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Social workers' perceptions of self-determination in the mentally ill

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SOCIAL WORKERS' PERCEPTIONS OF SELF-DETERMINATION IN THE MENTALLY ILL

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

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by

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ABSTRACT

Mentally ill individuals are not only stigmatized and treated differently by the public, but in this study it was hypothesized that social workers' perceptions can have a negative affect on self-determination in this population. This quantitative study examined the perceptions that social workers' have regarding the mentally ill. This study found that there were only significant differences in two of ten questions within the survey. The remaining eight questions showed no significant differences in social workers' perceptions of self-determination in the mentally ill population. Therefore, mental illness was not a determining factor of whether or not social workers believed in self-determination in the mentally ill population.

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DEDICATION

I would like to dedicate this project to the ones who have supported me throughout this journey. To my son Brandon "Caillou", this project is to let you know that you can accomplish whatever you put your heart and soul into. To my parents John and Sandra Alfred, you both don't even realize how much I have appreciated your unconditional love, support, and what it has meant to me throughout these last 3 years of the program. To Quaran, this hasn't been an easy 3 years, but I thank you for putting up with my numerous mood swings, keeping me grounded, and supporting me throughout this endeavor. To my brother John Jr., thank you for the random telephone calls and texts just to tell me you are proud of me. I love you all!

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CHAPTER ONE

INTRODUCTION

This chapter examines the perceptions of the public towards people who are living with a mental illness. This chapter also discussed social workers who are in the mental health field, and their opinions of whether or not they believe in self-determination when it comes to mentally ill individuals seeking treatment on their own. Many social workers have negative attitudes towards the mentally ill population due to frustrations with clients' behaviors, treatment issues, unreasonable caseloads, and long hours.

Problem Statement

During the past century the treatment of people with mental disorders has undergone enormous changes. Working with the Severe and Persistently Mentally Ill (SPMI) population continues to be one of the most challenging issues for social workers who work in a mental health setting. Kessler et al., posits that "Psychiatric disability affects about 4.8 million adults in the United States each year" (as cited in Carpenter, 2002, p. 1). Many social workers who do not work in a behavioral

health setting may at some point have to treat an individual that is affected by mental illness. The United States is a society in which people often fear individuals living with mental illnesses. In a recent study Crisp, Gelder, Rix, Meltzer, and Rowlands (2000) found that public opinions about mental illness were more influenced by dramatic reports depicted by media than they were influenced by actual personal contacts with the mentally ill. Stroebe and Insko (1989) suggest that if people observe a particular group of individuals behaving in a certain way, the observers may have a tendency to draw conclusions about the activity being typical for that group of people. Stroebe and Insko (1989) go on to say that interaction with a mentally ill individual can dispel one's stereotypic perceptions of this population, through contact, one learns about their positive characteristics.

According to social learning theory, a person with more knowledge and experience about people with mental disabilities might perceive himself as being more equipped to interact with them Stroebe and Insko (1989). In addition, Stroebe and Insko (1989) state, according to psychoanalytic theory, further knowledge and experience

might reduce psychological insecurity and thereby may prove one's acceptance of out groups by suppressing the authoritarian tendency that legitimizes the use of aggression and discrimination against people with mental illness.

There are many false perceptions about people who are living with mental illnesses. For example, mentally ill individuals are perceived by some in society to not have the ability to follow through with their own individual treatment planning in order to treat the disorder with which they are living. According to Shor and Sykes stigma related to mental illness "is not only prevalent in general society, but also among all helping professions, including psychiatry, psychology, and social work" (as cited in Schwartz, 2003, p. 33). Stigma can lead to the mentally ill individual disengaging from participation in society and other groups; ultimately becoming socially isolated.

Social workers who have worked in the behavioral health field have created their own perceptions or biases about clients in the behavioral health system of care. Freedberg (1989) stated "Social workers must confront the basic contradiction in their roles as client advocate and

as intermediate agent of a society in which clients are disenfranchised" (p. 33). Freedberg (1989) goes on to say "Social workers are encouraged to apply the concept of self-determination to empower both clients and the social work profession" (p. 33).

According to the National Association of Social Workers (NASW) Code of Ethics (2012) the social worker should seek to foster maximum self-determination within their clients (Ethical Standards, 1.02, Self-Determination). Social workers as a whole should afford the utmost value regarding the maximization of client self-determination. However maximizing self-determination is not always easy because many social workers are overwhelmed with an unreasonable number of client's in their caseloads, lack of client participation, budget cuts, and long hours.

Purpose of the Study

The purpose of this study was to add to the existing literature regarding social workers' perceptions of and attitudes about self-determination in the mentally ill population. In addition, the study looked at how these biases affect the mentally ill population. This study

also looked at examining perceptions and attitudes of social workers to determine the underlying factors of why some populations of mental health professionals have created these biases. It is important to study social worker biases about the mentally ill population in order to identify the stressors that cause biases. Identifying the cause of social worker bias can potentially create solutions in the services rendered to the mentally ill population. Additionally, finding solutions for social worker bias can also assist in mentally ill individuals having a sense of self-worth and maximize their ability to seek out quality care, ultimately leading them to becoming productive citizens of society.

According to Rothman, Smith, Nakashima, Paterson, and Mustin (1996) "social workers find themselves caught between two compelling but sometimes competing notions: outcome oriented and competency based practice and client self-determination" (p. 396). Social workers should be held to a standard of professional ethics when working with the mentally ill population. Levy indicated that the social worker needs:

> to allow the client to make his own choices to the maximum extent the situation and his competence

> permits...to make the situation as permissive as possible and to help the client to equip himself as well as he can to exercise his own judgment and initiative. (as cited in Rothman et al., 1996, p. 396)

The results of this study may be used as an informal needs assessment to create departmental trainings regarding social workers attitudes towards individuals living with a mental illness, which will in turn address staff needs and benefit future clients.

The single blind study design in the study employed two vignettes followed by a questionnaire with a total of ten questions regarding the vignette that was be measured using a five point Likert scale with responses ranging from one (strongly agree) to five (strongly disagree). The survey was administered using a sampling method to approximately 51 social workers who are currently providing mental health services.

Significance of the Project for Social Work

The significance of this project to social work is related to increasing awareness about negative perceptions that social workers sometimes project on

individuals with a mental illness. There are many mental health agencies that have social workers who provide daily psychiatric assistance to this population of individuals. If social workers continue to display negative opinions about their clients, and do not feel that their clients are capable of self-determination, clients may become discouraged to seek services within the public or private mental health system of care.

This study was an attempt to assess some of the perceptions that social workers have about the mentally ill population. In addition, this study was an effort to bring awareness to social work professionals regarding how negative attitudes and biases towards the mentally ill can have a detrimental effect on their client population. Social workers need to be aware that individuals with mental illness who are seeking services at their agencies are part of an especially vulnerable population who may already have a history of being stigmatized by public and private mental health system professionals.

It is hypothesized that the more negative the social workers' attitude towards self-determination in the

mentally ill, the greater the impact on individuals' willingness to seek services for their treatment.

CHAPTER TWO

LITERATURE REVIEW

Chapter two focuses on self-determination literature and provides an overview of several different factors of the internally driven strength of self-determination. This was accomplished by reviewing studies that focus on historical perspectives on self-determination. It also included theories surrounding self-determination in addition to social workers' perceptions of self-determination in general.

Historical Perspectives

Historically within social work several themes have repeatedly emerged: empowerment, human liberation, and autonomy (Freedberg, 1989). Tillich's work on the historical perspective mentions that "Every historical period creates different forms, ideas, and conditions in which self-determination may be realized" (as cited in Freedberg, 1989, p. 33). The social work literature long has emphasized the importance of client self-determination in helping clients help themselves. Berlin states self-determination is a condition in which personal behavior emanates from a person's own wishes,

choices, and decisions (as cited in Freedberg, 1989). Social workers are faced daily with issues that are challenging to deal with in terms of meeting expectations of agencies and providing effective services to clients in the community. Social workers strive to provide that balance between these two forces in order to maintain a certain level of consistency between their agencies and their clients. Freedberg (1989) also mentions that "the idea of humans as social beings who must adjust within a community suggests a social context to the concept of self-determination; a sense of belonging places relative limits on self-determination" (p. 33).

Just as with many professions, the history of social work is filled with both positive and negative instances relating to interactions with the mentally ill (Freedberg, 1989). During the 1940's social workers had to mobilize resources immediately to assist those families who were effected physically, socially, and emotionally by the war (Freedberg, 1989). Many people during that time were faced with losing loved ones, the breaking of family ties, and the increasing effects of juvenile delinquency (Freedberg, 1989). Freedberg goes on to say these factors contributed to social workers having

to deal with increased caseloads, budget cuts, which increased the demands of client cooperation and problem solving skills on the behalf of the workers. In addition, Freedberg (1989) asserts "Less attention was paid to theoretical development, social change efforts, methods of treatment, and principles of practice (such as client self-determination), and more attention was paid to the necessary transformation of institutional structures to ease the burdens caused by war" (p. 35). The effects of the war caused enormous negative impact on inhibiting client self-determination.

In the 1960's social workers often identified more heavily with institutions rather than the in client base because institutions represented the power structure (Freedberg, 1989). She goes on to say the choice of self-determination rested with the individual, not with the social group. This was contrary to the needs of clients during that time in history. According to Rothman and Glasser, self-determination was conceptualized during this time as a rights versus needs issue (as cited in Freeberg, 1989). Freedberg (1989) adds "Although the self-determined person was seen theoretically as having an inalienable right to participate actively in the

decisions in the casework process, social workers found it difficult to incorporate into practice these democratic ideals of human freedom" (p. 33).

Freedberg (1989) asserts "In the 1970's and 1980's a dramatic change occurred in the political and social context of social work practice and in the way self-determination can be applied in practice" (p. 37). The political system was a significant influence on the social welfare system during this time of the Nixon administration. During this historical period of struggle many of the mentally ill population did not have the ability to advocate for themselves. Anthony (1993) discusses the concept of community support system as identifying and providing adequate resources for those in a community who are psychiatrically disabled.

Gaylin states "Modern society has been characterized by an emphasis on the ability of humans to think out their futures with a certain degree of self-awareness over instinctual behavior" (as cited in Freedberg, 1989, p. 33). Eack and Newhill (2008) conducted a study that investigated experiences and attitudes of social workers in a post-master's degree practice in mental health who work with individuals with severe and persistent mental

illnesses. The results suggested that the social workers' attitudes were related to frustrations from client behaviors and treatment issues rather than frustrations with system-related issues. These challenges that social workers experience on a daily basis shape their attitudes and may create the biases that many social workers display while working with clients who experience mental illness.

Self-Determination in the Mentally Ill

There are many perspectives that guide the concept of self-determination in the mentally ill. These perspectives are dependent on the individual who is defining this fundamentally driven strength. This section provides a comprehensive overview of the two significant factors that can guide self-determination within clients. Social workers' perceptions and client capacity to make choices is discussed.

As stated earlier, social workers' perceptions and biases are determined by a number of factors. Given that working with a population of mentally ill individuals is challenging, it is reasonable to hypothesize the frustrations experienced in clinical work with

individuals who are mentally ill may be related to the development of negative attitudes (Eack & Newhill, 2008). Although, many social workers in the mental health field are aware of the challenges this population brings, many are not prepared to deal with those challenges on a daily basis. A recent study conducted by the Community Mental Health Center (CMHC) staff reported findings indicating extrinsic system factors, such as large caseloads and role ambiguousness, are among some of the frustrations of mental health professionals, and these frustrations may have a distinct negative impact on staff retention (Acker, 2004; Mason, Olmos-Gallo, Bacon, McQuilken, Henley, & Fisher, 2004). In addition, professionals' attitudes may also have an impact on the way clients interact with their external networks (Schwartz, 2004). Schwartz goes on to say social workers attitudes toward people with mental illness are influenced by familiarity, knowledge, and experience with mental illness.

In contrast to the Taylor (2006) study that found both the importance and utility of self-determination were heartily endorsed by the majority of the participants, Kassel and Kane (1980) found that the majority of the respondents in their study felt there are

issues that can be more important than client self-determination. The respondents in Kassel and Kane's (1980) study felt that decisions which affect others, the ability of the client to care for self, and matters of life and death are situational outcomes superseding the client's right to the instrumental process of self-determination. Perlman and McDermott give an example of the debate about self-determination that affects both the practitioner and client:

> The debate about self-determination tends to center on whether or not the concept should be more 'practitioner-driven' such as when a social worker makes therapeutic calls about what is good for a client; or more 'client-driven,' with a focus on client choice, when the client makes their own decision about what is best despite the risk of failure. (as cited in Taylor, 2006, p. 7)

Self-determination in clients who are able to function in terms of following a treatment plan, being compliant with medication, have social support, and utilize community resources for themselves may be perceived differently by social workers than a client who has been inconsistent with taking medications, and not

following a treatment plan which may ultimately place the client at a higher risk of being a danger to self, danger to others, or gravely disabled.

Deci, Vallerand, Pelletier, and Ryan (1991) discuss self-determination theory as "When a behavior is self-determined, the regulatory process is choice, but when it is controlled, the regulatory process is compliance, or in some cases, defiance" (p. 327). Often times if clients are seeking voluntary services they are willing to follow through with a treatment plan, on the contrary if clients are mandated to seek treatment there may opposition which can lead to non-compliance of treatment.

Examining the wants and needs of clients is an invaluable tool when attempting to attain positive outcomes in treatment. Uncovering the wants and needs can be as simple as seeking input and insight from an individual. Deci et al., (1991) state "When a behavior is self-determined, the person perceives that the locus of causality is internal to his or her self, whereas when it is controlled, the perceived locus of causality is external to the self" (p. 327). When clients have the ability to assist with the goal setting process they are

more willing to follow through with the treatment plan, whereas if clients are forced or in an involuntary situation they may be resistant to following through with treatment plans.

Barnes, Carpenter, and Dickson (2000) conducted a study regarding attitudes toward community care and professional stereotypes, and found that social workers agreed that, "with modern approaches, even people with severe mental health problems can lead reasonably 'normal' lives in the community." In addition, this same group disagreed strongly with the proposition that "people with mental health problems cannot express their own needs and should rely on professionals" (p. 572). Penhale (1991) states that even critics of the 'best interest' approach suggest in such difficult situations the person should be allowed some expression of their individuality, accepting that in some cases this will involve a degree of risk-taking. After examining the controversial issue of self-determination, it is more than likely that all topics will exist for decades.

Stigma and its Affects on Clients in the Mental Health System

Stigma can affect persons positively or negatively in a variety of ways. This section discusses stigma and its affects on individuals who are mentally ill. Stigma can motivate an individual to prove others wrong and dispel the stigma, or on the other hand it can engender a significant loss of self-esteem and self-determination.

According to Schwartz (2004) "People with mental illness are affected by stigma that causes discrimination and interrupts social inclusion" (p. 34). Watson, Corrigan, Larson, and Sells (2007) suggest persons with mental illnesses such as schizophrenia may internalize mental illness stigma and experience diminished self-esteem and self-efficacy. Not every individual who is living with a mental illness is affected and suffers low self-esteem. There are individuals who may not react or become indifferent about the stigma. However, in addition to those who may experience low self-esteem and low self-efficacy, Watson et al. (2007) stated that other perspectives have suggested that "individuals constrict their social networks and opportunities in anticipation of rejection due to stigma, which leads to isolation,

unemployment, and lowered income" (p. 1312). Watson and Corrigan's (2002) research on understanding the impact of stigma on people with mental illness suggests that the majority of citizens in the United States and many Western European nations have stigmatizing attitudes about mental illness.

Link, Struening, Neese-Todd, Asmussen, and Phelan (2001) comment on the effects of self-esteem of persons who have serious mental illness. They stated that people develop conceptions of mental illnesses early in life between the ages of two and ten from family lore, personal experience, peer relations, and the media's portrayal of people with mental illness. They go on to say that because of these experiences people form expectations about whether most people will accept or reject an individual based on his or her mental illness. They also stated for a person who never develops a serious mental illness these beliefs have little personal relevance, but on the contrary, these beliefs are very relevant for individuals living with mental illness. Link et al. (2001) also found that the stigma associated with mental illness harms the self-esteem of many people who have serious mental illnesses. They go on to conclude

that an important consequence of reducing stigma would be to improve the self-esteem of people who have mental illnesses.

Theories Guiding Conceptualization

The theories guiding conceptualization of this project were ecological systems theory and the recovery model. Andreae suggests systems theory is congruent with social work values and goals (as cited in Turner, 1996). The author goes on to say "Systems theory has provided social work theorists and practitioners with a unique and profound perspective on the complex functioning of individuals, groups, families, organizations, and communities in contemporary 21st-century Canadian and American society" (p. 253). Ecological systems theory posits that the environment plays an important role in influencing individual's actions in society. There are many levels to ecological systems theory which include micro, mezzo, and macro levels. All are interrelated structures that interact with the individual at different levels. Within those systems there are additional interacting systems called subsystems. These systems can be open or closed to interaction with the outside world.

These systems can be affected positively or negatively, creating states of homeostasis, or instability within the system. An individual's ability to adapt to his or her environment is significant for their overall functioning in society. Germain and Gitterman, (1987) stated that the environment exchanges over time; it is never fixed but shifts in reciprocal exchanges. They go on to say when exchanges over time are generally negative, development, health, and social functioning might be impaired and the environment could be damaged.

Systems theory assisted in guiding this study by borrowing the notion that there are mutual adaptations between individuals and their social and physical environments (Germain & Gitterman, 1987). They go on to assert that the exchanges between people and environments will either support or inhibit the striving for adaptedness. In addition, Wakefield (1996) suggests "The influence of the systems perspective on social work has been sufficiently profound that the intellectual creditability of the profession has to some degree become linked to the perspective's validity" (p. 5).

The recovery model also assisted in guiding this study by delineating the range of modalities that are

incorporated within this model. Recovery is a process that includes change and the development of acknowledging and accepting the illness, developing the desire and motivation to change, and finding and utilizing a source of hope and inspiration (Young & Ensing, 1999). Service providers must embrace the belief that every consumer can achieve hope, healing, empowerment, and connection, no matter what his or her current status (Jacobson & Greenley, 2001). They go on to say that this belief must lead providers to focus on the person, not the illness, and on his or her strengths and goals.

Young and Ensing (1999), suggested recovery occurs in five stages: "1.) overcoming 'stuckness', 2.) discovering and fostering self-empowerment, 3.) learning and self-redefinition, 4.) returning to basic functioning, and 5.) improving quality of life" (p. 219). All five of the preceding stages are important in the recovery process of the mentally ill. This model originated in the field of substance abuse and has been embraced by the mental health field. The concept of "recovery" is not new. In fact Anthony suggests the origin of the construct of recovery can be traced back to

the 1970's (as cited in Young & Ensing, 1999). Anthony goes on to define the recovery vision as follows:

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, and feelings, and goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life. (p. 220)

Hatfield and Lefty conceptualized recovery in terms of adaptation stating that "it is thought to be a process of adaptation at increasingly higher levels of personal satisfaction and interpersonal functioning" (as cited in Young & Ensing, 1999, p. 220).

Several negative factors which can hinder the recovery process were discussed by Amador and David (2004) who found that poor insight frustrates clinicians which lead to patients feeling coerced into accepting medications for a condition they believe they don't have. They go on to say many patients will refuse the treatment if possible, but often times they accept for as long as it takes for them to be able to get back out into society. These aspects are important to keep in mind

given that if individuals are not in compliance with their medications, they may not have the insight to follow through with the necessary treatment causing stages of psychological instability.

Jacobson and Greenly (2001) mention a recovery-oriented mental health model that focused on internal and external conditions that can affect an individual during the recovery process. Internal conditions such as hope, healing, empowerment, and connecting are all interrelated within the recovery process. Social workers individually play a role in clients learning how to reconceptualize the illness in a way that they do not see it as being the mental illness, but as being individuals who are living with a mental illness.

According to the Community Mental Health Center, Inc. website (2009)

> Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. (Home page, para. 1)

The concept of empowerment is central to the recovery model. The way clients define their mental illnesses can determine the success of their recovery. The ability to rebuild a sense of self and a sense of hope are also central themes within the model of recovery. Young and Ensing (1999) add that "self-efficacy," "will," and "control" are also terms that are frequently used conjunctively and sometimes interchangeably to describe a common underlying element of recovery. Recovery is the stage where individuals may be inspired concerning what is to come of their lives. The more mentally ill individuals take crucial steps towards the progression of their recovery process, the more hope is generated.

Summary

In summary, the theoretical models that guided this study are ecosystems theory and the recovery model. These theories were considered and examined in order to convey the importance of what these two models are to the social work field because it is important to understand how the influence of the environment can affect the mental health population positively or negatively. The utilization of ecosystems theory allows individuals to understand and

explore the systems around them by looking at each interrelated structure of the environment from a micro, mezzo, and macro perspective.

The recovery model is an empowering aspect of recovery-oriented services. Recovery allows individuals to build a sense of self. According to Young and Ensing (1999) an important aspect of recovery is a quest for a newly defined, coherent, and stable sense of reality. This process leads to hope, inspiration and a reduced sense of stigma which can be reflected in a reconstructed positive outlook on life.

CHAPTER THREE

METHODS

Introduction

This chapter contains the methodology and procedures of this research project. The study design and sampling procedures which include the survey tool is discussed. In addition, the data collection and instruments are discussed. Finally, the protection of human subjects and data analysis are also discussed in this section.

Study Design

This study explored social workers' perceptions of self-determination in the mentally ill, and also examined why these perceptions are prevalent among the population of social work professionals. This study used a quantitative approach in regards to gathering information. The hypothesis proposed for this study is that negative perceptions and biases will have a negative affect on social workers' outlook regarding self-determination in the mentally ill.

The survey questionnaire (Appendix B) used in this study consisted of ten questions. The answers were

measured using a Likert scale with the responses ranging from one (strongly agree) to five (strongly disagree).

Sampling

A total of 51 social workers were asked to participate in this study. A nonprobability convenience sampling design was utilized. This sampling method was selected because the population of individuals to be included in the sample is clearly defined. The participants were not representative of the entire population because the target of the research was focused specifically on social workers providing direct client services to individuals who are seeking mental health services through a behavioral health system of care. In addition, using a convenience sampling design allowed for an ease of accessibility for the researcher.

Data Collection and Instruments

Data collected in this study was examined from the responses to the survey by each individual social worker solicited for this study. The demographics section of the survey (Appendix A) included sex and ethnicity which were measured at the nominal level of measurement. Age, education, years of work experience in social work, and

years of work experience in mental health were measured at the interval level of measurement. The responses from the survey were all measured at an ordinal level using a five point Likert scale with the responses ranging from one (strongly agree) to five (strongly disagree). Questions in the survey consisted of information regarding a client's ability to identify safe and adequate housing, shop for groceries and cook for himself once he becomes independent, provide input regarding the choice of doctor and healthcare provider, make decisions regarding his own medication, keep himself safe in the home without supervision, follow up with aftercare treatment, manage his own finances, need to continue relying on others to take care of his basic needs, and be able to socialize with others within the community.

The identified dependent variable was social workers' perceptions of self-determination in the mentally ill, and the independent variable was characteristics of social workers.

The data was collected by using a survey questionnaire (Appendix B) administered to each individual social worker. In addition, the survey consisted of a single blind study that included two

vignettes in which the participants were not aware of the variance in one of the vignettes. Survey vignette one (Appendix C) included a client who is diagnosed as schizophrenic, paranoid type, and with high blood pressure. Survey vignette two (Appendix D) included a slight variance taking out the information regarding the mental health diagnosis. The variance was used to determine the influence on perceptions of the social workers based on the client's supposed mental health status.

Procedures

Data was collected by conducting a nonprobability convenience sampling method because of the specific population of mental health social workers which was chosen for this study. This was accomplished by soliciting social workers who are currently providing direct services to individuals within a behavioral health clinic. Hardcopies of surveys were passed out to those participants who choose to participate in the survey. The surveys were collected at the time of completion.

The data retrieved from each participant was kept confidential. The participants received an informed

consent (Appendix E) with a debriefing statement (Appendix F). The timeframe of this data collection process was approximately eight weeks.

Protection of Human Subjects

Each participant that elected to be part of this study was provided an informed consent form that included a brief statement of the proposed study, rights regarding participation, confidentiality, contact person and phone number if there were questions and/or concerns about this study. There were no foreseeable risks to the participants. There was no identifying information on this survey tool. A debriefing statement was also attached thanking the participants, disclosing the reason for the variance of the survey vignette, as well as information as to where they can retrieve the results once available, i.e., in the John M. Pfau Library at California State University, San Bernardino after the summer of 2012. The data collected for this survey was kept in a locked cabinet and was only accessible to the researcher. The data that was kept in the computer was password protected to secure the results of the study.

Data Analysis

Quantitative data analysis was utilized to process the data in this project. The Statistical Package for the Social Sciences (SPSS) program was employed to determine responses given by participants. The data for univariate T analysis means, standard deviation, and frequencies were used. For Bivariate analysis T-Tests were used, and the alpha level was set at .05.

Summary

This chapter included a brief discussion of the methodologies that were employed in this project. This included study design, sampling procedures, data collection, and instruments including the identified dependent and independent variables, procedures, protection of human subjects, and data analysis. Informed consent, confidentiality, debriefing statement, information of when and where results can be retrieved, and data analysis can all be found in Appendices A, B, and C.

CHAPTER FOUR

RESULTS

Introduction

Included is a presentation of the demographic information collected from social workers who have participated in this study. This chapter will also include frequencies of social workers' responses to Vignette I and II. In addition, a presentation of the bivariate findings related to study's hypotheses will be provided.

Presentation of the Findings

The sample of this study consisted of 51 participants, in which 26 completed Vignette I and 25 completed Vignette II. Data were collected from all participants on age, sex, ethnicity, level of education, years of work experience in social work, and years of work experience in mental health. The age of the individuals in the sample ranged from 25 to 62 years old, (M = 42.90, SD = 10.43), with two participants not disclosing their age.

The ethnic composition was as follows: 42.3% (11) Caucasian, 23.1% (6) Latino/Hispanic, 15.4% (4) African

American/Black, 11.5% (3) Asian/Pacific Islander, and 3.8% (2) other.

Participants' years of work experience in social work ranged from less than 1 year to 21 years (M = 7.74, SD = 5.74%). Years of work experience in mental health ranged from less than 1 year to 38 years, (M = 9.54, SD = 7.76%).

Table 1. Group Statistics

	Vignette	N	Mean	Std. Deviation	Std. Error Mean
Q1	1.00	26	3.4231	.85665	.16800
	2.00	25	2.8000	1.11803	.22361
Q2	1.00	26	2.8846	.95192	.18669
	2.00	25	2.6000	1.11803	.22361
Q3	1.00	26	2.9615	.95836	.18795
	2.00	25	2.7600	1.12842	.22568
Q4	1.00	26	2.3846	1.02282	.20059
	2.00	25	2.1600	.74610	.14922
Q5	1.00	26	2.7308	1.07917	.21164
	2.00	25	2.7600	1.09087	.21817
Q6	1.00	26	2.8462	.83390	.16354
	2.00	25	2.4800	.82260	.16452
Q7	1.00	26	2.7692	1.03180	.20235
	2.00	25	2.8000	1.00000	.20000
Q8	1.00	26	3.3462	.89184	.17490
	2.00	25	2.9600	.88882	.17776

	Vignette	N	Mean	Std. Deviation	Std. Error Mean
Q9	1.00	26	2.2308	.81524	.15988
	2.00	25	2.9600	.97809	.19562
Q10	1.00	26	3.0000	.97980	.19215
	2.00	25	2.9600	1.09848	.21970

The results of the t-test analysis showed that there were significant differences in answers for question 1 and question 9. The participants that were given Vignette I which included a mental health diagnosis of schizophrenia tended to disagree more with question 1 ("Do you believe that William will be able to identify safe and adequate housing on his own?"), (M = 3.42, SD = 0.86), than did the participants that were not given a diagnosis in Vignette II (M = 2.80, SD = 1.12), $t(49) = 2.239$, $p = .03$. In addition, the same group tended to agree with question 9 ("Do you believe that William may need to continue relying on others to take care of his basic needs?"), (M = 2.23, SD = .81), than did the participants that were not given a mental health diagnosis in Vignette II (M = 2.96, SD = 0.98), $t(49) = 2.897$, $p = .006$. Significance was set at the 0.05 level (2-tailed).

Looking at the Mean and Standard Deviation for Questions 2 through 8 and 10 in each of the two Vignettes, questions were not significant at the following levels: Question 2 ("Do you believe that William will be able to shop for groceries and cook for himself once he becomes independent?") Vignette I (M = 2.88, SD = .952), Vignette II (M = 2.60, SD = 1.11). Question 3 ("Do you believe that William will have the ability to select his own case management staff?") Vignette I (M = 2.96, SD = .958), Vignette II (M = 2.76, SD = 1.13). Question 4 ("Do you believe that William will have the ability to provide input regarding the choice of Dr. and healthcare provider he is seeking?"), Vignette I (M = 2.38, SD = 1.02), Vignette II (M = 2.16, SD = .746). Question 5 ("Do you believe that William will have the ability to make decisions regarding his own medications?") Vignette I (M = 2.73, SD = 1.08), Vignette II (M = 2.76, SD = 1.09). Question 6 ("Do you believe that William will have the ability to keep himself safe in the home without supervision?") Vignette I (M = 2.85, SD = .834), Vignette II (M = 2.48, SD = .823). Question 7 ("Do you believe that William will have the ability to follow up with aftercare treatment if necessary?")

Vignette I (M = 2.77), SD = 1.03), Vignette II (M = 2.80, SD = 1.00). Question 8 ("Do you believe that William will have the ability to manage his own finances?") Vignette I (M = 3.35, SD = .891), Vignette II (M = 2.96, SD = .889). Question 10 ("Do you believe that William will end up finding another woman to take care of his basic needs?") Vignette I (M = 3.00, SD = .980), Vignette II (M = 2.96, SD = 1.10).

Summary

This chapter reviewed the univariate and bivariate findings relevant to the purpose of this study. Specifically, univariate findings were provided with frequencies of demographic variables to describe the sample in this study. Additional frequencies were provided to display the responses to questions. Bivariate findings included results from the independent-sample t-tests.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter will provide an in depth discussion of the findings in this research project. Literature on ecosystems and the recovery model will also be utilized to aid the discussion. In addition, limitations of the study and recommendations for social work practice policy will also be presented. Lastly, this chapter concludes with a summary of the study's findings as well as a direction for future research.

Discussion

The purpose of this exploratory study was to gain a greater awareness of social workers' perceptions of self-determination in the mentally Ill. It was hypothesized that the more negative the social workers' attitude towards self-determination in the mentally ill, the less likely they would agree with self-determination within the mentally ill population. This study found that responses in two of the questions differed significantly depending on which vignette the respondents were given.

The remaining 8 questions were found not to be significant.

Respondents who read Vignette I, which included the mental health diagnosis of schizophrenia, were more likely to disagree with Question 1 ("Do you believe that William will be able to identify safe and adequate housing on his own?"). The respondents who read Vignette II which did not include a mental health diagnosis of schizophrenia were more likely to agree with Question 1. Comparing Question 1 with responses from both Vignettes show that schizophrenia had a negative effect on how respondents responded to Vignette I. They believed William was not capable of self-determination and finding safe and adequate housing on his own due to his diagnosis of schizophrenia. Those who responded to Vignette II shows that diabetes had no effect on whether or not they felt William was able to find safe and adequate housing on his own.

Those who read Vignette II, which did not include a mental health diagnosis, were more likely to agree with Question 9 ("Do you believe that William may need to continue relying on others to take care of his basic needs?"). This response indicates although there was not

a mental health diagnosis, the majority of respondents believed William was too unstable to take care of his basic needs. Those who read Vignette I were more likely to agree with Question 9, again indicating that William's schizophrenia diagnosis has a hindrance on whether or not he was able to achieve self-determination.

In addition, the responses from Question 1 and Question 9 question is the only confirmation that validates the hypothesis that social workers do have negative perceptions of the mentally ill population when it comes to self-determination, therefore possibly impacting services to this population.

Limitations

The results of this study were intended to add to the current literature regarding social workers' perceptions of and attitudes about self-determination in the mentally ill population. One of the limitations in this study's survey was the formatting of the questions. Many of the survey questions asked if William was able (or had the ability) to follow through with certain tasks. One of the social workers wrote "He can be able,

but is he willing?" (Participant 14, personal communication, July, 2011).

In addition to the formatting issues, there were apparent limitations of the vignette methodology and for the study. Participants indicated that there needed to be additional information in order for them to make a more informed decision. Respondents also commented on the content of the vignettes noting, "There was information lacking to make good estimates?" (Participant 38, personal communication, July, 2011). In addition, the same respondent noted, "The diagnosis may or may not have been helpful as it's actual functioning levels that count which was not provided." (Participant 38, personal communication, July, 2011). Another respondent noted 3 questions and one statement, 1.) "Has he ever been diagnosed with mental illness, schizophrenia, or schizotypal personality disorder?" (Participant 2, personal communication, September, 2011). 2.) "Is he delayed developmentally or suffering from normal age decline?" (Participant 2, personal communication, September 5, 2011). 3.) "Is there a risk for potential harm?" (Participant 2, personal communication, September, 2011). 4.) "Clearly he has limited social skills (3

divorces, isolating self) impacting his ability to work." (Participant 2, personal communication, September, 2011). It can be stated that with the omission of this information, the respondents would have to assume certain characteristics about William which would change the objective about what the survey was examining.

Another limitation is that results of the study may not be representative of social workers who work outside of San Bernardino County. The majority of social work respondents in this study work within San Bernardino County's system of care and there may be several differences in specialized or mandatory training opportunities, seminars, and actual experience received from other county's which could have an impact on the results of this survey.

Recommendations for Social Work Practice, Policy and Research

If systemic frustrations intensify client frustrations towards social workers in relation to treatment, this could lead to social workers projecting negative attitudes towards clients regarding getting them the treatment they need (Eack & Newell, 2008). They go on to say client-related frustrations directly impact the

attitudes of social workers; therefore it is important that these frustrations be addressed in supervision and practice. Although attitudes are a difficult area to measure, supervision can offer a supportive environment for social workers in order for them to maintain awareness of certain biases which lead to negative attitudes that critically affect clients.

According to Andreae "General systems theory provides social work practitioners with a conceptual framework that shifts attention from the cause-and-effect relationship between paired variables (does the environment cause the person to behave in a certain way, or does the person affect the environment in a certain way?) to a person/situation as an interrelated whole" (as cited in Turner, 1996, p. 246). Andreae also states, "Regardless of the particular methodology or combination of approaches employed, social workers possess an in-depth understanding of the relationship of the individual to various environments and the synergistic relationship that each entity has to the other" (as cited in Turner, 1996 p. 242). Germain and Gitterman (1987) states person and environment continually influence one another. Therefore, social workers should have the

ability to understand the importance of how mentally ill individuals are affected by their interactions with the mental health system on a micro, mezzo, and macro level.

Systems theory is considered to be holistic and focuses on the give and take interpersonal relationships. Looking at the mental health client population most have grown up in a complex family system and have been greatly affected by his or her involvement within their families. Therefore as social workers treat clients they may not be able to connect with those involved directly within the clients' family system. Being aware of the existence of important systems and subsystems and the potential impact on a client's functioning can allow the social worker to provide a more comprehensive assessment and effective treatment plan for a client.

The recovery model discusses the belief that hope, healing and empowerment are all central themes throughout the recovery process. Social workers play an essential role in working with their clients to help them establish goals which can ultimately enable clients to forge connections with others. Recovery can also encourage some individuals to give back to the community by acting as a role model or becoming an advocate within the community.

Jacobson and Greenley (2001) state "Many consumers report that the most powerful form of connection is helping others who are also living with mental illness" (p. 483).

Examining the issue of working with the severe and persistently mentally ill from a strengths-based perspective one can challenge the idea of labeling and stigmatizing this population and focus on the positive aspects of what social workers can offer. To assist in developing competent social workers, agencies can look to provide ongoing trainings in effective supervision and current treatment modalities. In addition, future research in this area can ultimately yield improved ways of creating more positive attitudes about the severely and persistently mentally ill population.

Conclusions

This study explored social workers perceptions of self-determination in the mentally ill. The results of the T-Test analysis showed significance within two questions and non-significance in the remaining 8 questions therefore contradicting what the hypothesis of this study declared. Mental illness in a client did not

affect whether or not social workers perceived that the client could achieve self-determination.

Swartz (2004) states "Social integration and normalization emphasize that the success of rehabilitation and community care of people with mental illness requires an accepting community" (p. 34). Reducing social worker caseloads may assist in the effectiveness of client care when paired with social workers who are able to use the abilities they have to look for strengths in their SPMI clients. Ultimately reducing or eliminating dependency so clients can build on their internal strengths to achieve self-determined goals and move toward a successful recovery. If professional social workers are to be instrumental in mediating social integration, the starting point must be their own attitudes (Schwartz, 2004).

APPENDIX A

DEMOGRAPHICS

DEMOGRAPHICS

Please complete this form.

1. Age: _____
2. Sex: Please Choose One
   Male ☐
   Female ☐
3. Ethnicity:
   African American/Black ☐
   Asian/Pacific Islander ☐
   Caucasian ☐
   Latino / Hispanic ☐
   Native American ☐
   Other : Please Specify ☐ _____
4. Education: Please Mark One
   High School/GED ☐
   Associate of Arts ☐
   Bachelor Degree ☐
   Masters Degree ☐
   Doctorate ☐
5. Years of Work Experience in Social Work: _____
6. Years of Work Experience in Mental Health: _____

Developed by Tristin Dawn Alfred

APPENDIX B

QUESTIONNAIRE

SURVEY QUESTIONNAIRE

Please read the instructions carefully. Below is a list of questions regarding the vignette you have just read. Please indicate the degree to which you agree with each statement by circling the appropriate number.

1 = Strongly Agree (SA)
2 = Agree (A)
3 = Neither Agree or Disagree (N)
4 = Disagree (D)
5 = Strongly Disagree (SD)

1. Do you believe that William will be able to identify safe and adequate housing on his own?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
SA	A	N	D	SD
1	2	3	4	5

2. Do you believe that William will be able to shop for groceries and cook for himself once he becomes independent?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
SA	A	N	D	SD
1	2	3	4	5

3. Do you believe that William will have the ability to select his own case management staff?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
SA	A	N	D	SD
1	2	3	4	5

4. Do you believe that William will have the ability to provide input regarding the choice of Dr. and healthcare provider he is seeking?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
SA	A	N	D	SD
1	2	3	4	5

5. Do you believe that William will have the ability to make decisions regarding his own medications?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
SA	A	N	D	SD
1	2	3	4	5

6. Do you believe that William will have the ability to keep himself safe in the home without supervision?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
SA	A	N	D	SD
1	2	3	4	5

7. Do you believe that William will have the ability to follow up with aftercare treatment if necessary?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
SA	A	N	D	SD
1	2	3	4	5

8. Do you believe that William will have the ability to manage his own finances?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
SA	A	N	D	SD
1	2	3	4	5

9. Do you believe that William may need to continue relying on others to take care of his basic needs?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
SA	A	N	D	SD
1	2	3	4	5

10. Do you believe that William will be able to socialize with others within the community?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
SA	A	N	D	SD
1	2	3	4	5

Developed by Tristin Dawn Alfred

APPENDIX C

VIGNETTE I

SURVEY VIGNETTE I

William is a 65 year old Caucasian male who was diagnosed with Schizophrenia, paranoid type and high blood pressure. He is prescribed several medications to manage his illness. William has never been able to hold down a steady job for any significant amount of time. Through the years, he has had several temporary jobs. After 20 years of an unstable marriage, William's wife filed for divorce eight months ago, and it will be finalized in approximately two weeks. This will be William's 3rd divorce. He reports that he has been unable to achieve any deep emotional connection with his spouses. His emotional detachment, unpredictable behavior, and inability to hold down a steady job were contributing factors in his divorce. William does not identify with having a support system.

William has two adult children (a son and daughter) from his first marriage in which he regrettably was never a constant figure in their lives. Both of his children are living in a different state.

William is the eldest of 6 siblings and he has always stayed isolated from his family because of the issues he experienced growing up with an alcoholic mother and a non- custodial father. William does not socialize often and prefers to be by himself.

William recently began receiving $680 a month from Social Security. William's soon to be ex-wife has allowed him to stay in the home until he is able to find sufficient housing. Now that he has steady income William is seeking housing within the community that will afford him the opportunity to live independently and provide for his basic needs. William's wife feels that he should seek an assisting living facility since she was the one who took care of all of his needs for 20 years, and she doesn't feel that he will be able to take care of himself on his own. William feels that he is finally able to live on his own without a woman providing for him. William is seeking a social worker to help him with his housing needs and for referral to additional services as needed.

Developed by Tristin Dawn Alfred

APPENDIX D

VIGNETTE II

SURVEY VIGNETTE II

William is a 65 year old Caucasian male who was diagnosed with high blood pressure. He is prescribed several medications to manage his illness. William has never been able to hold down a steady job for any significant amount of time. Through the years, he has had several temporary jobs. After 20 years of an unstable marriage, William's wife filed for divorce eight months ago, and it will be finalized in approximately two weeks. This will be William's 3rd divorce. He reports that he has been unable to achieve any deep emotional connection with his spouses. His emotional detachment, unpredictable behavior, and inability to hold down a steady job were contributing factors in his divorce. William does not identify with having a support system.

William has two adult children (a son and daughter) from his first marriage in which he regrettably was never a constant figure in their lives. Both of his children are living in a different state.

William is the eldest of 6 siblings and he has always stayed isolated from his family because of the issues he experienced growing up with an alcoholic mother and a non- custodial father. William does not socialize often and prefers to be by himself.

William recently began receiving $680 a month from Social Security. William's soon to be ex-wife has allowed him to stay in the home until he is able to find sufficient housing. Now that he has steady income William is seeking housing within the community that will afford him the opportunity to live independently and provide for his basic needs. William's wife feels that he should seek an assisting living facility since she was the one who took care of all of his needs for 20 years, and she doesn't feel that he will be able to take care of himself on his own. William feels that he is finally able to live on his own without a woman providing for him. William is seeking a social worker to help him with his housing needs and for referral to additional services as needed.

Developed by Tristin Dawn Alfred

APPENDIX E

INFORMED CONSENT

INFORMED CONSENT

The study in which you are about to participate is being conducted by Tristin Dawn Alfred, MSW Candidate, California State University San Bernardino, School of Social Work. The purpose of this study is to gather information regarding social workers' decisions regarding clients. The information obtained will be recorded and analyzed to contribute additional knowledge to the field. This study has been approved by the Institutional Review Board Sub-Committee within the School of Social Work at California State University San Bernardino.

This study will consist of a brief survey vignette followed by 10 questions and will take approximately 10 minutes to complete. There are no foreseeable risks or personal benefit as a result of your participation in this study. Please be advised that participation in this study is completely voluntary. You have the right to withdraw at any time without penalty. Please be reassured that your name will not be used in this study at any time. All data will be recorded by a number coding system and your responses will remain confidential.

Your responses are valuable to the social work profession and will contribute to the professional literature regarding social worker attitudes.

For questions regarding participant's rights please contact **Dr. Ray E. Liles, DSW, LCSW** Assistant Professor of Social Work at **(909) 537-3775** at the California State University, San Bernardino. The results of this study will be made available at the John M. Pfau Library at the California State University, San Bernardino after September 2012.

By placing an "X" on the line below, you acknowledge that you have been informed of, and understand the nature and purpose of this study. You freely consent to participate in this study. You also acknowledge that you are at least 18 years of age.

"X" indicates agreement	**Date**

APPENDIX F

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

Thank you very much for your participation in this study. The survey you have just completed was a single blind survey designed to investigate social workers' perceptions of self-determination in the mentally ill population. In this study there were two sets of vignettes in which there was a slight variance in the client regarding a diagnosis of schizophrenia, paranoid type. Vignette I included the mental health diagnosis, and vignette II did not, the rest of the information remained the same. You received only one of these vignettes for the purposes of this study. This study was conducted by Tristin Dawn Alfred, MSW Candidate, California State University San Bernardino, School of Social Work.

If you have any questions regarding participation in this study, findings, publication, or if you would like to obtain a copy of the group results of this study it will be made available at the John M. Pfau Library at the California State University, San Bernardino after September 2012 , or you may feel free to contact **Dr. Ray E. Liles, DSW, LCSW** Assistant Professor of Social Work at **(909)-537-3775** at the School of Social Work located at California State University San Bernardino at end of September, 2012. Again thank you for taking the time out to participate in this survey.

APPENDIX G

T-TEST

Notes

Output Created		21-Dec-2011 23:25:38
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	Cases Used	Statistics for each analysis are based on the cases with no missing or out-of-range data for any variable in the analysis.
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	Elapsed Time	00 00:00:00.000

Independent Samples Test

		Levene's Test for Equality of Variances	
		F	Sig.
Q1	Equal variances assumed	2.691	.107
	Equal variances not assumed		
Q2	Equal variances assumed	.778	.382
	Equal variances not assumed		
Q3	Equal variances assumed	1.187	.281
	Equal variances not assumed		
Q4	Equal variances assumed	3.235	.078
	Equal variances not assumed		
Q5	Equal variances assumed	.005	.945
	Equal variances not assumed		
Q6	Equal variances assumed	.130	.719
	Equal variances not assumed		
Q7	Equal variances assumed	.003	.955
	Equal variances not assumed		
Q8	Equal variances assumed	.209	.650
	Equal variances not assumed		
Q9	Equal variances assumed	2.570	.115
	Equal variances not assumed		
Q10	Equal variances assumed	.001	.975
	Equal variances not assumed		

Independent Samples Test

		t-test for Equality of Means				
		t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Q1	Equal variances assumed	2.239	49	.030	.62308	.27823
	Equal variances not assumed	2.228	44.983	.031	.62308	.27969
Q2	Equal variances assumed	.980	49	.332	.28462	.29037
	Equal variances not assumed	.977	47.134	.334	.28462	.29129
Q3	Equal variances assumed	.688	49	.494	.20154	.29275
	Equal variances not assumed	.686	47.090	.496	.20154	.29370
Q4	Equal variances assumed	.893	49	.376	.22462	.25154
	Equal variances not assumed	.898	45.736	.374	.22462	.25001
Q5	Equal variances assumed	-.096	49	.924	-.02923	.30390
	Equal variances not assumed	-.096	48.874	.924	-.02923	.30396
Q6	Equal variances assumed	1.578	49	.121	.36615	.23204
	Equal variances not assumed	1.578	48.966	.121	.36615	.23197
Q7	Equal variances assumed	-.108	49	.914	-.03077	.28469
	Equal variances not assumed	-.108	48.996	.914	-.03077	.28451
Q8	Equal variances assumed	1.548	49	.128	.38615	.24940
	Equal variances not assumed	1.548	48.934	.128	.38615	.24938
Q9	Equal variances assumed	-2.897	49	.006	-.72923	.25173
	Equal variances not assumed	-2.886	46.748	.006	-.72923	.25264
Q10	Equal variances assumed	.137	49	.891	.04000	.29121
	Equal variances not assumed	.137	47.871	.892	.04000	.29187

Independent Samples Test

		t-test for Equality of Means	
		95% Confidence Interval of the Difference	
		Lower	Upper
Q1	Equal variances assumed	.06394	1.18221
	Equal variances not assumed	.05975	1.18640
Q2	Equal variances assumed	-.29890	.86813
	Equal variances not assumed	-.30135	.87058
Q3	Equal variances assumed	-.38676	.78984
	Equal variances not assumed	-.38928	.79235
Q4	Equal variances assumed	-.28087	.73010
	Equal variances not assumed	-.27870	.72793
Q5	Equal variances assumed	-.63993	.58147
	Equal variances not assumed	-.64011	.58164
Q6	Equal variances assumed	-.10014	.83245
	Equal variances not assumed	-.10002	.83233
Q7	Equal variances assumed	-.60287	.54134
	Equal variances not assumed	-.60252	.54098
Q8	Equal variances assumed	-.11503	.88734
	Equal variances not assumed	-.11502	.88732
Q9	Equal variances assumed	-1.23511	-.22335
	Equal variances not assumed	-1.23756	-.22090
Q10	Equal variances assumed	-.54521	.62521
	Equal variances not assumed	-.54689	.62689

APPENDIX H

FREQUENCIES

Frequencies for Vignette 1

Notes

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	Cases Used	Statistics are based on all cases with valid data.
Syntax		FREQUENCIES VARIABLES = Participant Vignette Age Gender Ethnicity Education YrsSocWrk YrsMentalH Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10 /STATISTICS = STDDEV MEAN /ORDER = ANALYSIS.
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	Elapsed Time	00 00:00:00.000

Statistics

		Participant	Vignette	Age	Gender	Ethnicity	Education
N	Valid	26	26	26	26	26	26
	Missing	0	0	0	0	0	0
Mean		13.5000	1.0000	45.8846	1.6538	3.0385	3.8846
Std. Deviation		7.64853	.00000	11.48678	.48516	1.34107	.81618

		YrsSocWrk	YrsMentalH	Q1	Q2	Q3	Q4
N	Valid	25	26	26	26	26	26
	Missing	1	0	0	0	0	0
Mean		8.2200	9.6988	3.4231	2.8846	2.9615	2.3846
Std. Deviation		5.95658	8.33012	.85665	.95192	.95836	1.02282

		Q5	Q6	Q7	Q8	Q9	Q10
N	Valid	26	26	26	26	26	26
	Missing	0	0	0	0	0	0
Mean		2.7308	2.8462	2.7692	3.3462	2.2308	3.0000
Std. Deviation		1.07917	.83390	1.03180	.89184	.81524	.97980

Frequency Table

Participant

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	1	3.8	3.8	3.8
	2.00	1	3.8	3.8	7.7
	3.00	1	3.8	3.8	11.5
	4.00	1	3.8	3.8	15.4
	5.00	1	3.8	3.8	19.2
	6.00	1	3.8	3.8	23.1
	7.00	1	3.8	3.8	26.9
	8.00	1	3.8	3.8	30.8
	9.00	1	3.8	3.8	34.6
	10.00	1	3.8	3.8	38.5
	11.00	1	3.8	3.8	42.3
	12.00	1	3.8	3.8	46.2
	13.00	1	3.8	3.8	50.0
	14.00	1	3.8	3.8	53.8
	15.00	1	3.8	3.8	57.7
	16.00	1	3.8	3.8	61.5
	17.00	1	3.8	3.8	65.4
	18.00	1	3.8	3.8	69.2
	19.00	1	3.8	3.8	73.1
	20.00	1	3.8	3.8	76.9
	21.00	1	3.8	3.8	80.8
	22.00	1	3.8	3.8	84.6
	23.00	1	3.8	3.8	88.5
	24.00	1	3.8	3.8	92.3
	25.00	1	3.8	3.8	96.2
	26.00	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Vignette

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	26	100.0	100.0	100.0

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	30.00	2	7.7	7.7	7.7
	31.00	3	11.5	11.5	19.2
	32.00	1	3.8	3.8	23.1
	34.00	1	3.8	3.8	26.9
	35.00	1	3.8	3.8	30.8
	38.00	1	3.8	3.8	34.6
	40.00	2	7.7	7.7	42.3
	42.00	1	3.8	3.8	46.2
	50.00	3	11.5	11.5	57.7
	53.00	1	3.8	3.8	61.5
	54.00	1	3.8	3.8	65.4
	55.00	2	7.7	7.7	73.1
	57.00	2	7.7	7.7	80.8
	58.00	1	3.8	3.8	84.6
	59.00	2	7.7	7.7	92.3
	60.00	1	3.8	3.8	96.2
	62.00	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	9	34.6	34.6	34.6
	Female	17	65.4	65.4	100.0
	Total	26	100.0	100.0	

Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Afr American/Black	4	15.4	15.4	15.4
	Asian/Pac Islander	3	11.5	11.5	26.9
	Caucasian	11	42.3	42.3	69.2
	Latino/Hispanic	6	23.1	23.1	92.3
	Native American	1	3.8	3.8	96.2
	Biracial	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	High School/GED	1	3.8	3.8	3.8
	Bachelors	4	15.4	15.4	19.2
	Masters	17	65.4	65.4	84.6
	Doctorate	4	15.4	15.4	100.0
	Total	26	100.0	100.0	

YrsSocWrk

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	4	15.4	16.0	16.0
	2.00	1	3.8	4.0	20.0
	3.50	1	3.8	4.0	24.0
	5.00	4	15.4	16.0	40.0
	6.50	1	3.8	4.0	44.0
	7.00	2	7.7	8.0	52.0
	9.50	1	3.8	4.0	56.0
	10.00	4	15.4	16.0	72.0
	12.00	2	7.7	8.0	80.0
	14.00	1	3.8	4.0	84.0
	16.00	1	3.8	4.0	88.0
	17.00	1	3.8	4.0	92.0
	18.00	1	3.8	4.0	96.0
	21.00	1	3.8	4.0	100.0
	Total	25	96.2	100.0	
Missing	System	1	3.8		
Total		26	100.0		

YrsMentalH

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.17	1	3.8	3.8	3.8
	1.00	1	3.8	3.8	7.7
	2.00	1	3.8	3.8	11.5
	3.00	1	3.8	3.8	15.4
	4.00	4	15.4	15.4	30.8
	5.00	3	11.5	11.5	42.3
	6.00	1	3.8	3.8	46.2
	6.50	1	3.8	3.8	50.0
	9.50	1	3.8	3.8	53.8
	10.00	2	7.7	7.7	61.5
	11.00	2	7.7	7.7	69.2
	12.00	1	3.8	3.8	73.1
	13.00	3	11.5	11.5	84.6
	16.00	1	3.8	3.8	88.5
	21.00	1	3.8	3.8	92.3
	25.00	1	3.8	3.8	96.2
	38.00	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Q1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	5	19.2	19.2	19.2
	Neither Agree or Disagree	6	23.1	23.1	42.3
	Disagree	14	53.8	53.8	96.2
	Strongly Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Q2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	12	46.2	46.2	46.2
	Neither Agree or Disagree	6	23.1	23.1	69.2
	Disagree	7	26.9	26.9	96.2
	Strongly Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Q3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	11	42.3	42.3	42.3
	Neither Agree or Disagree	6	23.1	23.1	65.4
	Disagree	8	30.8	30.8	96.2
	Strongly Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Q4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	11.5	11.5	11.5
	Agree	16	61.5	61.5	73.1
	Neither Agree or Disagree	2	7.7	7.7	80.8
	Disagree	4	15.4	15.4	96.2
	Strongly Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Q5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	7.7	7.7	7.7
	Agree	12	46.2	46.2	53.8
	Neither Agree or Disagree	4	15.4	15.4	69.2
	Disagree	7	26.9	26.9	96.2
	Strongly Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Q6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	10	38.5	38.5	38.5
	Neither Agree or Disagree	11	42.3	42.3	80.8
	Disagree	4	15.4	15.4	96.2
	Strongly Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Q7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	3.8	3.8	3.8
	Agree	13	50.0	50.0	53.8
	Neither Agree or Disagree	4	15.4	15.4	69.2
	Disagree	7	26.9	26.9	96.2
	Strongly Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Q8

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	5	19.2	19.2	19.2
	Neither Agree or Disagree	9	34.6	34.6	53.8
	Disagree	10	38.5	38.5	92.3
	Strongly Disagree	2	7.7	7.7	100.0
	Total	26	100.0	100.0	

Q9

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	15.4	15.4	15.4
	Agree	14	53.8	53.8	69.2
	Neither Agree or Disagree	6	23.1	23.1	92.3
	Disagree	2	7.7	7.7	100.0
	Total	26	100.0	100.0	

Q10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	11	42.3	42.3	42.3
	Neither Agree or Disagree	5	19.2	19.2	61.5
	Disagree	9	34.6	34.6	96.2
	Strongly Disagree	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Frequencies for Vignette 2

Notes

Output Created		20-Nov-2011 15:43:38
Comments		
Input	Data	/Users/Ashley/Documents/Tristin Data.sav
	Active Dataset	DataSet1
	Filter	Vignette = 2 (FILTER)
	Weight	< none >
	Split File	< none >
	N of Rows in Working Data File	25
Missing Value Handling	Definition of Missing	User-defined missing values are treated as missing.
	Cases Used	Statistics are based on all cases with valid data.
Syntax		FREQUENCIES VARIABLES = Participant Vignette Age Gender Ethnicity Education YrsSocWrk YrsMentalH Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10 /STATISTICS = STDDEV MEAN /ORDER = ANALYSIS.
Resources	Processor Time	00 00:00:00.012
	Elapsed Time	00 00:00:00.000

Statistics

		Participant	Vignette	Age	Gender	Ethnicity	Education
N	Valid	25	25	23	25	25	25
	Missing	0	0	2	0	0	0
Mean		39.0000	2.0000	39.5217	1.8400	3.0400	3.7200
Std. Deviation		7.35980	.00000	8.05588	.37417	1.39881	.79162

		YrsSocWrk	YrsMentalH	Q1	Q2	Q3	Q4
N	Valid	25	25	25	25	25	25
	Missing	0	0	0	0	0	0
Mean		7.2500	9.3800	2.8000	2.6000	2.7600	2.1600
Std. Deviation		5.58644	7.29338	1.11803	1.11803	1.12842	.74610

		Q5	Q6	Q7	Q8	Q9	Q10
N	Valid	25	25	25	25	25	25
	Missing	0	0	0	0	0	0
Mean		2.7600	2.4800	2.8000	2.9600	2.9600	2.9600
Std. Deviation		1.09087	.82260	1.00000	.88882	.97809	1.09848

Frequency Table

Participant

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	27.00	1	4.0	4.0	4.0
	28.00	1	4.0	4.0	8.0
	29.00	1	4.0	4.0	12.0
	30.00	1	4.0	4.0	16.0
	31.00	1	4.0	4.0	20.0
	32.00	1	4.0	4.0	24.0
	33.00	1	4.0	4.0	28.0
	34.00	1	4.0	4.0	32.0
	35.00	1	4.0	4.0	36.0
	36.00	1	4.0	4.0	40.0
	37.00	1	4.0	4.0	44.0
	38.00	1	4.0	4.0	48.0
	39.00	1	4.0	4.0	52.0
	40.00	1	4.0	4.0	56.0
	41.00	1	4.0	4.0	60.0
	42.00	1	4.0	4.0	64.0
	43.00	1	4.0	4.0	68.0
	44.00	1	4.0	4.0	72.0
	45.00	1	4.0	4.0	76.0
	46.00	1	4.0	4.0	80.0
	47.00	1	4.0	4.0	84.0
	48.00	1	4.0	4.0	88.0
	49.00	1	4.0	4.0	92.0
	50.00	1	4.0	4.0	96.0
	51.00	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Vignette

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2.00	25	100.0	100.0	100.0

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	25.00	1	4.0	4.3	4.3
	30.00	1	4.0	4.3	8.7
	31.00	1	4.0	4.3	13.0
	32.00	2	8.0	8.7	21.7
	33.00	1	4.0	4.3	26.1
	34.00	1	4.0	4.3	30.4
	36.00	1	4.0	4.3	34.8
	37.00	3	12.0	13.0	47.8
	38.00	2	8.0	8.7	56.5
	39.00	1	4.0	4.3	60.9
	40.00	1	4.0	4.3	65.2
	43.00	1	4.0	4.3	69.6
	44.00	2	8.0	8.7	78.3
	50.00	2	8.0	8.7	87.0
	51.00	1	4.0	4.3	91.3
	52.00	1	4.0	4.3	95.7
	56.00	1	4.0	4.3	100.0
	Total	23	92.0	100.0	
Missing	System	2	8.0		
Total		25	100.0		

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	4	16.0	16.0	16.0
	Female	21	84.0	84.0	100.0
	Total	25	100.0	100.0	

Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Afr American/Black	5	20.0	20.0	20.0
	Asian/Pac Islander	2	8.0	8.0	28.0
	Caucasian	9	36.0	36.0	64.0
	Latino/Hispanic	7	28.0	28.0	92.0
	Other	2	8.0	8.0	100.0
	Total	25	100.0	100.0	

Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Associates	2	8.0	8.0	8.0
	Bachelors	6	24.0	24.0	32.0
	Masters	14	56.0	56.0	88.0
	Doctorate	3	12.0	12.0	100.0
	Total	25	100.0	100.0	

YrsSocWrk

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	4	16.0	16.0	16.0
	.25	1	4.0	4.0	20.0
	2.00	1	4.0	4.0	24.0
	4.00	2	8.0	8.0	32.0
	5.00	3	12.0	12.0	44.0
	6.00	2	8.0	8.0	52.0
	7.00	2	8.0	8.0	60.0
	9.00	1	4.0	4.0	64.0
	11.00	3	12.0	12.0	76.0
	12.00	2	8.0	8.0	84.0
	13.00	1	4.0	4.0	88.0
	15.00	1	4.0	4.0	92.0
	16.00	1	4.0	4.0	96.0
	20.00	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

YrsMentalH

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	1	4.0	4.0	4.0
	2.00	2	8.0	8.0	12.0
	4.00	3	12.0	12.0	24.0
	4.50	1	4.0	4.0	28.0
	5.00	3	12.0	12.0	40.0
	6.00	1	4.0	4.0	44.0
	7.00	2	8.0	8.0	52.0
	8.00	1	4.0	4.0	56.0
	9.00	1	4.0	4.0	60.0
	10.00	2	8.0	8.0	68.0
	11.00	1	4.0	4.0	72.0
	12.00	1	4.0	4.0	76.0
	13.00	2	8.0	8.0	84.0
	15.00	1	4.0	4.0	88.0
	21.00	1	4.0	4.0	92.0
	26.00	1	4.0	4.0	96.0
	30.00	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Q1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	16.0	16.0	16.0
	Agree	6	24.0	24.0	40.0
	Neither Agree or Disagree	6	24.0	24.0	64.0
	Disagree	9	36.0	36.0	100.0
	Total	25	100.0	100.0	

Q2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	16.0	16.0	16.0
	Agree	9	36.0	36.0	52.0
	Neither Agree or Disagree	6	24.0	24.0	76.0
	Disagree	5	20.0	20.0	96.0
	Strongly Disagree	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Q3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	12.0	12.0	12.0
	Agree	9	36.0	36.0	48.0
	Neither Agree or Disagree	5	20.0	20.0	68.0
	Disagree	7	28.0	28.0	96.0
	Strongly Disagree	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Q4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	12.0	12.0	12.0
	Agree	17	68.0	68.0	80.0
	Neither Agree or Disagree	3	12.0	12.0	92.0
	Disagree	2	8.0	8.0	100.0
	Total	25	100.0	100.0	

Q5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	8.0	8.0	8.0
	Agree	11	44.0	44.0	52.0
	Neither Agree or Disagree	4	16.0	16.0	68.0
	Disagree	7	28.0	28.0	96.0
	Strongly Disagree	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Q6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	8.0	8.0	8.0
	Agree	12	48.0	48.0	56.0
	Neither Agree or Disagree	8	32.0	32.0	88.0
	Disagree	3	12.0	12.0	100.0
	Total	25	100.0	100.0	

Q7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	4.0	4.0	4.0
	Agree	12	48.0	48.0	52.0
	Neither Agree or Disagree	3	12.0	12.0	64.0
	Disagree	9	36.0	36.0	100.0
	Total	25	100.0	100.0	

Q8

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	4.0	4.0	4.0
	Agree	7	28.0	28.0	32.0
	Neither Agree or Disagree	9	36.0	36.0	68.0
	Disagree	8	32.0	32.0	100.0
	Total	25	100.0	100.0	

Q9

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	11	44.0	44.0	44.0
	Neither Agree or Disagree	5	20.0	20.0	64.0
	Disagree	8	32.0	32.0	96.0
	Strongly Disagree	1	4.0	4.0	100.0
	Total	25	100.0	100.0	

Q10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	8.0	8.0	8.0
	Agree	7	28.0	28.0	36.0
	Neither Agree or Disagree	8	32.0	32.0	68.0
	Disagree	6	24.0	24.0	92.0
	Strongly Disagree	2	8.0	8.0	100.0
	Total	25	100.0	100.0	

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