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INVESTIGATING THE ATTITUDES OF GRADUATE SOCIAL WORK STUDENTS TOWARD SEVERE AND PERSISTENT MENTAL ILLNESS

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INVESTIGATING THE ATTITUDES OF GRADUATE SOCIAL
WORK STUDENTS TOWARD SEVERE AND PERSISTENT
MENTAL ILLNESS

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
Jennifer Nicole Thompson

June 2017

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ABSTRACT

Stigma is one of the foremost barriers to effective mental health treatment of consumers. Social workers currently provide the majority of mental health treatment in the United States. Examining levels of stigma present in social work students would be valuable in providing future interventions. A quantitative study was conducted utilizing an online questionnaire. The survey was distributed by the CSUSB Department of Social Work to graduate social work students. Statistical analysis utilizing SPSS software was conducted following data collection. Data analysis indicated that there was no significant difference in the attitudes regardless of exposure to severe mental illness. The findings of this study indicate that exposure to severe mental illness may not be the only factor in determining one's attitude. Implications of these findings for social work research include outlining the need for further examination of stigma to identify more specific factors in the formation of stigmatic attitudes.

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DEDICATION

To my Grandmother, Mother, Sisters, as well as countless other family and friends: thank you for your endless understanding through my busy schedule, long nights of homework and stress through this program. Thank you for always showing interest and support in my work throughout my academic career and providing me with your faith and love. I could not have done this without you.

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CHAPTER ONE

INTRODUCTION

Introduction

This paper will examine and discuss the attitudes of graduate social work students towards severe and persistent mental illness (SPMI). The following chapter will discuss the problem of stigma as an impediment to effective mental health treatment as well as the consequences of health professionals with stigmatic beliefs on the quality of healthcare provided to clients. In order to further understand the level of stigma present in mental health workers' attitudes, graduate social work students will be surveyed for their perceived judgment of severe and persistent mental illness by the general public. The possible implications of this study on social work research, policy and practice will be discussed in detail as well.

Problem Statement

Mental illness is one of the greatest public health risks facing the United States today (WHO, 2014). In 2007, the National Alliance on Mental Illness (NAMI) reported that nearly 43 million people in the United States suffer from some form of mental illness. This number may not take into account those who are undiagnosed or currently without mental health care. Although a variety of mental health treatments exist, NAMI found that treatment was provided to just over 40% of adults diagnosed with a mental illness in 2015, and just over 50% of

children aged 8-15 received services (2016). The effects of untreated mental illness can be devastating; there is an increased risk for chronic illness, dropping out of school, and suicide (NAMI, n.d.). Suicide is the second most prominent cause of death for people age 15-24, and mood disorders are the third most prevalent cause for hospitalization among young people age 18-44 (NAMI, 2016). The World Health Organization (WHO) and NAMI (n.d.) have both cited a variety of barriers to successful mental healthcare, stigma being one of the foremost mentioned (2014). This identifies stigma as a key mechanism which affects treatment that can be reported upon and more importantly can be changed through intervention.

Stigma is defined by NAMI as being stereotyped with negative characteristics that result in shame, discrimination and prejudice of the individual by others (n.d.). Stigma occurs among multiple systems; interpersonal relationships, mental health provision, media portrayals, educational settings, workplaces, and larger institutions throughout society (WHO, 2014). These systems are informed by social norms as well as personal beliefs and experiences. This is apparent in different facets of society; the misattribution of dangerous and criminal behavior to mental illness by the media as well as the restricted rights that many individuals with severe mental illness face across the states (WHO, 2014). The pervasive nature of stigmatic beliefs can make it difficult for individuals with mental illness to retain employment, gain housing, attain an education, and have a strong support system.

WHO (2014) reported that stigma is an effective barrier against both beginning treatment as well as completing it. The disparity between the number of practitioners and resources available compared to the utilization of mental health services and recovery is cause for concern, and research into the barriers to access of treatment is vital. In 2014, the United States Department of Labor reported that nearly 650,000 social workers practice in the United States, and that social workers comprise the majority of mental health practitioners. This suggests that social workers have a large impact on the outcome of individuals with severe mental illness, some of the most vulnerable members of society. Social workers who internalize stereotypes about severely mentally ill people as dangerous, unstable, untrustworthy, or unable to take care of themselves may inadvertently affect the treatment and recovery of consumers seeking wellness. This is contradictory to the strict ethical code of the National Association of Social Workers, which outlines that social workers must respect the dignity and worth of a person, seek social justice for oppressed members of society, practice with integrity and competence, and most importantly serve people in need (1996). Examining the attitudes of graduate social work students who will soon enter the field and provide treatment for individuals with mental illness or their families is important to understand stigma as a possible barrier to effective treatment, as well as to incentivize preventative measures to impede stigmatic beliefs.

Purpose of the Study

The purpose of this study is to measure the attitudes of CSUSB graduate social work students' attitudes towards people with severe and persistent mental illness. In order to offer competent and ethically sound treatment, it is vital that any possible limitations or roadblocks to effective treatment are investigated for the purpose of being addressed with interventions. Existing literature suggests that stigma acts as a barrier for clients with severe mental illness in terms of accessing resources, finding support systems, seeking out mental health treatment, or completing mental health treatment (Theriot and Lodato, 2012). Lack of support systems, resources, and treatment can make it difficult for individuals with mental illness to function in society at all or to reach any level of recovery. Social workers interact with clients at a time when they are at their most vulnerable, and it is vital to evaluate any factors that could negatively affect treatment.

Theriot and Lodato (2012) continue to point out that negative beliefs about the characteristics of mental illness can act as a roadblock to recovery for individuals as well as their ability to lead independent, functioning lives. CSUSB students complete both educational coursework on mental illness as well as fieldwork, often in a mental health or public health field. As a result, CSUSB students have a level of exposure and education that may affect their beliefs of individuals with mental illness, as well as be effected by any personal or outside interaction with mental illness. This study will investigate CSUSB graduate social

work students' attitudes towards severe and persistent mental illness. A quantitative-survey questionnaire design will be implemented and distributed via email to students enrolled in the Master of Social Work Program at California State University, San Bernardino.

Significance of the Study for Practice, Policy and Research

The effects of this study can potentially impact social work practice, policy and research. Investigating the attitudes of graduate social work students towards individuals with mental illness can create a better understanding of the challenges facing social workers and their clients during treatment. An essential step in beginning treatment is building a strong therapeutic alliance with the client is a sense of unconditional positive regard; any negatively pre-formed stereotypes regarding the idea of what individuals with mental illnesses look like, behave like, and acts they are capable of can negatively affect the quality of treatment provided. Building rapport with a client who the social worker may fear or have pre-existing opinions of may make it difficult for the client and social worker to build an honest and trusting relationship. In turn, assessing the client and treatment planning can be affected by the social workers predisposed beliefs about the diagnosis and treatment options regardless of the clients' desire for recovery.

Investigating the attitudes of graduate students who have not yet entered into the field as professionals can provide a clearer picture of potential treatment barriers. This knowledge can fuel further research or policy changes regarding

the effect of stigma on treatment. Regardless of the particular field a social worker may find themselves entering, it can be assumed that at one point they provide services for an individual with severe mental illness or their families; therefore, it is vital to assess the attitudes not only of social work students specializing in mental health, but social work students across the board. Identifying any gaps in perceived dangerousness, ability to take care of themselves, or any other level of functioning can help faculty or social work programs design more intensive psycho-education regarding stigmatic beliefs. It may also drive more research to further assess whether interventions such as psychoeducation or exposure to people with mental illness in a non-clinical setting would make a difference in social work students' perceptions of severe mental illness.

A general knowledge of the occurrence of stigmatic beliefs in social work students may in turn encourage further reflection of counter-transference that social work students may project onto consumers that will negatively affect their treatment; this is vital to remaining a competent, ethical, and effective social worker. Surveying graduate social work students may also provide information that could incentivize change at a departmental level. The attitudes of graduate social work students towards severe mental illness would provide insight into the specific mechanisms of stigma as a barrier, possible sources of stigma, and any protective factors that they may be aware of. Gathering data on the attitudes or beliefs of local social work students which could later be researched more

extensively can provide insight into areas of social work practice and policy that need improvement.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter will discuss the array of literature regarding the conceptualization of stigma, and how it effects the experience of mental health practitioners, the community and individuals with severe mental illness. The literature explores beliefs about severe mental illness, the impact of stigma on treatment, internalized stigma, stigmatic beliefs present in mental health professionals, as well as the effect that exposure or familiarity with mental illness may have on stigmatic beliefs. Theories steering the understanding of how stigma forms and the ways in which people may behave to avoid it will be explored to better conceptualize the issues surrounding stigma and mental illness.

Beliefs about Severe Mental Illness

Link, Cullen, Struening, Shrout and Dohrenwend (1989) measured the beliefs about stigmatic treatment among psychiatric patients and untreated community members and found that both sample groups reported stigmatic beliefs about mental illness as being associated with violence. The presence of similar reports of stigma between the general population and individuals in inpatient treatment at a psychiatric hospital suggests that stigma is prevalent

regardless of the presence of mental illness because of the social beliefs regarding the nature of people with mental illness.

Corrigan and Watson (2002) report that the effects of stigma can be conceptualized in four different behaviors; social exclusion, different levels of prioritization of physical and mental illness, as well as both resistance to providing treatment and forcing treatment for individuals with mental illness. These mechanisms are utilized by society and justified through the beliefs about the ability level, risk to public safety, ability to be independent, and moral failings of people with mental illnesses. Corrigan and Watson also report that stigma exists in both a public and self-form, and that in both of these phenomena stigma can be understood through the lens of stereotypes, discrimination and prejudice.

Corrigan and Wassel (2008) later expand on the findings of Corrigan and Watson (2002) by identifying avoidance of labels as another facet of the stigma faced by individuals with severe mental illness. They purport that the active avoidance of behaviors or actions that are associated with the stigmatized behavior can effectively act as a barrier to achieving goals not only related to treatment, but goals in other areas such as education and interpersonal relationships (Corrigan and Wassel, 2008). Corrigan and Wassel also suggest methods such as education and protest against discriminatory treatment as necessary for the challenging of prejudicial and discriminatory attitudes about mental illness in the United States.

Internalized Stigma and Treatment

Corrigan (2004) found that the presence of stigma is related to the lack of pursuit of mental health services by those with mental illness; he purports the effects of stigma on an individual are profound and negatively affect both self-esteem and the ability for an individual to connect socially with others. Corrigan additionally found that the effect of stigma on an individual's social supports and self-esteem may become internalized by the individual and therefore becomes a barrier to seeking or receiving effective treatment. Three years later, Corrigan (2007) found that while the existence of a diagnosis as it groups together symptoms may be useful for the conceptualization of causes and treatments, homogenous grouping together of all people with the disorder enables the entire group to be characterized with negative stereotypes regardless of the heterogeneity of symptoms, course, and prognosis. Corrigan (2007) suggests that the very act of being labeled with a diagnosis and therefore grouped together with other people who may show a variety of symptoms within the disorder and have different prognoses affects not only how social institutions view them, but how the patients view themselves. He suggests that replacing a diagnostic category with a continuum instead of strict grouping of symptoms as well as a recovery-based model can facilitate more positive outcomes (Corrigan, 2007).

Crocker (1999) argues that although there is a common belief that the internalization of stigma acts as a barrier to treatment, that the effects of stigma on an individual are contingent not only on the cultural beliefs about the

stigmatized behavior but whether or not the situational aspects are relevant to the stigma. Crocker (1999) finds that the shared cultural beliefs about the stigmatized condition combined with the aspects of the situation are the synergistic effect needed in order to produce the full effect of stigma; if the situational aspects are not present than stigma may not necessarily occur. This suggests that self-esteem and self-concept among the stigmatized and non-stigmatized may be different or similar depending not on the presence of stigma, but of the situation the stigma occurs in. Crocker further purports that building positive self-concept may act as a buffer or protective factor against the harmful effects of stigma.

Lannin, Vogel, Brenner, Abraham and Heath (2016) conducted a study to determine if any relationship existed between self-stigma and the likelihood of seeking out mental health services. Results found a negative correlation between self-stigma and seeking out mental health services; those with a higher level of self-stigma were less likely to seek out counseling information or treatment than those who reported a lower level of self-stigma. Lannin et al. (2016) argue that the negative perceptions associated with needing mental healthcare, such as being weak, crazy, or deficient in some way, acted as a deterrent to seeking out mental health services. There was also a negative correlation between reported amount of distress and likelihood of seeking services, suggesting that if symptoms are severe enough individuals may be more likely to seek out treatment regardless of their self-stigma or perception of social stigma (Lannin et

al., 2016). Stigma can affect treatment due to resistance to seek treatment because of resulting stigma, or to stay in treatment after being diagnosed with a severe mental illness. Corrigan (2004) found that public stigma and internalized stigma incite a fear of labeling or fear of feeling bad due to being diagnosed may prompt individuals suffering from symptoms to avoid treatment; this can have a debilitating effect on symptoms and life functioning.

Stigma in the Mental Health Profession

Literature suggests that there is a higher level of stigma among mental health professionals than that of the general public, perhaps due to the level of exposure to highly symptomatic severe mental illness. In order to understand the effect that stigma has on effective treatment, it is important to understand not only the stigma that is present in society and the individual but that may be present in mental health professionals as well.

Swiss researchers Nordt, Rossler, and Lauber (2006) surveyed and provided vignettes to both mental health professionals and members of the general population on their attitudes towards stereotypes of people with mental illness, attitudes about the restriction of the rights of people with psychotic disorders, social exclusion and ability to correctly diagnose a person with a severe mental illness such as schizophrenia. Psychiatrists reported a less positive attitude toward the severely mentally ill population than those of the general public, and no significant difference was found from the general population in regards to the restriction of rights such as voting, and

recommending abortion for pregnant women with severe mental illness, and hospitalization against the will of the client (Nordt et al., 2006). No significant differences were found in social distance between professionals and the general population, and there were mixed results among the different group of professionals and their responses of diagnoses to the vignettes. The study concludes that a mental health education and experience in the field may not affect attitudes or stereotypical beliefs or restrictions regarding the rights of people with mental illnesses in comparison to people with no mental health training or experience.

Tsao, Tummala, and Roberts (2008) found that professionals in mental health settings have similar rates and development of stigma and negative beliefs about people with mental illnesses as the general population. Tsao et al. (2008) found that in a study of medical students the only factor that was associated with lower reports of negative attitudes was the association of a loved one with a mental illness. The occurrence of stigma amongst mental health professionals may be attributed to the diagnostic process, during which stereotypes and expectations of behavior occur that may be informed by past negative experiences, education or prejudices (Tsao et al., 2008).

Ahmedani (2011) suggests that stigma against people with mental illnesses develops among mental health and healthcare professionals much the same as it does with the general population; influences from stereotypes, upbringings, cultural beliefs, and even burnout from working in the field. This

stigma creates a barrier to effective treatment not on the part of the individual, but the professional who is supposed to be providing the treatment. Emphasis on the acknowledgment on personal biases and cultural competency, as well as training, may help circumvent the effects of stigma on treatment.

Exposure to Mental Illness and Stigma

There is a sizeable amount of literature that suggests that contact with people with severe mental illness may effectively reduce stigma, however this is countered by studies that indicate that mental health practitioners, who are exposed to individuals with mental illness at a much greater rate, develop stigmatic beliefs at much the same rate as the general public (Ahmedani, 2011). Corrigan (2004) suggests that there are three methods that can be utilized in order to combat stigma; protesting, psychoeducation and contact with individuals with mental illness. Corrigan (2004) cites these methods can shed light on stereotypic beliefs about mental illness, however using such methods may result in the individuals' stigmatic beliefs becoming even stronger in a defensive move against being coerced. Corrigan (2004) argues that exposure to individuals with severe mental illness can result in a decrease in stigma as long as the contact happens in a non-competitive, fair, equal ground in which both groups have a common interest in interacting.

Eack and Newhill (2008) found that exposure is not the only effective measure of in reducing stigma; the amount of correct information an individual or group has about mental illness affects their beliefs about the group. This is

supported by evidence that many of the beliefs and attitudes exhibited by society about individuals with mental illness originate in the media, namely the news, which highlights cases severe enough to garnish attention.

Eack and Newhill (2008) further purport that social workers, although trained to be non-biased and self-aware, do not practice in a cultural vacuum and can be unconsciously informed by social beliefs about mental illness. Their study consisted of surveying first and second year social work students about their knowledge of, exposure to, and corresponding confidence level of working with individuals with severe mental illness. Their results indicated that the students with the most positive attitudes towards individuals with mental illness reported not only a high level of interpersonal experience, but a high level of knowledge of severe mental illness.

Wallach (2004) conducted a similar study in which 162 psychology students were exposed to a variety of contact levels- educational, institutional, and volunteer work. The results indicated that individuals with only educational exposure scored lower in attitudes than individuals with hospital visits or who volunteered. The literature suggests that a combination of accurate education about mental illness as well as exposure, preferably in a non-clinical environment, significantly improved attitudes of participants (Wallach, 2004).

Theories Guiding Conceptualization

Conceptualizing stigma and the effect of the environment on individuals requires an understanding of how stigma is conceived as well as the different

forms stigma takes. Examining the effect of stereotypes and labels on the opportunities that people have in terms of jobs, education, and even the ability to maintain relationships with others is necessary to fully conceptualize the effect that stigma can have on an individual's life. Stigma can further act as a barrier in the event that people with severe mental illness avoid treatment or disclosing their diagnoses to avoid a self-view in which they may be labeled or stereotyped negatively.

Goffman (1963) created Stigma Theory which was later extended within the framework that society creates categories of deviance, or stigma, from which people work to avoid. Link and Phelan (2001) furthered his work when they defined stigma in the terms of labeling, stereotyping, status loss, separation, and discrimination. Society labels people into categories based on "difference", and those may be connected to characteristics that are undesirable; people in these groups may suffer discrimination because other people do not want to be associated with these groups (Link and Phelan, 2001). The effects of the stigma surrounding mental illness consequently deter the person from seeking help or completing treatment, as well as impact the quality of treatment they receive based on the practitioners' own stigma. Stereotyping of individuals with mental illness in terms of diagnoses, symptoms, and treatment can prevent effective and individualized treatment that clients and their families deserve. Status loss and labeling of individuals with severe mental illness affects opportunities in domains

such as employment, interpersonal relationships and education (Link and Phelan, 2001).

Bronfenbrenner's Ecological Theory of Development posits that a person develops within the constructs of several different ecosystems that function together to form a synergistic relationship with the person. These systems range from family and friends in the microsystem to larger concepts such as political norms and mass media in macro system (as cited in Warren, 2010). This theory is important in the conceptualization of stigma as a barrier to treatment because it focuses on the interaction between systems and the effect that a system may have on an individual. Personal relationships, family and friends have a profound impact on an individual as their main support system; their opinions and treatment of mental illness may increase resistance or hesitance to seek or stay in treatment. Community resources, health centers, educational settings and work setting all also provide a setting in which a person with mental illness must function; if work places and educational settings are not supportive of working with someone with a mental illness, that may deter someone from seeking treatment (as cited in Warren, 2010). Larger social constructs such as laws and policies, the effect of mass media and the economy are all systems in which a person is immersed and must navigate within while suffering from a mental illness. Media portrayals of people with mental illness as unstable and a threat to society further the stigma and ostracized treatment that many people with severe mental illness face (as cited in Warren, 2010).

Self-Affirmation Theory proposes that people act in ways that uphold a positive self-image; they will ignore parts of themselves that threaten that image and focus on other areas (Sherman and Cohen, 2006). The stigmatization of mental illness could result in mental health care being perceived as a threat to their positive perception of themselves. Avoiding treatment or seeking knowledge about their diagnosis in order to avoid the negative consequences of stigmatization may result. However, not seeking treatment for mental illness does not bring relief from the symptoms, and many symptoms of various mental illnesses cause significant psychosocial, cognitive, interpersonal and emotional distress. The deterioration of function that may occur as a result of untreated mental illness can have negative consequences in the form of health risks, job loss, dropping out of school, loss of friendship, and even risk of suicide (NAMI, n.d.). It is important to understand the effect of stigma on self-image and work to better understand its development so that it can be treated more successfully for the benefit of those with mental illnesses. While this theory may not directly relate to social work students' future treatment of individuals with mental illness, counter-transference of feelings of avoidance towards mental illness could negatively affect mental health treatment of consumers and is therefore important to be cognizant of.

Summary

Stigma is just one of many barriers preventing initial or effective treatment of severe mental illness, however it is also able to be rectified. Research

supports that through increased exposure to individuals with mental illnesses or their families, individuals with stigmatic beliefs are exposed to realistic views of what mental illness looks like instead of the image perpetuated by media and other sources in society.

CHAPTER THREE

METHODS

Introduction

The following section will outline the study design and sampling technique that was used to recruit participants. The Devaluation-Discrimination Scale (Link et al., 1989) was described in detail in terms of the content of the items listed on the scale as well as the purpose of the scale and the rating system used to measure responses. Survey distribution as well as data collection techniques were described, along with the measures taken to protect participants' identities and confidential information. The data analysis techniques used to analyze and describe any significant trends or correlations between the items in the scale and demographic information gathered from the participants were outlined in the section.

Study Design

This study measured the attitudes of graduate social work students towards severe and persistent mental illness. The information gained from this study will be used to further understanding of stigmatic beliefs of social workers about to emerge into the field of practice. This will be accomplished through the use of a quantitative survey design using self-administered email questionnaires. A quantitative study design was utilized in order to gather information from a large group of people in a convenient and easily completed manner that protects

participant identities and guarantees anonymity. The independent variables were demographic information such as age, gender, class standing, previous and current field placements, as well as personal experience with people with severe mental illness. The specific research question was: What are the attitudes of CSUSB graduate social work students towards severe and persistent mental illness?

Limitations to this study included the non-probability sampling used to gain participants which disallowed the results to be generalized out to the larger population. Another limitation is the phenomena of social desirability; people may not have wanted to answer questions truthfully if the answer could have been perceived a negative reflection of their beliefs. To reduce the chance of social desirability affecting participant rating, the measure asked the participants to answer based on how they believe “most people” would respond.

Sampling

Criteria to be included in the study were to be over the age of 18 and currently enrolled as a student in California State University, San Bernardino’s Master of Social Work program. An email containing a description of the study as well as a link providing access to the survey was distributed by a department staff member. Due to the small student body of the department, the survey was sent to all students in order to maximize potential participant response for the optimal sample size. The students who returned a completed questionnaire represented a non-probability convenience sampling consisting solely of

graduate social work students. No identifying information was collected at any time during the study.

Data Collection and Instruments

A pre-existing instrument was utilized to measure attitudes towards severe and persistent mental illness. The Devaluation-Discrimination Scale (PDDS) was developed by Link and Cullen (1983) to measure the effects of labeling on the perceived devaluation and discrimination of ex-psychiatric patients. The measure is a 12 item Likert scale measuring the perceived attitudes towards people with mental illness. The scale utilizes 1-5 point scale corresponding with “not at all”, “a little”, “some”, “a lot”, and “a great deal (Link and Cullen, 1983). The statements listed in the measure describe situations such as having a neighbor with serious mental illness, dating a person with serious mental illness, entrusting children in the care of a person with serious mental illness, as well as the general trustworthiness or dangerousness of severely mentally ill individuals (Link and Cullen, 1983). Internal reliability for the PDDS has been reported at .86 and .88 (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). No reports of validity were found. For the purposes of this study, the scale was adjusted to specify “person with a severe mental illness” in place of “former mental patient”. A definition of severe and persistent mental illness was provided participants before answering the questionnaire.

Procedures

The survey questionnaire was distributed to participants through email after obtaining required permissions from the Master of Social Work Program through the School of Social Work. Questionnaires were self-administered via email and no identifying information such as name, school identification number or address was collected by the researcher. The email contained a link to a survey through Qualtrics enclosing an informed consent form, a demographic information form, the questionnaire, as well as a debriefing statement. The informed consent form contained information about the purpose of the study and described the voluntary nature of participation in the study. A description of the possible risks and benefits of completing the survey and the option of ending participation in the study at any time were also included in the informed consent. The informed consent was marked with an “x” in order to avoid collection of any identifying information of the participants.

Participants were prompted to respond to basic demographic questions such as age, gender, ethnicity, and program standing. Additional demographic questions were asked concerning their current internship placement site (e.g. child welfare, mental health, school based, medical and other) as well as exposure to severe mental illness (e.g. do they know someone with a mental illness, have they ever been diagnosed with a mental illness, have they ever been employed in a setting in which they are exposed to individuals with severe mental illness?).

Participants were then directed to complete the questionnaire. Participants were asked to respond to questions indicating their level of agreement with statements describing the way most people would respond to situations involving people with mental illness. Responding with what they believe would be most people's reactions or attitudes to the statements may help negate the chance that participants would answer in a way that was perceived as socially desirable. Upon completion of the questionnaire, participants were presented with a debriefing statement about the purpose of the study in the spirit of transparency as to not be manipulative. Campus psychological counseling resources were provided in the event that any participants are distressed by any of the questionnaire items. This questionnaire was in January 2017 and completed questionnaires were collected through March 2017. Completion of the questionnaire should have taken each participant between 15-20 minutes, and the participant was able to withdraw from completing the survey at any time without consequences.

Protection of Human Subjects

The researcher took proper precautions to protect the anonymity of all study participants. Identifying information including names, addresses, names of workplaces or field placement sites, or participant acquaintances were not collected at any portion of the survey. Each participant was assigned a number corresponding to the order in which they were received upon completion via

email. Consent forms were marked with a check box in order to avoid identifying signatures or written confirmation.

The data was kept confidential through restricted access of the data by individuals other than the researcher. The data was kept in protected file that only the researcher had access to. The original data were destroyed after being entered electronically and coded. Participants were made aware in the consent form of the anonymity measures prescribed in the study and given the option to leave the survey at that time.

Study participants were advised that at any point during the survey they had the right to withdraw or refuse to answer any questions. Participants were informed of any possible risk or benefits associated with completing the survey, namely awareness of their own attitudes towards people with mental illness. Participants were provided with a debriefing statement explaining the purpose of the survey as well as a list of departmental, campus and local community resources should the participants have experienced any distress as a result of completing the survey.

Data Analysis

Quantitative analysis techniques were used to analyze the data. Demographic information as well as survey items were coded numerically, entered electronically and analyzed statistically. Data was analyzed utilizing descriptive statistics in order to identify the demographic profile of the sample.

Pearson correlation was utilized to identify any significant relationships between the independent variable (experience with SPMI) and the dependent variable (perception of attitudes towards SPMI). Experience with SPMI included having a diagnosis, having a friend with a diagnosis, loved one or neighbor with a diagnosis, learning about SPMI, watching or reading media about SPMI, and willingness to work with persistently mentally ill individuals in the future. Perception of attitudes towards SPMI measured levels of agreement with responses indicating acceptance or rejection of severely mentally ill individuals. Chi-square test was administered to identify any association between types of exposure to severe mental illness such as watching a show or movie about severe mental illness and reading a book or article about severe mental illness. Descriptive analysis was used to identify frequencies of age, gender, specialization, and current/past field placements. An independent t-test was used to compare the PDDV scores between participants who responded “yes” to watching a show or movie about severe mental illness with participants who had responded “no”.

Summary

This study investigated the attitudes of graduate social work students toward mental illness using a modified version of the PDDS (Link and Cullen, 1983). A quantitative survey design using self-administered questionnaires was utilized in the study. Participants were invited to participate in the study through an email sent out by the School of Social Work directing them to the study.

Participants were provided an informed consent explaining the purpose of the study as well as their rights as study participants. In order to protect participant anonymity, no identifying information was collected during the demographic portion of the survey or the questionnaire. A debriefing statement was provided following completion of the questionnaire. Data was coded electronically and analyzed through SPSS using quantitative analysis techniques. Results of the study were submitted to the assigned research adviser and ScholarWorks.

CHAPTER FOUR

RESULTS

Introduction

The following chapter will report the statistical findings of analysis of the relationship between exposure to severe and persistent mental illness and perceived societal response toward people with severe and persistent mental illness. Demographic characteristics such as age range, gender identity, ethnicity, class standing, former field placement, and specialization will be listed. The results of statistical analysis of data utilizing Pearson r, Chi-square, independent t-tests, will be presented and outlined in detail.

Presentation of Findings

Descriptive Statistics

Table 1 represents demographic characteristics of the participants. Of the sample, 35.3% (n=30) reported as White and 38.8% (n=33) reported as Latino/Latina. 9.4% (n=8) of participants identified as black and less than 4% of the sample identified as Asian (1.2%, n=1), Pacific Islander (1.2%, n=1), or Native American (1.2%, n=1). Of the sample, 80% (n=68) identified as cisgender women and 11.8% (n=10) identified as cisgender male. 4.7% (n=4) of individuals preferred not to state their gender identification. In order to represent a full spectrum of genders, options included transgender male, transgender female, or agender and gender-fluid. No participants selected these genders. Forty-one of the participants were between the ages of 25 and 34 (48.2%), while 22.4%

(n=19) were between the ages of 18-24 and 20% (n=17) were between the ages of 35-44. Six of the participants were above the age of 45 (7.1%).

Table 1. Demographic Information

<u>Category</u>	<u>N</u>	<u>Frequency</u>
Age Range		
18-24	19	22.4%
25-34	41	48.2%
35-44	17	20.0%
45-54	6	7.1%
Missing		1 1.2%
Gender		
Cisgender male	10	11.8%
Cisgender female	68	80.0%
Prefer not to state	4	4.7%
Missing		1 4.2%
Ethnicity		
Black	8	9.4%
Asian	1	1.2%
White	30	35.3%
Am. Indian	1	1.2%
Latino	33	38.8%
Other/Mixed	10	11.8%
Missing		1 1.2%

Academic demographic statistics were collected to identify the academic standing, specialization, and former field placement setting of study participants.

Table 2 presents the frequencies of these categories. Of the participants, 20% (n=17) were full-time first year students, 36.5% (n=31) were full-time second year

students, 11.8% (n=10) were part-time first year students, 17.6% (n=15) were part-time second year students, and 11.8% (n=10) were part-time third year students. Former field placement setting information was requested in order to ascertain how many of the participants were in a mental health/non-mental health setting. A majority of the participants identified either mental health or child welfare as their former placement site setting, with 20% (n=17) of the participants reporting their former field placement as child-welfare and 25.9% (n=22) reporting a mental health setting. Of the remaining sample, 2.4% (n=2) identified a gerontology setting, 7.1% (n=6) identified a medical setting, and 11.8% (n=10) reported their field placement as other or not listed. Information about the participant's specializations were collected as well; 29.4% (n=25) identified their specialization as child-welfare and 36.5% identified mental health. Medical social work was identified by 11.8% (n=10) of the participants, and gerontology and forensic social work were each identified by 1.2% (n=1) of the participants. 11.8% (n=10) preferred not to state or were undecided and 5.9% (n=5) reported that their specialization was not listed.

Table 2. Academic Demographic Information

Category		N	Frequency
Class Standing	FT 1st year	17	20.0%
	FT 2nd year	31	36.5%
	PT 1st year	10	11.8%
	PT 2nd year	15	17.6%

	PT 3rd year	10	11.8%
	Missing	1	1.2%
Field placement			
	Child welfare	17	20.0%
	Mental health	22	25.9%
	Gerontology	2	2.4%
	Medical	6	7.1%
	other/not listed	10	11.8%
Specialization			
	Child welfare	25	29.4%
	Mental health	31	36.5%
	Gerontology	1	1.2%
	Medical	10	11.8%
	Forensic	1	1.2%
	Prefer not to state/undecided	10	11.8%
	Other/Not listed	5	5.9%
	Missing	1	1.2%

Inferential statistics

Pearson correlation was conducted to analyze the relationship between types or level of experience and perceived societal response toward severe mental illness. No significant relationship was found between amount of exposure to severe and persistent mental illness and perceived attitudes towards individuals with severe and persistent mental illness, $r = -.082$, $n = 82$, $p = .47$. Table 3 reports the frequency, mean scores and standard deviation between the sum of total experiences reported by participants and the sum PDDS scores reported by participants.

Table 3. Correlation Between Experience with SPMI and PDDS Scores

	Mean	Std. Deviation	N
Total Experiences	32.95	1.8	89
Sum PDDS	29.96	6.9	82

A Chi-square test for independence indicated no significant relationship between experience working with severe and persistent mental illness and watching a show or movie about persons with severe mental illness, $X^2 (1, n = 89) = .01$, $pi = .93$. Table 4 illustrates the frequencies of participants who answered “yes” or “no” in response to the statements “I have watched a movie or show about SPMI” and “I have worked in a setting where I was exposed to SPMI”.

An independent samples t-test was conducted to compare mean scores of the PDDV scale between participants who responded “yes” or “no” in response to statements assessing their personal experience with severe mental illness. The results of the analysis reported that in response to the statement, “I have watched a movie or a show about a person with severe mental illness”, there were no significant differences in the PDDV scale sum mean scores of participants who answered “no” ($M=30.82$, $SD =5.92$) and participants who answered “yes” ($M=29.72$, $SD =7.09$); $t (80) = .59$, $p = (.56)$.

Table 4. Correlation Between Work Setting Exposure and Media Exposure to SPMI

		I have watched show/movie about SPMI			Total Count
		No	Yes		
I have worked in a setting where I was exposed to SPMI	No	N %	6 7%	19 21%	25 28%
	Yes	N %	13 15%	51 57%	64 72%
Total		N %	19 21%	70 79%	89 100%

In response to the statement, “I have read an article or a book related to severe mental illness”, there were no significant differences in the PDDV scale sum mean scores of participants who answered “no” (M=31.00, SD =5.00) and participants who answered “yes” (M= 29.72, SD = 7.72); $t(80) = .65, p = (.52)$. Table 5 illustrates the frequencies and mean PDDS scores of participants who answered “yes” or “no” in response to the statement “I have read an article or book related to severe mental illness”.

Summary

This chapter presented the results of the statistical analyses conducted on data collected during this study. Demographic and academic information was illustrated to identify frequencies of age, gender, ethnicity, as well as class standing. Results of Pearson correlation analysis, chi-square analysis, and an independent t-test analysis were presented and discussed.

Table 4. Independent Group T-Test Between Exposure/Non-Exposure to SPMI Literature

I have read an article or a book related to severe mental illness.	N	Mean	SD
No	15	31.0	5.0
Sum PDDS			
Yes	67	29.8	7.2

CHAPTER FIVE

DISCUSSION

Introduction

The following section will present the inferences and suggestions that can be formed in response to the results of the statistical analysis. Limitations of the study, including small sample size and the influence of social desirability on the integrity of participant responses will be presented as well as the possible ramifications of those limitations on the study. The potential impact of the findings of this research on future research, policy and practice in the social work field will be examined.

Discussion

The results of the statistical analysis suggest there is no significant relationship between amounts of exposure to severe mental illness and perceived attitudes toward severe mental illness by CSUSB graduate social work students. More specifically, there were no significant differences in the PDDS scores between participants who had been diagnosed with a severe mental illness, had a loved one or friend with a severe mental illness, had been exposed to media concerning severe mental illness, worked in a setting related to severe mental illness, or had read a book or article about severe mental illness. These results partly align with the findings of Eack and Newhill (2008), who argued that exposure does not solely impact the attitude or beliefs of an individual with

severe mental illness, as there is a wide variety of information and situations available about severe mental illness in society, as well as a diverse population of individuals with severe mental illness across a spectrum of severity and symptomology. Their findings suggested that exposure and the quality of knowledge were greater predictors of positive attitudes (Eack and Newhill, 2008). However, the results do not align with the findings of Corrigan (2004), who found that exposure to people with severe mental illness effectively decreases levels of stigma. Ahmedani (2011) found that mental health practitioners and the general public acquired and expressed stigmatic beliefs at a similar rate, regardless of mental health practitioners' greater exposure to knowledge and severely mentally ill individuals. The results of this study as well as existing literature that while exposure and amount of education may have an effect on the development of stigmatic beliefs, these elements may not be the sole factors that influence the attitudes or beliefs about severe mental illness, regardless of occupation.

Limitations

Limitations were present in the study that may have had an impact on the outcome of the data analysis. The small sample size may have limited the full range of beliefs and experiences represented by the entire CSUSB social work department from being reported. Social desirability to portray a positive self-image may have affected participants' willingness to answer honestly if the answer resulted in the participant feeling negatively about themselves or others.

Suggestions for Social Work Policy, Practice and Research

The findings of this study can potentially impact social work policy, practice and research. The knowledge that exposure to severe mental illness does not significantly affect the attitudes of future social workers indicates that the current curriculum and exposure offered by the department is providing an unbiased education severe and persistent mental illness to the students in the program. This suggests that the steps that the department has taken should be continued and perhaps even further work can be done to incorporate exposure to severe mental illness throughout the duration of the program as opposed to being only fully discussed during micro practice classes. The CSUSB Department of Social Work policies and curriculum can recognize the need to address not only knowledge about the symptomology of mental illness, but the beliefs about people with mental illness that can often be negative and potentially affect the biases of students who will go out into the field and practice.

No significant correlation was found between level of exposure and the perceived social response towards people with severe mental illness reported by participants. The range of attitudes toward severe mental illness indicates that there may be other factors involved in the formation of stigmatic beliefs. These findings could potentially drive future actions taken by programs or agencies to evaluating their students' or employees' attitudes and beliefs about people with severe mental illness. This would be a vital step to take to address barriers such as social workers' beliefs about a consumer's self-efficacy, trustworthiness, or

ability to improve as they may have a negative effect on treatment. Addressing beliefs and challenging bias should not only be addressed while in school, but should be a regular part of practice in the field to remain self-aware of any impact that bias might have on the services received by people with severe mental illness or their families.

Further research regarding the relationship between stigmatic beliefs and exposure to mental illness should be conducted in the future. Studies with larger, more diverse sample sizes could result in a clearer view of the elements that impact beliefs about severe mental illness as well as specific interventions that can be employed to prevent misleading or dangerous beliefs about mental illness to be continuously present or develop in social work settings. This study contained no questions about specific cultural beliefs or impacts on attitudes about mental illness, and in future studies that may provide a clearer picture of the influences that affect the beliefs of individuals about severe mental illness. Research conducting a pre-test and post-test following a controlled exposure or psychoeducation about severe mental illness may provide a more direct observation of the direct effect of exposure or education on changes in attitudes or beliefs toward severe mental illness.

Conclusions

No significant relationship was found between the amount or type of exposure to severe and persistent mental illness and the attitudes of perceived reactions toward people with severe and persistent mental illness of CSUSB

graduate social work students. Limitations such as sample size and social desirability may have impacted the outcome of the study and these factors should be taken into account in future research. Future research concerning stigma should be conducted in more culturally-minded or experimental settings to expand the scope of exploration of attitudes about severe mental illness. Future practice and policy should be improved to address any impact that bias or attitudes may have on the effectiveness of treatment in order to continuously improve the quality of services provided not only to consumers and their families, but to communities and institutions as well.

APPENDIX A:
PERCEIVED DEVALUATION-DISCRIMINATION SCALE

Perceived Devaluation-Discrimination Scale

Modified from Link and Cullen, 1989.

Directions: Please rate how much you personally agree with the following statements.

1. Most people would accept a person who has been in a mental hospital as a close friend.

Not at all A little Some A lot Very Much

2. Most people believe that someone who has been hospitalized with a severe mental illness is dangerous.

Not at all A little Some A lot Very Much

3. Most people believe that person who has been hospitalized for a severe mental illness is just as trustworthy as the average person.

Not at all A little Some A lot Very Much

4. Most people would accept a person who has fully recovered from a severe mental illness as a teacher for young children in a public school.

Not at all A little Some A lot Very Much

5. Most employers will not hire a person who has been hospitalized for a severe mental illness.

Not at all A little Some A lot Very Much

6. Most people would be willing to marry someone who has been a patient in a mental hospital.

Not at all A little Some A lot Very Much

7. Most employers will hire a person who has been hospitalized for a severe mental illness if they qualified for the job.

Not at all A little Some A lot Very Much

8. Most people believe that being hospitalized for mental illness is a personal failure.

Not at all A little Some A lot Very Much

9. Most people will not hire a person who has been hospitalized for severe mental illness to take care of their children, even if they had been well for some time.

Not at all A little Some A lot Very Much

10. Most people in my community would treat a person with severe mental illness just as they would treat anyone.

Not at all A little Some A lot Very Much

11. Most people would be reluctant to date someone who has been hospitalized for a severe mental illness.

Not at all A little Some A lot Very Much

*When scoring, items 2, 5, 8, 9, and 11 were reversed for analysis.

APPENDIX B:
INFORMED CONSENT

PARTICIPANT INFORMED CONSENT

You have been identified as an eligible participant in the following study due to your status as a student currently enrolled in the Master of Social Work program for the 2016-2017 academic year at California State University, San Bernardino. The study is being conducted by Jennifer Thompson, an MSW student under the supervision of Dr. Armando Barragan, Assistant Professor in the School of Social Work at California State University, San Bernardino. 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 examine the attitudes of graduate social work students towards severe and persistent mental illness.

DESCRIPTION: Participants will be asked to respond to demographic questions inquiring basic information such as age, gender, grade standing, exposure to severe and persistent mental illness and general setting of previous and current field placements. After completion of the demographic section, participants will be asked to respond to a 12-item scale consisting of statements about feelings of interacting with individuals with severe and persistent mental illness in a variety of settings.

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.

ANONYMITY: No identifying information will be collected in the demographic portion of this study. Your responses will remain anonymous and data will be reported in group form only.

DURATION: It will take 15-20 minutes to complete the survey.



College of Social and Behavioral Sciences
School of Social Work

RISKS: Foreseeable risks associated with participating in study are minimal and consist of awareness of personal beliefs or attitudes about mental illness that may produce negative feelings. Resources will be provided in debriefing statement referring you to campus and community resources for psychological treatment.

BENEFITS: There will not be any direct benefits to the participants.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Armando Barragan at Armando.Barragan@csusb.edu.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks (<http://scholarworks.lib.csusb.edu/>) at California State University, San Bernardino after July 2018.

This mark indicates that I am above the age of 18 and have read and understood all of the above.

Please mark X if you wish to participate in the study _____

Date _____

909.537.5501 • fax: 909.537.7029 • <http://socialwork.csusb.edu/>

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

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APPENDIX C:
DEBRIEFING STATEMENT



College of Social and Behavioral Sciences
School of Social Work

DEBRIEFING STATEMENT

This study you have just completed was designed to investigate attitudes of CSUSB Master of Social Work students towards severe and persistent mental illness. We are interested in identifying beliefs about mental illness and attitudes towards individuals with severe and persistent mental illness that may potentially effect mental health treatment as future practitioners. These results may be used to identify and incentivize a need for further psychoeducation regarding stigmatic and stereotypical beliefs about severe and persistent mental illness. 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. Armando Barragan or Dr. Janet Chang through the School of Social Work at (909)-537-5301. If you would like to obtain a copy of the group results of this study, please go online at <http://scholarworks.lib.csusb.edu> after July 2017.

If after participating in this study you feel distressed, you may seek psychological treatment at the CSUSB Psychological and Counseling Services. You may reach them at (909) 537-5040.

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APPENDIX D
DEMOGRAPHICS

Demographic Information

Please choose one or more ethnicities that you consider yourself to be.

1. White
2. Black or African American
3. American Indian or Alaska Native
4. Asian
5. Native Hawaiian or Pacific Islander
6. Latino/Latina
7. Other _____

What is your age range?

1. 18-24 years old
2. 25-34 years old
3. 35-44 years old
4. 45-54 years old
5. 55 years or older

What gender do you identify with?

1. Cisgender Male
2. Cisgender Female
3. Trans Male
4. Trans Female
5. Agender/Genderfluid/Bigender
6. Prefer not to state

What year of the program are you currently enrolled in?

1. Full-time first year
2. Full-time second year
3. Part-time first year
4. Part-time second year
5. Part-time third year

What is your specialization?

1. Child Welfare
2. Mental Health
3. Gerontology
4. Medical
5. Forensic
6. Prefer Not To State
7. Not Listed/Undecided

Please pick a category that would best describe your current field placement.

1. Child-Welfare
2. Mental Health
3. School-Based
4. Medical
5. Forensic
6. Gerontology
7. Prefer Not To State
8. None Of These

Please pick a category that would best describe your former field placement; if this is your first year of field placement please choose "Not Applicable"

1. Child-Welfare
2. Mental Health
3. School Based
4. Medical
5. Gerontology
6. Forensic
7. Prefer Not To Answer
8. Not Applicable

Please choose all of the following statements that apply to you:

1. I have been diagnosed with a severe mental illness.
2. Someone in my family has been diagnosed with a severe mental illness.

3. I have worked in a setting in which I was exposed to people with severe mental illness.
4. I have a friend or neighbor who has been diagnosed with a severe mental illness.
5. I would be open to working with people with severe mental illness in the future.
6. I have watched a movie or show about people with severe mental illnesses.
7. I have read an article or book related to people with severe mental illness

REFERENCES

- Ahmedani, B. (2011). Mental health stigma: Society, individuals, and the profession. *Journal of Social Work Values and Ethics*, 8(2).
- Corrigan, P.W. (1998). The impact of stigma on severe mental illness. *Cognitive and Behavioral Practice*, 5, 201-222.
- Corrigan, P.W. (2004). Changing stigma through contact. *Advances in Schizophrenia and Clinical Psychology*, 1(2), 54-58.
- Corrigan, P.W. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614-625.
- Corrigan, P.W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Worker*, 52(1), 31-39.
- Corrigan, P.W. and Wassel, A. (2008) Understanding and influencing the stigma of mental illness. *Journal of Psychiatric Nursing and Mental Health Services*, 46(1), 42-48.
- Corrigan, P.W. and Watson, A.C. (2002) Understanding the impact of stigma on people with mental illness. *World Psychiatry*, 1(1), 16-20.
- Crocker J. (1999) Social stigma and self-esteem: Situational construction of self-worth. *Journal of Experimental Social Psychology*, 35, 89–107.
- Eack, S.M. and 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(3), 77-95.

- Goffman, E. (1963). *Stigma: Notes on the management of the spoiled identity*.
New Jersey: Prentice-Hall.
- Lannin, D.G., Vogel, D.L., Brenner, R.E., Abraham, W.T., and Heath, P.J. (2016).
Does self-stigma reduce the probability of seeking mental health
information? *Journal of Counseling Psychology*, 63(3), 351-358.
- Link, B.G. and Cullen, F.T. (1983). Reconsidering the social rejection of ex-
mental patients: Levels of attitudinal response. *American Journal of
Community Psychology*, 11(3).
- Link B.G., Cullen F.T., Struening E.L., Shrout P.E. and, Dohrenwend B.P. (1989).
A modified labeling theory approach in the area of mental disorders: An
empirical assessment. *American Sociological Review* (54), 100–123.
- Link, B.G. and Phelan, J.C. (2001) Conceptualizing stigma. *Annual Review of
Sociology*, 27, 363-385.
- Link, B.G., Struening, E.L., Neese-Todd, S., Asmussen, S., and Phelan, J.C.
(2001). Stigma as a barrier to recovery: The consequences of stigma for
the self-esteem of people with mental illness. *Psychiatric Services*, 52(12),
1621-1626. <http://dx.doi.org/10.1176/appi.ps.52.12.1621>
- National Association of Mental Illness (2016). *Mental health by the numbers*.
Retrieved from <https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>

- National Association of Social Workers. (1996). Code of ethics of national association of social workers. Retrieved from <http://socialworkers.org/pubs/code/code.asp>
- National Association of Mental Illness (n.d.) Facts about stigma and mental illness in diverse communities. Retrieved from <https://namihowardcounty.org/wp-content/uploads/sites/51/2015/01/StigmaandMentalIllnessinDiverseCommunities.pdf><http://www2.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=5148>
- Nordt C, Rössler W, Lauber C. (2006). Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophrenia Bulletin*, 32(4), 709.
- Sherman, D.K. and Cohen, G.L. (2006). The psychology of self-defense: self-affirmation theory. *Social Psychology*, 38.
- Theriot, M.T. and Lodato, G.A. (2012). Attitudes about mental illness and professional danger among new social work students. *Journal of Social Work Education*, 48(3), 403-423.
- Tsao, C.I.P, Tummala, A., and Roberts, L.W. (2008). Stigma in mental health care. *Academic Psychiatry*, 32(2), 70-72.
- United States Bureau of Labor. (2015). Social workers. Retrieved from <http://www.bls.gov/ooh/Community-and-Social-Service/Social-workers.htm>

- Warren, John. (2010). Bronfenbrenner's ecological theory of development.
Retrieved from <http://www.articlesbase.com/history-articles/bronfenbrenners-ecological-theory-of-development-2128561.html>
- Wallach, H.S. (2004). Changes in attitudes towards mental illness following exposure. *Community Mental Health Journal*, 30(3), 235-248.
- World Health Organization. (2014). Mental health: A state of well-being.
Retrieved from http://www.who.int/features/factfiles/mental_health/en/