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Attitudes of mental health professionals toward mental illness : comparisons and predictors : a project based upon an investigation at Department of Youth Services, Massachusetts

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Attitudes of Mental Health Professionals Toward Mental Illness: Comparisons and Predictors

ABSTRACT

This quantitative descriptive study examines the differences in attitudes toward mental illness and the mentally ill between different groups of mental health workers by asking the following questions: Do mental health workers with higher levels of education show lower levels of mental health stigma? Do mental health workers with more experience in the field show lower levels of mental health stigma?

This study uses a data set collected with the help of David Browne and analyzed by Marjorie Postal of Smith College. The sample consists of 64 DYS staff who attended a Staff Appreciation Day and filled out a survey which included demographic questions and the 40-item Community Attitudes Toward Mental Illness (CAMI) Questionnaire.

The findings of this research showed that that the amount of time working in the field had significant associations with levels of Authoritarianism and Benevolence, two of the four constructs measured by the CAMI.

ATTITUDES OF MENTAL HEALTH PROFESSIONALS

TOWARD MENTAL ILLNESS:

COMPARISONS AND PREDICTORS

A project based upon an investigation at Department of Youth Services, Massachusetts, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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CHAPTER I

INTRODUCTION

Over the past decade there has been a growing body of research looking at the stigma that is associated with mental illness. These studies have shed light on the attitudes of various populations toward mental illness, led to the creation of theories to explain how mental illness stigma operates, and detailed the multitude of ways that stigmatizing beliefs negatively impact persons with mental illness. Despite this growing knowledge-base, there has been relatively little investigation of how mental illness stigma manifests itself in the attitudes and beliefs of mental health professionals. Within this group of professionals there is a particular need to examine the attitudes of direct line staff (often called Mental Health Counselors or MHCs) as there is a dearth of information about this group. In hospital and residential settings, MHCs often spend more time with patients than any other provider and are tasked with supervising activities and monitoring patient behavior. Measuring the level of stigmatic beliefs among MHCs and other mental health workers is an important task because of the impact it has on the people they work with and the obstacles it can create for treatment (Corrigan, 2004; Perlick et al., 2001).

Professionals in the field of mental health exist in a unique position as it relates to mental illness stigma. Like the general population, they are exposed to biased media portrayals of mental illness as well as the prevailing cultural norms, both of which can lead to the development of stigma. At the same time however the nature of the work itself and the demographic composition of the workforce contain a number of protective factors that have been shown to decrease stigmatizing attitudes, such as direct contact

with persons with mental illness, higher levels of education, and consisting of predominantly female workers (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Corrigan, Larson, & Kuwabara, 2007; Nordt, Rössler, & Lauber, 2006; Roth, Antony, Kerr, & Downie, 2000). But just as persons with mental illness are not a homogenous group, neither are mental health professionals. The purpose of this study is to survey mental health professionals and assess if variables within this group such as age, gender, level of education, agency role, type of client, or experience in the field have any association with the level of stigmatizing beliefs that are held. This information could then be used to create tailored trainings for mental health workers from the many evidence-based programs that have been shown to be efficacious in reducing the stigma associated with mental illness (Corrigan & Wassel, 2008). With this in mind I have formulated the following research question: What are the attitudes and beliefs about both mental illness and persons with mental illness of mental health workers.

Several experiences from my previous work in the field have prompted my interest in this topic. For the past several years I have worked in a variety of short and long-term residential settings as both a Mental Health Counselor and supervisor, and have seen firsthand some of the stigmatizing beliefs of the direct line staff regarding the nature and cause of the problems that bring someone to residential treatment. There was often a lack of understanding or dismissal of a DSM diagnosis, replaced instead with lay theories that the patient was "just a jerk" or a "bitch" and that "what (they) really need is a good slap in the face." There were also many staff who did not share these beliefs, and even those who initially had more negative viewpoints were often able to shift their

attitude when they learned more about the effects of trauma and chaotic family environments that contributed heavily to acting out behavior they were seeing.

For this study I chose a quantitative quasi-experimental design. This design was chosen both for the high number of responses that could be gathered using a valid and reliable questionnaire (Sévigny et al., 1999), along with the anonymity it would offer to mental health professionals who might be reluctant to reveal their opinions in a one-on-one interview. Initially the study was to be drawn from a funded comprehensive analysis of all 63 facilities run by the Massachusetts Department of Youth Services (DYS), a state agency which provides behavioral interventions and residential treatment for youth involved in the juvenile justice system. Unfortunately state budget cutbacks led to delays with the larger project of which this project was one component, so the project was modified to be a pilot survey of a smaller pool of DYS staff before the eventual full-scale study.

Questionnaires were distributed from 12-4 pm during "Staff Appreciation Day," which took place on March 18th, 2010 at the Holiday Inn in Taunton, Massachusetts. The event was attended by approximately 200 staff from a variety of agencies that work with DYS-involved youth. Participants were recruited with incentives of free candy and raffle tickets for a drawing for 3 gift cards. The director of DYS, Dr. Yvonne Sparling, also made an announcement at the end of the day requesting that those who had not filled out a survey try to do so to help myself and Dr. David Burton, who was my collaborator on this project and had previous research for DYS. Those persons that were interested in participating were given a 2 page anonymous survey that included a variety of demographic questions and the Community Attitudes toward Mental Illness

(CAMI) questionnaire. The CAMI consists of 40 questions, with each subset of 10 questions measuring the constructs of Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology.

The stigma of mental illness causes serious economic, social and health consequences to patients, families, and caregivers, as well as to society at large. My hope and purpose for this study is to reduce the effects of stigma on persons with mental illness living in residential settings by assessing if staff could benefit from anti-stigma education and training.

CHAPER II

LITERATURE REVIEW

This section will address the issue of mental illness stigma and its consequences in order to provide a framework for this author's investigation into the attitudes and beliefs of mental health professionals. We will review the various misperceptions that are held about persons with mental illness, a range of factors that have been correlated with lower or higher levels of mental illness stigma, and theories about where this stigma originates. In addition, information about the level of stigma within both general population and the helping professions and the impact of stigma upon persons with mental illness will provide context and justification for the current study.

Stigma is a negative label that is frequently attached to persons or groups who deviate from social norms in some respect, such as in appearance, race, or physical or mental health (Falk, 2001). Stigma exists when elements of labeling, separating, status-loss, stereotyping, and discrimination co-occur in a power situation that allows those processes to unfold (Link & Phelan, 2001). The stigma associated with psychiatric disease continues to be a barrier to rehabilitation for many people in our society.

The general public holds a number of different stereotypes about persons with mental illness, some of which include: they are dangerous and unpredictable, they have a "weak moral backbone" and are responsible or blameworthy for their condition, they are hard to talk to, they "feel different from the way we do," and that they should be treated like children and need a parental figure to make decisions for them (Corrigan & Wassel, 2008; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). In part because of these commonly held stigmas there is a willingness by the public to endorse wide-ranging legal

and social restrictions on persons with mental illness (Nordt et al., 2006). The existence of these stereotypes within the public consciousness is due in part to a lack of knowledge about mental illness combined with misperceptions from biased and misleading media portrayals (Hinshaw & Stier, 2008). Media is the main source of knowledge about mental illness for Americans, which is problematic because an analysis of the American media showed that mental illness was the most commonly depicted health problem and 72% of the characters with mental illness either killed or injured someone (Giorgianni, 2004). Many people are unable to recognize specific mental disorders when confronted with pathological behaviors, and stress is overwhelmingly seen as the main casual explanation of mental illness regardless of the specific presentation (Angermeyer & Dietrich, 2006; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Even in areas where public perception is in agreement with psychiatric literature, the influence of stigma can still have an insidious effect. So while most of the population agrees that many forms of mental illness will improve with treatment (with a few exceptions, such as dementia), there is still a widely held belief that "most people look down on someone who was once a patient in a mental hospital" and "most people feel that entering psychiatric treatment is a sign of personal failure" (Crisp et al., 2000; Struening et al., 2001). In addition, certain demographic variables such as age have also been correlated with negative attitudes toward mental illness and the mentally ill, although it must be noted that while these variables are statistically significant, they often have poor explanatory power (Angermeyer & Dietrich, 2006). Comparisons between different regions, ethnic groups, and countries have also revealed differences in beliefs about mental illness and those afflicted with it. For example, population studies of non-

Western ethnic groups have shown that they are less aware of and knowledgeable about mental illness as compared to Western ethnic groups, and tend to attribute the cause of the illness more to the individual (Angermeyer & Dietrich, 2006). It is unclear however whether this results from cultural and educational differences.

While initially this seems to paint a fairly grim picture, there are also several protective factors that can reduce the power of stigma. People who have had previous contact or are more familiar with the reality of mental illness are more likely to offer help, experience more pity, feel less fear and anger, and are less likely to avoid people with psychiatric disorders (Corrigan et al., 2003; Roth et al., 2000). The nature of the contact, including the duration, whether it was voluntary, and the type of illness all mediate the effect of the contact itself (Crisp et al., 2000). So while a brief visit to a psychiatric hospital ward led to an increased desire for distance and social restrictiveness from persons with mental illness, working voluntarily in the same setting over a period of several weeks resulted in positive shifts in attitudes towards persons with mental illness in multiple areas (Wallach, 2004). This kind of direct exposure only helped improve attitudes if it was in a setting that provided good care, competent supervision, positive role models, and supervisors with positive attitudes towards persons with mental illness (Packer, Prendergast, Wasylenki, & Toner, 1994). In addition to those who have had exposure in psychiatric settings, people with personal or familial experiences of mental illness or higher levels of education were more accepting and had fewer negative attitudes toward persons with mental illness, though they were also more in favor of compulsory admission for its treatment (Angermeyer & Dietrich, 2006; Nordt et al., 2006). It could be that this comfort with non-consensual treatment is more representative

of trust in the efficacy of psychiatric hospitals and psychopharmacology rather than an authoritarian stance. As far as demographic variables, women have consistently shown fewer prejudicial and discriminatory attitudes towards persons with mental illness or their families than men (Corrigan & Watson, 2007). This may be due in part to other variables that women possess disproportionately to men, such as social empathy, because empathic people are less likely to endorse stigma or the use of more restrictive and authoritarian methods for dealing with the mentally ill (Corrigan & Watson, 2007). Another variable that may mediate the effects of gender on stigma beliefs is hyper-gender adherence. When hyper-gender adherence is controlled for (that is, adherence to rigid gender roles), the differences between men and women on measures of stigma disappear (Hinkelman & Granello, 2003).

While there are a large variety of psychiatric diagnoses that fall under the rubric of "mental illness," there are some experiences of stigmatization and discrimination commonly faced by persons with mental illness regardless of the specific label they have been given. Part of the reason for this blanket stigmatization has to do with lay theories of how mental illness originates. When the blame for mental illness is placed on the person who is diagnosed with it, the observer is likely to experience decreased feelings of pity and increased feelings of anger and fear, which in turn leads to rejecting social responses such as avoidance, the withholding of help, and the endorsement of coercive treatment (Corrigan et al., 2003; Weiner, Perry, & Magnusson, 1988). From this viewpoint, persons with mental illness are seen as morally weak and as making a willful decision to engage in pathogenic behavior (Link et al., 1999; Weiner et al., 1988). Despite the fact that those with mental illness are seen as more responsible for their

condition when compared to other afflictions (such as physical illnesses) and thus would presumably be more likely to change or improve their situation through their own efforts, outsiders are still less likely to offer help (Weiner et al., 1988). The differences in level of stigmatization becomes even more apparent when you consider that physical illnesses are seen as far more stable (that is, less likely to be reversible), yet people are much more likely to express sympathy and a desire to produce change in someone suffering from physically based stigma (Weiner et al., 1988).

In addition to the beliefs that persons with mental illness are to blame for their own misfortune, there is also a widespread belief among the public that persons with mental illness are dangerous and unpredictable. In a poll measuring the perceived risk of violence, persons labeled as depressed or schizophrenic were rated as significantly more dangerous than a generic "troubled" condition, although persons abusing alcohol or dependent on cocaine were rated as the most dangerous of all (Link et al., 1999). The combination of perceived dangerousness and attributions of accountability account for 63% of the variability in help vs. avoidance behavior of those interacting with persons with mental illness, as well as 73% of the variability in their beliefs about coercion and segregation (Corrigan et al., 2003). These results were consistent with other findings that persons with certain disorders that are viewed as more to blame for their condition (e.g. alcoholism and substance abuse) or thought to be more at risk for being unpredictable or violent (e.g. schizophrenia and substance abuse) experience more rejection than those diagnosed with depression or anxiety (Angermeyer & Dietrich, 2006). There is also a strong correlation between the public's perceived risk of someone becoming violent and their corresponding social distancing behavior, so while only 29% of the people polled in

one study would try and limit contact with a "troubled person," 47% were unwilling to engage with someone with the relatively benign diagnosis of depression (Link et al., 1999). The consequences of being considered dangerous by the public are far-reaching, and can lead to increased willingness to withhold help, avoidance of the person socially, and an endorsement of mandatory treatment (Angermeyer & Dietrich, 2006; Corrigan et al., 2003).

Unfortunately stigma is not confined solely to those who lack direct experience with mental illness and have been influenced by biased media portrayals, but is also present in those whose occupations involve interacting with persons suffering from mental illness on a daily basis. While is true that professionals in the mental health field tend to hold fewer stereotypes than the general public, as would be predicted by their increased exposure to mental illness and those afflicted with it, they still subscribe to many stigmatizing beliefs (Emrich, Thompson, & Moore, 2003; Nordt et al., 2006). For example while psychiatrists and psychologists are comparatively more tolerant in their beliefs towards persons with mental illness than non-psychiatric physicians, they hold similar beliefs about the level of impairment caused by mental illness, such as the inability of this population to maintain employment (Roth et al., 2000). Psychiatrists also hold a greater number of negative stereotypes than other mental health professionals or the general public. Mental health professionals (psychiatrists, social workers, and nurses) were also found to desire the same amount of social distance from the mentally ill as the general public, despite having a higher level of "mental health literacy" (Lauber, Anthony, Ajdacic-Gross, & Rössler, 2004; Nordt et al., 2006). There were also further discrepancies between different vocations within the mental health field when it comes to

the treatment of mental illness. So while doctors and nurses had some broad agreement about the most helpful treatments for the mentally ill, nurses had a much wider range of interventions that they believe can be helpful (Caldwell & Jorm, 2001). Specifically nurses endorsed many types of lifestyle changes and counseling, and rated some medical interventions such as ECT and seeing a general practitioner as unhelpful while psychiatrists and psychologists held the opposite view, which is troubling as they often work together closely when formulating treatment plans (Caldwell & Jorm, 2001). There was also a stark difference of opinion between treatments seen as most helpful by psychiatrists (such as medication) and the general public (which viewed medication negatively and tend to endorse lifestyle changes), with a middle ground between the two viewpoints occupied by nurses (Caldwell & Jorm, 2001). Though there is disagreement within the mental health professionals about what is therapeutic, they all held less optimistic views about the long-term prognosis of having mental illness than the general public (Hugo, 2001). While some would suggest that this has more to do with being realistic than pessimistic, these attitudes were primarily based on personal experience which may be skewed as they are seeing people when they are not doing well (Hugo, 2001). The attitudes of professionals in the mental health field also vary depending on whether the case of mental illness is seen as a temporary or more chronic condition. This is because treatment of persons with chronic mental illness is often seen as an unrewarding and frustrating experience with little hope for a positive outcome (Mirabi, Weinman, Magnetti, & Keppler, 1985).

Perhaps the most telling study of stigma among mental health professionals was a survey of 567 psychiatrists in the Michigan Psychiatric Society, 50% of whom said they

would choose to treat themselves rather than risk having a record of treatment for mental illness on their health insurance records(Balon, 2007). Overall we see that despite having a great deal more training about mental illness as well as experience working with the mentally ill, professionals in the mental health field hold many of the same stigmatizing beliefs as the general public.

While there have been many studies of doctors, nurses, psychiatrists, social workers, and other hospital staff, there is a relative dearth of information about the direct care staff who are often have the most contact with patients (Caldwell & Jorm, 2001; Nordt et al., 2006; Roth et al., 2000). One such study which did address this group compared the attitudes of ward attendants at an adult inpatient hospital with the caretakers (friends and family) of clients at an affiliated outpatient service connected to the hospital using the CAMI (Community Attitudes Towards Mental Illness) Scale (Taylor & Dear, 1981; Vibha, Saddichha, & Kumar, 2008). The CAMI measures the dimensions of authoritarianism, benevolence, social restrictiveness, and community mental health ideology and has been found to have high internal, external, and predictive validity (Link, Yang, Phelan, & Collins, 2004; Taylor & Dear, 1981). While the attitudes of the ward attendants toward the patients they worked with were generally more positive than the caretakers, they still had a number misperceptions and negative attitudes toward the patients on the ward. For example, 90% of the ward staff agreed with the statement "Mental patients need the same kind of control and discipline as a young child." The initial hypothesis of the study was that ward attendants would have more positive and less negative attitudes towards mental illness due to their relatively higher levels of education and increased length of contact, but no differences were found between the ward

attendants and caretakers on measures of authoritarianism or benevolence. The authors hypothesized that ward attendants were influenced by similar attitudes and opinions as the caretakers and the general public, which could have negative implications for the therapeutic value of ward attendant interactions with patients. The ward attendants did however have far more progressive beliefs about social restrictiveness and community mental health, which would be expected given the duration of contact they have with people living with mental illness (Angermeyer & Dietrich, 2006; Link et al., 1999).

Unfortunately this was the only study measuring the attitudes of direct care staff that could be found within the last several decades. Because there is great variability in beliefs between different cultures and countries about mental illness, the results are not generalizeable (Angermeyer & Dietrich, 2006; Corrigan & Watson, 2007). This circumstance merits further study of the attitudes and beliefs of direct care mental health workers (often called Mental Health Counselors).

Stigmatizing attitudes and beliefs of those who interact with the mentally ill can have detrimental real-life outcomes. In a cross-cultural survey of actual employers about hiring persons who had been diagnosed with a psychotic disorder in the past, more than a quarter admitted strong concerns about the safety threat to other employees and customers, productivity and job performance, strange behavior, and potential for symptom relapse (Tsang et al., 2007). Even the general public is less willing to support helping someone find a job or maintain employment if they have been given the label of mental illness (Corrigan et al., 2007). As we can see merely having a label of a past psychotic disorder brings with it a whole host of assumptions that may seriously impair ones chances of becoming gainfully employed.

While some of the distress and lost opportunities that accompany mental illness result from a combination of psychiatric symptoms, cognitive dysfunction, and social skill deficits, much of it is also due to the personal demoralization of being shamed and avoided that accompanies of mental illness (Corrigan & Wassel, 2008; Wahl, 1999). Some individuals internalize the stigmatizing beliefs held by the public, which can result in reduced self-esteem and self-efficacy, leading to the "why try" effect (Corrigan & Wassel, 2008). This negative self-talk may manifest itself in such ways as saying "Why should I try to get work? Someone like me is not able to handle a job!" or "Why should I try to live on my own? Someone like me is not worthy of such goals!" Along with internalized stigma, there is also the issue of label avoidance. Many people who have not been professionally diagnosed as having mental illness may seek to avoid engaging in treatment to avoid the associated labels and stigma that it would bring, such as being seen as "crazy" or "weak," and it is estimated that between one half and two thirds of those who could opt for psychiatric services do not pursue them (Corrigan, 2004; Corrigan & Wassel, 2008). Even those who are able to overcome the barriers and become engaged in treatment are still at risk because the perceived stigma they associated with their illness prior to coming to treatment was predictive of treatment noncompliance (Sirey et al., 2001). Concern over stigma related to mental illness is also predictive of poorer social and leisure functioning which can impact the quality of life, the absence of close or confiding relationships outside of the immediate family, and has been associated with a greater risk of relapse and non-remission among persons with depression (Perlick et al., 2001; Sherbourne, Hays, & Wells, 1995).

Summary

Living with mental illness often means being stereotyped and labeled as someone who is dangerous, unpredictable, and just "different." The studies above outlined the ways in which this kind of "us vs. them" thinking has developed, and the consequences of believing that someone who has mental illness is to blame for their condition. Researchers have also found a number of factors that have been associated with lower levels of stigma, such as increased education and certain kinds of direct exposure, which have all provided clues for interventions to reduce the influence of stigma. These interventions are all the more needed because of the many spheres of life that are impacted by being labeled as "mentally ill," from personal relationships to medical care to work.

It is ironic in a way that those who often have the most contact with persons with mental illness in residential mental health facilities have been the least studied despite previous research findings that persons with mental illness are sensitive to and influenced by the attitudes of rehabilitation and treatment personnel that they interact with, and staff attitudes toward mental illness and mental health patients influence the quality of treatment (Antonak & Livneh, 1988; Keane, 1991; Levey & Howells, 1994; Wallach, 2004). The purpose of this study is to provide more information about the attitudes and beliefs of MHCs and other mental health professionals about mental illness and the mentally ill given the gaps in existing research. Various factors that have been shown to have an impact on stigma in previous research, such as age, gender, and direct contact with persons with mental illness will be measured so they can be taken into account.

Additionally, the CAMI scale that has been used in a number of previous studies will be included so that the results of this current study can be directly comparable to other populations that have been surveyed in the past.

CHAPTER III

METHODOLOGY

The purpose of this study is to measure the attitudes of MHCs and other mental health workers toward mental illness and persons with mental illness, a population and context which has not been well described before. With this purpose in mind, the research question is: how do the attitudes and beliefs about both mental illness and the mentally ill of direct line staff (often called Mental Health Counselors) compare to other mental health workers. Subsumed under this research question are two hypotheses of difference that will be investigated in this quantitative, descriptive research study. The first hypothesis is: Mental health workers with higher levels of education will endorse lower levels of mental health stigma (which on the CAMI scale measurements includes lower Authoritarianism, higher Benevolence, less Social Restrictiveness, and higher Mental Health Ideology). The second hypothesis is: Mental health workers with more experience in the field will endorse lower levels of mental health stigma (which on the CAMI scale measurements includes lower Authoritarianism, higher Benevolence, less Social Restrictiveness, and higher Mental Health Ideology).

The type of design that best fits the research question is quantitative descriptive research, a fixed methods design. This type of allows for the gathering of normative data about attitudes toward mental illness of mental health professionals (Anastas, 1999). The greatest benefit of this design is it produces straightforward and unambiguous results, though with the caveat that it does not explain how or why the phenomenon occurred

(Anastas, 1999). To account for this shortcoming, previous theories and research about mental illness stigma guided the formulation of the survey and will be used in evaluating the results.

Sample

The original sampling plan was to study the population of all mental health workers within the Massachusetts DYS. This project was attached to another research project being conducted by Dr. David Burton that would be gathering data from the entire agency. Due to unforeseen circumstances his study was delayed indefinitely, and a backup plan was implemented to survey staff at the annual "Staff Appreciation Day," a large and diverse gathering of staff from multiple agencies within DYS. To be included in the analysis, participants needed to be working in the mental health field in some capacity that involved DYS-involved clients. Persons who did not meet this standard were excluded based on their answers to the question "What is your role-position within DYS" if they checked the box "Other" and wrote a role that was outside the scope of this study. Because "Staff Appreciation Day" was specifically for DYS staff, there was no need to exclude any of the persons present from participation.

The goal in the data collection was to have at least 50 responses so that there would be an adequate number of participants for a robust statistical analysis. This was a feasible goal as there were expected to be 200 attendees to the "Staff Appreciation Day." We had cooperation from the director of DYS, Dr. Yvonne Sparling, to conduct the study. Additionally, a number of the staff at DYS had a positive working relationship with Dr. David Burton based on past research with the agency or in some cases being past students of his. In order to get a diverse sample, every person who came near the

table where the study and inducements (candy, raffle tickets) were set up was asked to fill out a survey.

Ethics and Safeguards

In order to protect confidentiality, no names or other identifying information were collected on the forms and the information collected was aggregated for analysis. In addition, the context of the form as a DYS pilot survey for all DYS staff meant that there would be no stigma associated with being seen by others filling out the survey.

Possible risks to participants include emotional distress that might be raised answering questions involving stigma and stereotypes about persons with mental illness. This risk was reduced by a verbal explanation that the survey was voluntary and that the free inducements were not contingent on a survey being completed, the general nature of the questions (rather than a specific vignette or asking the participant about a life experience), and that the survey has been used in a number previous large population studies without adverse effects to the participants. The survey also polled attitudes and opinions, not behaviors or past actions which might have been more emotionally distressful. All DYS staff have access to their Employee Assistance Program for counseling or referral should they feel it was warranted after completing the survey.

The survey information was entered into a computer data file on the day after the study, and all completed surveys were stored in a locked file cabinet for the duration of my study. The data file was then password-protected and hidden within another file via encryption software on a password-protected secured computer. This author and the statistical analyst Marjorie Postal were the only persons who had access to the information in this file.

After the study was completed and my thesis has been approved, I will disseminate the findings to the Smith College School for Social Work community. All findings will be presented in aggregate form without identifying information. After my thesis requirements are completed, I will keep the completed surveys in a locked file cabinet for three years to conform with Federal regulations.

This project was approved by the Institutional Review Board of the Massachusetts Department of Youth Services.

Data Collection

Quantitative data were collected by setting up a table from 12-4 pm during "Staff Appreciation Day," and asking anyone who passed by if they would be interested in filling out a survey. Information about the reason for the study, that I was a graduate student collaborating with Dr. Burton to gather data for a research project was given if asked. The event was attended by approximately 200 staff from a variety of agencies that work with DYS-involved youth. Participants were recruited with incentives of free candy and raffle tickets for a drawing for 3 gift cards. The director of DYS, Dr. Yvonne Sparling, also made an announcement at the end of the day requesting that those who had not filled out a survey try to do so to help myself and Dr. David Burton.

Those persons who were interested in participating were given a two page anonymous survey that included a variety of demographic questions (age, gender, ethnic background, highest level of education completed, professional licensing, years of experience in the field, age and gender of DYS clients worked with) along with the Community Attitudes toward Mental Illness (CAMI) questionnaire, a scale developed by Taylor and Dear (1981) that has been demonstrated to be reliable and valid (Sévigny et

al., 1999). The CAMI is a self-report scale designed to measure the negative and positive attitudes toward mental illness and mentally ill patients. The scale includes 40 items with four dimensions:

1. Authoritarianism: corresponds to a view of the mentally ill person as someone inferior who requires coercive handling.
2. Benevolence: refers to a paternalistic and sympathetic view of the mentally ill.
3. Social Restrictiveness: concerns the belief that the mentally ill are a threat to society and should be avoided.
4. Community Mental Health Ideology: refers to the acceptance of mental health services and mentally ill patients in the community.

Each dimension has 10 questions: five positive and five negative. Each question is scored using a Likert scale where response categories range from 1 (strongly disagree) to 5 (strongly agree). See appendix B for a copy of the full survey.

Data Analysis

When the completed surveys were coded, two adjustments were made to simplify the process of data analysis. First, participants who had checked off multiple boxes (N=2) for racial/ethnic background were classified as "Biracial or Multiracial." Secondly, those who checked off being both a clinician and an administrator (N=6) or wrote in that they were a "clinical director" (N=5) were coded as "administrator" as this was the highest level role they played within the organization.

Once the data had been coded and entered into an electronic spreadsheet, the scores from the 40 CAMI questions were broken down into 10 question blocks representing the dimensions of Authoritarianism (questions 1-10), Benevolence

(questions 11-20), Social Restrictiveness (questions 21-30), and Community Mental Health Ideology (questions 31-40). In each of these 10 question subsets, the scores of questions 6-10 are reversed and combined with the scores of questions 1-5 to get a mean for each subscale. A Chronbach's alpha test was run to test the internal reliability of each subscale to ensure they could be combined into one score, and all alpha scores were above the acceptable cutoff of .60.

Descriptive statistics were used to describe the demographic information of participants in the study. In the analysis t-tests were used to compare gender (male vs. female) and role (therapist vs. administrator). A one-way ANOVA was used to compare different levels of experience in the field, with a follow-up Bonferroni post-hoc test to determine where differences originated from.

CHAPTER IV

FINDINGS

The primary question of this research project was: how do the attitudes and beliefs about both mental illness and the mentally ill of MHCs compare to other mental health workers. Secondary to this question, it was hypothesized that mental health workers with higher levels of education and/or more experience in the field would endorse lower levels of mental health stigma.

A total of 64 surveys were collected during Staff Appreciation Day for DYS staff. Participants varied in age from 23 to 68 (Mean=38.80, SD=14.385) and were predominantly self-identified as female (N=53) and white (N=48). The highest level of education achieved was primarily a master's degree (N=58) and 69% had professional licensing (N=44). For more demographic information, see Table 1.

Table 1

Selected Demographics of Participants

Gender	*Frequency*	*Valid Percent*
Male	11	17.2
Female	53	82.8
Total	64	100.0
Ethnicity	*Frequency*	*Valid Percent*
Biracial or Multiracial	6	9.4
Latino/Hispanic/Chicano	1	1.6
African American/Black	8	12.5
White/Caucasian	48	75.0
Other	1	1.6
Total	64	100.0
Highest Level of Education	*Frequency*	*Valid Percent*
College Graduate	2	3.1
Masters Degree	58	90.6
Ph.D./Psy.D.	4	6.3
Total	64	100.0
License	*Frequency*	*Valid Percent*
Yes	44	68.8
No	20	31.8
Total	64	100.0

There was a large degree of variability in the amount of time participants had worked in mental health settings, though their role within DYS was predominantly as a clinician (N=45). See Table 2 and Table 3 for further information.

Table 2

Time Worked in DYS or Other Mental Health Settings

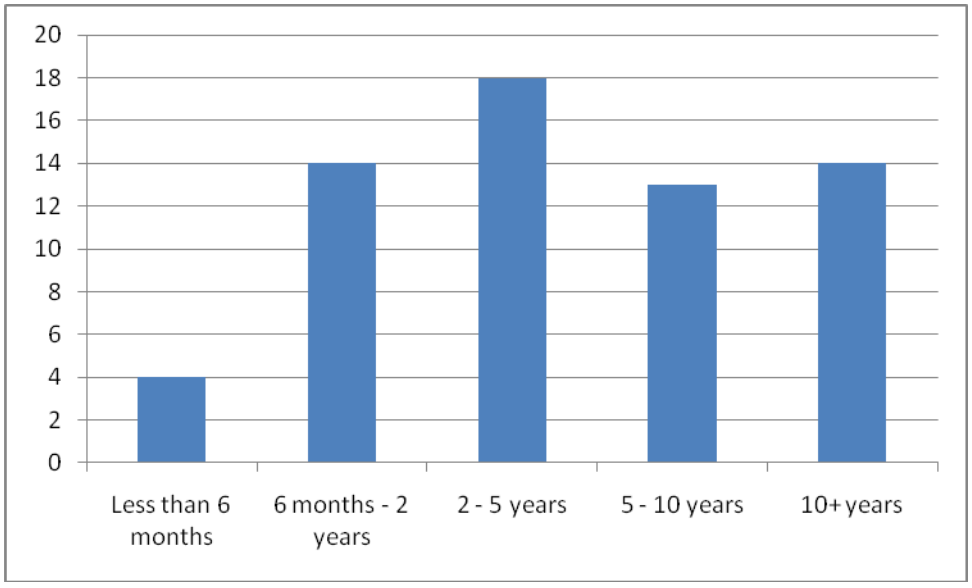
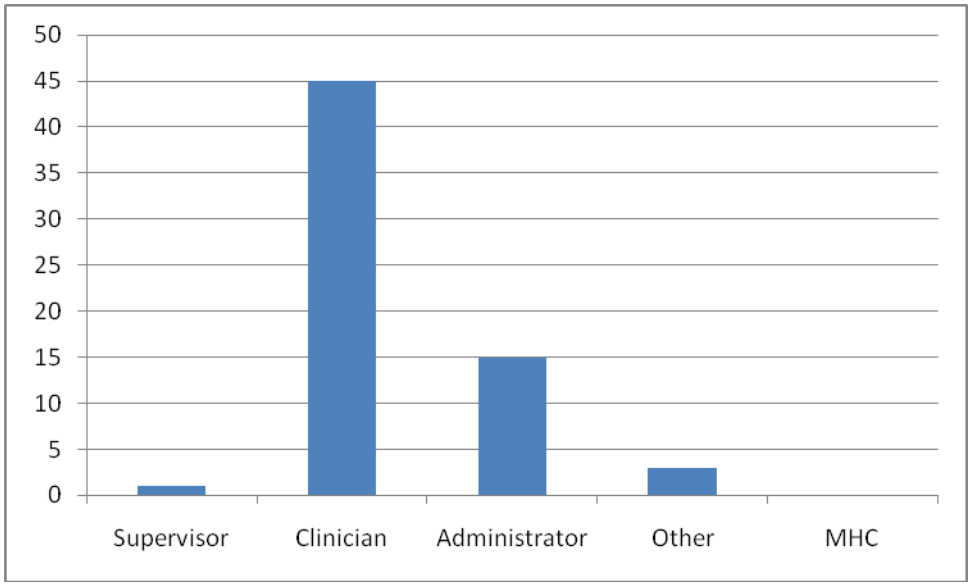


Table 3

Role/Position Within DYS



Unfortunately the primary research question regarding the attitudes of MHCs as compared to other mental health workers could not be assessed due to a lack of responses from MHCs. Multiple t-tests were run comparing therapists and administrators along the

four dimensions measured by the CAMI scale, but no significant differences were found. There were also no significant differences associated with gender or age. See Table 4 and 5 for more information.

Table 4

CAMI Scale Differences by Gender

Scale	*Gender*	*N*	*Mean*	*Std. Deviation*	*Std. Error Mean*
Authoritarianism	Male	11	2.1000	0.33764	0.10180
	Female	53	1.9361	0.49165	0.06753
Benevolence	Male	11	4.2000	0.52726	0.15897
	Female	53	4.3075	0.35495	0.04876
Social Restrictiveness	Male	10	1.7100	0.44833	0.14177
	Female	53	1.7325	0.38110	0.05235
Comm. MH Ideology	Male	11	3.8455	0.69190	0.20862
	Female	53	3.8816	0.49442	0.06791

Table 5

CAMI Scale Differences by Role

Scale	*Role*	*N*	*Mean*	*Std. Deviation*	*Std. Error Mean*
Authoritarianism	Clinician	45	2.0047	0.47781	0.07123
	Administrator	15	1.8933	0.43337	0.11190
Benevolence	Clinician	45	4.2605	0.40187	0.05991
	Administrator	15	4.3585	0.37003	0.09554
Social Restrictiveness	Clinician	44	1.7636	0.41769	0.06297
	Administrator	15	1.6215	0.29590	0.07640
Comm. MH Ideology	Clinician	45	3.8760	0.58023	0.08650
	Administrator	15	3.9333	0.38853	0.10032

The correlation of educational level and attitude toward mental illness and the mentally ill could not be directly compared as almost all of the respondents had a masters degree (N=58) and comparison groups of college graduates (N=2) and Ph.D./Psy.D.'s (N=4) were not large enough. This was a side effect of not being able to recruit any

MHCs to complete the survey, as their jobs require less formal education than clinicians and administrators.

In the comparison of time worked at DYS and other mental health settings, the category of 6 months and below was combined with 6 months to 2 years to create more evenly distributed groups for analysis. When compared with a one-way ANOVA, there were found to be significant differences in Authoritarianism ($F(3,59) = 3.408$, $p = .023$) and Benevolence ($F(3,59) = 3.382$, $p = .024$) based on years of experience. A Bonferroni post hoc test showed in both cases the significant difference was between those with 2-5 years of experience and 6-10 years of experience. Participants with 6-10 years of experience scored significantly higher on both the scale Benevolence and significantly lower on the scale of Authoritarianism.

While limitations in the sample prevented aspects of the original research question from being tested, it was found that more experience in the field was associated with higher levels of Benevolence as well as lower levels of Authoritarianism. Overall the participants showed high levels of Benevolence (Mean=4.28, SD=0.39) and Community Mental Health Ideology (Mean 3.88, SD=0.53) along with low levels of Authoritarianism (Mean=1.96, SD=0.47) and Social Restrictiveness (Mean 1.73, SD=0 .39). Unfortunately the CAMI scores of mental health professionals in this study could not be compared to studies on other population due to differences in the way the scores were measured and compiled.

To understand the relevance of this study and to provide context, we must look at the strengths and weakness of this study and how the findings relate to previous research.

Once this has been taken into account, the implications of this study can be considered for DYS practice and policy.

CHAPTER V

DISCUSSION

The purpose of this study was to assess if there were any differences in attitudes toward mental illness and persons with mental illness between MHCs and other mental health workers. It was hypothesized if there was a difference, part of the reason may be due to differences in education/training or length of time worked in mental health settings. Though the primary research question was unable to be assessed due a lack of survey data from MHCs, a number of other results were obtained.

Contrary to prior research (Corrigan & Watson, 2007), no differences in attitude were found between men and women. These previous findings were largely based on surveys of the general population however, whereas the participants in this study were a relatively homogenous group of DYS clinicians and administrators. The majority of the participants were also been trained as social workers and operate under the same set of ethical guidelines, so it is not surprising that gender differences may play a smaller role in the formation of their attitudes.

Although prior research had shown that certain kinds of exposure to mental illness can be beneficial (Corrigan et al., 2003; Crisp et al., 2000; Roth et al., 2000), no previous research that I have found directly addresses the impact that working with persons with mental illness over a more prolonged period of time would have on stigma. In this study it was shown that there were a significantly higher levels of Benevolence and lower levels of Authoritarianism over time worked in mental health settings, specifically

between those who had worked 2-5 years and those who had worked 6-10 years. Without any other research to corroborate these findings it is difficult to provide an explanation. It could be that the right kind of exposure has a cumulative effect of increasing levels of Benevolence and decreasing levels of Authoritarianism, or that persons who have these attitudes in the first place tend to stay in the field for a longer period of time. Further study is needed to determine an explanation for this finding.

As mentioned previously, no direct comparison between MHCs and other mental health workers was able to be made due to a lack of MHC participation. This was also the reason that the effect of different levels of education on mental illness stigma in mental health workers was not able to be measured. To see if there were any differences between other subgroups of mental health workers that data had been gathered on, clinicians and administrators were compared but no significant differences were found. This was not unexpected, as many of the administrators had either previously worked as clinicians or worked in a dual role as both clinician and administrator and had similar educational backgrounds.

This study has a number of strengths, including the use of an instrument that has been shown to be reliable and valid (Sévigny et al., 1999) and which allows for direct comparison to several other studies that used the CAMI scale. The sample was also large and represented a diverse group of mental health workers from a variety of different agencies within DYS. There are also several limitations to consider. First, the survey data collected during Staff Appreciation Day was likely not a representative sample of the DYS as a whole, as seen by the low participation rate by MHCs. Because the data comes from a convenience sample, the findings have limited generalizeability to DYS

staff or other mental health workers. In addition, because this was quantitative descriptive research, the information gathered serves only to describe what is being measured and does not have explanatory power.

The lack of a comparison group of MHCs in the study also limits the implications it can have for practice and policy. Although there are a number of anti-stigma trainings that have been empirically supported (Finkelstein, Lapshin, & Wasserman, 2008), it is unclear without MHC data whether any of these interventions are needed at this time. Information gathered about MHCs within DYS would also have to take into account any training they currently receive, which may be more or less comprehensive that other mental health agencies and thus make it more difficult to generalize.

Although some interesting information was found in the data analysis, the major conclusion coming from this project is that more care and effort needs to be taken in future studies to ensure that MHCs are active participants in the research. When this is done we will be able to more adequately assess if they are receiving adequate training and education for the work they do, and thus whether they are helping to create a therapeutic environment for the people they work with.

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Appendix A

DYS Pilot Survey

Thank you for taking the time to complete this confidential survey. Fill out the attached raffle ticket after completing the form to enter a drawing for a chance to win one $50 gift card or one of two $25 gift cards.

Check the box with the Best Response for Each Question

What is your age?

Age: _____

What is your gender?

□ Male □ Female □ Transgender □ Other: _____

Which of the following best describes your racial/ethnic background?

□ Biracial or Multiracial □ Latino, Hispanic, or Chicano

□ African American or Black

□ Native American, North or South American Indian, or Alaskan

□ Asian or Pacific Islander □ White or Caucasian

□ Cape Verdean □ Other: _____

What is the highest level of education you have attained?

□ Some High School □ High School Graduate/GED

□ Trade School □ Some College □ College Degree (BS/BA)

□ Some Graduate School □ Masters Degree □ Ph.D./Psy.D.

□ M.D. □ Other: _____

Are you professionally licensed? (If yes please specify type of license)

□ No □ Yes: _____

What is the gender of the clients/residents you work with?

□ Boys □ Girls □ Both

What age are the clients/residents you work with?

□ Latency (age 6-12) □ Adolescents (age 13-17)

□ Both (age 6-17)

~~**What level of DYS care do you work in? (Check all that apply)**~~

~~□ Level 1 □ Level 2 □ Level 3 □ Level 4 □ Level5~~

What is your role/position within DYS? (if Other, please specify)

□ Line Staff/MHC □ Supervisor □ Clinician

□ Administrator □ Other: _____

How long have you worked within DYS or other mental health settings?

□ Less than 6 months □ 6 months – 2 years □ 2 years – 5 years

□ 5 years – 10 years □ 10+ years

Please indicate the extent of your agreement with the following statements:

Question:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. One of the main causes of mental illness is a lack of self-discipline and will power	□	□	□	□	□
2. The best way to handle the mentally ill is to keep them behind locked doors	□	□	□	□	□
3. There is something about the mentally ill that makes it easy to tell them from normal people	□	□	□	□	□
4. As soon as a person shows signs of mental disturbance, he should be hospitalized	□	□	□	□	□

Question:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5. Mental patients need the same kind of control and discipline as a young child	□	□	□	□	□
6. Mental illness is an illness like any other	□	□	□	□	□
7. The mentally ill should not be treated as outcasts of society	□	□	□	□	□
8. Less emphasis should be placed on protecting the public from the mentally ill	□	□	□	□	□
9. Mental hospitals are an outdated means of treating the mentally ill	□	□	□	□	□
10. Virtually anyone can become mentally ill	□	□	□	□	□
11. The mentally ill have for too long been the subject of ridicule	□	□	□	□	□
12. More tax money should be spent on the care and treatment of the mentally ill	□	□	□	□	□
13. We need to adopt a far more tolerant attitude toward the mentally ill in our society	□	□	□	□	□
14. Our mental hospitals seem more like prisons that like places where the mentally ill can be cared for	□	□	□	□	□
15. We have a responsibility to provide the best possible care for the mentally ill	□	□	□	□	□
16. The mentally ill don’t deserve our sympathy	□	□	□	□	□
17. The mentally ill are a burden on society	□	□	□	□	□
18. Increased spending on mental health services is a waste of tax dollars	□	□	□	□	□
19. There are sufficient existing services for the mentally ill	□	□	□	□	□
20. It is best to avoid anyone who has mental problems	□	□	□	□	□

Question:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
21. The mentally ill should not be given any responsibility	□	□	□	□	□
22. The mentally ill should be isolated from the rest of the community	□	□	□	□	□
23. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered	□	□	□	□	□
24. I would not want to live next door to someone who has been mentally ill	□	□	□	□	□
25. Anyone with a history of mental problems should be excluded from taking public office	□	□	□	□	□
26. The mentally ill should not be denied their individual rights	□	□	□	□	□
27. Mental patients should be encouraged to assume the responsibilities of normal life	□	□	□	□	□
28. No one has the right to exclude the mentally ill from their neighborhood	□	□	□	□	□
29. The mentally ill are far less of a danger than most people suppose	□	□	□	□	□
30. Most women who were once patients in a mental hospital can be trusted as babysitters	□	□	□	□	□
31. Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community	□	□	□	□	□
32. The best therapy for many mental patients is to be part of a normal community	□	□	□	□	□
33. As far as possible, mental health services should be provided through community based facilities	□	□	□	□	□
34. Locating mental health services in residential neighborhoods does not endanger local residents	□	□	□	□	□

Question:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
35. Residents have nothing to fear from people coming into their neighborhood to obtain mental health services	□	□	□	□	□
36. Mental health facilities should be kept out of residential neighborhoods	□	□	□	□	□
37. Local residents have good reason to resist the location of mental health services in their neighborhood	□	□	□	□	□
38. Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great	□	□	□	□	□
39. It is frightening to think of people with mental problems living in residential neighborhoods	□	□	□	□	□
40. Locating mental health facilities in a residential area downgrades the neighborhood	□	□	□	□	□