administered instrument developed in the United States by the Recovery Initiative Research Team, consisting of a group of mental health users, mental health professionals, and graduate students and researchers from Hamilton County (Ohio) intended to measure the attitudes displayed towards mental health recovery by a range of stakeholders, including consumers, health professionals, family members, or significant others, and community members [33].

The questionnaire contributes towards assessing feelings relating to recovery and monitoring adherence to the principles of recovery by mental health services. The original 21-item scale was reduced to 7 items, and the addition of a further two items to measure "somewhat unconventional attitudes about mental illness and its treatment but which are important to the idea of recovery." The questionnaire identifies two factors: (1) *"Recovery is possible and needs faith"* (e.g., recovery is possible even if the symptoms of mental illness persist; recovery from mental illness is possible no matter what you think may be the cause; (2) *Recovery is difficult and differs from person to person* (e.g., Stigma associated with mental illness may slow down the recovery process; people differ as to how they recover from a mental illness). The RAQ includes a brief introduction based on the concept of recovery defined by William Anthony [1]. Each item is measured on a 5-point scale ranging

from 1, strongly disagree, to 5, strongly agree. Concurrent validity was also found in that consumer respondents who identified themselves as being in recovery, and who were in recovery for longer periods, displayed the most favorable attitudes to recovery [33]. Higher total scores indicate a more positive attitude to the concept of recovery.

The **Recovery approach staff questionnaire** [34] is a structured self-report measure developed by the Southwark Recovery Approach Implementation Group, which included an ex-service user, specifically created for application in forensic services, although the content was guided by published work on the recovery approach [35, 36], where the focus is on teaching and training service users. It consists of 50 closed questions investigating the individual's knowledge and understanding of the principles of the recovery approach and social inclusion. Apart from item 2 ("*I have attended a training course on the recovery approach to care*," which was rated either as "true" or "false" and was the key predictor in the research), the remaining 49 items were rated on a three-point scale: true (3), not sure (2), and false (1). The scoring was reversed for items requiring a negative endorsement: false (3), not sure (2), and true (1). The maximum score for the 49 questions was 147 (range 49–147).

The **Staff attitudes to Recovery Scale (STARS)** is a self-rating instrument consisting of 19 items, developed by Crowe et al. [37] to evaluate staff attitudes and hopefulness related to the goal striving and recovery possibilities for the mental health consumers with whom they work. Principles and constructs that influenced item construction included the interrelatedness of hope, goal setting, and recovery. Three of the STARS items address general hopefulness (e.g., "*All of these clients are capable of positive change*"). Eight items were adapted from the Adult Dispositional Hope Scale [38] (e.g., "*There are lots of ways around any problem*" became "*There are lots of ways to deal with any problems that these clients have*"). Each item was rated on a 5-point scale ranging from 1, strongly disagree, to 5, strongly agree. Scores range from 19 to 95, with higher scores reflecting more positive and hopeful attitudes.

The collaborative **Recovery Knowledge scale**, developed by Crowe et al. [37], consists of 13 multiple-choice items related to knowledge of the key principles and intervention characteristics representing components of the collaborative recovery model that provides an integrative framework combining (a) evidence-based practice; (b) manageable and modularized competencies relevant to case management and psychosocial rehabilitation contexts; and (c) recognition of the subjective experiences of consumers [39]. Sample questions follow: *"Research evidence demonstrates that well-being is related to: a) achieving as many goals as possible, b) achieving autonomous goals, c) not having goals, or d) having only one goal" and "Resistance is: a) a treatment opportunity, b) always an obstacle, c) the client's fault, d) proof the client is not motivated, or e) evidence that treatment is failing."* Each item answered correctly was scored as 1, incorrect items were scored as 0. Possible scores range from 0 to 13, with higher scores indicating better knowledge.

The **Wellness Recovery Action Plan (WRAP) questionnaire** is a self-assessment tool administered to consumers and mental health professionals to

evaluate their attitudes towards and knowledge of recovery after attending a WRAP workshop in New Zealand [40]. The tool represents a 5-point Likert-type rating scale (1 = strongly disagree, 5 = strongly agree) consisting of 16 items (e.g., "*I believe that for some recovery is not possible"; "People who experience mental illness should have the opportunity to choose what treatment they will receive"; "I understand what is meant by peer support"; "It is important that non-consumers know about mental health recovery concepts"; "People who experience mental illness should decide whether or not family members and significant others are to be consulted regarding their treatment and recovery process"*).

The two items that vary to allow a negative acceptation are "*I believe that for some recovery is not possible"* and "*The opinions of health professionals should be given more weight than a person receiving treatment*," both of which were reversed items.

## 5.4 Measures of Recovery Orientation in Mental Health Services

In addition to investigating the recovery orientation of mental health professionals, numerous measures have been developed to assess the recovery orientation of mental health services. In their systematic review of measures relating to the recovery orientation of mental health services, Williams et al. [41] selected papers in a conceptual framework of recovery comprising five recovery processes: connectedness; hope and optimism; identity; meaning and purpose; and empowerment (CHIME). Comparisons between the measures were hampered by the use of a series of different models of recovery and by the lack of uniformity on the level of organization at which services were assessed [41].

Among the six instruments considered in their review, we selected the **Recovery Self-Assessment (RSA)** [42], which includes 4 different versions for persons in recovery, significant others, service providers, and service directors. The 36-item RSA was developed to "go beyond rhetoric into the routine" in an attempt to assess changes in practice. The scale was intended to reflect objective practices associated with the conceptual domains of recovery: indicators, such as the involvement of service users in management meetings and staff education, activities geared towards expanding social networks and social roles, degree of service user choice and self-determination, and staff attitudes and philosophy towards recovery. Factor analysis revealed five factors: *Life Goals*, *Involvement*, *Diversity of Treatment Options*, *Choice*, and *Individually-Tailored Services*.

Mental health professionals, persons in recovery, and family members generally agreed that their agencies were providing services consistent with recovery orientation, although "providers" assigned significantly lower ratings to three of the five factors, e.g., Life Goals, Involvement, and Individually-Tailored Services. The authors highlighted their efforts to operationalize the principles of recovery into objective practices, offering an effective tool to contribute towards strengthening collaborative evaluation-stakeholder feedback loops [42].

## 5.5 Italian Study of the Knowledge of and Attitudes Displayed Towards Personal Recovery from Mental Illness by Mental Health Operators

Within the context of Italian psychiatry, the values and recovery-oriented practices of which stemmed largely from the Law of 1978, the authors were keen to verify how closely mental health professionals adhered to the model proposed by the RKI, an internationally recognized tool for use in the assessment of "recovery." The aims of our study were (1) to examine the knowledge of and attitudes displayed towards the concept of personal recovery by Italian mental health professionals and students enrolled in the graduate studies course in psychiatric rehabilitation [43] through administration of a questionnaire survey based on the Recovery Knowledge Inventory (RKI) [44], and (2) to examine the differences among mental health professionals and students in understanding recovery domains [45].

An extensive sample of 436 Italian mental health operators, including 349 professionals from Italian Services and 87 students from Italian Universities, recruited during mental health and psychiatric rehabilitation meetings and conferences, were included in the study [44]. The abovementioned survey also included a specific schedule comprising questions relating to the respondent's professional role, gender, age, level of experience (years), work setting, and questions regarding previous exposure to recovery information and training.

Three groups of mental health operators were evaluated: the first group represented 23% of the total sample and consisted of 100 psychiatrists (50% women; mean age = 49.3, SD = 11.8); the second group of 249 mental health professionals represented 57% of the total sample (nurses, social workers, psychologists, psychiatric rehabilitation technicians, and others, 82% women; mean age = 42.5, SD = 12), and the third group consisting of 87 students of psychiatric rehabilitation techniques (79% women; mean age = 24.6, SD = 5.6) represented 20% of the total sample. The position of Psychiatric Rehabilitation Technician (PRT) refers to an Italian mental-health academic and professional specifically trained in conducting psychosocial interventions, which was created in the wake of the Law 180 [43]. Approximately 57% of participants were working as part of community mental health teams, while 20% were working on acute psychiatric inpatient wards. The majority of participants had received no formal training in personal recovery principles, with those who had previously been exposed to this concept having gained their knowledge by means of informal methods rather than structured programs.

Recovery orientation was reported as "low recovery orientation" and "high recovery orientation." No statistically significant differences in the level of overall orientation towards personal recovery were found among the three groups, as measured by RKI total score. Over the 40 years since the introduction of Law 180 in 1978, which abolished psychiatric hospitals and sought to integrate psychiatric care within the social context of the community, Italian psychiatrists, mental health operators, and students of mental health have come to reflect a recovery-oriented biopsychosocial perspective in their attitudes and their work. Professionals appeared to agree on the principles of user identity, treatment involvement based on their goals,

and the validity of support received from individuals affected by mental disorders. However, the same professionals seemed to encounter difficulty in accepting users' well-being "beyond" treatment adherence, and "non-linearity" of the individual "journey" undertaken to achieve personal recovery, viewing psychopathological stability as a key factor.

With regard to *gender-related differences*, women seemed to be more favorable towards accepting the decision-making of consumers and risk-taking in planning their lives *("Roles and responsibilities in recovery")* compared to men. In our sample, more than two-thirds of the professionals investigated were women, with the highest percentage of male respondents being represented by psychiatrists. Compared to the other two groups, the older groups of psychiatrists with greater work experience comprised a higher percentage of men. The scarce propensity among male psychiatrists included in the study to acknowledge the issue of "therapeutic risk" for their users may be linked to the potential of professional liability in the medical profession, a highly relevant issue in modern-day Italy. Indeed, recent sentences issued by the Italian courts for crimes such as manslaughter have reiterated the culpability of psychiatrists in view of their obligations of custody and constant monitoring of users in their various care settings, thus prompting a more cautious attitude among mental health professionals [46–48].

*Differences between less experienced* (respondents with fewer than 15 years' experience in the field of mental health) and *more experienced professionals* were detected with regard to "*expectations of recovery.*" Less-experienced staff and graduate students enrolled in psychiatric rehabilitation courses displayed more positive attitudes and knowledge compared to the more experienced respondents with regard to expectations of recovery. Compared to their more experienced colleagues, younger mental health operators and students were characterized by a higher degree of cognitive openness and flexibility, in contrast therefore with the low consumer expectations expressed by the older professionals, which could potentially result in delayed recovery and encourage learned helplessness (Roberts & Wolfson, 2004).

## 5.6 Conclusions

The absence of institutional responses to situations of risk (namely, protocols for the management of aggressive or violent users) and the professional liability impinging on psychiatrists are heavily linked, the former resulting in negative attitudes towards users, and the latter placing limitations on acknowledging users' rights "to take the risk" they choose, a "milestone" principle in the personal recovery paradigm.

An improved understanding of the concept underlying the personal recovery paradigm would provide an incentive for all mental health professionals to decrease stigmatization and improve their attitudes towards individuals with mental disorders in daily clinical practice. This, in turn, would contribute towards fostering a recovery-oriented reorganization of mental health services.

Although numerous mental health services would tend to assert their "recovery-oriented" status, it is uncommon in everyday clinical practice to witness a focus on

the empowerment, identity, meaning, and resilience of facility users [49]. The journey to recovery among the users of mental health services would benefit greatly from an enhanced awareness of hope, empowerment, and meaning in life [5] supported by the relevant mental health professionals. The latter may indeed require time to gain familiarity with the model of personal recovery, but may hopefully already display an effective community-based psychiatry, recovery-oriented biopsychosocial perspective in their attitudes and work.

The principles of recovery, self-determination, and other evidence-based practices for individuals affected by psychiatric disorders should be integrated into professional training courses and medical, social, and behavioral sciences curricula [50], with the aim of disseminating and adding further impetus to the "recovery model" underlying the existing practices envisaged by the Italian Department of Mental Health, with the key goal of fostering inclusion and citizenship of the mentally ill and duly acknowledging their rights to live satisfying lives.

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