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Does degree matter? : an exploration into the stigmatization of mental illness by social workers and other mental health professionals

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Abstract

This quantitative descriptive study sought to explore any differences in stigmatization by social workers and other mental health professionals. The second research question explored whether mental health professionals felt their degree program actively challenged them to explore stigma towards those with mental illness. Fifty participants completed an anonymous online survey that included the Community Attitudes Towards Mental Illness scale, measuring stigma of mental illness. There were an additional four Likert scale questions exploring stigma of mental illness, and the participants perspectives of their education about stigma. The findings indicated that social workers had a lower mean score on the subscale of authoritarianism than other mental health professionals. Additionally, the research indicated that the majority of mental health professionals felt that their degree program did not address stigma. Implication for future research, and the field of social work are also discussed.

DOES DEGREE MATTER? AN EXPLORATION INTO THE STIGMATIZATION OF MENTAL ILLNESS BY SOCIAL WORKERS AND OTHER MENTAL HEALTH PROFESSIONALS

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TABLE OF CONTENTS

LIST OF TABLES

Table

Chapter I

Introduction

The purpose of this research is to investigate stigma towards mental illness and its prevalence among different mental health clinicians. Though the effects of stigma on those living with mental illness have been investigated quite thoroughly, only a small amount of research has examined the ways mental health treatment providers may harbor stigma that mirrors that of the larger society. The proposed research will study whether stigma against mental illness by specific types of mental health clinicians occurs at different rates and whether it is correlated with the type of education they have received. This study is needed as the views of different types of mental health clinicians can lead to significant impacts on treatment as these professionals are the ones making clinical decisions for and with this population at varying levels of treatment.

In order to understand how to measure stigma among mental health professionals there must first be a conceptualization of what stigma is. Mental illness stigma has been conceptualized as the negative treatment or perception of individuals as a result of having an attribute (such as mental illness) that society at large sees as "devalued," (Stromwall, Holley, & Bashor, 2011) or attributing any characteristics that are perceived as negative, to their status as a person with mental illness (Stier & Hinshaw, 2007). This stigma is inextricably linked to mental health professionals and the field of mental health treatment (Schulze, 2007). The ways that mental health clinicians conceptualize and discuss mental illness often affects the way the population at large will view this demographic (Lofgren, Hewitt, & das Nair, 2014).

Unfortunately, some research has indicated that mental health professionals have a more negative view of prognosis than the general public, indicating that providers may harbor less hope and positive regard for their clients with mental illness (Stromwall et al., 2011). Aside from the implication for society at large, understanding the attitude of mental health professionals towards those with mental illness is important as attitude often impacts behavior (Stull, McGrew, Salyers, & Ashburn-Nardo, 2008). Evidence suggests that stigma impacts clinical decisions and perceived treatment outcomes (Stull et al., 2008).

Within the literature there seems to be little differentiation between specific types of clinical training (ie. Psychiatry, social work, psychology) and the implications of education on implicit stigma (Schulze, 2007). This study collected demographic information regarding types of education along with measures of stigma in an attempt to fill this gap. A deeper understanding of the attitudes of mental health providers as a whole, could challenge social work institutions (and others) to create systems and programs that challenge this stigma before clinicians enter the field of mental health and begin working with these clients. Therefore the intent of this study is to better understand whether education in the training of mental health professionals addresses stigma.

This study analyzed the responses of 50 clinical mental health professionals who completed a masters degree or higher in the fields of social work, psychiatry or psychology. This data was collected through an anonymous online survey including both demographic questions and a measurement of stigmatization of mental illness. This survey also included a question measuring whether or not professionals felt their degree program challenged them to explore their stigma towards those with mental illness.

Utilizing this survey I intended to add to the literature around stigma specifically within the mental health profession by linking education as a means of stigma reduction. Specifically, I hoped to identify whether the education mental health professionals receive about the etiologies of mental illness such as primarily biological, or a combination of factors, impacts their levels of stigma. Additionally, I hoped to determine whether these mental health professionals felt their degree programs challenged them to explore the stigma they may harbor towards he mentally ill. This thesis is organized into five chapters. Chapter II explores current literature on the topic of mental health stigma and its limitations. Chapter III presents the methods used to conduct the research and test this study's hypothesis. Chapter IV describes the findings of this study, and Chapter V is a discussion of the results and implications of this study given the current literature.

Chapter II

Literature Review

This chapter will review some of the empirical literature on stigma towards those with mental illness in order to frame the current study. It will explore the need for the current study to examine whether the type of education a mental health provider receives, impacts attitudes towards clients with mental illness. This chapter will be divided into five sections:, stigma and impact, stigma among mental health professionals, contributing factors, reduction and prevention, as well as limitations. The first section provides a conceptualization of stigma and its impact on those living with mental illness. Next, the research focuses on understanding how pervasive stigma of mental illness is within culture and more specifically the mental health profession. The third section will frame what some of the contributing factors to higher levels of mental illness stigma are and how this may be related to the type of education mental health providers receive about mental illness. Then, the literature will discuss what have been mediating factors to reduce stigma. Lastly, this review explores some of the limitations of the previous literature and implications for future research.

Stigma and Impact

Stigma has been conceptualized as the negative treatment or perception of individuals as a result of having an attribute (such as mental illness) that society at large sees as devalued (Stromwall et al., 2011). Stigma can include a variety of stereotypes, prejudices and discriminatory behaviors towards those with mental illness (Stuber, Rocha, Christian, & Link,

2014). Stigma encompasses both explicit and implicit processes. Explicit stigma is the attitudes or beliefs that are under conscious control, whereas implicit stigma often encompasses the attitudes and beliefs that are present without the conscious knowledge of the person (Stier & Hinshaw, 2007). Explicit and implicit stigma are complexly related with explicit stigma being a better predictor of "intentional behaviors that are under conscious control such as friendliness," (Stier & Hinshaw, 2007 p. 111) and implicit stigma a better measure of automatic behaviors. This means that although someone may not seem to have explicit stigma, they could harbor a significant amount of implicit stigma that should be considered when doing research on the subject (Stier & Hinshaw, 2007). Stigmatization of people with mental illness encompasses all of these processes as well as attributing any characteristics that are perceived as negative, to the individual's status as a person with mental illness (Stier & Hinshaw, 2007). Corrigan (2004) identified two primary types of stigma impacting those with mental illness: public stigma, which is stigma imposed on someone from the larger society, and self-stigma, which is the stigma someone with mental illness might internalize and place on themselves.

Public stigma can manifest in a multiplicity of ways including believing that all people with mental illness are dangerous, that mental illness is a character flaw, and attempts at avoiding or distancing oneself from this population (Corrigan, 2004; Stuber et al., 2014). This stigma can have profound negative effects on those living with mental illness (P. Corrigan, 2004; Stier & Hinshaw, 2007; Stromwall et al., 2011; Stull et al., 2008). Stigma impacts a variety of things such as treatment engagement, access to medical services, employment, housing, and safety for people diagnosed with a mental illness (Corrigan, 2004; Schulze, 2007). One study conducted by Thornicroft et al. (2009) found that 29% of individuals with severe mental illness reported discrimination while attempting to find employment. Corrigan et al. (2003) as cited in

Sickel, Seacat, & Nabors (2014), found that as many as 32.2% of people who participated in a study conducted in multiple states reported housing discrimination based on having a "psychiatric disability," (p. 205). These experiences of stigma and discrimination begin to impact the individual's view of themselves (P. Corrigan, 2004; Lucksted & Drapalski, 2015).

Recently the idea of self-stigma or internalized stigma has been researched more thoroughly. Lucksted & Drapalski (2015) discuss that "ideas about ourselves are profoundly shaped by how we believe others see us," (p. 99). Although there are many reasons one might have internalized stigma, societies' larger judgmental concepts of mental illness as a devalued identity, certainly may play a role (P. Corrigan, 2004; Lucksted & Drapalski, 2015). Much like public stigma, self-stigma has significant impacts on those living with mental illness. People who internalize stigma may experience a reduction in self-esteem and self-efficacy, which may result in higher rates of shame (Corrigan, 2004). Some even experience a loss of hope and empowerment, in addition to an increase in symptoms (Lucksted & Drapalski, 2015). The result of this stigma and the subsequent beliefs about one's self can often be linked to lack of engagement in treatment, community participation and social relationships (Lucksted & Drapalski, 2015). If mental health professionals have stigma about those with mental illness, it can be especially impactful as they are the ones often providing services and supporting clients who experience the negative effects of stigma from the general population (Stull et al., 2008).

Stigma Among Mental Health Professionals

With mental illness affecting one in four individuals in the United States, it is no surprise that stigma is one of the number one problems that people with mental illness encounter, (P. Corrigan, 2004; Parcesepe & Cabassa, 2013; Stier & Hinshaw, 2007). It is estimated that nearly two thirds of people with a mental health condition do not seek treatment as a result of stigma

(Barczyk, 2015). Although the general public seems to be in favor of people seeking out mental health services for their illness, the public view that people with mental illness are dangerous seems to have increased over time (Parcesepe & Cabassa, 2013).

More specifically, the beliefs of mental health professionals is important because these professionals often engage with people with mental illness when they are most vulnerable (Stier & Hinshaw, 2007; Stuber, Rocha, Christian, & Link, 2014). The literature indicates a varied perspective including both negative and positive perceptions of those with mental illness by mental health professionals (Schulze, 2007; Stuber et al., 2014; Wahl & Aroesty-Cohen, 2010). Many of the studies included a range of positive and negative beliefs from the mental health providers (Wahl & Aroesty-Cohen, 2010). However, negative attitudes by mental health clinicians were noted even in the studies with more overall positive results (Wahl & Aroesty-Cohen, 2010). In fact, "nearly three quarters of the relevant publications report that beliefs of mental health care workers do not differ from those of the population, or are even more negative (Schulze, 2007, p. 142). This may be an indication that the beliefs of mental health professionals contribute to the overall continued negative perception of those with mental illness (Lofgren et al., 2014; Wahl & Aroesty-Cohen, 2010).

People who are receiving mental health services have reported experiencing stigma directly from their mental health clinicians (Stromwall et al., 2011). This stigma takes on a number of different forms including poor or dehumanizing communication, negative prognosis or lowered expectations, failure to describe options or side effects of medication, and infantilization (Stromwall et al., 2011). One study found that, "service recipients attributed fully one quarter of their total experienced stigma to their clinicians," (Stromwall et al., 2011, p. 473). This research highlights the importance of gaining a better understanding of what might affect

mental health professional stigma, in an attempt to address the issue of stigma before it can impact these clients directly.

It is also important to note that the majority of the current literature has only examined explicit bias of mental health clinicians (Schulze, 2007; Wahl & Aroesty-Cohen, 2010), which may lack an acknowledgement of social desirability and positive self-presentation biases among mental health professionals (Stier & Hinshaw, 2007). This is because responses to measurements of explicit bias are under conscious control and the person is likely influenced by a desire to appear unbiased or unprejudiced (Stier & Hinshaw, 2007). Measurements that explore implicit bias more accurately assess underlying attitudes especially when they are considered socially unacceptable (Stier & Hinshaw, 2007).

Contributing Factors

With the 1990's being deemed the decade of the brain, mental illness became a spotlight of research and subsequently came more forcefully into the public eye (Schomerus, Schwahn, Holzinger, Corrigan, Grabe, Carta & Angermeyer, 2012). One movement that came out of this time and continues today is the declaration of mental illness as having genetic or biological etiologies (Schomerus et al. 2012). Many anti-stigma campaigns were launched to portray mental illness as an illness like any other (Schomerus et al. 2012). The hope of these campaigns was that people would become more conscious about mental illness, mental health treatment would be more accepted, acceptances of people with mental illness would increase and the stereotypes about them would be diminished (Schomerus et al. 2012). Unfortunately, the results on stigma have not been what was anticipated (Pattyn, Verhaeghe, Sercu, & Bracke, 2013, Schomerus et al. 2012). Although public awareness and mental illness literacy have increased, attitudes towards those with mental illness seem to have remained poor or gotten worse (Schomerus et al. 2012).

It is thought that much of the stigmatization of mental illness is a result of how people conceptualize the etiologies or causes of mental health issues (Link et al., 1999). If it is believed that those with mental illness are responsible for their illness, or can control their behaviors, the public is likely to respond with more stigmatizing attitudes and behaviors (Corrigan et al., 2003; Link et al., 1999). Additionally, the public media tends to portray people with mental illness as violent and dangerous. When people with mental illness are seen as dangerous the public will often try to create more distance (Corrigan et al., 2003). Although the exact reason behind the stigmatization of mental illness is difficult to isolate, what is clear in the research is that the various conceptualizations of mental illness within the mental health field seem to impact stigma. (Schulze, 2007).

The ways that mental health clinicians conceptualize and discuss mental illness often affects the way the population at large will view this demographic (Lofgren et al., 2014). A study in Belgium looked at the ways that the conceptualization of mental illness as having medical or psychosocial etiologies impacts rates of stigma in the general population. Pattyn, Verhaeghe, Sercu, & Bracke (2013) found that the medicalization of mental illness resulted in higher rates of stigma as people saw the illness as stable and less susceptible to change. The study also found that although psychosocial attribution of mental illness resulted in lower rates of stigma, it also resulted in lower rates of formal help seeking (Pattyn et al., 2013). It appears that even though the aim has been to decrease stigma, the public's awareness that there is a biological or genetic basis for mental illness has lead to an increased rate of stigma for some mental illnesses (Pattyn et al., 2013, Schomerus et al. 2012, Stier & Hinshaw, 2007). These results are interesting to consider when exploring the models of education different mental health professionals receive, and how this education may impact their own stigma.

Additionally, a more negative view of mental illness has been correlated with a strong tendency to categorize others as different from yourself (Stier & Hinshaw, 2007). This may be of particular interest in studying the views of mental health providers as they are often placed in positions which separate them from their clients with mental illness. They might subscribe to the idea that although there is no "substantive attribution for separateness," providers are different from their clients (P. W. Corrigan, Bink, Fokuo, & Schmidt, 2015). This may be further illustrated through the tendency mental health providers have to seek more social distance from those with mental illness than from the general public (Stromwall et al., 2011).

Reduction and Prevention

Some research has explored the ways in which stigma towards those with mental illness can be reduced. In the general public, education about mental illness, as well as positive relationships with people living with a mental illness, contributed to lower rates of stigma (P. Corrigan, 2004). Some research has found that when an individual believes in the ability of a person to recover from a mental illness, they may endorse less stigma (Barczyk, 2015). Considering this, it would be useful when educating the general public to highlight the potential for recovery in order to hopefully reduce or prevent stigma (Barczyk, 2015). Some research has indicated that demographic characteristics have been associated with less stigma in both the general public and mental health providers. Specifically, being non-hispanic white, being female, being more educated and younger have been correlated with lower rates of stigma (Stuber et al., 2014).

Research investigating what has been shown to reduce or prevent stigma in mental health professionals has been very limited. One study found that personal experience with mental illness, and more years of work experience in mental health settings were predictors of more

positive views of those with mental illness (Stuber et al., 2014). The limited amount of research specific to clinicians in this area emphasizes a greater need to explore more directly mental health professional's bias for both what is associated with higher rates of bias and what may reduce it.

Limitations

Most of the previous research that has been conducted about stigma towards those with mental illness has primarily focused on stigma faced by adults living with mental illness. Additionally, the limited amount of research that has been conducted about mental health professionals has primarily centered around psychologists, psychiatrists and psychiatric nurses (Schulze, 2007; Stier & Hinshaw, 2007) often leaving out statistics about clinical social workers who frequently provide services to people living with mental illness. As mentioned previously, there has also been little research done to determine what might mediate stigma specifically within the mental health profession. One limitation to studying bias or stigma within this profession is social desirability bias. As providers of service for those with mental illness, explicit measures may not accurately depict underlying beliefs and behaviors (Stier & Hinshaw, 2007).

Summary

Stigma towards those with mental illness is pervasive in our culture from the public and even mental health professionals. The studies above have outlined that with the mental health field often leading the education of the general public it is important to understand the beliefs of providers. Understanding the attitudes of mental health professionals towards those with mental illness is important as attitude often impacts behavior (Stull et al., 2008). Evidence suggests that stigma impacts clinical decisions and perceived treatment outcomes (Stull et al., 2008)

Additionally, increased awareness of perception is important, as mental health providers may not even recognize stigma in the same way a person with the lived experience of mental illness would (Stromwell, et al., 2011). Developing a better understanding of the beliefs of mental health providers and the impact of education may provide a valuable opportunity to inform pedagogy in various mental health disciplines.

Chapter III

Methodology

The following chapter describes the purpose of this quantitative, descriptive study and the methodology used to complete the research. This study built on previous research used to explore factors that contribute to the stigmatizing of mental illness in the general public and to see if those are applicable to mental health professionals. The research question seeks to determine whether stigmatizing by mental health professionals is correlated with the education they received to obtain their degree. Specifically, it examines the attitudes and educational experiences of social workers, psychologists, and psychiatrists.

Research Method and Design

Prior to the process of data collection, this methodology was approved by the Human Subjects Review Committee at Smith College School for Social Work (Appendix A). A non-probability, snowball sampling technique was used to identify participants. The principle researcher utilized contacts through professional networks, education, and personal connections in the field of mental health beginning with Maine Behavioral Healthcare and Smith College School for Social Work. Participants were encouraged to send this survey along to colleagues across the country to obtain a more representative sample.

A quantitative descriptive methodology was used to best capture the attitudes of mental health professionals while reducing social desirability bias. Using an anonymous survey, it was assumed that professionals might feel more comfortable answering these questions. Using a

quantitative methodology allowed for a higher number of responses. This process best allowed for analysis of difference among social workers and non-social worker mental health professionals. Snowball sampling was primarily chosen for its convenience and accessibility. The limitations to this methodology were that there was no ability for the researcher to ask clarifying questions of respondents. Additionally, with snowball sampling, the results may not be generalizable as participants may only pass the survey along to likeminded colleagues who may not represent mental health professionals generally.

Participants were identified through a recruitment email (Appendix B) sent by the principle researcher that included a link to an anonymous survey requesting their participation in the study. In the initial email participants were informed of the purpose of the research, sample criteria and ways to contact the principle researcher with any questions during the process. In this email, participants were also encouraged to send this email to their colleagues in the fields of social work, psychology, or psychiatry. If they were interested in participating in the study, participants were encouraged to follow the link included in the email to the anonymous survey at Qualtrics.com.

A second email communication was sent a week later (Appendix C) to this initial list to thank those who had completed the survey, and to encourage those who had not yet responded to do so. In this email they were again given the inclusion criteria, purpose, and principle researcher's contact information. Once again they were encouraged to follow the link to the online survey and to forward this email with the survey link to their colleagues for a larger sample.

Once participants followed the link to the survey, the first question on the survey was a consent agreement (Appendix D). Once identifying that they agreed to be a participant in the

study, and that they the met the inclusion criteria, participants would begin to complete the anonymous online survey (Appendix E). The survey included three sections: demographics, the Community Attitudes Toward Mental Illness scale, and an additional four Likert scale questions. At this point, when all fifty survey questions were completed, participants then were asked to submit their responses for data analysis and were thanked for their participation.

Sample

This study included a sample of mental health professionals with master's level degrees or higher in social work, psychology or psychiatry who are currently practicing clinically in their field of study. The sample was obtained utilizing non-probability quota sampling methods in an effort to obtain 25 participants from each field of study. Through the data collection process it became clear that a sample size of 75 could not be obtained within the time constraints. The sample size was lowered to 50 with a quota of at least 20 total psychiatrists or psychologists. All gender identities, sexual orientations, racial or ethnic identities, and ages were welcome in this study as long as they met the inclusion criteria. Participants were allowed to have obtained only one of the three degrees (social work, psychology, or psychiatry) to participate. This was in an effort to keep the groups distinct.

Data Collection

The data collection was done through a structured survey with both multiple choice and Likert scale questions. The survey began with a series of descriptive, multiple choice, demographic questions including age, gender, race or ethnicity, degree, populations worked with, and years practicing clinically. Once they had completed the demographic questions, participants would begin the Community Attitudes towards Mental Illness (CAMI) scale. The CAMI is a self-report scale that is designed to measure positive and negative attitudes towards those with

mental illness (Taylor and Dear, 1981). The CAMI questionnaire explores attitudes towards mental illness with forty questions on four dimensions: authoritarianism, benevolence, social restrictiveness, and community mental health ideology (Taylor and Dean, 1981). At the end of these forty questions, participants completed an additional four questions with the same Likert scale related to their beliefs about mental illness and education. The CAMI is available in the public domain, and therefore no special permission was needed to include it within the survey. The data was coded through the website Qualtrics.com and processed by the principle researcher with the support of Marjorie Postal, Smith College School for Social Work's statistician.

Ethics and Safeguards

In order to protect the confidentiality of participants in this study, no identifying information was requested or collected. All participants were provided with the same survey link so their entry could not be traced to them. With data collection happening anonymously online, participants could be assured that there would not be stigmatized for responses as there would be no way to indicate who had completed the survey.

The responses were stored at Qualtrics.com, whose procedures were approved by the Human Subjects Review Committee at Smith College School for Social Work. The survey and the participant's responses were password protected. These individual survey responses were only available to the principle researcher and the statistician through Smith College School for Social Work as necessary for analysis. All research materials including analyses and consent documentation will be stored according to federal regulations for three years. All of this data will be password protected and stored electronically by the principle researcher. In the event that the material are needed beyond the three years, they will be kept until they are no longer needed and then destroyed.

Data Analysis

Once the data was collected and subsequently coded through Qualtrics.com, it was then processed by the principle researcher. First, ten respondents were removed for not completing the survey in its entirety. Of the respondents who completed the survey, the demographic questions were coded as descriptive statistics and their frequencies were logged. The CAMI questions were divided utilizing the four subscales of authoritarianism, benevolence, social restrictiveness, and community mental health ideology as outlined by Taylor and Dear (1981). A Chronsbach Alpha test was run for each of the four subscales to determine internal reliability. All of the subscales came back with moderate to strong internal reliability, indicating that they can be used as scales. Each subscale had a total of ten questions. The first five questions of each subscale were scored with strongly disagree with the value of one, disagree=2, neutral=3, agree=4, and strongly agree=5. The last five questions of each subscale were scored in the reverse, with strongly disagree with a value of 5, agree=4, neutral=3, disagree=2, and strongly disagree=1. These scores were then combined, and a mean for each of the four subscales was calculated. Once the mean scores were determined for each subscale for each profession, T-Tests were run to see whether there were differences in subscales by profession. Lastly the additional four Likert scale questions were scored with the same numerical values as the first five questions of the CAMI subscales. An additional T-Test was completed to determine if there were significant statistical differences in the ways these questions were answered by the different professional groups.

Chapter IV

Findings

This study explored mental health professionals' self reported rates of stigma and the possible contributing factors of differing educational experiences through an anonymous online survey. This survey was designed to measure differences between social workers' and other mental health professionals' (psychologists and psychiatrists) levels of stigma, and messages received about stigma in their degree programs. Due to the lower number of responses from psychologists and psychiatrists, these two professions were combined into one group to compare with social workers. This survey utilized the Community Attitudes towards Mental Illness (CAMI) assessment tool, to measure stigma. The CAMI reports on four subscales associated with stigma towards mental illness; benevolence, authoritarianism, social restrictiveness and community mental health ideology. This study found that social workers had statistically significant differing rates compared to the other group on the authoritarianism scale, indicating lower rates of authoritarianism than the other mental health professionals. Social workers also reported feeling that their degree programs may have challenged them to explore their internalized stigma towards those with mental illness slightly more than the psychiatrists or psychologists in the study.

The findings are reported below beginning with participant demographics. Next, the results of the Community Attitudes Towards Mental Illness responses are presented in the four

subscales of benevolence, authoritarianism, social restrictiveness and community mental health ideology. Lastly, the findings conclude with responses to the four Likert scale questions.

Participant Demographics

Sixty-Two participants began the study, with fifty participants completing the study. The information collected from these fifty participants was utilized for this study. The sample had a diverse range of ages, with the highest percentage of respondents being between the ages of 25-34 at 50%. The other fifty percent of respondents were divided as follows, 2% 18-24, 14% were between the ages of 35-44, 10% fell between the ages of 45-54, 16% were 55-64 years old and an additional 8% of respondents were 65 and older.

Table 1. What is your age?

Age	Frequency	Percent
18-24	1	2.0
25-34	25	50.0
35-44	7	14.0
45-54	5	10.0
55-64	8	16.0
65 and older	4	8.0

With regard to gender, 70% of respondents identified as female. The remaining respondents identified 24% as male, 4% as transgender or gender non-conforming, and 2% preferred not to answer.

The majority of participants identified their racial and ethnic identity as Caucasian/white with 90% of responses in this category. The next highest represented group was Asian/Pacific

Islander at 4%. Biracial/Multiracial, prefer not to answer, and other (Ashkenazi Jewish) each represented 2% of participants.

With regard to degrees obtained, participants were given three options to choose from, social work, psychiatry or psychology. Social workers had the highest rate of responses at 54%. The remainder of participants were split between the two remaining groups with 16% having degrees in psychiatry and 30% with a degree in psychology.

Table 2. Which of these degrees have you received?

Degree	Frequency	Percent
Psychiatry	8	16.0
Social Work	27	54.0
Psychology	15	30.0

To better understand the populations that the participants work with, they were given the option of selecting all that apply. In order of highest to lowest responses, 62% of participants work with children and adolescents, 60% work with adults 18+, 32% work with families, and 12% work with couples.

The distribution of years participants have been practicing clinically was similar to that of the age range with the majority of participants on the either end of the spectrum. The highest number of participants had been practicing for 0-5 years making up 56% of respondents. Those practicing for 21 years or more represented 30% of participants. The remaining 14% fell between two groups, 6-10 years with 8% and 11-15 years with 6%.

Community Attitudes Towards Mental Illness

After collecting the demographic and descriptive statistics above, the survey went on to collect responses from participants using the Community Attitudes Towards Mental Illness scale. This scale includes forty questions divided into four subscales including benevolence, authoritarianism, social restrictiveness, and community mental health ideology. Each subscale has 5 positive associated questions and five negatively associated questions, the scores from these responses are averaged to find the mean for each subscale. The lower the score, the less stigma a participant has. For ease of reading, the answers to these questions have been provided in tables in aggregate form by profession.

The T-Tests revealed that there was a statistically significant difference between the two groups on the authoritarianism subscale. Social workers had a lower mean score (m=1.66) than the other professionals in the study (m=1.91). This indicates that the social workers in the study tended to have lower rates of authoritarianism than the psychiatrists and psychologists who completed the study. There were no other statistically significant findings on the CAMI subscales between the two groups.

Table 3. Community Attitudes Towards Mental Illness Subscales

Subscale	Profession	Frequency	Mean	Std. Deviation
Authoritarianism	Social Worker	27	1.6630	.34435
	Psychologist or Psychiatrist	23	1.9130	.50928
Benevolence	Social Worker	27	4.5630	.31397
	Psychologist or Psychiatrist	23	4.3435	.49802

Social Restrictiveness	Social Worker	27	1.9185	.35196
	Psychologist or Psychiatrist	23	1.9957	.35863
Community Mental Health Ideology	Social Worker	27	4.1630	.48765
	Psychologist or Psychiatrist	23	4.0913	.47760

Likert Scale Questions

For the first three Likert scale questions there was no statistical significance. For the last question on the survey, there was a significant difference between the two groups. Social workers had a mean of 3.44 as compared to the other group who had a mean of 2.43. This is significant, as it indicates that social workers more often felt that their degree program encouraged them to explore their own internalized stigma towards those with mental illness. It is also significant to note though, that although social workers reported higher rates than the other group, this number still falls between "neither agree or disagree, and agree" which does not necessarily indicate that social workers were satisfied with their education on the subject. Overall, of the participants in the study only 44% (n=2) agreed, or strongly agreed that their program challenged them to explore stigma as shown in Table 5.

Table 4. My degree program actively challenged me to explore my own internalized stigma towards those with mental illness? **(T-Test)**

Profession	Frequency	Mean	Std. Deviation
Social Worker	27	3.44	1.281
Psychologist or Psychiatrist	23	2.43	1.161

Table 5. My degree program actively challenged me to explore my own internalized stigma towards those with mental illness? (Overall Responses by all participants)

Response	Frequency	Percent of overall response
Strongly Disagree	6	12.0
Disagree	18	36.0
Neither Agree nor Disagree	4	8.0
Agree	15	30.0
Strongly Agree	7	14.0

Summary

Major findings from the anonymous online survey including self reported rates of stigma were presented above. Statistically significant findings were found in analyzing the responses to the Community Attitudes Towards Mental Illness Scales, and the last question on the survey examining whether participants felt their degree programs challenged them to examine stigma. The next chapter will compare these findings to previous literature, as well as highlight the strengths and limitations. Lastly, the next chapter will conclude with suggestions for future research.

Chapter V

Discussion

This study was designed to explore two primary questions, 1) Are there differences in self-reports of stigma by mental health professionals based on the degrees they obtained? 2) Do these mental health professionals feel that their degree programs challenged them to explore the stigma that they may harbor towards those with mental illness? This chapter will discuss the findings illustrated in the previous chapter by placing them in the context of the current literature and demographics of mental health professionals at large. Additionally, this chapter will explore this study's limitations, implications for social work and suggestions for future research.

Participant Demographics

Age. Although it is challenging to find demographics on mental health professionals, on average, the participants in this study appear to be younger than the national averages of mental health providers with 52% of respondents between the ages of 18 and 34 years old. Additionally, the social workers that participated in the study had a lower mean age than the other participants in the study. This is of particular interest as previous research has indicated that younger age is correlated with higher rates of stigma

This low mean age may be the result of this study being conducted entirely online from recruitment through participation. It is possible that older mental health professionals may not have been as comfortable, or had as much access to the online survey instrument. The youth of the participants may also be explained by the snowball sampling technique. It is possible that in

the disbursement of the recruitment emails professionals passed the survey along to colleagues of similar ages.

More research should be conducted on the current mental health workforce and the demographics of these professionals.

Gender. By 2000, women accounted for about 85% of MSW graduates (Schilling, Morrish, & Liu, 2008). Within this research, 70% of respondents identified as female, 24% as male and 4% as transgender or gender non-conforming. These numbers likely represent the participation of psychologists and psychiatrists in addition to the social workers. Additionally, the research on demographics has been conducted on a binary system, which does not account for those who may identify as something other than male or female.

Race and Ethnicity. With 90% of respondents identifying as Caucasian or white, this sample does not represent mental health clinicians as a whole. Although most health care professions are less racially and ethnically diverse than the general U.S. population (NASW, 2006), and there is little information on the demographics of social workers, psychologists and psychiatrists as a whole, it is clear this number does not represent those who make up the profession currently. This sample of predominantly white clinicians may be the result of the snowball sampling technique utilized in this research, in this research. Much of the recruitment of this sample was done in a predominantly white New Much of the recruitment was done in a predominantly white New England state, which may have contributed to the low numbers of clinicians of color.

Differences By Profession

Considering that much of stigmatization may be the result of how the etiologies of mental illness are conceptualized (Link et al., 1999), this could begin to explain the differences reported by social workers compared to the other mental health professionals. Within the CAMI subscales, the subscale of authoritarianism encompasses beliefs about ideologies (ie. The mentally ill are to blame for their problems) as well as thoughts about what types of treatments they should receive when (ie. As soon as a person shows signs of mental illness they should be hospitalized), (Taylor & Dear, 1981). As reported in the previous chapter, the social workers who completed this study had a lower mean score on the authoritarian subscale than the other group.

Previous research has shown that individuals with more psychosocial beliefs about etiologies had lower rates of stigma than those who saw mental illness as having more genetic or biological etiologies (Pattyn et al., 2013). Social workers are often educated about mental illness through a biopsychosocialspiritual lens, which may be different from the traditional medicalization that other mental health providers have received during their education. This could begin to explain why the social work group had a lower mean score on the subscale of authoritarianism than the other group in this study.

One study showed that the medicalization of mental illness at higher rates, although intending to reduce stigma, increased stigma as people saw the illness as stable and unchanging (Pattyn et al., 2013). This medicalization of mental illness likely contributes to higher rates of authoritarianism, as providers may see a greater need for enacting more external structure if they believed mental illness to be stable and unchanging. They may feel a greater need for external intervention and have less recognition for the individuals' power and ability to make change.

Medicalization also places clinicians and professionals as the only experts, whereas a more biopsychosocialspiritual approach should encompass the knowledge of the person with lived experience also as expert and as having power to contribute to their own recovery.

Study Limitations

This study utilized a self-report tool, the Community Attitudes Towards Mental Illness (CAMI) Scale to measure and compare stigma among the two groups. Although this tool allowed for that comparison to happen in a statistically reliable way, the CAMI was not specifically designed for mental health professionals and may not address social desirability bias. Additionally, the CAMI was originally developed in 1981, which may make it less culturally relevant today. Many of the questions were gendered (ie. A women should not marry a man…), and the language used to describe those with mental illness, such as "mentally ill," are no longer acceptable in disability culture (Dunn & Andrews, 2015). Considering that it is a self-reported scale, it also does nothing to measure implicit bias, which has been shown to be a better predictor of discrimination (Stier & Hinshaw, 2007; Stull et al., 2008). Although explicit and implicit bias are linked, someone with implicit bias may not demonstrate explicit bias on a self report measure (Stier & Hinshaw, 2007). This is why research that includes measures of both explicit and implicit bias are the most effective at capturing an accurate picture an individuals associations.

Participation by psychiatrists and psychologists was lower than that of social workers. This fact prevented the researcher from directly comparing the three groups. Instead participants were divided into two groups, social workers and other mental health professionals. Considering that psychologists and psychiatrists have very different educational and training experiences (Heisler & Bagalman, 2015), in a larger sample size their responses may have shown more

difference and they would not have been a statistically similar group. As a result of the small sample size, these findings are not generalizable.

Implications for Clinical Practice and Training

Considering that the ways mental health professionals and social workers conceptualize mental illness inherently affects their work, it is useful to consider the importance of teaching from a place that reduces the stigmatization of mental illness by professionals. When asked to rate on a scale of strongly disagree, disagree, neither agree nor disagree, agree and strongly agree whether their degree program actively challenged them to explore their own stigma towards mental illness, 56% of participants answered other than agree or strongly agree. The highest percentage of responses were disagree at 36%. This indicates that the majority of participants in the study felt that their education did not address the stigma they had before they entered the field. This shows that social work and mental health professionals education lack recognition of this important factor to consider before someone should be able to work with those with mental illness, potentially when they are at their most vulnerable.

With stigma as a frequent factor in the avoidance of treatment by those with mental illness (P. Corrigan, 2004), social work institutions should work to incorporate education about stigma towards mental illness into their curriculum. This would make an impact on the entering clinicians' beliefs about mental illness, and likely result in better care for the clients, better treatment adherence, and better outcomes.

Implications for Future Research

This study illustrates that there is a growing need to comprehensively study what contributes and mediates mental health professionals' stigma towards those with mental illness. Further research on this subject should include both explicit and implicit measurements to avoid

the potential of social desirability bias (Stull et al., 2008). Further research should also utilize instruments and measures that reflect the current culture and controversy about mental illness. It seems that it would also be helpful to have more comprehensive demographic statistics for mental health professionals such as age, gender, race and ethnicity for the comparison to the general population. Any additional research should include a much larger and representative sample that could have generalizable results. This research should explore whether cultural beliefs of mental health professionals impact their stigmatization of those with mental illness. Lastly, research should also explicitly explore what current mental health professional education programs are including in their curriculum to address individual and societal stigma of mental illness at large.

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Appendix A

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 27, 2016

Alexandria Huber

Dear Dri,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Claudia Staberg, Research Advisor

Appendix B

Dear Mental Health Professional,

My name is Alexandria (Dri) Huber and I am an MSW candidare in clinical social work at Smith College School for Social Work. I am currently conducting research on associations between stigma of mental illness and education for my MSW thesis. This research has been approved by the Human Subject Review Committee at Smith College School for Social Work. You are receiving this email because you are a practicing professional in either psychology, psychiatry or social work.

I am writing to ask that consider participating in my research by completing an online survey. This survey will take approximately 20 minutes to complete, including a series of demographic questions and the Community Attitudes Towards Mental Illness (CAMI) questionairre that explores attitudes towards mental illness. I believe this study will provide you the opportunity to reflect on your own understanding and associations of individuals living with mental illness, and provide valuable information to help inform pedagogy and training for mental health professionals.

All information you provide will be anonymous, confidential and presented in aggregate form. To participate please follow this link: INSERT LINK HERE

If you would like to receive a brief summary of the survey results and implications, please email me at ahuber@smith.edu and one will be provided to you at the conclusion of this study.

In hopes of obtaining a larger sample size, I also ask you to consider forwarding this survey onto other psychiatry, psychology or social work colleagues. It is important to me to include professionals from varying geographic regions within the United States, so please feel free to pass thing along far and wide.

If you have any question about this study, your participation or if you would like to receive a brief summary of the survey results and implications, please email me at ahuber@smith.edu.

Thank you for your time,

Alexandria Huber

M.S.W. Candidate, Smith College School for Social Work

Appendix C

Dear mental health professional,

A week ago I sent an email requesting your participation in a study looking at the associations between education and stigma of mental illness for my MSW thesis. If you have responded to the survey, thank you! If you have not responded but would like to participate, you can do so by clicking this link: Insert Link Here.

Again, it is imperative that this reach as many people as possible to obtain a large and diverse sample. Please consider passing this along to other colleagues in social work, psychology or psychiatry that may be interested in participating.

This research has been approved by the Human Subject Review Committee at Smith College School for Social Work. This survey will take approximately 20 minutes to complete, including a series of demographic questions and the Community Attitudes Towards Mental Illness (CAMI) questionairre that explores attitudes towards mental illness. I believe this study will provide you the opportunity to reflect on your own understanding and associations of individuals living with mental illness, and provide valuable information to help inform pedagogy and training for mental health professionals.

If you have any question about this study, your participation or if you would like to receive a brief summary of the survey results and implications, please email me at ahuber@smith.edu.

Thank you for your time,

Alexandria Huber

M.S.W. Candidate, Smith College School for Social Work

Appendix D

SMITH COLLEGE

2015-2016

Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

……

Title of Study: Mental Health Stigma and Education

Investigator(s): Alexandria Huber,

Smith College School for Social Work Master's Student

xxx-xxx-xxxx

……

Please print or make a copy of this consent form for your records

Introduction

You are being asked to be in a research study exploring connections between education and stigma of mental illness. You were selected as a possible participant because of your having a Masters degree or higher in psychology, psychiatry or social work and currently being a mental health professional in this field. We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

The purpose of the study is to understand if there is an association between the degree one might obtain and stigma of mental illness. This study is being conducted as a research requirement for my masters degree in social work. Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

If you agree to be in this study, you will be asked to do the following things:

- Consent to participation in this study
- Complete an online survey on the web platform Qualtrics

Risks/Discomforts of Being in this Study

There are no reasonable foreseeable (or expected) risks of participating in this study.

Benefits of Being in the Study

As a participant in this study you would have the opportunity to reflect on your understanding and bias of individuals with mental illness. The benefits to social work and society at large are a deeper understanding of the potential associations between education and stigma of mental illness, which could be used to inform pedagogy and training of mental health professionals.

Confidentiality

This study is anonymous. We will not be collecting or retaining any information about your specific identity. Please do not provide any information that would identify you.

Payments

This study is voluntary and you will not receive any financial payment for your participation.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* before the end of the survey by selecting the "exit survey" button on every page. If you exit the survey prior to selecting the "Done" button, all of your responses will be eliminated. However, once you click the "Done" button on the final page, I will be unable to remove your responses due to the anonymous nature of the survey.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the study. If you have any further questions about the study, at any time feel free to contact me, Alexandria Huber, at ahuber@smith.edu or by telephone at xxx-xxx-xxxx If you would like a summary of the study results, one can be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

Due to the online nature of this survey, by checking "Agree" and clicking "Next" you are indicating that you have read the above information, that you have had the opportunity to ask questions about the study, you understand your rights and that you agree to participate in this study.

□ I AGREE

Appendix E

2. What is your age?
18--24
25--34
35--44
45--54
55--64
65 and older

3. What is your gender?
Male
Female
Transgender or Gender non--conforming
Prefer not to answer

4. How would you best classify your race or ethnicity?
Asian/Pacific Islander
Black/African American
Caucasian/ White Latino/Hispanic
Biracial/Multiracial
Prefer not to answer
Other: Please Specify

5. Which of these degrees have you received?
Psychology
Psychiatry
Social Work

6. What populations do you primarily work with? (Check all that apply)
Children and Youth
Adults (18 +)
Couples
Families

7. How long have you been practicing clinically?
0--5 years
6--10 years
11--15 years
16--20 years
21 years or more

8. One of the main causes of mental illness is a lack of self-discipline and power
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

9. The best way to handle the mentally ill is to keep them behind locked doors
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

10. There is something about the mentally ill that makes it easy to tell them from normal people
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

11. As soon as a person shows signs of mental disturbance, he should be hospitalized
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

12. Mental patients need the same kind of control and discipline as a young child
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

13. Mental illness is an illness like any other
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

14. The mentally ill should not be treated as outcasts of society
Strongly Disagree

Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

15. Less emphasis should be placed on protecting the public from the mentally ill
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

16. Mental hospitals are an outdated means of treating the mentally ill
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

17. Virtually anyone can become mentally ill
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

18. The mentally ill have for too long been the subject of ridicule
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

19. More tax money should be spent on the care and treatment of the mentally ill
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

20. We need to adopt a far more tolerant attitude toward the mentally ill in our society
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

21. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

22. We have a responsibility to provide the best possible care for the mentally ill
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

23. The mentally ill don't deserve our sympathy
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

24. The mentally ill are a burden on society
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

25. Increased spending on mental health services is a waste of tax dollars
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

26. There are sufficient existing services for the mentally ill
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

27. It is best to avoid anyone who has mental problems
Strongly Disagree

Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

28. The mentally ill should not be given any responsibility
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

29. The mentally ill should be isolated from the rest of the community
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

30. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

31. I would not want to live next door to someone who has been mentally ill
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

32. Anyone with a history of mental problems should be excluded from taking public office
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

33. The mentally ill should be denied their individual rights
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree

Strongly Agree

34. Mental patients should be encouraged to assume responsibilities of normal life
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

35. No one has the right to exclude the mentally ill from their neighborhood
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

36. The mentally ill are far less dangerous than most people suppose
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

37. Most women who were once patients in a mental hospital can be trusted as babysitters
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

38. Residents should accept the location of mental health facilities in their neighborhood serve the needs of the local community
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

39. The best therapy for many mental patients is to be part of a normal community
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

40. As far as possible, mental health services should be provided through community based facilities

Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

41. Locating mental health services in the residential neighborhoods does not endanger local residents

Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

42. Residents have nothing to fear from people coming into their neighborhood to obtain mental health treatment

Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

43. Mental health facilities should be kept out of residential neighborhoods

Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

44. Local residents have good reason to resist the location of mental health services in their neighborhood

Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

45. Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great

Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

46. It is frightening to think of people with mental health problems living in residential neighborhoods
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

47. Locating mental health facilities in a residential area downgrades the neighborhood
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

48. People with mental illness should not be mental health providers
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

49. I would be comfortable if my supervisor had a mental illness
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

50. My colleagues have stigma towards the mentally ill
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree

51. My degree program actively challenged me to explore my own internalized stigma towards mental illness
Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree