6-2016

MENTAL HEALTH PRACTITIONER STIGMA, ATTITUDE, AND BELIEF: A MULTIDIMENSIONAL STUDY ON MARRIAGE AND FAMILY THERAPISTS, CLINICAL SOCIAL WORKERS, AND CLINICAL PSYCHOLOGISTS

Jessica Ann De La Rosa
California State University - San Bernardino, delaj318@coyote.csusb.edu

Ruxandra Elena Tanase
California State University - San Bernardino, 005062885@coyote.csusb.edu

MENTAL HEALTH PRACTITIONER STIGMA, ATTITUDE, AND BELIEF: A MULTIDIMENSIONAL STUDY ON MARRIAGE AND FAMILY THERAPISTS, CLINICAL SOCIAL WORKERS, AND CLINICAL PSYCHOLOGISTS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

---

by

Jessica Ann De La Rosa

Ruxandra Elena Tanase

MENTAL HEALTH PRACTITIONER STIGMA, ATTITUDE, AND BELIEF: A MULTIDIMENSIONAL STUDY ON MARRIAGE AND FAMILY THERAPISTS, CLINICAL SOCIAL WORKERS, AND CLINICAL PSYCHOLOGISTS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

---

by

Jessica Ann De La Rosa and Ruxandra Elena Tanase

June 2016

Approved by:

Dr. Herb Shon, Faculty Supervisor, Social Work

Dr. Janet Chang, M.S.W Research Coordinator

ABSTRACT

Existing stigma in the form of negative attitudes towards individuals with severe mental illness by mental health practitioners, has the potential to set barriers towards recovery. A survey of 72 mental health practitioners from three disciplines were surveyed, in an attempt to measure mental health practitioner attitudes towards individuals with severe mental illness, and how their attitudes impact their belief in client recovery. This was a quantitative study, based on two Likert Scale surveys and distributed both in paper form and using Survey Monkey. Participants were gathered through a snowball effect, and consisted of 42 social workers, 18 marriage and family therapists, and 12 clinical psychologists. The Opening Minds Stigma Scale for Mental Health Practitioners was utilized in an attempt to measure stigmatizing behaviors. The Consumer Optimism scale was also incorporated in an attempt to measure practitioner's belief in recovery. Content analysis was conducted through Statistical Package for the Social Sciences (SPSS) version 20. The findings of the study were inconclusive and did not support the original hypothesis, as no relationship between mental health practitioner attitudes towards individuals with severe mental illness and their belief in recovery was found. However, two key finding emerged through further content analysis. A positive relationship was found between negative attitudes and the practitioner's desire to be socially distant from individuals with severe mental illness. Practitioners from inpatient work settings showed higher levels of belief in client recovery, than those in outpatient

and private practice. Further research can be conducted regarding the potential reasons that inpatient mental health workers have higher belief in client recovery, in order to help outpatient agencies and private practice individuals also achieve higher levels of optimism towards recovery. The findings of negative attitudes in mental health practitioners and their desire to remain socially distant from individuals with a severe mental illness can also be a key component in recent efforts to combat stigmatizing behaviors.

ACKNOWLEDGEMENTS

We would like to acknowledge our professors who have supported us and empowered us on our journey through graduate school. We would also like to say a special thank you to Dr. Shon, Dr. Chang, and Dr. McAllister for guiding us through the daunting process of research. You have impacted our lives in more ways than you could imagine and we are forever in gratitude.

DEDICATION

A special dedication to Jake, Lukie, Mom, Dad, and Mamaie,

I would like to dedicate this research project to my family who has stood by my side and supported me through my hardships and success. You have helped me in accomplishing my dream, without you this dream could not have become a reality. Thank you for everything you have done for me, this is for you.

Love your wife, mother, daughter, and granddaughter Ruxandra

A special dedication to my family,

Mom, you have impacted me in more ways than you know. You have been my best friend and biggest cheerleader throughout my long journey through school. I could never repay you for your devotion and love for me. My dreams are not as much my dreams, but rather, they are our dreams together. You have helped me become the woman that I am, and I am forever grateful for that.

Dad, thank you for being the man who I can always depend on. You have helped me to grow and blossom in who I am and always supported my dreams and goals. You are an admirable man who I know, will always be by my side. Thank you for all that you have done for me and putting up with my chaos through my difficult voyage in school, I know that at times it was challenging and I will never forget your patience. I love you dad!

Julia, my sister, I could never express the love you have placed in my heart. You have protected and guided me since I was a child. Through your love for me, I have been able to dream big and confront difficult situations in my life. I

know that anything is possible when you are by my side. I love you my sister, thank you for being my best friend and confidant all of these years.

Joanna, my sister, thank you for all that you have done for me. You have been by my side through difficult times and happy moments. You are one of the most determined woman I know, and I hope that you know how much you inspire me. I want you to know how special you are to me, and how thankful I am to call you my sister. I know that as time passes you will continue to be my best friend, I love you sis.

Anthony, Lilly, and Layla you light up my life. I love you all to the moon and back. Thank you for bringing me joy every day, I am a proud and blessed aunt.

Additionally, I would like to dedicate this research project to God who has blessed me beyond belief, my gratitude is endless.

Love your daughter, sister, and aunt, Jessica

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION

Current research has identified the negative impact stigma has on individuals in many areas of life, and this fact is a major concern in healthcare and human services (Hugo, 2001). As practitioners, it is important to be aware of our personal attitudes regarding individuals with severe mental illness in order to provide adequate services and abide by the NASW's 'do no harm' code of ethics. In this study, chapter one will entail a clear problem formulation regarding the impact of health practitioner's attitudes towards individuals with severe mental illness. The purpose of the study will also be presented, along with the significance of the project and the implications on Social Work practice.

Problem Statement

The specific problem this study addresses, is the problem of stigma within the mental health practitioner belief system, and how that stigma affects the practitioner's belief in the client's recovery of a mental health disorder. There has been a significant growing interest in stigma among mental health practitioners in the past decade. More than 4,278 related articles have been published regarding stigma, of which more than half of them were published between 2000-2005. In 2001, the National Institute of Mental Health held a major international conference on stigma and mental health in an effort to arouse interest and

research regarding stigma in mental health practitioners and its consequences. Emphasis has been placed on understanding the roots of stigma, and the impact it has on client recovery. Since the increasing research, many agencies have taken initiatives to combat stigma by introducing new policies and participating in anti-stigma campaigns (Mak, Poon, Pun, and Cheung, 2007). However, research on mental health practitioners and their personal stigma regarding individuals with severe mental illness, is an increasing area of interest that contains less research. Hugo (2001) stated that little research has been conducted regarding the attitudes of mental health practitioners toward individuals with severe mental illness, and practitioner approaches to modifying negative attitudes towards consumers. Client recovery is the goal of the practitioners and many agencies that provide mental health services. Creating more research in this area will help agencies and schools better prepare practitioners to serve those with severe mental illness, by bringing awareness to inward stigma. It has been shown that mental health practitioner's negative attitudes regarding severe mental illness negatively affected client recovery and treatment outcomes (Hugo, 2001).

Mental health professionals were found to have more negative feelings towards individuals with severe mental illness, than the general public. Jorm, Korten, Jacomb, and Christensen (1999) stated that with this negative attitude, long-term outcomes of recovery are less likely to occur. The study goes on to discuss the importance of practitioner's awareness of their negative feelings, as those negative feelings will presumably be projected onto the consumer. There is

also existing research that consumers who feel devalued or rejected will have worse outcomes, thereby hindering or diminishing the possibility of recovery (Link, Yang, Phelan, and Collins, 1997). Currently, there is extensive research on the negative impact stigma has on those being stigmatized. However, as previously stated, there is still little research on the impacts of negative attitudes and stigma in Clinical Social Workers, Marriage and Family Therapists, and other Clinical Psychologists. This area of research is currently understudied, and this study will richly contribute to increasing knowledge of social work research and clinical practice.

Purpose of the Study

The purpose of the study was to explore the potential presence of stigmatizing attitudes in mental health practitioners and the possibility of correlation between negative attitudes and belief in recovery regarding clients with severe mental illness. Individuals with severe mental illnesses are often encountering stigma in their community, hindering their journey to recovery. A study conducted by Corrigan, Roe, and Tsang (2013) showed that negative attitudes regarding severe mental illness impacted the client's ability to be successful in important areas of life, such as employment, housing, relationships and health care. Some of the most stigmatizing attitudes tended to be held by those working closest with the consumers, which were the mental health care providers. The workers tended to see the population of mentally ill clients when

they were experiencing the most severe symptoms, leading to stigmatizing thoughts and actions by the mental health practitioners (Corrigan et al., 2013).

Wilrycx, Croon, and Broek (2012) stated that studies show how staff's skills and behaviors directly impacted the process of recovery. Poor communication, the inability to provide hope and appropriate self-disclosure, and a lack of equal partnership and respect had poor treatment and recovery outcomes. A practitioner would often fail in providing the above mentioned necessities, if they possessed negative attitudes towards individuals with severe mental illness and their ability to recover and integrate back into the community. Wilrycx et al. (2012) mentioned educational programs implemented that fostered an organizational shift of culture that is recovery oriented. However, some do not believe that these competencies can be trained. This is where removing stigma through increased self-awareness of transference/counter transference is essential to creating that culture change towards recovery.

This study conducted was a quantitative study in order to gather as much data as possible regarding attitudes toward individuals with severe mental illness and client recovery. The instruments utilized to measure the independent variable and dependent variable were the Opening Minds Scale for the Health Care Practitioner (OMS-HC), and Consumer Optimism Scale. The Opening Minds Scale was utilized to measure the independent variable (attitudes towards individuals with severe mental illness), and the Consumer Optimism Scale was utilized to measure the dependent variable (belief in client recovery). The Job

Diagnostic Scale was also incorporated in the survey. Three questions were chosen from the Job Diagnostic Scale regarding job satisfaction. The three scales were condensed for this study's survey, in order to gather information from as many clinicians as possible, from various job settings. These measurements were utilized because they were the most relevant to the study, and provided exceptional validity and reliability.

Significance of the Study

Understanding the impact of personal attitudes regarding severe mental illness is vital to one's ability to practice with success. The Social Work profession teaches practitioners to develop an increased level of self-awareness in order to avoid projecting negative emotions onto clients, and thereby hindering recovery. Clinicians are required to create a safe space for clients to grow and be supported on their path to recovery. Conducting a study in this area will create additional knowledge that can contribute to the Social Work profession and clinical practice.

The results collected from this study will have the most impact on the beginning, planning and implementing phases of the generalist intervention process. Recognizing negative attitudes in practitioners will change the beginning phase by working to eliminate negative attitudes in supervision, in order to better build rapport with consumers. The planning phase will be more collaborative and the practitioner with a positive attitude will be able to better elicit effective goals that protect the self-efficacy of the client and promote recovery. How

interventions are implemented will also be changed due to higher levels of empathy and belief in recovery.

Increased knowledge in this area of research can assist programs and agencies in developing better training curriculum to prepare clinicians in working with individuals who have a severe mental illness. As we continue to learn more through research, we can attempt to correct what is not working and implement positive changes. Social work schools can learn how to better train students, both through exposure to severe mental illness and classroom curriculum. Agencies can also become more aware of the stigma their practitioners might have, and provide safe environments through supervision and further training regarding this issue. The research question formulated to collect this information is: how do Mental Health Practitioners own attitude of severe mental illness affect their beliefs in client recovery?

CHAPTER TWO

LITERATURE REVIEW

In chapter two, literature is presented that pertains to the study. Section one of chapter two will attempt to state the negative impacts stigma has on individuals, as it is defined by multiple authors. Section two, will consider findings from previous studies regarding the correlation of stigma and treatment outcomes. Section three, will highlight existing articles written on the subject of belief in recovery. Finally, section four will provide application of theories guiding conceptualization.

Impacts of Stigma

According to Corrigan et al. (as cited in Rusch, Angermeyer, and Corrigan, 2004) there are three main components to stigma: stereotypes, prejudice, and discrimination. Similarly, another study indicated that stigma endorses a person's prejudice such as negative attitudes and emotional responses, behaviors that are discriminatory and aimed at individuals that do not fit into society's standards Corrigan (as cited in Mak, 2007, p.245). Another source defined stigma as **"**an attribute that is deeply discrediting" and implies that the person being stigmatized is reduced "from a whole and usual person to a tainted, discounted one" Goffman (as cited in Yang et al., 2006, p. 1525). Goffman's theory continued to describe stigma as a conflict between a person's social identity (how a person is seen by

society) and the person's actual identity (the person's actual attributes). This definition implies that a person is labeled as 'flawed' or 'deviant' by societies standards. Yang, Kleinman, Link, Phelan, Lee, and Good (2006) concluded in his research that stigma "is fundamentally tied to moral and existential experience" (p.1534).

Link et al. (2004) provided numerous definitions and impacts of stigma developed by previous researchers and stated, stigma has the ability to strip individuals of their dignity and disrupts their participation in society "Link et al. (as cited in Executive Summary, U.S. Department of Health and Human Services, 1999)". He goes on to define stigma as a mark that identifies a person's specific attribute to an undesirable characteristic that will discredit them in the eyes of society. Three significant actions take place when stigma occurs which include; labeling, stereotyping, and separating. Ultimately, labeling places individuals into categories and creates separation between the stigmatized and the rest of society. The degree of stigma projected on an individual may vary and worsen depending on their mental health condition. If an individual possesses a severe mental health condition, they are more likely to be viewed negatively (Link et al., 2004).

However, Horsfall, Cleary, and Hunt (2010) defined stigma as more than just social exclusion and determination, and argued that it is also personal attitudes as well as stereotypes. In carrying these attitudes, the person then interacts in a manner that is from the assumptions drawn by the stereotypes.

Horsfall et al., drew on Goffman's extensive work with stigma in mental health. Goffman stated, people who are stigmatized are often blamed for their situation, which is inherent to their personality "Goffman (as cited in Horsfall et al., 2010)". Goffman continued to explain, individuals who are stigmatized are also more likely to be maltreated, exploited, and increasingly focus on their social behaviors than individuals who do not experience stigmatization "Goffman (as cited in Horsfall et al., 2010)". Individuals who are stigmatized have similar reactions including, "hurt, disgrace, shame, guilt, secrecy, diminished self-efficacy, and anger," according to "El-Badri et al. (as cited in Horsfall et al., 2010, p.450)". When diagnosed with a mental health disorder, a person is then viewed as possessing a personality that is defective and dislikable among the community. Goffman indicated that these individuals are understood to be feeble, foolish, devious, has increased or decreased emotional expression, and dangerous (Horsfall et al., 2010). Horsfall et al. (2010) concluded his research by stating ways to decrease stigma such as challenging your beliefs, educating on stigma and how destructive it is, changing the focus of mental illness into an optimistic approach, and eliminating insulting words and phrases about mental illness all together (Horsfall et al., 2010).

Correlation of Stigma and Treatment Outcome

The majority of research has found that negative attitudes in mental health practitioners and the general public towards individuals with severe mental illness can hinder proper treatment. Corrigan (2004) stated that persons with

mental illness would avoid seeking treatment due to feelings of shame. Hugo (2001) stated that the negative attitudes of mental health practitioners towards consumers, or individuals who have at one point experienced mental illness, is often projected onto the consumer resulting in negative treatment outcomes. Although the discrepancies in perception between the general public and clinicians could be reflective of a more realistic view or greater knowledge regarding mental health disorders, the negative impact on consumers is the main concern. One strength concerning negative perceptions that Hugo stated is regarding work setting and satisfaction. Hugo (2001) stated that previously conducted studies have not considered the correlation between job satisfaction and work settings, and whether job dissatisfaction influences on the practitioner's view toward the consumers.

A leading theory in Hugo's research regarding attitudes is based on the four psychological functions: social-adjective, value-expressive, self-esteem maintenance and experiential schematic. The study consisted of 266 professionals working within the mental health environment and employed in a wide range of mental health treatment settings. Participants included, 156 mental health nurses, 51 medical staff (medical officers, psychiatrists and trainee psychiatrist) and 59 health staff (social workers, clinical psychologist, occupational therapist, and activity supervisors) (Hugo, 2001). The study utilized a survey design, and distributed a questionnaire to participants. Half of the participants were provided a vignette consisting of an individual with a DSM-IV

diagnosis of major depression. The other half of the participants were given a vignette of an individual with a diagnosis of schizophrenia. The gender related to the vignette was randomly assigned as John (male) and Mary (female) (Hugo, 2001). The major findings consisted of significant differences between the way mental health professionals rate long term outcomes for people who have experienced mental health treatment, and that these outcomes were significantly more negative than the general public (Hugo, 2001). Although long-term outcomes were negatively viewed, respondents to the survey indicated that with proper care by mental health professionals, consumers had the ability to recover (Hugo, 2001). Furthermore, limitations of this study consisted of a small sample size that did not represent all mental health practitioners and staff.

Ponizovsky, Shvarts, Sasson, and Grinshpoon (2008) studied attitudes of social workers on consumers with a severe mental illness. Half of the participants were involved in the Supported Education Program (SEP), which was compared to a control group who did not participate in SEP. Twenty-five social workers within SEP participated in the study. Twenty eight social workers participated in the control group. The control group worked in various rehabilitation programs unrelated to SEP. The control group specifically served individuals with psychiatric disabilities, and their main focus was on housing. The study implemented a qualitative approach and provided face-to-face interviews from January to March 2005. The SEP and control group consisted of 89.5% women, 72% married, and 86.8% university graduates with a mean age of 40. Work

experience did not differ between the SEP and the control group (Ponizovsky et al., 2008).

The interview instrument comprised of a 17-item questionnaire that consisted of questions related to knowledge of mental health and attitudes directed towards rehabilitation. Findings indicated differences among the two groups; attitudes toward consumers with a severe mental illness differed depending on the amount of exposure to that population (Ponizovsky et al., 2008). The SEP group were found to have more contact with consumers and ultimately possessed more positive attitudes (Ponizovsky et al., 2008). The study concluded that providing the supported education program to social workers greatly impacted their beliefs on mental illness and patient's ability to maintain a higher quality of life. SEP participants stated that individuals with schizophrenia were no more dangerous than any other member of society, and students with a mental health condition were able to do well in school, maintain relationships, and have a productive life (Ponizovsky et al., 2008). Some limitations of the study were that the sample size was significantly small, and the differences among the social work SEP and control group attitudes may differ due to other factors beyond the information provided in the study. There may be numerous other experiences and circumstances that inhibit beliefs and attitudes among the two groups. Despite the limitation of a small sample size, the study provided information supporting increased contact with social workers and clients who

have a severe mental illness. Social workers higher level of contact resulted in a better attitude toward the population in general (Ponizovsky et al., 2008).

In contrast, a meta-analysis of stigma and mental health was conducted by Mak et al. (2007). There was inconclusive findings regarding the stigma-mental health relationship. The findings were varying from strong negative to zero correlations. The meta-analysis was comprised of studies that were conducted between the years of 1985 and January 2005 using the PsychINFO and PubMED databases. The criteria for the studies were to include: empirical and quantitative studies in English, relationship between stigma and mental health, and have at least one measure of stigma and mental health. Only 82 studies met all of the criteria. However, 14 more studies were added by using the reference list of the studies found, providing a total of 96. After looking over all the articles in detail, the researchers were only able to use 42 articles and 7 dissertations remained. Stigma correlations were acquired from the articles or through statistics addressed in the articles (Mak et al, 2007). One of the limitations to the study was the number of studies were fairly small, leaving more room for sampling error, and too small to allow for separate analysis. Not including the stigma studies that were non-English also took away from being able to understand more about stigma and mental health cross culturally.

Yang, Kleinman, Link, Phelan, Lee, and Good (2006) stated that stigma in general predisposes individuals to poor outcomes in academia, self-esteem, and mental or physical health. Yang et al. (2006) utilized moral-somatic and moral-

emotional theories to illustrate that stigma has dimensions. Yang et al. (2006) discussed the implications of previous studies of stigma on the measurements used. A methodological review of 109 studies on stigma spanning from the years of 1995-2003 stated that 60% of the survey methods were a fixed item response, and that this method is the best in assessing stigma in individuals. Yang et al. (2006) indicated that it is important to understand stigma and how it affects those who are stigmatized. The study concluded by providing anti-stigma interventions and education to the community, and argued that attitudes have the ability to be modified. By allowing the public to view the lives and struggles of individuals who are stigmatized, this may assist in recognition of the effects of stigma. Finally, Yang et al. (2006) stated that stigma was connected with "moral and existential experience" and in order to enhance understanding and preclude stigma, the public must be open to this idea in the forthcoming years (Yang et al., 2006).

Belief in Recovery

Recent research indicated that stigma does not only impact treatment outcomes, but also client recovery. Lorenza, Fiorillo, De Rosa, Malangone, and Maj (2004) reported a study comparing beliefs of mental health professionals, the general community, and relatives of individuals diagnosed with schizophrenia. The study compared all three groups' beliefs in consequences of having schizophrenia, causes, and treatment of the disorder. The study took place in 30 separate regions of Italy through random selection. Regions were separated by location including northern, central, and southern Italy. Participants consisted of

714 lay respondents, 465 professionals, and 709 relatives of an individual with a diagnosis of schizophrenia (Lorenzo et al., 2004). A survey design was conducted using the Opinions about Mental Illness QO (31) questionnaire (Lorenza et al., 2004).

Results indicated that only 2% of Mental Health practitioners, 17% relatives, and 35% of the general community believed recovery was possible for individuals diagnosed with schizophrenia (Lorenza et al., 2004). The findings of the study demonstrated the impact of family support on recovery, which is relevant for community members, practitioners, and family members. Lorenzo et al. (2004) stated that action must be taken in order to inform the community of treatment and features of schizophrenia. Furthermore, Lorenzo et al. (2004) concluded that campaigns must be developed in order to provide knowledge on stigma and discrimination of individuals who possess a mental health diagnosis, specifically schizophrenia. Finally, by developing new policies within agencies, and implementing family interventions, reduction of negative belief in recovery should come to pass (Lorenzo et al., 2004). A limitation to the study was that data was collected in Italy and may not be reflective of other countries and mental health organizations. A strength of this study was random selection, which provided exceptional validity, and the ability to generalize responses throughout the Italian northern, central, and southern regions (Lorenza et al., 2004).

In support of Lorenzo et al., Corrigan (as cited in Mak et al., 2007) indicated that family shame regarding mental illness held a strong correlation to avoidance of treatment. Findings in another study indicated that positive attitude regarding mental illness encouraged seeking treatment services (as cited in Greenley et al., 1987). Similarly, Jorm indicated that the general public held higher optimism regarding recovery than health practitioners such as psychiatrists and clinical psychologists (as cited in Hugo, 2001). However, Covarrubias and Han (2011) survey results regarding belief in recovery among MSW students showed no significant predictor to levels of stigma.

Horsfall et al. (2010) stated that negative outcomes of stigma are “shame, guilt, hurt, disgrace, diminished self-efficacy, and anger” (p.450). He goes on to explain that the consequences of being stigmatized is to become exploited and victimized. Horsfall et al. (2010) draws on Goffman’s work regarding stigma and stated that stigma is formed from stereotypes that have been upheld by society and culture, and ultimately embraced by the mental health practitioner.

Horsfall et al. (2010) also stated that mental health practitioners are less optimistic about client recovery and the consumer’s ability to integrate into the community. The source goes on and reported that practitioners have been known to treat clients with disrespect and ignore their requests. Practitioners must work from a place of continuous self-examination and self-awareness in order to combat stigma. Making hope and recovery a focus and working from a person-centered/recovery centered approach can alleviate stigmatizing behaviors,

eliminating the negative consequences of stigma such as avoiding participation in treatment “Goffman (as cited in Horsfall et al., 2010)”.

Theories Guiding Conceptualization

The theory that most coincides with the essential research presented is The Recovery Model (Farkas, 2007). As currently addressed throughout the literature, the recovery of severe and persistent mental illness has been debated over time. Recovery is defined as “the alleviation of symptoms and a return to premorbid functioning” (Farkas, 2007, p.69). According to Farkas (2007) recovery of mental illness is viewed on a two ended spectrum. Many believe that the inability to recover is due to biological factors. Others have questioned if mental illness is a medical condition and argue that life experiences, such as crises are evident as normal experiences that may take place in an individual's life (Farkas, 2007). The recovery model is not an intervention, rather it is a tactic that promotes involvement from consumers, family members, mental health practitioners, policy developers, and the community (Farkas, 2007). There are three core components that embody the recovery model and are implemented in practice: “person orientation, person involvement, and self-determination/choice” (Farkas, 2007, p.71). Person orientation, is described as the consumers desire to be treated like an individual by their practitioner rather than a ‘patient’. It also provides a gateway to services outside of mental health facilities in order to promote reintegration into the community (Farkas, 2007). Person involvement, empowers individuals who have experienced a mental health concern to plan

and implement services through peer support positions (Farkas, 2007). This does not only assist with the individual's own road to recovery, but also provides encouragement for consumers in the beginning phases of recovery. Self determination/choice, is the ability for consumers to make their own decisions on the type of treatment they desire; such as, developing their own treatment plans and goals with the assistance of a practitioner (Farkas, 2007). The goal of self determination is to provide consumers with the tools in order to make their own decisions. This assists with helping the individual to feel empowered and in control of their own circumstances, as well as accountable for their decisions. Furthermore, one last element to the recovery model is hope. Instilling hope in consumer recovery is viewed as a long term process rather than an initial outcome. Hope should be encompassed by not only the consumer, but also the practitioner (Farkas, 2007). As recovery is viewed in a more positive light, the outcomes can be great for all participants involved in treatment.

The theory of the recovery model guides this study by providing a foundation of the belief that attitudes of practitioners greatly affects client recovery. The recovery model stated that consumers and practitioners must believe in a hopeful outcome to recovery (Farkas, 2007). If a clinician possesses a negative attitude toward recovery, treatment may be affected as well as the relationship of practitioner and client. In essence, providing hope is the same as believing in your client. If the practitioner does not believe in the consumer's ability to recover, negative outcomes are more likely to transpire. The recovery

model demonstrates a shift in treatment. For decades practitioners have made decisions for their clients and consequently developed dependency and decreased confidence in one's own abilities. The recovery model provides a fresh new outlook on treatment. Consumers have the ability to take control of their lives, and make a difference for themselves as well as others. The recovery model is essential to this study because it provides a framework for the new era of treatment. Participants involved in this study will have either been exposed to the recovery model, or implemented the model at their agencies. It is believed that attitude and belief in recovery will vary and hopefully be different from previous research discussed.

Summary

The literature presented in this chapter has provided an extensive overview of stigma, treatment outcomes, belief in recovery, and theories guiding conceptualization. Previous qualitative and quantitative studies have declared that attitudes of mental health professionals have been more negative than positive. Belief in recovery of a mental illness has the ability to improve through psycho-education on mental illness and exposure to the population. Recent research on the recovery model supported that implementing the recovery model has the ability to empower consumers and change the outlook of practitioners on recovery.

CHAPTER THREE

METHODS

The following chapter will present the research methods used to examine the attitudes of mental health practitioners and their belief in client recovery. This section will cover study design, sampling methods, data collection and instruments used, procedures, protection of human subjects and data analysis.

Study Design

The aim of this study was to evaluate the attitudes of mental health practitioners and their belief in the recovery of individuals with severe mental illness. Data was collected through a quantitative survey design which was distributed to mental health practitioners in multiple disciplines that currently work with individuals with severe and persistent mental illness. Participants were collected from various agencies and a paper survey and online survey were distributed. If agencies preferred to complete the survey electronically, then the researchers administered the questionnaire through Survey Monkey. A quantitative approach was utilized in order to collect as much data as possible regarding attitudes and belief in client recovery, to evaluate the findings, and compare and add to existing research.

A limitation to this study was that it relied heavily on clinician participation and respondents in order to conclude findings. This study also cannot fully be

generalized and applied to all mental health practitioners or account for a wide geographical area, but it can present as a beginning for others to explore this topic. Another limitation of the study is that the surveys are self-reports and may not reflect the true belief regarding recovery. The running research question is: how do mental health practitioners own attitude of severe mental illness affect their belief in client recovery?

Sampling

The participants recruited were clinical social workers, marriage and family therapists, and clinical psychologists currently practicing in the mental health field. Due to the nature of the survey, clinicians had to be currently involved with individuals with severe and persistent mental illness in order to have participated. In order to best analyze data, a total of 150 responders were desired. Clinical Social Workers, Marriage and Family Therapists, and Clinical Psychologists were the best population to obtain information regarding belief in recovery, because they are directly serving clients who have severe mental illness. Participants within the study were recruited through snowballing. Participants were accumulated by use of faculty within California State University, San Bernardino (CSUSB) as a resource for connections with individual practitioners and agencies. Mental health agencies from current and past field placements were utilized. Other mental health clinics were also contacted at random, and asked to participate. Supervisors and individual members of these agencies also provided connections with other agencies or individual practitioners who were willing to

participate. In an effort to recruit MFT's, the Inland Empire MFT Consortium was contacted and the Survey Monkey link was provided to practitioners.

Data Collection and Instruments

A survey design was utilized in order to address how practitioners own perception of severe mental illness impacts belief in client recovery. The independent variable of the study is attitude of the mental health practitioners. The independent variable of the study was measured by using the Opening Minds Scale for Health Care Providers (OMS-HC). This questionnaire has been previously administered in prior research conducted by Mogdill, Patten, Knaak, Kassam, and Szeto (2014). The instrument was a self-report that assessed three factors; attitudes of practitioners toward individuals who possess a mental illness, disclosure/help seeking, and social distance (Modgill et al., 2014). All items within the survey were based on a Likert scale. The Likert scale consisted of varying degrees which were: strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree. Each response had a number value ranging from 1 to 5. The higher the score is of the responders, the more stigmatizing attitude they possess toward individuals with severe mental illness. According to Mogdill et al. (2014) internal consistency of this measurement is satisfactory at (Cronbach's alpha= .79).

The entire OMS-HC consisted of 20 items and ranged from 20 to 100 in scoring. Twenty is referred as the least stigmatizing score, while 100 is referred to as the most stigmatizing score within the measure. Two factors that were

focused on in the survey were attitudes and social distance. Some questions that were from the attitude portion of the survey were:

> I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness. Despite my professional beliefs, I have negative reactions towards people who have mental illness. There is little I can do to help people with mental illness. More than half of people with mental illness don't try hard enough to get better. Health care providers do not need to be advocates for people with mental illness. I struggle to feel compassion for a person with a mental illness. (Modgill et al., 2014, p.10).

Some questions that were from the social distance portion of the survey were:

> If a colleague with whom I work told me they had a managed mental illness, I would be as willing to work with him/her. Employers should hire a person with a managed mental illness if he/she is the best person for the job. I would still go to a physician if I knew that the physician had been treated for a mental illness. I would not want a person with a mental illness, even if it were appropriately managed, to work with children. I would not mind if a person with a mental illness lived next door to me. (Modgill et al., 2014, p.10).

In Mogdill et al. (2014) the authors tested and examined the psychometric properties and responsiveness of the OMS-HC and concluded that the scale has

good internal consistency. The overall internal consistency was (alpha= .79) and the three subscales were (alpha=.67 and .68). Some strengths of this scale were the high reliability and validity. The survey is easy to understand and fairly short. According to Modgill et al. (2014) the scale had slightly less internal consistency when used for social workers.

The dependent variable was belief in client recovery. The dependent variable was measured using the Consumer Optimism Scale, which is also known as the Provider Expectations for Recovery Scale (Salyers, Brennan, and Kean, 2013). The scale was 16-items comprised of sections regarding alcohol/substance use, housing, and competitive employment. Participants were asked to think of their current consumers and answer the questions on a 5 point scale from 1 being 'none' to 5 representing 'almost all'. A greater score was reflective of higher optimism for consumer ability for recovery. The scale consisted of statements such as; "will be able to function very well in the community, will remain pretty much as they are now, will be able to have satisfying intimate relationships, will be able to live in their own apartment or home, etc." (Saylers, et al., 2013, p.156). The questions were on a five point scale, 1 being 'none' and 5 being 'almost all'. Although there are various instruments to measure belief in client recovery, this scale was selected because of the high reliability, validity, and internal consistency rates and content. This scale was expanded by Slayers, Tsai and Schultz in a 2007 study and the results were a stronger internal consistency (Cronbach's alpha= .91) compared to the

original (alpha =.83). Test-retest reliability over a two-week period was (r=.92) compared with the original (r= .81). A limitation to the scale may present in relative expectations of recovery. For example, successful recovery could be seen by some as no longer needing the mental health system while others can consider successful recovery even in the presence of ongoing symptoms (Saylers et al., 2013).

Job satisfaction was also assessed with a short 5 item subscale pulled from the Job Diagnostic Survey, which is rated on a 7-point scale from 1 = strongly disagree to 7 = strongly agree. This survey was utilized in order to analyze connections between job satisfaction and hope for recovery and it's relation to better attitudes toward individuals with severe mental illness and belief in recovery. In order for data to present a more accurate picture regarding mental health practitioner attitudes and how that correlates to outcomes, work satisfaction and work settings were surveyed. Therefore, job satisfaction was explored, as existing literature stated that job satisfaction is an important factor in belief in recovery and treatment outcomes (Hugo, 2001).

Some limitations of the instruments included the inability to address practitioners past experiences. The instrument lacks historical information that could be beneficial to the study, such as information from previous work experiences. Another limitation, was the cultural aspect of the instrument. The survey was cultivated toward the Americanized belief system of recovery and cultural differences and beliefs outside of the United States were not addressed

in the survey. This means, practitioners from other cultural backgrounds may have adverse beliefs that are not provided as options in the survey, and could ultimately determine inconclusive findings. Another limitation to this instrument was that it does not address relapse of a mental health condition. For example, a participant may believe that recovery is possible as well as relapse. An individual may be able to recover multiple times however, still face challenges and relapse. Strengths of this instrument included the ability to determine attitudes and beliefs outside of employment. The instrument asks questions that addressed personal preferences and beliefs such as, working with an individual who possess a severe mental health condition, or having them as a neighbor.

Another limitation to the study was that it can have a negative impact on clinician attitudes towards recovery in job satisfaction. In order to gain accurate data, questions were asked regarding job satisfaction that are pulled from the Job Diagnostic Survey. For the purpose of making the survey feasible for busy clinicians that have time constraints, the Job Diagnostic Survey was shortened from a 5 item subscale to three questions regarding job satisfaction.

Procedures

Mental health practitioners were recruited from January 1 through March 30, 2016. The participants were recruited from, county mental health agencies, mental health state hospitals, and local private practice agencies. Surveys were distributed through various forms depending on the availability of practitioners. Agencies were provided the option to obtain the survey online or through face to

face contact with researchers. Practitioners were sought through county mental health agencies, as well as individual agencies. After distinguishing eligibility for the study, mental health practitioners were invited to partake in the survey. The consent form and confidentiality statement were distributed to each participant and collected by the researchers before the study began. The fifty-seven item questionnaire took approximately 10-15 minutes to complete. The researchers distributed and collected the questionnaire. Upon completion of the survey, the participants were thanked for their participation. Each participant was given the option to leave their email in order to receive the conclusive findings of the study. After completion of the survey, the researcher provided an anonymous suggestion and question box for any participants in need of further assistance. If the practitioners took the survey online, the consent form appeared on the first page and provided a signature box to be signed electronically with an X. The debriefing statement and summary of the study followed the final page of the survey once the questionnaire was completed.

Protection of Human Subjects

In order to protect participants in this study, appropriate precautions took place. Participants were provided an informed consent and confidentiality statement. The informed consent and confidentiality statement offered an in depth description of the study addressing confidentiality, the purpose of the study, and voluntary participation. The confidentiality statement protected participants from any HIPPA violations. The form stated, participation was

entirely voluntary. Participants had the ability to reject involvement in the study, as well as discontinue the survey at any time if desired. The consent form provided a designated area for signature. The participants were encouraged to sign their name with an X. This offered protection from disclosure of personal information, and agreement to the terms of the study. The researchers addressed confidentiality and privacy of the study orally as well. This allowed participants to know their rights and enquire any concerns or questions before the study began.

Prior to beginning the study, participants were provided a statement within the informed consent that addressed additional information. The statement declared, if at any time the participant did not feel comfortable answering any particular questions within the survey, they had the right to skip any questions that were deemed unnecessary or intruding. This allowed participants to complete the study if desired, but avoid questions they did not want to answer. This statement offered participants the ability to feel empowered and in control of the information they chose to share with the researchers.

Participants were protected by allowing a debriefing session to take place after the study was completed. The debriefing statement declared, ‘the study you have just completed was designed to investigate mental health practitioner’s attitudes toward mental illness, and belief in client recovery in mental health agencies within the Riverside and San Bernardino county area. We are interested in assessing the current opinions of practitioners on mental illness of

their consumers. We are also interested in if these current opinions and attitudes of mental illness affect practitioner belief that clients have the ability to overcome and recover from their mental illness. Recovery is based on the ability to maintain relationships, daily activities, sustain a working position, and manage mental health needs including regular participation in mental health services and medication maintenance. This is to inform you that no deception is involved in this study'.

The study protected participant anonymity by not collecting identifying information such as; addresses, names, phone numbers, family history, employment, etc. The data was protected by placing the surveys and forms in a locked drawer at the researcher's residence. The researchers and faculty advisor were the only members with access to the documents. After the study was completed, all documented information used in the study were destroyed and deleted by the researchers. In order to further protect the participation of practitioners involved in the study, an IRB application was completed and submitted by the researchers. By obtaining approval from the IRB, contributors to the study were further protected.

Data Analysis

The study utilized a quantitative data analysis procedure in order to address the research question, 'how do mental health practitioners own attitudes of severe mental illness affect belief in client recovery?' The data collected from the questionnaire was entered into the SPSS program. This study utilized

descriptive statistics in order to describe characteristics of the sample. The descriptive statistics included measures of central tendency and variability, and frequency distribution. Inferential statistics were utilized in this study, in order to make inferences about relationships between the independent and dependent variable among Clinical Social Workers, Marriage and Family Therapists, and Clinical Psychologists within the community. A bivariate analysis was utilized in order to assess statistical support for the research question including the relationship between the independent variable, practitioner attitudes, and the dependent variable, belief in client recovery. This study employed t-tests in order to compare the means of the two samples and determine differences. The t-test was appropriate for this study because it allowed the groups to be compared. A posttest analysis was applied in order to evaluate differences between the groups of practitioners. Pearson's R was utilized in order to determine correlation, strength, and direction of the relationship in the study. Despite efforts to provide a sample that is representative of the entire mental health practitioner population, sampling error was evident and there was not a large enough sample size at the end of the study in order to avoid sampling error.

Summary

This chapter provided the methodology that was implemented in the study. The study provided proper documentation to participants in order to protect subjects from harm and confidentiality breach. The study utilized a quantitative design in order to address attitudes and beliefs of mental health practitioners, as

well as differences among the groups, Clinical Social Workers, Marriage and Family Therapists, and Clinical Psychologists. Sampling was conducted through a snowball effect and data analysis was determined by use of various statistical tests through SPSS. The statistical instrument, strengths, and limitations were also addressed in order to better understand the experiment and its many aspects.

CHAPTER FOUR

RESULTS

Chapter four will be presenting the results of the study including demographics, and significant findings of the Opening Minds and Consumer Optimism scale. This chapter will include data tables and percentages of frequencies for the scales and demographics.

Presentation of Findings

In this study, there were a total of 72 participants. Nearly 78% of the participants were female and 22% were male. The ages of the participants ranged from 25 years to 56 years and over. Nearly 32% reported they were between the ages of 35 and 44 years, 26% were 56 years and older, 22% between the ages of 45 and 55 years, and 19% between the ages of 25 and 34 years. Nearly 53% were Caucasian/White, 29% were Latino/Hispanic, 8% were African American, 4% were other, 3% were Pacific Islander, 1% were Asian, and 1% declined to answer. Nearly 32% had 16 or more years of experience in the mental health field, 28% had 11 to 15 years, 19% had 2 to 5 years, 18% had 6 to 10 years, and 3% had 1 year or less. Over 63% annual family income were $80,000 or higher, 25% were $60,000 to $79,999, 6% were $40,000 to $59,999, and 6% were $20,000 to $39,999. Fifty-seven percent were married, 27% were single, 9% were divorced, 4% were co-habitating, and 3% were widowed. Forty-eight percent current status were LCSW, 14% were LMFT, 11% were Licensed

Clinical Psychologist, 8% were MSW, 7% were MFT, 6% were Clinical Psychologist, 3% were MFTI, 1% were ACSW, and 1% were LMFT & LPCC Trainee. Fifty-one percent current job settings were inpatient clinic, 26% were outpatient clinic, 21% were private practice, and 1% were inpatient clinic/private practice (see Table 1 in Appendix A, p.47).

The results of the Opening minds stigma scale for health care providers (OMS-HC) reported that 72% strongly disagree or disagree to being more comfortable helping a person who has a physical illness, than helping a person who has a mental illness. Twenty-four percent stated that they neither agree nor disagree, and 4.2% strongly agreed. Fifty-one percent of participants either strongly disagree or disagree to attributing the complaints of physical symptoms (e.g., nausea, back pain, or headache) to the person's mental illness. Forty-two percent neither agree nor disagree, while 7% agree. Of the total participants, the vast majority (99%) answered that if a colleague reported they struggled with a mental illness themselves, they would be just as willing to work with them. One percent stated that they neither agree nor disagree. Thirty-nine percent either strongly agree or agree, that they would not disclose to their colleagues if they were under the treatment for a mental illness. Thirty-two percent answered that they neither agree nor disagree to disclose, while 29% either strongly disagree or disagree, meaning they would disclose. The majority (82%) of participants reported that they would be more inclined to seek help for a mental illness if the treating healthcare provider was not associated with their workplace, while 10%

either strongly disagree or disagree and 8% did not agree nor disagree. Again, the majority of the participants (87%), did not agree or strongly disagree to the statement that they would see themselves as weak if they had a mental illness and could not fix it themselves. Eight percent either strongly agree or agree to that statement, while 4% reported that they neither agree nor disagree with that statement. Eighty-six percent denied reluctance to seek help if they had a mental illness, 10% stated that they either agreed or strongly agreed to having reluctance, and 4% neither agree nor disagree. The vast majority of participants (93%) agreed or strongly agreed that employers should hire a person with a managed mental illness if they are the best person for the job. Three percent either strongly disagree or disagree, and 4% neither are nor disagree. Eighty-nine percent reported that they would still go to a physician even if that physician had been treated for mental health. Seven percent neither agree nor disagree, while 4% disagree. Forty-eight percent stated that they would tell their friends if they had a mental illness, 38% neither agree nor disagree, and 14% disagree. Eighty-six percent strongly agree or agree that it is the responsibility of the health care provider to inspire hope in people with mental illness. Eleven percent neither agree nor disagree, and 3% disagree. Eighty-nine percent strongly disagree or disagree that they have negative reactions towards people with mental illness, despite their professional belief. Six percent strongly agree or agree, and 6% neither agree nor disagree. The overwhelming majority (96%) strongly disagree or disagree to the statement that there is little they can do to help people with

chronic mental illness, while 3% neither agree nor disagree and 1% agree. Eighty-nine percent strongly disagree or disagree to the statement that more than half of people with mental illness do not try hard enough to get better. Ten percent neither agree nor disagree with the statement, and 1% do agree with the statement. Fifty-four percent strongly agree or agree that people with mental illness seldom pose a risk to the public, 29% strongly disagree or disagree, and 17% neither agree nor disagree.

In regards to questions that were added to the OMS-HC scale regarding stigma and recovery towards more specific diagnoses, 37% answered that they neither agree nor disagree to the best treatment for persons living with thought disorders is medication, 35% strongly agree or agree, and 28% strongly disagree or disagree. Thirty-six percent strongly agree or agree that medication is the best treatment for persons living with mood disorders, 35% neither agree nor disagree and 29% strongly disagree or disagree. Fifty-eight percent answered that they either strongly disagree or disagree that medication is the best treatment for trauma and stress related disorders, 32% neither agree nor disagree, while 8% strongly agree or agree. Seventy-eight percent either strongly disagree or disagree that medication is the best treatment for persons living with personality disorders. Fifteen percent neither agree nor disagree and 7% agree. Fifty-four percent answered that they strongly disagree or disagree to the statement that they would not want a person with a thought disorder to work with children, even if it was managed. Thirty-eight percent said they neither agree nor disagree and

8% agree. Sixty-eight percent answered that they either strongly disagree or disagree to the statement that they would not want a person with a mood disorder to work with children, even if appropriately managed. Twenty-eight percent neither agree nor disagree with the statement and 4% agree. Sixty-nine percent strongly disagree or disagree that they would not want a person with a trauma related disorder to work with children, 28% neither agree nor disagree and 3% agree. The vast majority (97%) of participants believe that healthcare providers need to be advocated for individuals with chronic mental illness and 3% neither agree nor disagree. Seventy percent answered that they either strongly agree or agree that they would not mind if a person with a thought disorder lived next to them. Twenty-three percent neither agree nor disagree and 7% strongly disagree or disagree. Seventy-six percent reported that they would not mind if a person with a mood disorder lived next door to them. Fifteen percent neither agree nor disagree and 8% disagree. Eighty-two percent would not mind if a person with a trauma related disorder lived next door. Thirteen percent neither agree nor disagree and 1% disagree. Eighty-seven percent strongly disagree or disagree to the statement that they struggle to feel compassion for a person with a thought disorder. Eleven percent strongly agree or agree to the statement and 1% neither agree nor disagree. Ninety-two percent strongly disagree or disagree to the statement that they struggle to feel compassion for a person with a mood disorder. Seven percent strongly agree or agree. The vast majority (90%), strongly disagree or disagree to the statement that they struggle to feel

compassion for a person with a trauma related disorder. Seven percent agree and 3% neither agree nor disagree (see Table 2 in Appendix B, p.49).

In the Consumer Optimism scale, 42% of the participants believe that the majority or almost all of their clients will remain in the mental health system for the rest of their lives. Thirty-nine percent answered some, and 19% believe that almost none or very few will. Forty-seven percent of participants answered that they believe that only some of their clients will be able to greatly increase their involvement in community. Thirty-five percent stated that they believe majority will, 15% stated very few will and only 3% stated that almost all will. Fifty-seven percent of participants answered that they believe only some of their clients will be able to function well in the community. Thirty-seven percent answered that the majority or almost all will, and only 7% believe that only very few will. Forty-eight percent of participants believe that some of the clients will need to be hospitalized again in the future, 30% believe the majority will, and 23% believe that very few or almost none will. Fifty-eight percent answered that they believe their clients will remain as they are now, 25% stated very few or almost none, and 17% stated the majority. Forty-four percent believe that their patients will find work that enables them to be economically sufficient, 35% believe that very few or almost none will, and 24% believe that majority or almost all will. Forty-five percent answered that they believe their clients will be able to have satisfying intimate relationships, 45% believe that the majority or almost all will, and 15% answered only very few will. Sixty-one percent of participants stated they believe

their clients will be able to have satisfying friendships, 37% stated they believe only some will, and 3% believe that very few or almost none will. One-half (51%) of participants reported that they believe their clients will be able to achieve personal goals. Forty-five percent of the respondents stated only some, and 4% believe that very few or none will be able to. Forty-three percent believe that their clients will be able to work in a competitive job within the community, 32% believe that very few or almost none will, and 25% stated the majority or almost all will. One-half (51%) of the participants reported that they believed that only some of their clients will be able to cope successfully with persistent symptoms, 42% believe that the majority or almost all will, and only 7% believe that very few will. Just under one-half (49%) of the respondents reported that they believe majority or almost all of their patients will be able to take their medications independently, 44% reported only some, 7% believe that very few will. Nearly four-fifths (79%) of respondents believed that majority or almost all of their patients will be able to engage in leisure, hobbies and recreational activities, 18% believe some will, and only 3% believe very few will. Seventy-one percent believe that the majority or almost all their patients will be able to pursue spiritual/religious activities, and the remaining 29% answered only some will. Sixty-two percent of practitioners answered that they believe some of their clients will go on to depend on alcohol or drugs, 25% believe that few or almost none will and 13% believe that majority or almost all will. Fifty-one percent of practitioners answered that they believe some of their clients will be able to live in

their own housing, 32% believe that the majority or almost all will and 17% believe that very few or almost none will (see Table 3 in Appendix C, p.54).

The results of the Job Diagnostic Survey reported that 64% were satisfied in their job and found it very meaningful, 24% were extremely satisfied, 7% were dissatisfied, and 6% were neither satisfied nor dissatisfied. Nearly 39% reported they were neutral to people often think of quitting this job, 35% reported not very often, 20% reported often, and 7% reported very often. Over 47 % reported they were satisfied with the amount of pay and benefits they receive, 19% were extremely satisfied, 17% were neutral, 13% were dissatisfied, and 4% were extremely dissatisfied (see Table 4 in Appendix D, p.57).

The OMS-HC scale was originally a 20 item scale, scaled down to 15 items with the 5 remaining item responses discarded (5,11, 15, and 16) due to low item significance and in order to reflect the newly revised OMS-HC scale. The 15 items were structured into 3 subscales: attitudes of practitioners towards individuals with mental illness, practitioner's disclosure and willingness to seek help themselves, and practitioner's desire for social distance from individuals with mental illness. Three questions in the scale were averaged (17, 19 and 20) in order to compute the variables for attitudes, social distance, and disclosure/help-seeking. The results of the three subscales are as follows: attitudes (*M*=10.28, *SD=2.63)* minimum was 6 and maximum was 20. The results of disclosure were: (*M*=9.48, *SD*=2.3) minimum was 5, maximum was 14. The results of social distance subscale are (*M=9.57, SD=2.06),* minimum was 5, maximum was

5.33. The Consumer Optimism Scale was originally a 16 item scale, scaled down to 11, again to reflect the revised scale. The results of the scale are (*M=26.9, SD=6.09),* minimum was 11.5, maximum 39.5.

Results of the Consumer Optimism scale showed significance only regarding workplace setting. In running a one way ANOVA to compare the effects Consumer Optimism Scale and workplace setting, there was a significant effect of the Consumer Optimism Scale on work place setting at the $p<.0005$ level for the two conditions [$F(65)=10.72$, $p<.0005$]. Through the statistically significant results in the ANOVA test, a post hoc test was conducted to further investigate statistically significant findings. The Scheffe post hoc test was utilized for further exploration. This test was used in order to compare the scale to the individual workplace settings such as outpatient, inpatient, and private practice. The results of the Scheffe post hoc test indicated that the significance for outpatient clinics was at $p<.001$ level, indicating that practitioners in inpatient settings reported higher optimism regarding the recovery of individuals with severe mental illness, than practitioners at the outpatient and private practice settings. A T- test and correlation coefficient test were also conducted to explore potential significant findings regarding age, years of experience, income, marital status, and professional discipline. No significant findings were discovered.

In regards to the three subscales of the OMS-HC, a T-test, correlation coefficient, and ANOVA were conducted. In running a correlation coefficient test to find the relationship between social distance and attitudes, there was positive

relationship, reporting that higher negative attitudes in practitioners desired greater social distance from individuals with severe mental illness [$r(67)=.53$, $p<.0005$]. A test analysis was conducted to identify if the three subscales had a relationship, however findings indicated no significance. No significant relationship was found in regards to practitioner's stigma and belief in recovery.

CHAPTER FIVE

DISCUSSION

This chapter will present the major findings of the study and their implications for social work practice, policy, education, training, and future research. This chapter will also present the strengths and limitations of the study. Recommendations for future research will be discussed.

Discussion

Findings of the study showed that there was no relationship between mental health practitioners' attitudes towards individuals with severe mental illness and their belief in client recovery. However, through further testing of the data, a positive relationship was found between negative attitudes of practitioners and an increased desire to be socially removed from individuals with severe mental illness. Horsfall et al., (2010) reported findings that practitioners are less optimistic regarding client recovery and their ability to integrate into the community. The study also found a correlation between more years of experience and increased negative attitudes, however no significant findings were found in the study.

In regards to belief in client recovery and workplace setting, practitioners at the inpatient work setting reported a higher optimism towards the recovery of individuals with severe mental illness than practitioners at the outpatient and

private practice setting. This finding was supported by Ponizovsky et al. (2008), and Eack et al. (2008), which stated that social workers who had a higher level of contact with individuals who suffer from severe mental illness, resulted in better attitudes. The majority of the respondents reported being employed at Patton State Hospital, a forensic inpatient facility. Currently, it is known that Patton State Hospital's mental health practitioners use the recovery model as a tool for providing patient care (California Department of State Hospitals, 2016), which could indicate why no significance was found . According to Farkas (2007) present negative attitudes in practitioners, has a negative effect on client recovery. Hugo (2001), Marques, Figueiras, and Queiros (2012), and Jorm et al. (1999) presented consistent findings that indicated general stigmatizing attitudes resulted in negative belief in client recovery, which was inconsistent with the findings of this study. Mak et al. (2007) reported inconclusive findings in regards to negative attitudes and mental health practitioners. Similarly, in this study the findings indicated that the independent variables were unable to predict the measures.

This study had multiple limitations. This study consisted of a considerable amount of participants who indicated their current status as Licensed Clinical Social Workers. Therefore, this study cannot be generalized to the entire population of mental health practitioners within and outside of the San Bernardino and Riverside County area. Another limitation to this study consisted of a small sample size, further lowering generalizability. This study's initial

desired sample size was 150 participants, however, the study resulted in 72 participants in which, more than half were female. Therefore, this study cannot be representative of male and transgender mental health professionals. Additionally, due to type two sampling error, the participants in this study cannot be generalized to the entire population of mental health practitioners, and the findings could initially be significant in future studies with a larger sample of participants. Finally, this study did not address previous life experiences of participants that may have contributed to inherent stigma that resulted in a negative attitude towards severe mental illness.

Another limitation to the study is regarding workplace setting. The majority of participants were practitioners at an inpatient psychiatric hospital, with only few practitioners from different settings. Adding questions regarding different diagnoses to both scales also posed as a limitation in this research, in that the results of the tests do not have proven reliability and validity. Additionally, this study obtained participants through snowball sampling, which resulted in the findings inability to be generalized to the overall mental health practitioner population.

Strengths within this study included the use of scales that have proven validity and reliability. The OMS-HC scale, and Consumer Optimism Scale, have been utilized and proven effective to measure stigma and recovery optimism. Additionally, this study incorporated effective literature, which provided a basis for the research conducted, and description of stigma, attitudes, and belief in

recovery among practitioners in the mental health field within and outside of the United States. Finally, strengths of this study included the ability to incorporate findings and develop a plan of action for potential research in the future.

Recommendations for Social Work Practice, Policy, and Research

In regards to implications for future social work research, it is encouraged that further investigation is conducted on the topic of attitudes of practitioners and belief in client recovery. Although the study did not present findings regarding the presented hypothesis, variation was found indicating that current agencies are employing some workers who hold negative feelings towards individuals with mental illness, as well as practitioners who report low belief in recovery. It is recommended that considerations be taken to further research regarding the variations presented. Some potential policies to be developed around the findings of this study can be regarding implementing requirements for training on attitudes and recovery at both outpatient, inpatient and private settings. Educational settings can also begin to better prepare mental health practitioners through incorporating educational materials in classroom setting exploring the harm and impact negative attitudes can have on individuals. Supervisors can also be trained to identifying and exploring potential negative attitudes in student interns, before entering the professional field.

Conclusion

Although no relationship was found to support the hypothesis of this research, two correlations were discovered. This study had several limitations

due to limited participants and limited workplace settings, and results did not have generalizability. The scales utilized had strong reliability and validity and could be utilized for further research on this topic. With these findings, organizations can begin to consider developing further policies and trainings to work on reducing stigmatizing behaviors and help practitioners work with their clients towards recovery.

APPENDIX A

TABLE 1. DEMOGRAPHICS OF PARTICIPANTS

Table 1. Demographics of Participants

Variable	Frequency	Percentage
Gender		
Female	56	77.8
Male	16	22.2
Age		
25-34	14	19.4
35-44	23	31.9
45-55	16	22.2
56 and over	19	26.4
Ethnicity		
African American	6	8.3
Asian	1	1.4
Caucasian/White	38	52.8
Latino/Hispanic	21	29.2
Pacific Islander	2	2.8
Decline to answer	1	1.4
Other	3	4.2
Years of Experience in Mental Health		
1 year or less	2	2.8
2-5 years	14	19.4
6-10 years	13	18.1
11-15 years	20	27.8
16 or more	23	31.9
Annual Family Income		
$20,000-$39,999	4	5.6
$40,000-$59,999	4	5.6
$60,000-$79,999	18	25.4
$80,000 or higher	45	63.4
Marital Status		
Single	19	26.8
Cohabitating	3	4.2
Married	41	57.7
Divorced	6	8.5
Widowed	2	2.8
Current Status		
MSW	6	8.3
ACSW	1	1.4
LCSW	35	48.6
MFT	5	6.9
MFTI	2	2.8
LMFT	10	13.9
LMFT & LPCC Trainee	1	1.4
Clinical Psychologist	4	5.6
Licensed Clinical Psychologist	8	11.1
Current Job Setting		
Inpatient Clinic	37	51.4
Inpatient Clinic/Private Practice	1	1.4
Private Practice	15	20.8
Outpatient Clinic	19	26.4

APPENDIX B

TABLE 2. OPENING MINDS SCALE FOR HEALTH CARE PROVIDERS

Table 2. Opening Minds Scale for Health Care Providers

Variable	Frequency	Percentage
I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness		
Disagree	28	38.9
Neither agree nor disagree	17	23.6
Strongly agree	3	4.2
Strongly disagree	24	33.3
If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain, or headache), I would likely attribute this to their mental illness.		
Disagree	24	33.3
Strongly disagree	13	18.1
Neither agree nor disagree	30	41.7
Agree	5	6.9
If a colleague with whom I work told me they had a managed mental illness, I would be just as willing to work with him/her.		
Neither agree nor disagree	1	1.4
Agree	32	45.7
Strongly agree	37	52.9
If I were under treatment for a mental illness I would not disclose this to any of my colleagues.		
Strongly disagree	1	1.4
Disagree	20	27.8
Neither agree nor disagree	23	31.9
Agree	20	27.8
Strongly agree	8	11.1
I would be more inclined to seek help for a mental illness if my treating health care provider was not associated with my workplace.		
Strongly disagree	2	2.8
Disagree	5	7.0
Neither agree nor disagree	6	8.5
Agree	31	43.7
Strongly agree	27	38
I would see myself as weak if I had a mental illness and could not fix it myself.		
Strongly disagree	24	33.8
Disagree	38	53.5
Neither agree nor disagree	3	4.2
Agree	5	7
Strongly agree	24	33.8
I would be reluctant to seek help if I had a mental illness.		
Strongly disagree	25	35.2
Disagree	36	50.7
Neither agree nor disagree	3	4.2
Agree	6	8.5
Strongly agree	1	1.4
Employers should hire a person with a managed mental illness if he/she is the best person for the job.		
Strongly disagree	1	1.4
Disagree	1	1.4
Neither agree nor disagree	3	4.2

Agree	30	41.7
Strongly agree	37	51.4
I would still go to a physician if I knew that the physician had been treated for a mental illness.		
Disagree	3	4.2
Neither agree nor disagree	5	6.9
Agree	45	62.5
Strongly agree	19	26.4
If I had a mental illness, I would tell my friends.		
Disagree	10	14.1
Neither agree nor disagree	27	38
Agree	27	38
Strongly agree	7	9.9
It is the responsibility of health care providers to inspire hope in people with mental illness		
Disagree	2	2.8
Neither agree nor disagree	8	11.3
Agree	27	38
Strongly agree	34	47.9
Despite my professional beliefs, I have negative reactions towards people who have mental illness.		
Strongly disagree	32	44.4
Disagree	32	44.4
Neither agree nor disagree	4	5.6
Agree	2	2.8
Strongly agree	2	2.8
There is little I can do to help people with chronic mental illness		
Strongly disagree	38	52.8
Disagree	31	43.1
Neither agree nor disagree	2	2.8
Strongly agree	1	1.4
More than half of people with mental illness don't try hard enough to get better		
Strongly disagree	25	34.7
Disagree	39	54.2
Neither agree nor disagree	7	9.7
Agree	1	1.4
People with mental illness seldom pose a risk to the public		
Strongly disagree	2	2.8
Disagree	19	26.4
Neither agree nor disagree	12	16.7
Agree	31	43.1
Strongly agree	8	11.1
The best treatment in general for client's living with a thought disorder is medication		
Strongly disagree	6	8.5
Disagree	14	19.7
Neither agree nor disagree	26	36.6
Agree	20	28.2
Strongly agree	5	7.0
The best treatment in general for clients living with a mood disorder is medication		
Strongly disagree	2	2.8
Disagree	19	26.4
Neither agree nor disagree	25	34.7
Agree	22	30.6
Strongly agree	4	5.6

The best treatment in general for clients living with a trauma- and stress-related disorder is medication		
Strongly disagree	5	6.9
Disagree	37	51.4
Neither agree nor disagree	23	31.9
Agree	5	6.9
Strongly agree	1	1.4
The best treatment in general for clients living with a personality disorder is medication		
Strongly disagree	19	26.4
Disagree	37	51.4
Neither agree nor disagree	11	15.3
Agree	5	6.9
I would not want a person with a thought disorder, even if it were appropriately managed, to work with children		
Strongly disagree	4	5.6
Disagree	34	47.9
Neither agree nor disagree	27	38
Agree	6	8.5
I would not want a person with a mood disorder, even if it were appropriately managed, to work with children		
Strongly disagree	5	7
Disagree	43	60.6
Neither agree nor disagree	20	28.2
Agree	3	4.2
I would not want a person with a trauma disorder, even if it were appropriately managed, to work with children		
Strongly disagree	6	8.5
Disagree	43	60.6
Neither agree nor disagree	20	28.2
Agree	2	2.8
Healthcare providers do not need to be advocates for individuals with a chronic mental illness		
Strongly disagree	36	50
Disagree	34	47.2
Neither agree nor disagree	2	2.8
I would not mind if a person with a thought disorder lived next door to me		
Strongly disagree	1	1.4
Disagree	4	5.7
Neither agree nor disagree	16	22.9
Agree	38	54.3
Strongly Agree	11	15.7
I would not mind if a person with a mood disorder lived next door to me		
Disagree	6	8.3
Neither agree nor disagree	11	15.3
Agree	42	58.3
Strongly Agree	13	18.1
I would not mind if a person with a trauma disorder lived next door to me		
Strongly disagree	1	1.4
Disagree	3	4.2
Neither agree nor disagree	9	12.7
Agree	43	60.6
Strongly Agree	15	21.1
In general I struggle to feel compassion for a person with a thought disorder		

Strongly disagree	37	52.1
Disagree	25	35.2
Neither agree nor disagree	1	1.4
Agree	6	8.5
Strongly Agree	2	2.8
In general I struggle to feel compassion for a person with a mood disorder		
Strongly disagree	39	55.7
Disagree	26	37.1
Agree	3	4.3
Strongly Agree	2	2.9
In general I struggle to feel compassion for a person with a trauma disorder		
Strongly disagree	2	58.3
Disagree	23	31.9
Neither agree nor disagree	2	2.8
Agree	3	4.2
Strongly Agree	2	2.8

APPENDIX C

TABLE 3. CONSUMER OPTIMISM SCALE

Table 3. Consumer Optimism Scale

Variable	Frequency	Percentage
Will remain in the mental health system for the rest of their lives		
The majority	19	26.8
Almost all	11	15.5
Some	28	39.4
Very few	11	15.5
Almost none	2	2.8
Will be able to greatly increase their involvement in the community		
The majority	25	34.7
Almost all	2	2.8
Some	34	47.2
Very few	11	15.3
Will be able to function well in the community		
The majority	19	26.8
Almost all	24	33.3
Some	41	56.9
Very few	4	5.6
Will need to be hospitalized again in the future		
The majority	21	29.6
Some	34	47.9
Very few	8	11.3
Almost none	8	11.3
will remain pretty much as they are now		
The majority	12	16.7
Some	42	58.3
Very few	13	18.1
Almost none	5	6.9
Will find work that enables them to be economically self-sufficient		
The majority	13	18.1
Almost all	4	5.6
Some	32	44.4
Very few	19	26.4
Almost none	4	5.6
Will be able to have satisfying intimate relationships		
The majority	25	35.2
Almost all	5	7
Some	30	42.3
Very few	11	15.5
Will be able to have satisfying friendships		
The majority	37	52.1
Almost all	6	8.5
Some	26	36.6
Very few	1	1.4
Almost none	1	1.4
Will be able to achieve personal goals		
The majority	31	43.7
Almost all	5	7.0
Some	32	45.1
Very few	2	2.8

Almost none	1	1.4
Will be able to work in a competitive job (in community for real wages)		
The majority	14	19.4
Almost all	4	5.6
Some	31	43.1
Very few	17	23.6
Almost none	6	8.3
Will be able to cope successfully with persistent symptoms		
The majority	26	36.1
Almost all	4	5.6
Some	37	51.4
Very few	5	6.9
Will be able to participate in leisure, hobbies and recreational activities		
The majority	40	55.6
Almost all	17	23.6
Some	13	18.1
Very few	1	1.4
Will be able to pursue spiritual/religious activities		
The majority	36	51.4
Almost all	14	20
Some	20	28.6
Will continue to be dependent on alcohol or drugs		
The majority	8	11.1
Almost all	1	1.4
Some	45	62.5
Very few	15	20.8
Almost none	3	4.2
Will be able to live in their own apartment or home		
The majority	18	25
Almost all	5	6.9
Some	37	51.4
Very few	10	13.9
Almost none	2	2.8

APPENDIX D

TABLE 4. JOB SATISFACTION

Table 4. Job Satisfaction

Variable	Frequency	Percentage
Most people on this job find the work very meaningful		
Dissatisfied	5	6.9
Extremely Satisfied	17	23.6
Neither Satisfied nor Dissatisfied	4	5.6
Satisfied	46	63.9
People on this job often think of quitting		
Neutral	28	38.9
Not Very Often	25	34.7
Often	14	19.4
Very Often	5	6.9
The amount of pay and benefits I receive		
Dissatisfied	9	12.5
Extremely Dissatisfied	3	4.2
Extremely Satisfied	14	19.4
Neutral	12	16.7
Satisfied	34	47.2

APPENDIX E

PARTICIPANT SURVEY

Survey on Mental Health Practitioners and Client Recovery

This voluntary survey is designed to learn more about mental health practitioners and client recovery. There are no right or wrong answers, and your responses will remain anonymous. Please circle your answer. You may skip questions or stop taking the survey at any time. After you complete the survey, please return it back to the researcher.

We would like to ask about your attitude toward mental illness.

1. I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree

2. If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain, or headache), I would likely attribute this to their mental illness.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree

3. If a colleague with whom I work told me they had a managed mental illness, I would be just as willing to work with him/her.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree

4. If I were under treatment for a mental illness I would not disclose this to any of my colleagues.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree

5. I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree

6. I would see myself as weak if I had a mental illness and could not fix it myself.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree

7. I would be reluctant to seek help if I had a mental illness.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree

E. strongly agree
8. Employers should hire a person with a managed mental illness if he/she is the best person for the job.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
9. I would still go to a physician if I knew that the physician had been treated for a mental illness.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
10. If I had a mental illness, I would tell my friends.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
11. It is the responsibility of health care providers to inspire hope in people with mental illness.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
12. Despite my professional beliefs, I have negative reactions towards people who have mental illness.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
13. There is little I can do to help people with mental illness.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
14. More than half of people with mental illness don't try hard enough to get better.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
15. People with mental illness seldom pose a risk to the public.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
16. The best treatment in general for client's living with a thought disorder is medication.
A. strongly disagree

B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
17. The best treatment in general for clients living with a mood disorder is medication.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree

18. The best treatment in general for clients living with a trauma- and stress-related disorder is medication.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
19. The best treatment in general for clients living with a personality disorder is medication.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
20. I would not want a person with a thought disorder, even if it were appropriately managed, to work with children.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
18. I would not want a person with a mood disorder, even if it were appropriately managed, to work with children.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
19. I would not want a person with a trauma disorder, even if it were appropriately managed, to work with children.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
20. Healthcare providers do not need to be advocates for people with a thought disorder.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
21. Healthcare providers do not need to be advocates for people with a mood disorder.
A. strongly disagree

B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
22. Healthcare providers do not need to be advocates for people with a trauma disorder.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
23. I would not mind if a person with a thought disorder lived next door to me.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
24. I would not mind if a person with a mood disorder lived next door to me.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
25. I would not mind if a person with a trauma disorder lived next door to me.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
26. In general I struggle to feel compassion for a person with a thought disorder.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
27. In general I struggle to feel compassion for a person with a mood disorder.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
28. In general I struggle to feel compassion for a person with a trauma disorder.
A. strongly disagree
B. disagree
C. neither agree nor disagree
D. agree
E. strongly agree
Consumer Optimism Scale

This portion of the survey is about belief in client recovery.

Please answer the following questions with your current consumers in mind:

How many of your current consumers do you believe:

1. Will remain in the mental health field for the rest of their lives

A. almost none
B. very few
C. some
D. the majority
E. almost all

2. Will be able to greatly increase their involvement in the community

A. almost none
B. very few
C. some
D. the majority
E. almost all

3. Will be able to function well in the community

A. almost none
B. very few
C. some
D. the majority
E. almost all

4. Will need to be hospitalized again in the future

A. almost none
B. very few
C. some
D. the majority
E. almost all

5. will remain pretty much as they are now

A. almost none
B. very few
C. some
D. the majority
E. almost all

6. Will find work that enables them to be economically self-sufficient

A. almost none
B. very few
C. some
D. the majority
E. almost all

7. Will be able to have satisfying intimate relationships

A. almost none
B. very few
C. some
D. the majority
E. almost all

8. Will be able to have satisfying friendships

A. almost none
B. very few

C. some
D. the majority
E. almost all

9. Will be able to achieve personal goals
A. almost none
B. very few
C. some
D. the majority
E. almost all

10. Will be able to work in a competitive job (in community for real wages)
A. almost none
B. very few
C. some
D. the majority
E. almost all

11. Will be able to cope successfully with persistent symptoms
A. almost none
B. very few
C. some
D. the majority
E. almost all

12. Will be able to take medications independently
A. almost none
B. very few
C. some
D. the majority
E. almost all

13. Will be able to participate in leisure, hobbies and recreational activities
A. almost none
B. very few
C. some
D. the majority
E. almost all

14. Will be able to pursue spiritual/religious activities
A. almost none
B. very few
C. some
D. the majority
E. almost all

15. Will continue to be dependent on alcohol or drugs
A. almost none
B. very few
C. some
D. the majority
E. almost all

16. Will be able to live in their own apartment or home
A. almost none
B. very few
C. some
D. the majority
E. almost all

Job Diagnostic Survey

This portion of the survey addresses job satisfaction.

1. Most people on this job find the work very meaningful
A. extremely dissatisfied
B. neutral
C. extremely satisfied

2. People on this job often think of quitting
A. extremely dissatisfied
B. neutral
C. extremely satisfied

3. The amount of pay and benefits I receive
A. extremely dissatisfied
B. neutral
C. extremely satisfied

TELL US ABOUT YOURSELF

The following questions are optional. The information below will help us understand mental health practitioner belief in client recovery.

1. What is your gender?
A. Female
B. Male
C. Transgendered
D. Other_____
2. What is your age? _____
3. What is your ethnicity? (circle all that apply)
A. Latino
B. African American
C. White
D. Asian Pacific Islander
E. Native America
F. Other, Specify_____
4. Which best reflects your years of experience in the mental health field?
A. 1 year or less
B. 2-5
C. 6-10
D. 1-15
E. 16 or more
5. What was your annual family income before taxes last year?

A. Less than $19,999
B. $20,000-$39,999
C. $40,000-$59,999
D. $60,000-$79,999
E. $80,000 or higher

6. What is your present marital status?
A. Never married/ single
B. Cohabitating
C. Married
D. Divorced
E. Widowed
F. Other, specify_____

7. Current job setting_____
8. Number of years in current job setting_____
9. Number of years working in mental health field_____
10. Number of years working with individuals with severe mental illness___
11. Which one of the following categories best reflects your current status?
A. MSW
B. ASW
C. MFT
D. LCSW
E. LMFT
F. LPCC
G. Licensed Clinical Psychologist
H. Licensed Educational Psychologist

Thank You very much for your participation!

Retrieved from Modgill et al., 2014 & Slayers et al., 2013

APPENDIX F

INFORMED CONSENT

CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

College of Social and Behavioral Sciences
School of Social Work

INFORMED CONSENT

The study in which you are asked to participate in is designed to examine mental health practitioner's attitude and belief in client recovery in Riverside and San Bernardino County. The study is being conducted by MSW students Jessica De La Rosa and Roxie Tanase, School of Social Work, California State University, San Bernardino under the supervision of Dr. Herb Shon, CSUSB. The study has been approved by the Institutional Review Board Social Work Sub-committee, California State University, San Bernardino.

PURPOSE: The purpose of the study is to explore the potential presence of attitudes in CSW (clinical social workers) and MFT (marriage and family therapist) practitioners, and belief in client recovery.

DESCRIPTION: Participants will be asked of a few questions addressing attitudes toward mental illness, belief in client recovery, and demographics.

PARTICIPATION: Your participation in the study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY OR ANONYMITY: Your responses will remain anonymous and data will be reported in group form only.

DURATION: It will take 10 to 15 minutes to complete the survey.

RISKS: There are no foreseeable risks to the participants.

BENEFITS: There will not be any direct benefits to the participants. However, results can benefit CSW and MFT community members and agencies by providing results indicating the application/lack of application of the Recovery Model within agencies.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Herb Shon at 909-537-5532 at CSUSB.

RESULTS: Please contact Dr. Herb Shon (hshon@csusb.edu), or the Pfau Library at California State University, San Bernardino after December 2016.

This is to certify that I read the above and I am 18 years or older.

_____ _____

Place an X mark here Date

California State University, San Bernardino
Social Work Institutional Review Board Sub-Committee
APPROVED 12/21/2015 VOID AFTER 12/20/2016
IRB# SW1612 CHAIR

909.537.5501
5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

APPENDIX G

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

The study you have just completed was designed to investigate mental health practitioner's attitudes toward mental illness, and belief in client recovery in mental health agencies located in Riverside and San Bernardino County. We are interested in assessing the current opinions of practitioners on the severe mental illness of their consumers. We are also interested in correlations between their attitudes of mental illness and how it might affect the practitioner's belief that clients have the ability to overcome and recover from their mental illness. Recovery is based on the ability to maintain relationships, daily activities, sustain a working position, and manage mental health needs including regular participation in mental health services and medication management. This is to inform you that no deception is involved in this study.

Thank you for your participation. If you have any questions about the study, please feel free to contact Dr. Herb Shon at 909-537-5532. If you would like to obtain a copy of the group results of this study, please contact Dr. Shon (email: hshon@csusb.edu), or the Pfau Library at CSUSB after September 2016.

REFERENCES

California Department of State Hospitals (2016). *Department of state hospitals Patton.* Retrieved from http://www.dsh.ca.gov/Patton/.

Corrigan P. (2004). How stigma interferes with mental health care. *American Psychologist, 59,* 614-625.

Corrigan, P. W., Roe D, & Tsang H. (2013). Challenging the stigma of mental illness: Lessons for therapists and advocates. *Journal of Mental Health, 23,* 291-292.

Covarrubias, I. (2011). Mental health stigma about serious mental illness among MSW students: Social contact and attitude. *Social Work, 56*(4), 317-325.

Eack S. M., & Newhill C. E. (2008). An investigation of the relations between student knowledge, personal contact, and attitudes toward individuals with schizophrenia. *Journal of Social Work Education, 44,* 77-95.

Eack S. M., Newhill, C. E., & Watson A. C. (2012). Effects of severe mental illness education on MSW student attitudes about schizophrenia. *Journal of Social Work Education, 48,*425-438.

Farkas, M. (2007). The vision of recovery today: What it is and what it means for service. *World Psychiatry, 6,* 68-74.

Horsfall, J., Cleary, M., & Hunt, G.E. (2010). Stigma in mental health: Clients and professionals. *Issues in Mental Health Nursing, 31,* 450-455.

Hugo, M. (2001). Mental health professionals' attitude towards people who have experienced a mental health disorder. *Psychiatric and Mental Health Nursing, 8*, 419-425.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry, 33,* 77-83.

Link B.Q., Yang L. H., Phelan J. C., & Collins P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin, 30,* 511-541.

Lorenza, M., Fiorillo, A., De Rosa, C., Malangone, C., & Maj, M. (2004). Beliefs about schizophrenia in Italy: a comparative nationwide survey of the general public, mental health professionals, and patients' relatives. *The Canadian Journal of Psychiatry, 49,* 322-330.

Mak, W. W., Poon, C. Y., Pun, L.Y., &Cheung, S. F. (2007). Meta-analysis of stigma and mental health. *Social Science and Medicine, 65*, 245-261.

Marques, A. J., Figueiras, J., & Queiros, C. (2012). Mental illness stigma in mental health professionals. *European Psychiatry, 27.*

Mogdill, G., Patten, S.B., Knaak, S., Kassam, A., & Szeto, A.C. (2014). Opening minds stigma scale for health care providers (OMS-HC): examination of psychometric properties and responsiveness. *BMC Psychiatry, 14*(120).

Ponizovsky A. M., Shvarts S., Sasson R., & Grinshpoon A. (2008). Mental health knowledge and attitudes among social workers employed in a supported education program for adult students with schizophrenia. *American Journal of Psychiatric Rehabilitation, 11,* 279-294.

Rusch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20*, 529-539.

Salyers, M. P., Brennan, M., & Kean, J. (2013). Provider expectations for recovery scale: refining a measure of provider attitudes. *Psychiatric Rehabilitation Journal,* 36(3), 153-159.

Weinbach, R. W., & Grinnel, R. M. (2009). Introduction (8th ed). *Statistics for Social Workers* (pp. 1-22). Boston, MA: Pearson.

Wilrycx, G., Croon, M. A., & Broek, A. V. (2012). Psychometric properties of three instruments to measure recovery. *Scandinavian Journal of Caring Sciences, 26,* 607-614.

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2006).

Culture and Stigma: adding moral experience to stigma theory. *Social Science and Medicine, 64,* 1524-1535.

ASSIGNED RESPONSIBILITIES

This was a two person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

    Team Effort by Jessica Ann De La Rosa & Ruxandra Elena Tanase

2. Data Entry and Analysis:

    Team Effort by Jessica Ann De La Rosa & Ruxandra Elena Tanase

3. Writing Report and Presentation of Findings:

    a. Introduction and Literature

        Team Effort by Jessica Ann De La Rosa & Ruxandra Elena Tanase

    b. Methods

        Team Effort by Jessica Ann De La Rosa & Ruxandra Elena Tanase

    c. Results

        Team Effort by Jessica Ann De La Rosa & Ruxandra Elena Tanase

    d. Discussion

        Team Effort by Jessica Ann De La Rosa & Ruxandra Elena Tanase