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Measuring mental health provider stigma:
The development of a valid and reliable self-assessment instrument

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of
Philosophy at Virginia Commonwealth University.

by

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Table of Contents

	Page
Acknowledgments.....	ii
Table of Contents.....	iii
List of Tables	viii
List of Figures.....	ix
Abstract.....	x
Chapter One – An Introduction	1
Purpose of the Study.....	1
Key Definitions and Context.....	1
Public and Structural Stigma.....	6
Public stigma incidence and prevalence.....	10
Consequences of public and structural stigma.....	11
Public stigma intervention.....	21
Perceived and Self-Stigma: Definitions and Consequences.....	23
Provider-Based Stigma.....	26
Contemporary service context	29
Consequences of provider-based stigma.....	46
Statement of the Problem.....	49
Significance of the Study and Relevance to Social Work.....	52
Chapter Two –Literature Review	53
Theoretical Foundation.....	53
Symbolic interactionism.....	53

Attribution theory.....	57
Modified labeling theory.....	59
Experience-based model.....	61
Measurement theory.....	66
Self-assessment.....	66
Pertinent Research.....	69
Key measures of public stigma.....	69
Self-stigma research and measurement.....	80
Provider stigma measures.....	84
Focus of the Study.....	88
Chapter Three – Methodology.....	89
Scientific Philosophy.....	90
Basics of Measurement Theory and Instrument Development.....	92
Research questions and hypotheses.....	95
Conceptualization and Operationalization.....	97
Development of the Item Pool.....	98
Current study’s item development.....	101
Measurement Format.....	101
Wording of the items.....	104
Current study’s format decisions.....	106
Refining the Item Pool.....	107
Questionnaire Design.....	108
Administration of Items to a Developmental Sample.....	109

Risks to human subjects.....	111
Evaluation of Items.....	112
Reliability estimation	112
Validity.....	116
Inclusion of validation items.....	118
Validity estimation.....	119
Optimization of Scale Length.....	124
Summary of Current Study Decisions	125
Summary of Data Analysis Steps.....	126
Chapter Four – Results.....	129
Initial Item Development.....	129
Face and Content Validity of Items.....	129
Academic/researcher focus group and consultation.....	130
Provider focus group.....	132
Consumers of mental health services stakeholder consultation group.....	133
Family member stakeholder consultation group.....	135
Description of the Disseminated Instrument.....	137
Sample Construction.....	139
Sample characteristics.....	141
Data Analysis.....	145
Preliminary analysis.....	145
Univariate analysis.....	148
Factor analysis.....	151

Item analysis and reliability.....	157
Interpretation of the Factors.....	161
Revised Scale.....	165
Assessment of Validity.....	167
Construct validity: Hypotheses.....	167
Factorial validity.....	171
Summary of Findings.....	172
Chapter Five – Discussion	174
Study Synopsis.....	174
Meaningful Findings.....	178
Differences between hypothesized model and factor solution.....	178
Refinement of the model.....	181
Answering the research questions, study hypotheses, and sub-hypotheses.....	188
Relationship of MHPSASS scored to validation variables.....	191
Differences in language used for survey questions.....	193
Limitations.....	194
Sample response.....	194
Scale length and missing data.....	195
Self-assessment.....	196
Social desirability.....	196
Implications for Practice.....	197
Implications for Social Work Education.....	206
Implications for Research.....	212

Conclusion.....	215
References.....	216
Appendices.....	246
A. Initial Item Pool for the Developing MHPSASS.....	246
B. Focus Group Handout.....	251
C. Academic/Researcher Focus Group Participants.....	259
D. Provider, Family, and Consumer Focus Group Recruitment Materials.....	260
E. Instrument as Disseminated.....	264
F. Original 62-Items of the MHPSASS.....	278
G. Administration Recruitment Materials.....	284
H. Factor Loadings and Communalities for the 61-Items of the MHPSASS.....	290
I. Reliability Assessment.....	292
J. Finalized MHPSASS 20-items.....	295
Vita.....	297

List of Tables

	Page
1. Descriptive Demographic Data.....	143
2. Respondent's Length of Time Employed in the Field and in their Role.....	144
3. Cook's D Values and Identified Outliers.....	147
4. Coding of Likert Scale Responses.....	148
5. Univariate Statistics for 62-items of MHPSASS.....	150
6. Factor analysis procedures performed.....	152
7. Total Variance Explained, SPSS Output Replication.....	156
8. Item Deletion Decisions.....	159
9. Factor Loadings and Communalities of the 20-Items of MHPSASS.....	162
10. Subscale Descriptive Statistics.....	166

List of Figures

	Page
Figure 1: The many levels of stigma.....	6
Figure 2: Social-cognitive model of public stigma development.....	7
Figure 3: The experience-based model of provider stigma.....	64
Figure 4: Burrell and Morgan's (1979) paradigmatic perspective.....	92
Figure 5: Scree plot for MHPSASS data.....	155
Figure 6: Reconciling the Four Factor Solution.....	171, 181
Figure B1: The experience-based model of provider stigma.....	252

Abstract

MEASURING MENTAL HEALTH PROVIDER STIGMA: THE DEVELOPMENT OF A VALID AND RELIABLE SELF-ASSESSMENT INSTRUMENT

By Jennifer L.K. Charles, MSW, Ph.D. Candidate

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2015

Major Directors: Kia J. Bentley, Ph.D., LCSW, Professor, School of Social Work
and
Patrick V. Dattalo, Ph.D., Professor, School of Social Work

Provider-based stigma is defined as the negative attitudes, beliefs, and behaviors of mental health providers toward clients they serve. Often unintentional and unknowingly conveyed, this phenomenon has been indicated in previous research (e.g. Lauber, Nordt, Braunschweig, & Rössler, 2006; Nordt, Rössler, & Lauber, 2006; Hugo, 2001; Schulze, 2007). Other instruments crafted to measure provider stigma have utilized theory in their development, without incorporating the voice of the client (e.g. Wilkins & Abell, 2010; Kennedy, Abell, & Mennicke 2014). To better address the social injustice posed by provider stigma, the profession requires a valid and reliable measure, guided by theory, which also reflects the client and family experience. This study attempts to do so, referencing the five themes of the experience-based model (Charles, 2013) to guide item development. These themes include: blame & shame;

disinterest, annoyance, and/or irritation; degradation & dehumanization; poor prognosis/fostering dependence; coercion/lack of 'real' choice.

The measure's item pool was generated following Nunnally and Bernstein's (1994) domain sampling method, in reflection of the experience-based model, and reviewed by a series of focus groups. The electronically hosted survey was distributed to a purposive sample of mental health service providers employed at Virginia's public mental health agencies. Using a final sample of $N = 220$, factor analysis indicated a four factor solution, accounting for 32.454% of the items' variance. Refinement resulted in a scale of 20-items demonstrating adequate internal consistency, measured by Cronbach's $\alpha = 0.817$. The four factors of the Mental Health Provider Self-Assessment of Stigma Scale (MHPSASS) were labeled: Irritation & Impatience (eight items); Choice & Capacity (five items); Adherence & Dependence (four items); Devalue & Depersonalize (three items). Hypothesized relationships were found between provider self-rating of burnout and MHPSASS score (Pearson's $r = 0.235, p = 0.001$) as well as social desirability level and MHPSASS score ($r = -0.169, p = 0.015$), supporting the MHPSASS' construct validity.

As a measure of provider-based stigma, the MHPSASS displays adequate reliability and validity. Future studies are indicated, including replication. Limitations include agency response rate, unknowable individual level-response rate, social desirability, and the potentially burdensome length of the survey package.

Chapter One – An Introduction

Purpose of the Study

This dissertation research project is concerned with the development and testing of a measurement tool intended to assess levels of stigma among mental health providers, a phenomenon defined and described in detail in the following pages. This dissertation begins with a brief introduction to the key terms related to the stigma of mental illness and its various permutations, followed by an in-depth discussion of stigma subtypes and their consequences for the individual consumer of mental health services, family, and providers. The argument will be made that the phenomenon of provider-based stigma requires accurate measurement to guide the future development of prevention and intervention programs. Further, the dissertation attempts to determine the psychometric properties of this new measurement in an effort to ensure its validity and reliability. The instrument is a self-assessment measure for use by mental health service providers to give them an idea of their attitudes or behaviors that clients may perceive as less-than-helpful. These provider attitudes and behaviors may even be harmful to recovery and the client's quality of life. Ultimately, the measure could be used in professional development activities and in-service trainings to prevent or remediate the influence of provider-based stigma in client interactions.

Key Definitions and Context

The former U.S. Surgeon General Dr. David Satcher referred to the stigma of mental illness as a pressing issue that presented the “most formidable obstacle to future progress in the arena of mental illness and mental health” (U.S. Department of Health and Human Services, 1999, p. 3) and echoed these sentiments in The President's New Freedom Commission on Mental Health (2003). *Stigma* refers to the negative attitudes, beliefs, and behaviors held and enacted toward

persons living with a mental illness. Traditional descriptions of stigma include the work of Goffman (1963) who asserts that a *stigma* describes any attribute that “is deeply discrediting” (p. 3). Link and Phelan (2001) take Goffman’s definition a step further, and construct a model of stigma specifically applicable to the stigma of mental illness. These authors argue that stigma exists when elements of labeling, stereotyping, separation, loss of status, and discrimination are present within the context of power imbalance. An integral element of Link and Phelan’s conceptualization of stigma is *power*, specifically social, economic, and political power. A power imbalance allows for the full execution of the stigma process or *stigmatization*, defined as the identification of difference, the construction of stereotypes, the separation of labeled persons into distinct groups, and the resulting disapproval, rejection, exclusion, and discrimination. Without an imbalance of power, the process of stigma, stigmatization, and subsequent negative consequences cannot exist to any meaningful degree.

To more specifically address the role of power in the manifestation of stigma, it should be considered why some instances of human difference are stigmatized and others are not. There are numerous examples from history of the obvious imbalances of social, economic and political power and subsequent stigmatization; for instance African slaves and white plantation owners in the 1800s. Those who perceived differences between particular groups and attributed importance on the basis of the differences were in positions of power. The groups who identified differences included persons who had social connections, influence, and financial resources, or observed the potential to gain more wealth. Those who were subjugated included individuals with less access to financial resources, social capital, and political influence. However, the role of power in stigma can be mistakenly interpreted as minimal, especially when the stigmatizable condition is one in which having the condition is the focus of attention. Link and Phelan (2001)

use mental illness, deafness, obesity, and one-leggedness as examples: having the condition and its attributes is the focus, as in ‘that person is talking to themselves,’ ‘they cannot hear,’ ‘he is very large,’ or ‘she only has one leg.’

Of course, persons who are members of a stigmatized group also may engage in the same cognitive processes producing stigma, but stigmatization does not actually occur, because the needed social, economic, and political power is not present. For example, Link and Phelan describe a hypothetical scenario in which a group of persons in treatment for serious mental illness might label staff members as “pill pushers” and connect this label with stereotypes of coldness, paternalism, and arrogance. These hypothetical clients may even avoid staff members identified as pill pushers and joke and degrade them in conversations with one another. Despite the clients engaging in every component of the stigma process, the staff member would still not become the stigmatized group. The client group does not have the needed social, economic, and political power to spread their evaluation of staff to the broader community or to impose more serious discriminatory consequences. As a result, the staff cannot be regarded as a stigmatized group. Without including the necessity of power differences to the development and existence of stigma, it becomes a broad concept applicable in most any circumstance, including to those noted to have extensive social, political, and economic power.

Based on this general conceptualization of stigma, the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in the context of a power imbalance (Link & Phelan, 2001), the scholarship surrounding the stigma of mental illness has further identified sub-categories of stigma: public stigma, structural stigma, perceived stigma, and self-stigma (e.g. Hayward & Bright, 1997; Corrigan & O’Shaughnessy, 2007; Link, Struening, Cullen, Shrout, Dohrenwend, 1989; Corrigan & Watson, 2002). *Public stigma* is thought of as

the negative attitudes, beliefs, and behaviors of the general public toward the population of individuals living with mental illnesses (Hayward & Bright, 1997; Rüsçh, Angermeyer, & Corrigan, 2005). *Structural stigma* is defined as the policies of government and non-government institutions that intentionally or unintentionally create limitations for persons living with mental illness regarding access to resources and opportunities (Corrigan & O’Shaughnessy). *Perceived stigma*, the perception of public stigma, occurs when an individual living with a mental illness identifies stigmatizing attitudes and behaviors emanating from the community or society directed toward them and/or individuals with mental illness (Link et al., 1989). *Self-stigma* is the internalization, endorsement, and self-application of stigma perceived in the general public (perceived stigma) by a person who lives with a mental illness (Corrigan & Watson, 2002). The construct of interest in this dissertation is a variant of public, structural, and perceived stigma, that of *provider-based stigma*. Provider-based stigma, or more concisely referred to as *provider stigma*, is comprised of the negative attitudes, beliefs, and behaviors of mental health providers directed toward their clients. It is characterized as the mental health service consumer’s experience of stigmatization by their mental health care provider in the contemporary service delivery context (Charles, 2013).

As provider stigma can be understood as an amalgamation of public, structural, and perceived stigma, (with the possibility to induce further self stigma) it is important to understand the definition and development of these other forms of stigma. It is only with such an understanding already in place that the complex phenomenon of provider stigma can be made more comprehensible. Therefore, a discussion of public, structural, perceived, and self-stigma is presented, the elements of which are illustrated in Figure 1, to assist in understanding how these subtypes ‘fit’ together. This figure compiles elements of models described by Corrigan, Mueser,

Bond, Drake, and Solomon (2008), Corrigan and Watson (2002), and Corrigan and O'Shaughnessy (2007). Each stigma subtype is defined, models and conceptualizations of its formation are depicted, and consequences for persons living with a mental illness are highlighted. The discussion concludes with a beginning definition and conceptualization of provider stigma; a more contextual look at provider stigma's development is included in Chapter 2. Having made the case for the deleterious effects of provider stigma, this chapter concludes with a statement of the context and problem as well as the significance of the current study and its relevance to social work as a profession and social work's values.

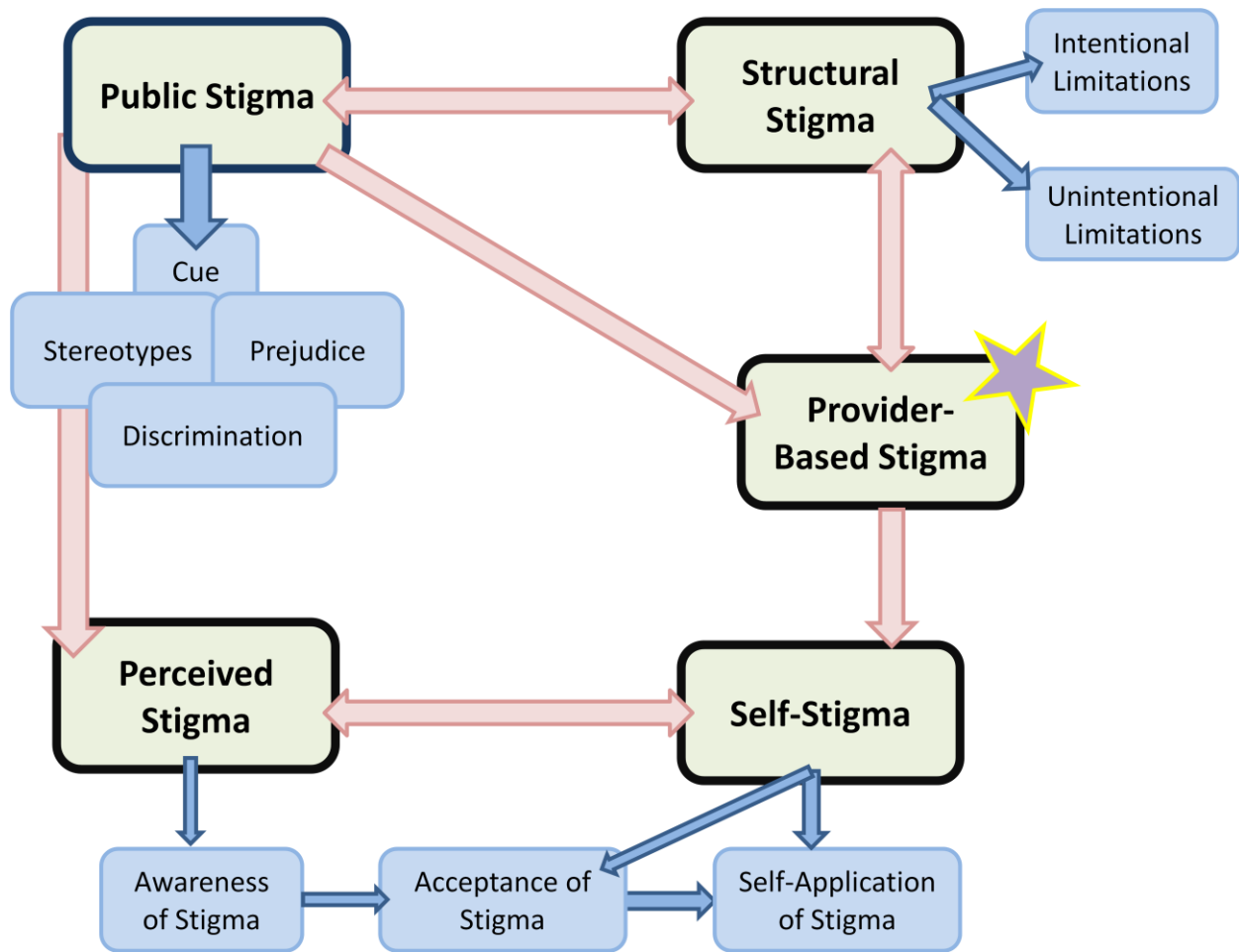


Figure 1. The many levels of stigma: Integrating the models of stigma formation at various levels. This model integrates the work of Corrigan et al. (2008), Corrigan and Watson (2002), and Corrigan & O’Shaughnessy (2007).

Public and Structural Stigma

As mentioned, *public stigma* is a negative reaction of the general public to people with mental illness and can be understood using a social-cognitive model described by Corrigan, Mueser, Bond, Drake, and Solomon (2008). The conceptual model of this process is provided here in Figure 2.

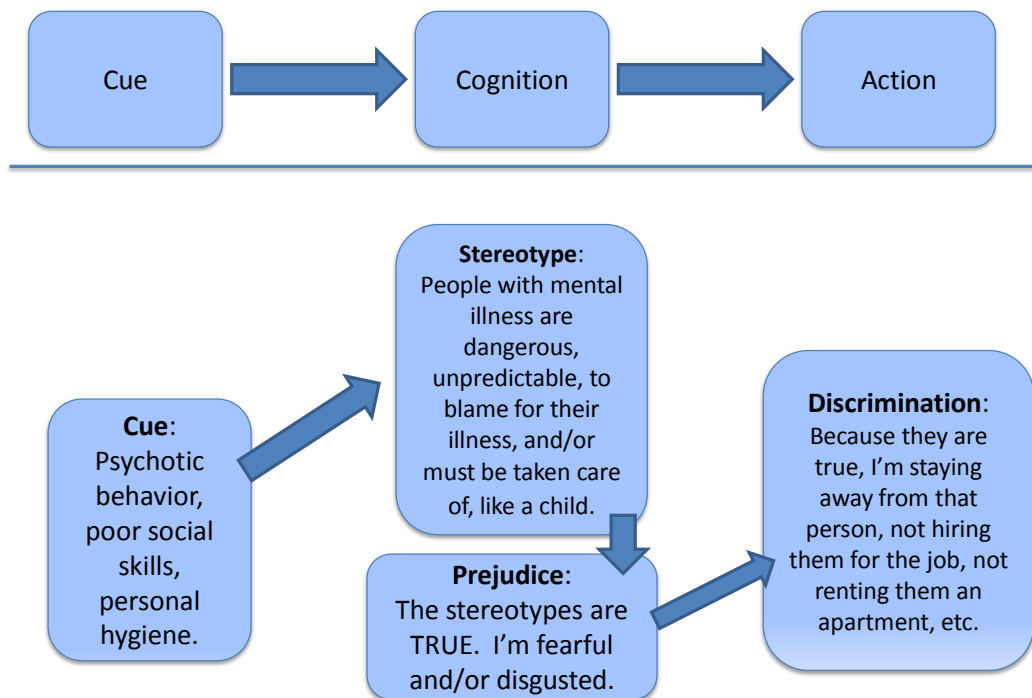


Figure 2. Conceptual model of public stigma's development (Corrigan et al., 2008).

According to Corrigan and colleagues, public stigma is initiated when a person with mental illness cues the public to the presence of illness. Four *cues* or *signals* are identified, including psychiatric symptoms, social skills deficits, poor physical appearance, and labels or diagnoses (Corrigan et al.). These signals trigger cognitive mediators, namely stereotypes and prejudice, which produce the consequent behavior of discrimination. *Stereotypes* are knowledge structures that are used in categorizing information about social groups (Rüsch, Angermeyer, & Corrigan, 2005). Commonly held stereotypes regarding individuals with mental illnesses include dangerousness, unpredictability, incompetence, inability to follow accepted social roles, personal responsibility for their conditions, weak characters, and their recovery having a poor prognosis (that mental illness is chronic and incurable) (Angermeyer & Matschinger, 2005; Corrigan et al.). More succinctly stated, stereotypes about individuals living with mental illness are rooted in

ideas of dangerousness, blame, benevolence/paternalism, and poor prognosis (Hayward & Bright 1997). *Prejudice* is an emotional reaction resulting from agreement with a stereotype. For example, emotions of fear and anxiety based on dangerousness stereotypes; anger and disgust in response to the acceptance of blame-based stereotypes; pity and sympathy resulting from acceptance of paternalistic stereotypes, and despondency and hopelessness as the result of embracing poor prognosis stereotypes. These prejudices may produce *discrimination*, which are behavioral responses, and are observable phenomenon. Common discriminating behaviors toward individuals living with a mental illness include avoidance, withholding help, and denying access to resources (Rusch et al.). For example, the behaviors of practicing avoidance, refusing employment, or not engaging in a social relationship with an individual living with a mental illness may be discrimination as the result of accepting stereotypes rooted in ideas of dangerousness. Also, mocking, avoidance, or withholding needed assistance may result from the acceptance of the stereotype of blame. And finally, endorsing care-taking roles, institutionalization, or encouraging an individual to lower their expectations in life, could be conceptualized as discrimination resulting from acceptance of the stereotype of benevolence/paternalism and poor prognosis.

Related to public stigma, is *structural stigma*, which emerges from collective public action and is defined by Corrigan and O'Shaughnessy (2007) as the policies of government and non-government institutions that intentionally or unintentionally create limitations for persons living with mental illness in terms of access to resources and opportunities. This 'structural' sub-type of stigma can also be understood as emerging from a process similar to Corrigan's model, only on a macro – as opposed to a micro – level, instead looking at how stigma operates within a culture (Overton & Medina, 2008). Structural stigma operates systemically and denies persons

living with a mental illness their entitlement to things that persons who do not have a mental illness take for granted. A historical example of governmental policies that intentionally restricted the rights of a stigmatized group were the Jim Crow laws enacted in southern states after the United States Civil War. The Jim Crow laws, or 'Black Codes,' were laws of states and cities that restricted the rights of African Americans on the basis of their skin color. The rights restricted include voting rights through literacy tests and poll taxes; the ability to rent property, choice of seating in restaurants and public transportation, and choices of marriage partner (National Park Service, 2012). A contemporary example of intended structural stigma directed toward those living with a mental illness include laws and legislations that are specifically written to restrict the individual's rights regarding parenthood, driving privileges, and voting. These manifestations of intended structural stigma are described in more detail in the coming pages.

An example of unintended structural stigma, from a broad perspective, are the admissions policies of universities and colleges that rely extensively on scores from standardized tests, like the SAT or ACT (Pincus, 1999). If admission is restricted to those scoring the highest on these tests, and minority groups typically receive lower scores than white students, it stands to follow that members of minority groups would be denied admission more often than white students (Corrigan, Markowitz, & Watson, 2004). In addition, the failure of the public, test creators, and university admissions personnel to recognize the biased impact of these standardized tests is in itself a manifestation of structural stigma. While the intention to limit minority groups' access to higher education is absent, it is the result all the same. Specifically related to the stigma of mental illness, an example of unintended structural stigma is the influence of popular economic principles essential to a capitalistic society: good business practices and cost-effectiveness

(Corrigan et al., 2004). These business practices have resulted in a reward differential between public and private mental healthcare – better salary and benefits for those providers who choose to work in the private sector. However, many of the individuals living with a severe mental illness most in need of quality care are served in the public sector. This differential, based on business practices, creates an unintended disparity in care. Providers most qualified and credentialed are likely to seek private employment, ensuring that private care is superior to public care.

Public stigma incidence and prevalence. Literature focusing on the stigma of mental illness has been commonplace since the late 1950s and 60s, synchronous with the civil rights movement. Regarding the persistence of stigma, a study conducted by Phelan, Link, Stueve, and Pescosolido (2000) compares responses to a national survey conducted in 1950 to responses on the same questions in the General Social Survey (GSS) in 1996. The national survey in 1950 included a focus on attitudes about mental illness and was championed by Shirley Starr. Questions used in the original survey about mental illness were included in the 1996 GSS, allowing a longitudinal comparison in findings about public conceptions and definitions of mental illness. Data was collected through face-to-face interviews and analysis involved identification of themes and categorization. The findings were unsettling. Definitions of mental illness broadened in the general public between the 1950s and 1996 and began to include more common illnesses, like mild depression and anxiety. However, stereotypes of dangerousness were more prevalent, especially when psychotic illnesses were identified as defining mental illness. The study concluded that when respondents identified psychosis synonymous with mental illness they were more likely to endorse stereotypes of dangerousness and unpredictability. The authors argue that while public conceptions of mental illness have

broadened, persons with the most serious mental illnesses (psychotic disorders) are still a group identified as a ‘them’ and are feared more in the recent survey than 40+ years before.

The public’s stigmatization of persons living with mental illness does not go unnoticed by those affected by such illnesses. For example, in a 1999 study conducted by Wahl, 1,301 mental health service consumers were surveyed about their experiences with public stigma and discrimination; follow-up interviews were conducted with 100 individuals who had participated in the larger survey. Some highlights of the findings include: seven in ten survey respondents noted that they had at least sometimes perceived being treated as less competent once their illness was known; 27% of the surveyed were often or very often advised to lower their expectations in life; and more than half (60%) of participants reported at least sometimes being shunned or avoided (Wahl, 1999). Further, one in three consumers reported the belief that they had been turned down for a job after their illness was known, despite being qualified for the position. The most commonly identified source of stigma (46 out of 100) was the general community, according to interview participants (Wahl).

Consequences of public and structural stigma. The social-cognitive model of stigma (Corrigan et al., 2008) illustrates how public and structural stigmas develop. Both types of stigma result in significant consequences, and stigma researchers Link and Phelan (2001) caution against singling out only one or two outcomes on which to focus. Rather, these authors conceptualize stigma as occurring on many levels interchangeably, producing multi-faceted results, which require stigma researchers to look at the many consequences of stigma simultaneously. These authors highlight that the primary consequence of public and structural stigma for persons living with mental illness is status loss or “a downward placement in the

status hierarchy” (p. 379). Incumbent consequences of this lowered social status, they argue, include:

- Decrease in life expectancy;
- Limited choice in sexual partners;
- Being less able to obtain gainful employment;
- Having fewer options for housing;
- Frequent exposure to negative and derogatory images of mental illness in the mass media.

It is essential to note, however, why this discussion is important in regard to provider stigma. The clients that are served by mental health providers come to the service context having experienced some, if not many, of the consequences described. Mental health providers are members of a general public, aware and witness to the consequences of public and structural stigma. Therefore, understanding these consequences gives the reader information about the experience of clients and the influence on providers outside the service setting. In addition, the consequences of public and structural stigma are important to note, as they can be compared to the consequences of provider stigma. Models and manifestations of public and structural stigmas may prove helpful in conceptualizing provider stigma, leading to clearer understanding, and possible mediation.

Employment. Specifically regarding employment, research has indicated that persons who have been labeled with a mental health diagnosis are more likely to be underemployed and earn less than persons who have similar mental health problems but have not been officially labeled, suggesting that the label alone may affect employment opportunities and benefits (Link, 1987).

Research also indicates the inclination of employers to believe that persons with mental illnesses

are more likely to be absent, dangerous, and unpredictable (Green, Hayes, Dickinson, Whittaker, & Gilheany, 2003). While people with mental illness may experience periods of significant impairment during which they are unable to work, Watson and Eack (2011) argue that there is evidence to suggest that employment inequities are made more prominent because of discrimination. In addition, fear of employment rejection, according to Stuart (2006b), may lead a person with mental illness to give up the search for a job altogether.

Housing. Property owners leasing rental properties seem to have similarly negative attitudes toward persons with mental illness, being less likely to lease an apartment to someone who they know has been labeled with a mental illness (Page, 1995). Not only is the availability of housing for persons with mental illness influenced by public and structural stigma, the location of viable housing options is also negatively affected. For example, Link and Phelan (2001) argue that structural stigma is reflected in a Not in My Back Yard (NIMBY) mentality, regarding locations of treatment facilities (and similarly, supported living facilities). As a result, these dwellings are more likely to be in lower-resourced communities, and often rife with violence and crime. Public and structural stigmas thus result in higher victimization rates of persons with mental illness, as compared to persons without such illnesses.

Media. One of the most important consequences of structural stigma for persons living with mental illness is the influence of the mass media on stigma's transmission and perpetuation. One reason for the media's significant influence on the existence of structural stigma is that it is reportedly the public's largest source of information about mental illness (Daniel Yankelovich Group, 1990; Wahl, 1995; Wilson, Nairn, Coverdale, & Panapa, 1999a, 1999b; Overton & Medina, 2008). Two common media images of persons living with mental illness include the violent, out-of-control psychotic killer and the comical buffoon, acting like a child in need of

care (Corrigan, Mueser, Bond, Drake, & Solomon, 2008). Pertaining exclusively to newspaper stories, a study by Corrigan, Watson, Garcia, Slopen, Rasinski, and Hall (2005) indicates that overall, news stories connecting mental illness to violence, danger, and crime are waning in incidence, but they are still the single largest focal point of mental health related stories. Keeping in mind three key stereotypes underlying the stigma of mental illness, namely dangerousness, unpredictability, and paternalism, the fact that these stereotypes mirror the most common media images is no surprise.

Media representations of mental illness are frequent: In the United States, one-fifth of primetime programs depict some aspect of mental illness and 2-3% of the adult characters are portrayed as having mental health problems (Signorielle, 1989; Diefenbach, 1997; Stuart, 2006a). Research indicates that exposure to even a single shocking media image of violence, in the presence of mental illness, seemingly increased a media consumer's expectation that persons with mental illnesses are likely to do physical harm to others (Wahl, 1995). For example, a study by Wahl and Lefkowitz (1989) showed that viewing a negative image of a person with mental illness increased the endorsement of negative attitudes and rejection of community placement for persons living with mental illness. Specifically, Wahl and Lefkowitz's study involved audiences viewing a television movie depicting a person with mental illness committing violent crimes while out of a psychiatric hospital on a day-pass. Even when the movie was accompanied by a narration asserting that violence was not characteristic of persons with mental illness, the reaction of the audience was the same; negative attitudes were endorsed and the notion of community placement for persons living with mental illness was more strongly rejected.

The media has produced a substantial inventory of negative imagery and "some of the most malignant depictions of madness and horrifying illustrations of psychiatric treatments (Stuart,

2006a, p. 99). The public's consistent exposure to inaccurate and negative depictions of persons with mental illness in the mass media has "...important and wide-ranging consequences for the lives of those with mental illnesses and for the ways people act toward others with psychiatric disorders" (Wahl, 1995, p. 87). These consequences include isolation of the individual and family, confusion about diagnosis and prognosis, as well as unnecessary fears related to dangerousness of self and loved ones.

For individuals and families living with mental illness, these media representations can have a confusing, isolating, and demoralizing impact. Misinformation learned through inaccurate mass media depictions of mental illness may increase the incidence of family confusion regarding a loved-one's diagnosis and symptom presentation. For example, if someone has the misinformed view that schizophrenia is synonymous with a multiple personality disorder, as has been a common myth, he or she may disagree with a professional who diagnoses their loved one with schizophrenia, not seeing symptoms that are indicative of multiple personalities (Wahl, 1995). Additionally, because mental illness is consistently misrepresented in the mass media, it poses an added stressor to those living with mental illness and their families. The media's misrepresentations can produce an isolating 'no one understands' mindset (Wahl). In fact, a majority of family advocates surveyed in the United States report that the negative media depictions they encounter leave them feeling sad, hurt, angry, and discouraged (Stuart, 2006a). Most particularly troubling, according to a study by Wahl (1999b) is the media's focus on violent and extreme cases, inaccurate portrayals, and derogatory language.

However, despite the overall negative view of the media espoused by clients and families of persons living with mental illness, Stuart cautions the out-right vilification of the media. In fact, the author recognizes that media depictions of persons living with mental illness have not been

all negative. In fact, the media can be credited with producing material that is sensitive and educational. Further, Stuart argues that the media may be enlisted to help challenge the stigma of mental illness and “promulgate mental health messages” (p. 104) and should likely be a part of any major anti-stigma campaign.

Civil rights. The impact of structural stigma on persons living with mental illness is particularly troublesome. As Link and Phelan explain, a person who develops a mental illness (in their example, schizophrenia) will be the recipient of structural discrimination, *regardless* of whether or not others happen to act in a discriminatory manner (2001). “Stigma has affected the structure around the person, leading the person to be exposed to a host of untoward circumstances (Link & Phelan, p. 373). For example, Hinshaw and Stier (2008) report that some states restrict the ability of persons who report a history of mental illness to obtain or renew a driver’s license, to serve on a jury, to vote, or to maintain custody of their children. In particular, Hemmens, Miller, Burton, and Milner’s (2002) replication of a 1989 survey of state legislations concerned with the civil rights of persons with mental illness and persons adjudicated as incompetent revealed that 27 states, in one way or another, have legislation restricting the parental rights of such persons. This number increased from 23 states, as reported by Burton (1990) in the original study, ten years earlier. This increase, coupled with increased restriction of other civil rights, including political and family-related rights, indicates a trend toward increased restriction of civil rights for persons living with mental illness or judicially ruled incompetent during the period between 1989 and 1999 (Hemmens et al). Additionally, the UPenn Collaborative on Community Integration (n.d.) specifically describes legislation in Arizona, Alaska, California, Kentucky, and North Dakota, in addition to Puerto Rico, that lists mental illness or disability as grounds for not providing reasonable efforts to reunify a family. The

standard of reasonable effort to reunify a family is dominant in child protective services, but in these five states, mental illness or disability are reasons why reasonable effort is not necessary. Even if persons in immediate contact with an individual living with a mental illness do not engage in discrimination, those who are living with a mental illness are still subjected to structurally stigmatizing laws, regulations, and access to resources.

Financial disparities. Another longstanding consequence of public and structural stigma documented in empirical literature is the allocation of less financial support to the mental health system as compared to the somatic health system (Rusch, Angermeyer, & Corrigan, 2005). The World Health Organization showed that while the proportion of global burden posed by neuropsychiatric diseases was around 13 percent, only a median 2 percent of health care budgets around the world were appropriated to mental health services (WHO, 2003). This disparity in funding has been attributed, at least in part, to the stigma of mental illness (Knapp, Funk, Curran, Prince, Grigg, & McDavid, 2006).

In addition, despite recent increases in funding for mental health related research, Sartorius (1998) maintains that these amounts still lag behind what is allotted for physical illnesses. Despite the fact that mental illnesses account for nearly 15% of the disease burden in developed countries, more than all forms of cancer, it is especially alarming that the proportion of funds allocated for mental health research is so low. Specifically, despite the burden, mental health research accounts for only 7% of research funding in North America and as low as 2% in the European Union (Holmes, Craske, & Graybiel, 2014). A 1995 study by Wahl describes research funding discrepancies in the mid-1990s between mental illness and other significant health problems. As an example, Wahl reports that an estimate \$1,000 per patient is federally funded

for muscular dystrophy research, \$130 per patient for heart disease research, but funding for schizophrenia research is only about \$14 per patient.

The inequity does not end there: Research suggests that the range and quality of physical health services available to persons with mental illness is less than those available to someone without such illness. Individuals living with mental illness may not be provided with equal care for their physical concerns, which produces differentials in life expectancies and mortalities, a well-documented disparity. In fact, the average individual living with a major mental illness will die 14 to 32 years earlier than the general population (Colton & Mandersheid, 2006). A recent study in London also indicates that the impact of mental illness on life expectancy is generally greater than the adverse effects of well-known health challenges, like diabetes, smoking, and obesity (Chang, Hayes, Perera, Broadbent, Fernandes, Lee, et al., 2011). This makes the average life expectancy of a person with a serious mental illness at 49 to 60 years of age – on par with the life expectancies of adults in Ethiopia and Sudan (52.9 and 58.6 years, respectively) (Insel, 2011). While the reasons for this differential can be attributed to causes such as the increased use of tobacco products and obesity in persons with mental illness, as well as the confounding issues of illness comorbidity, the disparity in life expectancy also indicates that the medical health system that is failing to meet the complex needs of persons living with mental illness (Aron, Honberg, Duckworth, et al. 2009).

Law enforcement and criminal justice. Stigma also has some bearing on the interface of mental illness and the criminal justice system: Persons giving signals of mental illness or exhibiting symptoms are more likely to be arrested than others who do not display such symptoms (Teplin, 1984). More recently, the increased likelihood of arrest by persons with mental illness has been expanded to include variables that were not previously considered.

These include the individual being under the influence of substances, combative, or non-cooperative, which have been shown to increase arrest likelihood (Engel & Silver, 2001). However, even though police may recognize that these arrestable offenses are the result of mental illness, they often have little choice about an individual's disposition, and may opt for what Markowitz (2011) refers to as "mercy bookings" (p. 41) in an effort to get the person into mental health treatment. The trend has been toward the criminalization of nominal offenses, a tendency which disproportionately influences people living with mental illness, as infractions include vagrancy, open-container laws, and drug-related offenses. It is the assertion of researchers (i.e. Corrigan & Kleinlen, 2005; Lamb & Weinberger, 1998) that this criminalization, along with the widespread closing of mental hospitals, has resulted in an influx of persons living with mental illness being housed in correctional institutions. For example, Hinshaw and Stier (2008) note the Los Angeles County Jail is really the largest public mental hospital in the nation, if not the world.

Once a person has come to the attention of law enforcement, the police officer's attitudes and beliefs about mental illness are influential in their disposition, whether they are taken to jail or not. In addition to the officer's personal beliefs about mental illness, their personal characteristics and organizational factors also seem to have a role in whether the client is thought to be dangerous or credible. For example, Bolton and Bentley (2003) report on an investigation concerning the influence of police officer's personal characteristics and organizational factors on perceptions of persons with mental illness. Concerned specifically with police officers attitudes about a person with mental illness' dangerousness, credibility, and self-sufficiency, Bolton and Bentley's study revealed the influence of an officer's age on perceived dangerousness. Namely, as age and experience as an officer increased, and ostensibly, contact with community members

with mental illness, so too their beliefs of dangerousness decreased. In addition, organizational factors that positively influence officers beliefs include an organizational emphasis on community policing, rather than enforcement (i.e. more arrests and traffic citations), and trainings specifically concerned with interacting with persons with mental illness. These findings may have some information helpful in understanding provider stigma, namely that the age of a provider might influence their beliefs about their clients. In addition, the finding that the law enforcement agency's organizational factors influence individual officer's beliefs may indicate that a mental health agency's organizational culture influences the beliefs and behaviors of their employees.

Oftentimes, however, even if police officers are aware they are dealing with a person with a mental illness, they may not choose, or have the ability to choose, a more suitable disposition that promotes mental health care (Lamb & Weinberger, 1998). These constraints, which may dictate the officer's choice to arrest a person with a mental illness, include strict criteria needed for involuntary hospitalization, a shortage of psychiatric inpatient facilities and beds, inadequate time in treatment for a person that police still consider dangerous, and mental health facilities' reluctance to accept and treat patients who are aggressive and perhaps combative. Once a person with a mental illness has been incarcerated, regardless of the factors that lead to the officer's decision to arrest, they are likely to spend more time incarcerated, on average, than offenders without such an illness (Steadman, McCarthy, & Morrissey, 1989). In addition, as a result of being arrested, the person now has a criminal record, which will likely factor into future interactions with law enforcement, thereby increasing the likelihood of being arrested again. This cycle of circumstances can make it quite difficult for a person with mental illness to avoid prolonged interaction with the criminal justice system. With such significant consequences for

the lives of individuals living with mental illness, stigma reduction interventions are of the utmost importance.

Public stigma intervention. Interventions that target correction of public stigma are based on the following basic methods: protest, education, and contact, according to Corrigan and Penn (1999). A tactic based on *protest* is one in which people are told to stop believing and/or endorsing negative ideas related to persons living with mental illness. For example, a recent Burger King commercial involved a cartoon-esque king who was shown being pursued by men who were intended to look like orderlies or mental health technicians in the outdated asylums (i.e. white pants, white shirts). The dialogue of the commercial was something to the effect of “someone needs to stop that king, he’s crazy!” This commercial attracted the attention of the National Alliance on Mental Illness’ (NAMI) StigmaBusters campaign. The response advised by StigmaBusters was rooted in the ‘protest’ approach, with the intention of having the advertisement removed from the air. This is a common method by which public stigma, especially in the media, is addressed. Unfortunately, there has been an unexpected effect of protest-based interventions: a rebound effect. Persons may initially show a decrease in stigmatizing beliefs shortly after being exposed to a protest-based intervention. However, the longer term influence can be a return to pre-intervention stigma beliefs and perhaps even an increase in levels of endorsement (Corrigan, River, Lundin, Penn, Uphoff-Wasowski, Campion, et al. 2001).

The next method used in anti-stigma intervention is *education* which involves changing beliefs about mental illness with a presentation of refuting facts and providing corrective education for common misconceptions. Support for the notion that education about mental illness decreases stigmatizing attitudes and beliefs are studies that show members of the general

population who are more knowledgeable about mental illness tend to be less likely to endorse stigma and discriminations (Link & Cullen, 1986; Link, Cullen, Frank, & Wozniak, 1987.; Roman & Floyd, 1981). As an intervention, research has shown that members of the general public have improved attitudes after completing short information sessions (Penn, Guynan, Daily, Spaulding, Garbin, & Sullivan, 1994; Penn, Kommana, Mansfield, & Link, 1999; Thornton & Wahl, 1996) and university courses (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). Education as an anti-stigma intervention has been shown to have short-term effects in reducing endorsement of stereotypes (Corrigan, River, Lundin, Penn, Uphoff-Wasowski, Campion et al., 2001; Corrigan, Rowan, Green, Lundin, River, Uphoff-Wasowski, K., et al., 2002).

Offering a critical review of one education-based intervention out of the United Kingdom, Pilgrim and Rogers (2005) examine the ‘Changing Minds: Every Family in the Land’ campaign developed by the Royal College of Psychiatrists in 1998. This campaign, led by the Royal College between 1998 and 2003, clearly states its objectives, first, to raise awareness that mental disorders are common and affect ‘every family in the land’ at some time or another. Other objectives include education of the public that the development of mental illness is genetically, as well as environmentally, influenced; and to promote the notion that mental disorders are treatable with effective interventions including medications, psychotherapy, and social support (Royal College of Psychiatrist, 1998). Although the stated aims of the education program are heartening, Pilgrim and Rogers remain critical of the implications of the campaign’s goals. These authors see the Changing Minds campaign as both an education-based intervention to address stigma, but also as a professional boost for psychiatrists in the United Kingdom.

The final method used to intervene in public stigma is based on *contact*, described as an intervention where persons without mental illness are in direct contact with persons living with mental illness. Employing contact as an intervention is a means by which the stereotypes related to mental illness, like dangerousness, blame, poor social skills, and poor prognosis, can be dispelled. A program that makes significant use of the contact-based intervention is the National Alliance on Mental Illness' (NAMI), *In Our Own Voice* (IOOV) curriculum. This program is delivered in 90-minute sessions facilitated by service consumers who review their personal experience with mental illness, treatment, and recovery.

It should be noted, however, that there are some stipulations to the contact-based intervention, elucidated by Pettigrew and Tropp (2000). First, the contact situation must be one without competition and with established common goals. Also, the contact situation should have the support of an organization's administration. Finally, the contact situation should be one in which participants are of equal social status and that the disconfirmation of stereotype is 'mild.' If the person with mental illness is perceived to be too-unlike the stereotype, the labeling of that person as having a mental illness to begin with is questioned, thus making the person a member of 'us' as opposed to 'them' neutralizing the intervention.

Perceived and Self-stigma: Definitions and Consequences

Directly related to public, structural, and provider stigma is perceived stigma. Closely aligned with these other phenomenon, *perceived stigma* occurs when a person living with a mental illness expects others (the public, the 'system,' and providers) to hold and enact negative attitudes, beliefs, and behaviors toward them because they have a mental illness. Simply stated, perceived stigma is the perception or the anticipation of stigma by persons living with mental illness. Often equated and used interchangeably in the literature, perceived stigma is necessary

for the formation of self-stigma. *Self-stigma* can be thought of as a phenomenon that results from an individual's perception, acceptance, and personal endorsement of socially held stigmatizing beliefs (Corrigan & Watson, 2002). The person perceives a cue that they have a mental illness, either by self-reflection, comparison to others, or via diagnosis by a mental health professional (a label). The cue triggers *stereotype awareness* of attitudes held by society regarding a person who is mentally ill (i.e. persons with mental illness are dangerous) (Watson, Corrigan, Larson, & Sells, 2007). If these stereotypes are endorsed, otherwise known as *stereotype agreement*, the individual agrees with the stereotype, and prejudicial beliefs emerge (i.e. I agree, people with mental illness are dangerous). The final step toward the development of self-stigma is application of the prejudiced belief to oneself (i.e. since I have a mental illness, I am dangerous). Watson et al. term this endorsement *self-concurrence* which results in self-stigmatization. The development of self-stigma often results in diminished self-esteem and sense of self-efficacy (Corrigan & Watson).

In addition to decrements to self-esteem and self-efficacy, self-stigma has additional, notable manifestations. Self-stigma can negatively influence every aspect of an individual's life (Caltaux, 2003) and often results in a 'why try' effect (Corrigan, 2004; Corrigan & Wassel, 2008). Exhibiting the 'why try' effect, the individual is less likely to pursue life goals, such as employment and independent living, deciding that they have failed to achieve their aspirations before ever trying, based on having a mental illness (Corrigan; Corrigan & Wassel; Corrigan, Watson, Byrne, & Davis, 2005). Additionally, self-stigma may influence those who could benefit from psychiatric services, but who decide not to do so in order to avoid being labeled as mentally ill. Corrigan refers to this as *label avoidance* which may even result in an exacerbation of psychiatric symptoms. In fact, according to Corrigan, epidemiological research indicates that

a majority of people who could benefit from mental health care either choose not to pursue it or do not fully adhere to treatment recommendations once begun. Gaebel, Zasko, and Baumann (2006) refer to label avoidance as a *treatment delay*, resulting in a higher threshold for help-seeking behavior. Treatment delay may lead to a more severe first manifestation of the illness than would otherwise be experienced.

However, having been diagnosed with a mental illness does not necessarily lead to self-stigma, low self-esteem, or diminished sense of self-efficacy (Watson, Corrigan, Larson, & Sells, 2007). There are exceptions to the negative effects of self-stigmatization, which Corrigan and Watson refer to as a *paradox* (2002). Specifically, a person with a mental illness who is aware of the stereotypes regarding people with mental illness held by the general public will perceive the stereotypes as legitimate or not. Those who believe the stereotypes legitimate and self-applicable are likely to experience self-stigmatization. However, those who hold the stereotypes as illegitimate will keep their self-esteem intact. Those believing the stereotypes to be illegitimate are further influenced by their group identification – to what extent do they identify themselves as a member of the stigmatized group? If the person has low-group identification, they do not believe they are a member of the stigmatized group, they are likely to be indifferent to the negative stereotypes. However, if a person highly identifies with other persons living with mental illness, they are likely to be prompted to righteous anger, that is oppose the implied stigmatization, and a positive self-perception emerges (Corrigan & Watson). For example, a person living with schizophrenia may be aware that the general public tends to equate this illness with violence. However, this person does not believe that having the illness of schizophrenia automatically implies violence, so their self-esteem remains intact. Further, the individual in question is highly involved in mental health advocacy efforts and is a peer counselor at the local

drop-in center, indicating high group identification. This person is likely to be prompted to righteous anger when confronted with stereotypical content about schizophrenia and may experience an increase in self-esteem as a psychological reaction to the attempted stigmatization.

Provider-Based Stigma

Understanding the sub-types of stigma that have been identified previously, namely public, structural, perceived, and self-stigma, it has been proposed that a another stigma subtype can be differentiated (Keast, 2012). Whereas public stigma is defined as the negative attitudes, beliefs, and behaviors of the general public toward individuals with mental illnesses (Hayward & Bright, 1997; Rüsçh et al., 2005), a related concept, that of *provider-based stigma*, can be defined as the negative attitudes, beliefs, and behaviors that mental health providers possess and enact toward the clients that they serve. Although helpful in conceptualizing its development, provider stigma cannot be understood as emerging from the same processes as public, structural, perceived, and self-stigma. Rather, provider stigma is an amalgamation of public, structural, perceived, and a reinforcement of self-stigma, with a developmental course that can only be understood by a thorough examination of the context in which mental health services are delivered and received.

Mental health providers are members of the general public, citizens of the general population, and are subject to the same influences of public stigma as any other citizen, including mass media. As a result, mental health providers often subscribe to the same stereotypes about persons with mental illness that are endorsed by the general public (Schulze, 2007). One of the most prevalent emotions reported by mental health providers about those living with mental illness is fear (Overton & Medina, 2008). Other prejudices, like dislike, anger, and neglect are also endorsed (Penn & Martin, 1998). Provider-based stigma can perpetuate and continue public stigma, initiate a client's development of self-stigma, and offer another obstacle in the structural

system that the client must overcome – representing another instance of structural stigma. Providing evidence for the existence of provider stigma, Wahl conducted a study in 1999 involving 1,301 mental health service consumers who were surveyed about their experiences with public stigma and discrimination. The study's participants were recruited through the National Alliance on Mental Illness (NAMI), where the survey was published in the organization's magazine *The Advocate*, disseminated to home locations through the 30 members of the Consumer Council, and through NAMI's website. Secondary follow-up interviews were conducted with 100 individuals who had participated in the larger survey. This second phase produced findings related to provider stigma. Namely, 28 of 100 interview participants reported experiencing stigma from "mental health caregivers" (1999, p. 473). Stigmatizing experiences in the mental health setting included being encouraged to lower their life goals and not feeling involved in their treatment planning. While a follow-up study by Dickerson, Sommerville, Origoni, Ringel, and Parente (2002) used a non-NAMI affiliated sample, who reported less experiences of discrimination and stigma, the perception of provider stigma was still reported. These two studies are telling: Consumers identify mental health providers as a substantial source of the stigmatization they experience.

The phenomenon of provider stigma has been indicated in a few studies (e.g. Lauber, Anthony, Ajdacic-Gross, Rössler, 2004; Lauber, Nordt, Braunschweig, & Rössler, 2006; Nordt, Rössler, & Lauber, 2006). First, in a study comparing attitudes of the public with those of mental health professionals in Switzerland, researchers found that "the general public has as many negative stereotypes about people with mental illness as mental health professionals do" (Nordt, Rössler, & Lauber, 2006, p.711). A similar investigation comparing stigmatizing beliefs held by psychiatrists versus the general population in Switzerland again found that there were no

differences in desired social distance from people with mental illness, although the psychiatrists had more positive opinions about community mental health (Lauber et al.)

In a comparison of psychiatric ward to general ward attendants employed in Indian hospitals, Vibha, Saddichha, and Kumar (2008) found no difference between the two groups when considering the constructs of Authoritarianism and Benevolence. Authoritarianism was measured by respondent's degree of agreement with statements that included "mental patients need the same kind of control and discipline as a young child" (p. 473). Ninety-percent of psychiatric attendants and general attendants agreed with this statement. In a study that compared the attitudes toward people with mental illness held by psychiatric and somatic nurses in Sweden, the authors discovered that these professionals did not substantially diverge from the opinions of the general public (Bjorkman, Angelman, & Jonsson, 2008). That studies have shown no difference between the attitudes of the general public and mental health professionals is counterintuitive, especially when considering that one of the most successful methods to reduce public stigma is that of consumer contact (Corrigan & Penn, 1999). The providers who are entrusted with the responsibility to assist persons living with mental illness were found to endorse statements similar to those endorsed by the general public when more positive statements would be expected.

In Ross and Goldner's (2009) review of nursing literature, the attitudes of psychiatric nurses, among other nurses, were investigated with regard to perceived stigmatization by persons living with mental illness. Specifically, the reviewed studies indicated that mental health/psychiatric nurses generally held more pessimistic attitudes about a client's prognoses and outcomes than the general public (Caldwell & Jorm, 2001; Hugo, 2001; Schulze, 2007). In an investigation of the attitudes of mental health providers toward people coping with co-morbid mental health and

substance misuse problems, Richmond and Foster (2003) found that although attitudes were generally nonstereotypic, treatment optimism did indicate low morale and pessimism about client prognosis. Hugo (2001) reported the findings of a study investigating attitudes of mental health professionals toward persons diagnosed with depression or schizophrenia, discovering that there were significant differences in the way provider groups rate the potential for successful long-term outcomes for people who have received treatment for a mental health concern. In addition, Hugo found that provider groups judge prognosis and outcome potential more negatively than the general public. In a similar study, Jorm, Korten, Jacomb, Christensen, and Henderson (1999) investigate attitudes toward people with mental illness in a sample of Australian health providers. These authors report that the main finding of their study was that health providers rate long-term outcomes more negatively than the public and believe that discrimination of people with mental illness is more likely.

In order to understand provider stigma's development, one must investigate the context in which provider's deliver services, including a review of contemporary service delivery challenges like the stratification of patients with respect to symptom severity, case load size, multidisciplinary teams and often divergent treatment ideologies, the stigmatization of mental health providers, professional burnout, microaggression, and other relevant structural stressors.

Contemporary service context. Philosophically, contemporary mental health services, particularly social work practice in mental health service settings, are theoretically guided by the principles of empowerment, strengths-focus, partnership, recovery, and rehabilitation (Bentley & Taylor, 2002). These approaches to practice embrace notions of a client's capability and resourcefulness, able to actively participate in making life choices, and ultimately in their ability to recover and experience an improved quality of life. While these ideas may be endorsed by

those providing mental health services, including whole public agencies in which they are employed, there are bureaucratic factors in place that make the practical application of these models problematic. While mental health services are no longer limited to institutionalized care, community mental health care being the new norm, the realities of service delivery present significant obstacles to service provision.

Most clients receive mental health services on an outpatient basis, typically from a multiservice mental health care organization (Scheid, 2004). In Virginia, the community service board (CSB) is the publically funded multiservice mental health organization, responsible for serving the public's behavioral health and developmental service needs in each of 40 locales (Virginia Association of Community Service Boards, Inc., 2014). These community care organizations provide a variety of services to diverse client populations. For example, a CSB may provide mental health services and substance abuse counseling, as well as supported community employment for individuals with developmental disabilities, to adults and children. These community organizations, as in the case of Virginia's CSBs, are generally publically funded.

The split created between services that are privately and publically funded presents a key issue in the contemporary context. Specifically, it has been argued that the current mental health service delivery context is two-tiered (Kemp, 2007). Individuals with more economic-resources and health insurance receive services in the private sector and those with limited resources tend to be served in the public sector, at community mental health centers. The individuals who have adequate income and insurance are typically coping with less-disabling mental illness, and receive care in office-based practice, benefitting from interpersonal therapy and psychopharmacological treatments. This is in contrast to uninsured clients, or those who qualify

for some form of Medicaid or Medicare, with inadequate or absent personal income. These individuals are likely to be coping with more serious mental illnesses, and benefit from case management services or the coordination of various services and supports (like medication, housing, and skills training). For the purposes of this dissertation, the primary focus is the attitudes of mental health providers in the public mental health service setting, as opposed to the private sector.

Publically funded community mental health centers generally have less financial resources than privately funded organizations, reflecting society's devaluation of these services, the lower priority of funding mental health services. As a result of these limited resources, Scheid (2004) notes that providers of services at public organizations are likely to be dissatisfied with their opportunities for promotion and salary. Low-pay has been cited as a major reason that staff choose to leave community mental health residential services (Ben-Drur, 1994). Social workers employed in public mental health settings report higher levels of emotional exhaustion, depersonalization, key components of professional burnout, and less personal accomplishment than those employed in private practice (Acker, 2010). Further explaining some of the repercussions of less financial resources, public mental health service providers typically are responsible for the care of more clients, maintaining a higher case load. Hromco, Moore, and Nikkel (2003) surveyed case managers employed by Oregon's public mental health services and found a trend toward increasing case load sizes. The average caseload in 2000 was found to be 35.2 cases per manager, an increase from the average in 1992 of 23.8 cases. These authors attribute the increase in case load size to financial constraints and practice management. Financial resources need to be used sparingly, so the demands on the limited number of providers are greater.

In addition, public community mental health services are conceptualized as a safety net, in effect ‘catching’ those clients with the least resources, but also with the most disabling, severe, and persistent mental illnesses (Institute of Medicine, 1997; Frank, Koyanagi, & McGuire, 1997). Providers of public mental health services, by virtue of the challenges of serving a more disabled population of clients, are more likely to be dissatisfied with their work and more vulnerable to stress (Oberlander, 1990). Providers of public mental health services are frequently in contact with individuals in crisis, interacting daily with individuals experiencing the worst of the worst symptoms, who perhaps have not taken prescribed medications, and/or have engaged in alcohol or substance abuse. These realities of practice, along with the frustration of bureaucratic issues, influence mental health provider’s attitudes toward their clients. As a result, provider attitudes may reflect a struggle between truly embracing a strengths-focused recovery approach to practice and stereotypical beliefs about negative prognosis, a client’s competence, and the need for paternalistic care. This inner conflict reflects a concept described by Taylor and Bentley, professional dissonance, or the conflict between the professional values of social work and expected or required job tasks (2005).

Multidisciplinary teams. Community-based mental healthcare has been particularly receptive to social work ideas and practice and, at its inception, absorbed many social workers into the new system (Aviram, 2002). Social workers comprise the largest professional group of practitioners in the mental health field, in addition to it being considered the largest field of practice in social work (NASW, 2015). In an occupational profile of social workers employed in mental health clinics, the NASW (2009) lists an array of job titles and duties that social workers perform in the mental health setting. Titles include clinical social workers, mental health specialist, counselor, therapist, or case manager. Employed in these roles, social workers determine client eligibility

for services, conduct assessments and take social histories, develop and implement treatment plans, manage crises and assess for safety, and advocate for client's services and welfare, to name a few key tasks (NASW, 2009). Also noted by the NASW (2009), social workers employed in mental health services are frequently members of a team, referred to as a multidisciplinary (or interdisciplinary) team.

The team approach to service delivery has become the new standard for community care (Schied, 2004), stemming from necessity, as no one discipline possesses the range of skills necessary for the achievement of clinical and social goals of treatment (Strathdee & Thornicroft, 1996). In addition to necessity, multidisciplinary teams have become the new standard for care because when they are working effectively, these teams can generate "creative solutions to clients' needs" (Toseland, Palmer-Ganeles, & Chapman, 1986, p. 46). The team environment is often characterized by attempts at consensual decision making and interdependence (Kane, 1980). Also, working on these teams has contributed to increased staff satisfaction and learning (Toseland et al.) and to reductions in individual burnout and burden (Diamond, 1996).

The problems inherent in a multidisciplinary team approach to treatment have implications for a provider's attitudes toward their clients. Since treatment ideologies are shared in a team environment and are open to adoption and endorsement by members, the attitudes of one provider will have an influence on the attitudes of others. That being so, the literature that describes stigmatizing attitudes of providers, regardless of discipline, will likely be helpful in understanding the attitudes of all provider groups. In addition, the stress and strain of practicing in multidisciplinary teams, due in part to role confusion and professional conflict, likely influences an individual's attitudes toward their work environment and the clients they serve.

The providers that make up these teams are educated in different disciplines and therefore conduct clinical practice in a variety of ways. To describe different approaches to treatment, Scheid defines *treatment ideology* as those ideas that ground one's clinical work, specifically about mental health, illness, the roles that providers play, as well as the goals for treatment. Members of multidisciplinary teams may each endorse a different treatment ideology, especially when specifying the goals of treatment. For example, medical professionals (nurses and psychiatrists) will often place medication management and symptom reduction as goals of the highest order, whereas social workers or occupational therapists tend to concentrate on social issues and daily functioning (Scheid). Interprofessional conflict is a likely consequence of divergent treatment ideologies.

Which profession's treatment ideology is likely to supersede the ideologies of the others? In reporting the results of a study involving qualitative interviews with mental health service providers, Schied (2004) calls to the reader's attention the supremacy of the psychiatrist and psychologist in the community care and team environment. Psychiatrists and psychologists are viewed as the 'legitimate' professionals and thus wield considerable power in the team and organization (Mitchell, 1993). In a qualitative study conducted by Mitchell, members of a long-standing mental health multidisciplinary team in the United Kingdom reported that the psychiatrist's assumption of authority and power still occurred with newly practicing physicians. Said another way, even when the psychiatrist was less-experienced than other team members, they maintained their high authority and power on the team. This domination of the service environment could also translate into the ready acceptance of the psychiatrist's medical-focus treatment ideology by professionals and paraprofessionals educated in other disciplines. For the social work provider in particular, they exist as a secondary or subordinate profession in a field

dominated by physicians. The social worker identifies with their professional group (social worker and its associated values) but also with their mental health colleagues, the psychiatrists, potentially resulting in conflicting identity orientations (Aviram, 2002). Also to be considered, demographic characteristics of team members may influence their acceptance of treatment ideologies. For example, younger workers are more likely to conform to these dominant treatment ideologies, because they have little power and little choice (Martin, 1992; Scheid, 2004). The dynamics of power and subordination between the disciplines making up the team may have an influence on the adoption and enactment of attitudes, beliefs, and behaviors that are in conflict with one's professional training. The influence of participation on a multidisciplinary team on a professional's approach to treatment is an important element of the context in which provider-based stigma can emerge.

In addition to conflict regarding treatment ideologies, the multidisciplinary team also increases the likelihood of redundancy, where multiple professional groups provide similar services (Robiner, 2006), role confusion (Onyett, et al. 1995), and role blurring (Mitchell, 1993). Aviram argues that one of the striking characteristics of role performance during the shift from institutional to community care was the diffusion and overlapping of responsibilities and roles (2002). As members of multidisciplinary teams, social workers join nurses, psychiatrists, psychologists, and paraprofessionals in providing services to their clients, different treatment ideologies merge into a team, but the services these individuals provide may be fairly similar. For example, counseling the client and helping with medication choices are tasks performed by all members of a care team. The boundaries between professions thus become blurred, potentially causing conflict, professional rivalry, and confusion.

Stigmatization of providers. While the influence of stigma on the lives of persons coping with mental illnesses is often discussed, the stigmatization of mental health providers, including psychiatry in general, psychiatrists, and other mental health providers is worthy of note when surveying the context in which provider-based stigma develops. The development of provider stigma may well be influenced by the stigmatization experienced by the provider from the media, the community, and within the medical profession. Shulze (2007) argues that mental health providers are involved with the stigmatization of mental illness in two key ways: as perpetrators, which is the focus of this dissertation; and as recipients of stigmatization, a key component of the context in which provider stigma develops. The mental health professional is also the target of public stigma in much the same way as their clients. Indeed, ever since psychiatry emerged as a medical specialty it has been the target of critical social analysis (Pilgrim & Rogers, 2005). In the mass media, psychiatrists and other mental health providers are often depicted as neurotic, mentally imbalanced, prone to substance abuse disorders, and otherwise maladjusted (Shulze; Thronicroft, 2006). In addition, portrayals of mental health providers involve aloof characters, who are self-absorbed, incompetent in their professional capacity, and especially likely to breach professional boundaries. More benign misperceptions include the assumption that mental health providers have x-ray vision, are capable of seeing into people's minds, and read other's thoughts. These stereotypical ideas of psychiatrists and other mental health providers are conveyed through the mass media and influence a provider's relationships within their profession, community, and interpersonal associations.

The stigma that is experienced by mental health providers can also be understood as *associative stigma* (Verhaeghe & Bracke, 2012) or *courtesy stigma* (Goffman, 1963).

Associative stigma is defined as stigma that persons experience not because of their own

discreditable characteristics, but because of they are associated or affiliated with persons belonging to a stigmatized group. Within a provider's profession, for instance, those specialties associated with mental health tend to receive less status than others and often are disrespected by colleagues (Dichter, 1992; Gabbard & Gabbard, 1992; Persaud, 2000). As an example, psychiatric nurses are considered of lower status than another specialty of nursing, such as a pediatric nurse (Verhaeghe & Bracke). In fact, the lower status of psychiatric specializations occurs early in professional education, for instance in medical school or during social work coursework. Research indicates that entering medical students may regard the psychiatric specialty as interesting and intellectually challenging, but that they also believe that it lacks a scientific foundation and is less enjoyable than other specializations (e.g. Malhi et al., 2003). Medical students have also been found to consider psychiatric specialization less attractive than others, leading to lower recruitment of students into psychiatry, which remains a concern in the United States (Rao, 2003; Sierles, Yager, & Weissman, 2003; United States National Resident Matching Program, 2006).

Associative stigma is viewed as a job stressor, another challenge to working in mental health services. Essentially, the cumulative effect of associative stigma on one's working environment influences job performance and interactions with clients (Holland et al., 1981; Weisman & Nathanson, 1985). The connection between associative stigma and provider stigma is partly investigated by Verhaeghe and Bracke, whose important study reveals an association between a provider's experience of associative stigma and client's self-stigma, as well as client satisfaction with mental health services (2012). Additionally, in much the same way that a client's acceptance and self-application of the stigma of mental illness forms self-stigma, the acceptance and self-application of associated stigma can result in self-stigmatization of providers. For

instance, a provider may be aware of the stigma associated with mental health providers, for example that they are perceived as erratic and less competent than other professional groups. If the provider believes this stigma to be true and applies it to themselves, they are likely to endorse ideas of self-stigmatization. This self-stigmatization, then, is based on the provider's association with persons living with mental illness. This is in line with Verhaeghe and Bracke's assertion that providers who experience associative stigma may display emotions related to this stigmatization, which could ultimately influence the emotional state of the clients with whom they work.

General attitudes of the community, the media, and within wider professional groups are not the only manifestations of stigma directed at mental health providers. A study conducted by Schulze and Angermeyer (2003) made use of intensive qualitative interviews with mental health providers. Thematic analysis of the responses revealed three manifestations of stigma experienced by providers, including: in their interpersonal relationships, through feelings of lack of appreciation for their work that are evoked by stereotypical public images of providers, and lack of resources with which to perform their jobs. The first two themes were touched upon in the above discussion of the common misperceptions of mental health providers and the influence of major media representations. It is interesting to consider that mental health providers perceive stigmatization as a result of the inadequate funding of mental health services. The modest budgets that are allocated to mental health providers are judged by these providers to be both restricting of therapeutic possibilities and as signaling a lack of recognition for their work. Provider stigma is most certainly influenced by the experience of associative stigma, its influences on a provider's self-stigma, and their feelings of job satisfaction and effectiveness. Providers who are consistently in contact with individuals in crisis, who experience denigration

in the larger community, in their interpersonal relationships, and in their professional disciplines, are perhaps susceptible to endorsing negative beliefs about the clients with whom they work.

Potentially due in part to the influence of associative stigma, social work providers of mental health services are increasingly moving away from public service environments, as suggested by the work of Aviram (2002). The representation of social work in the public sector of mental health services, while initially strong, has been waning in recent years. Taking a step back from social case work, social workers have increasingly opted for practice in other settings, namely private practice, as opposed to work with persons coping with serious mental illnesses. Aviram and Livne report survey findings indicating that “the majority [of social workers surveyed] prefers working with those having psychological distress, suffering from mild coping and adjustment problems than with the severely and chronically, disabled mentally ill persons” (1998, p. 630). The movement of professionals from the public mental health sector to other venues of practice is not solely a phenomenon in social work. In fact, the nationwide average rate of turnover for community mental health centers varies between 50 to 60 percent annually (Latta, 2012). While this rate includes other rationale for leaving public mental health, associative stigma is negatively correlated with job satisfaction (Verhaeghe & Bracke, 2012) and may be therefore a contributing factor to such high rates of turnover. Worker burnout, described next, is also associated with job satisfaction, performance, employee turnover, as well as related to the formation of provider stigma.

Burnout. The manifestation of provider-based stigma is likely influenced by the individual worker’s stress threshold and experience of burnout. For the purposes of this discussion, *stress* is defined as the emotional and physiological reactions to demands, situations, or circumstances that disrupt the perceiver’s equilibrium (Maslach, Jackson, & Leiter, 1996; Zastrow, 1984;

Lloyd, King, & Chenoweth, 2002). Carson and Kuipers (1998) further explore the development of stress in their *stress model*, arguing that the experience of stress is best understood via three levels: The first level, *stressors* come from three major external sources including occupational stressors, hassles or uplifts, and major life events. The next level of Carson and Kuipers' stress model are *moderators* of stress, including, for example, high self-esteem, good social support, and hardiness. The third and final level of Carson and Kuipers' stress model are *stress outcomes* which are the consequences of stress, including burnout, low job satisfaction, and psychological difficulties.

Burnout is defined as a syndrome that consists of three dimensions: emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment (Lloyd et al., 2002; Coyle, Edwards, Hannigan, Fothergill, & Burnard, 2001; Maslach, et al. 1996). Emotional exhaustion exists when the mental health professional feels they are no longer able to give of themselves to their clients at a psychological level. Depersonalization involves the development of cold, negative, and often cynical attitudes and feelings about their clients. Relatedly, cynicism is quite similar to provider-based stigma's manifestations of the poor prognosis stereotypes. The third dimension of burnout, reduced feelings of personal accomplishment refers to the worker's diminished view of their professional endeavors, particularly a negative perspective and dissatisfaction.

Factors associated with increased stress and the development of burnout include *professional dissonance* defined by Taylor and Bentley (2005) as the discomfort that arises from conflict between the professional values of social work and expected or required job tasks, what social workers are actually confronted with in practice. This is also referred to as role conflict and role ambiguity (Zellmer, 2003). Additional stressors leading to provider burnout include bureaucratic

constraints to offering individualized consumer services (i.e. competing values between administrators and social workers and cost effectiveness strategies), lack of worker autonomy, large caseloads, large amounts of paper work, inadequate funding, and even the unethical behavior of colleagues (Lloyd et al., 2002; Söderfeldt, Söderfeldt, & Wang, 1995; Zellmer). Stressors specifically related to mental health social workers also include not being able to help people that needed help (Balloch, Pahl, & McLean, 1998), too little time to perform job tasks to their satisfaction, scarce services and resources, difficulty meeting deadlines, the emotional demands of clients (Coyle, Edwards, Hannigan, Fothergill, & Burnard, 2005), degree of involvement with clients, the social worker's lack of social support (Barber, 1996), and as previously discussed, associative stigma (Verhaeghe & Bracke, 2012).

The impact of burnout on mental health social workers has been investigated in a meta-analysis of relevant literature by Coyle and colleagues (2005). Nineteen articles were included in their analysis, meeting inclusion criteria such as being English language publications, sampling mental health social workers, and measuring variables related to stressors, moderators, and stress outcomes. Among the primary findings of this study, one out of every two mental health social workers reported being 'emotionally drained' as a consequence of their work (Onyett, Pillinger, & Muijen, 1997). Additionally, 68% of community mental health social workers reported being under stress (Sze & Ivker, 1986). This stress, particularly the emotional exhaustion element of burnout, is experienced by social workers to a greater degree than either psychiatrists or psychologists. In addition, social workers report more depersonalization than psychologists (Snibbe, Radcliffe, Weisberger, Richards, & Kelly, 1989).

Additional support for the incidence and prevalence of burnout in mental health social workers is provided in a study conducted in England and Wales (Evans et al., 2006). This study

revealed that social workers felt highly stressed in their current roles within interdisciplinary mental health teams, perceived being undervalued by colleagues, and expressed a high desire to leave their current position. A social worker who is stressed, feels undervalued, and wants a different job is clearly in danger of developing burnout and its incumbent symptoms of emotional exhaustion and depersonalization, which influence the ability to provide empathic social services.

Consequences of mental health social worker burnout include job absenteeism and turnover (Lloyd et al., 2002). A negative influence on the client-provider relationship is also to be expected when burnout is present. Emotional exhaustion, or the provider's feeling that they are unable to give anymore of themselves psychologically, as well as depersonalization of the client influence the quality of care a professional is capable of giving. Burnout and its consequences are similar to the manifestations of provider-based stigma. For example, a negative view of a client coupled with pessimism and cynicism, which are incumbent with burnout's depersonalization, can lead a provider to endorse stereotypes related to poor prognosis or paternalism, key elements of provider stigma. How these endorsed stereotypes are enacted is of interest in this dissertation, including how a client perceives provider-based stigmatization.

Microaggression. Helpful to understanding a provider's subtle endorsement and enactment of stigmatizing beliefs is the phenomenon of *microaggression*. Microaggressions are defined as brief, commonplace, verbal, behavioral, and environmental slights and indignities directed toward 'others' (most often Black Americans), often automatically and unintentionally (Constantine, 2007; Solórzano, Ceja, & Yosso, 2000; Sue, Bucceri, Lin, Nadal, & Torino, 2007; Sue, Capodilupo, & Holder, 2008). The concept of microaggressions has been applied in the literature to differences based on race and sexual orientation. It could be argued that the

phenomenon of provider-based stigma, as conceptualized in this dissertation, is a manifestation of microaggression against persons living with mental illness.

Researchers have specified a taxonomy of racial microaggressions that includes three forms (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007). The first form of microaggression is a *microassault*: deliberate forms of discriminatory practice, conscious behaviors that are intended to harm or oppress a marginalized group (Sue, Capodilupo, et al). This type of microaggression closely resembles traditional discrimination, including name-calling and avoidant behavior, but occurs in situations where the perpetrator is anonymous, feels safe in expressing their true beliefs, or in situations where they feel out of control. For example, with respect to sexual orientation-based microassault, Shelton and Delgado-Romero's (2011) study offers as an example the remarks of a therapist working with lesbian, gay, bisexual, and queer clients (LGBQ). Specifically, remarks constituting a microassault were made in moments when the therapist became frustrated with their client's progress in therapy; when the therapist felt out of control, and made statements indicating the assumption that LGBQ persons need therapy because they are different, troubled, flawed, and suffer from a problem that needs to be fixed. As related to provider stigma, an example of a microassault enacted against a person with a mental illness could be when describing a client who has a history of frequent contact with crisis services as 'a frequent flyer' or automatically assuming the client is willfully placing themselves in crisis situations.

The second form of microaggression is called *microinsults*, which are described as behavior or verbal expressions that convey rudeness or insensitivity (Sue, Capodilupo, & Holder, 2008). As applied to racism, for example, referring to a Black student as 'articulate' with a surprising tone gives the underlying message, or microinsult, that Black Americans are unintelligent and

less articulate than others. An example of a microinsult from a mental health provider directed toward a person with mental illness could be commenting how ‘high-functioning’ a client is, with surprise, implying that persons with mental illness are not usually high functioning in major life areas. The third form of microaggression is the *microinvalidation*, which invalidates, negates, or diminishes the psychological thoughts, feelings, and reality of an individual (Sue, et al.). For example, regarding racism, when Black Americans are chided for being sensitive, that people are people, with the underlying message that their experience of denigration is not valid (Neville, Lilly, Duran, Lee, & Browne, 2000; Sue, et al.). An example of provider-based stigma in the form of microinvalidation is when a provider presents a treatment plan to a client for their approval, with the goals of treatment already specified, without the client’s participation, the underlying message being that the client is not capable of knowing what is best for themselves and that their goals are not as important as those suggested by the provider.

Microaggression, in its various forms, has consequences for both the perpetrator and the victim due to their unintended and subtle nature (Sue, Capodilupo, et al. 2008). While the perpetrator of microaggressions may dismiss these slights as trivial, the cumulative effect of microaggressions can be traumatic, generating feelings of invisibility and marginalization (Franklin, 1999; Pierce, 1988). One study describes the influence of microaggressions against Black clients in a mental health service setting (Constantine, 2007), finding that microaggressions were predictive of weaker therapeutic alliances, lower ratings of cultural competence, and less satisfaction with counseling in cross-racial dyads with White counselors. Microaggressions may also help explain why Black Americans underutilize mental health services and terminate mental health treatment with White therapists more frequently (Burkard & Knox, 2004). The detriment to the mental health service receipt experience that racial

microaggressions poses may perhaps have applicability to microaggressions that are based on mental illness.

Provider stigma resembles microaggression in a number of ways, primarily in its subtle, covert, often unintentional operation. It is likely that service providers are not operating in malice, attempting to demoralize their clients. It is more plausible that providers are subject to the same stereotypical beliefs engrained in the general public, and that stereotypic beliefs are exhibited outwardly in actions and attitudes that are seemingly benign, but are malignant to the recipient, nonetheless. In addition, microaggressions are shrugged off as innocent acts and often are not paid much attention, with perpetrators assuming that the acts are not harmful to the recipient (Sue, et al., 2008). Similarly, provider stigmatization that is unintended or benevolently motivated, rooted in ideas of paternalism, are often dismissed as being ‘in the client’s best interest,’ therapeutically necessary, or even that client’s are not perceptive enough to note their occurrence.

Contextual summary. The context in which provider stigma develops is stressed and strained by bureaucratic influences beyond an individual’s control, including the high pressure of large caseloads and functioning within the purview of one’s discipline as a member of a multidisciplinary team. In addition, the environment is already tense as a result of the continual interactions with persons in the most serious of crises. Adding in stigma felt by practitioners, associative stigma, and its incumbent negative effect on job satisfaction, along with professional burnout, the stage is set for the acceptance and application of distorted and flawed beliefs about persons with mental illness. Provider stigma emerges from this context and influences the lives and well-being of mental health service clients and their families. The consequences of provider stigma are discussed in the following section.

Consequences of provider-based stigma. It has been argued that provider attitudes must be understood and changing negative attitudes should be a goal for education (Chappel, 1992). Focusing on provider attitudes is imperative, because these attitudes directly influence a provider's behavior and choices in practice. In Carl Roger's (1995, 1995) seminal work on person-centered counseling, he argued that for humans to thrive certain conditions that foster personal growth must exist, of which positive relationships were a major component. In fact, for many mental health service users, the relationships they engage in, including those with mental health providers, constitute the most important factors helping them cope with mental distress (Faulkner, & Layzell, 2000). Person-centered therapeutic relationships with mental health providers are characterized by acceptance, genuineness, and empathy. *Acceptance* is described as a quality of a relationship that values or prizes the individual, accepting them for who they are without judgment or conditions; *genuineness* is present when a relationship includes open and honest communication, where professionals do not use their role or status of expert as a barrier; *empathy* involves a relationship characterized by communicated understanding of another's emotional and subjective view of themselves and the world (Rogers, 1994, 1995). If a provider endorses stigmatizing beliefs related to mental illness, namely that persons with mental illness are dangerous, to blame for their illnesses, child-like and need constant care and decisions to be made for them, and unlikely to ever recover or get better - than the elements of a successful therapeutic relationship are unlikely to occur. Acceptance is absent, genuineness is unlikely, and empathy is limited.

Providing further support for the deleterious effect of provider stigma on the therapeutic relationship is a measurement development study for assessing stigma of providers of services for persons living with HIV/AIDS (Stein, 2008). This study highlights the impact of stigma

toward the client, which is noted to possibly impede the provision of adequate and sensitive care to the consumer of services. Inadequate, ineffective, and insensitive services are consequences of provider stigma that emerge essentially from a fractured therapeutic relationship. The therapeutic relationship thus threatened, provider decisions reflecting stigma, as opposed to recovery and empowerment, treatment outcomes can be expected to be less promising. A strong therapeutic relationship is associated with more positive treatment outcomes. If outcomes are less positive, this equates to clients not achieving important treatment and life goals – less symptom stabilization, limited independence, blocked life goals of employment and independent housing, to name a few. Lauber, Nordt, Braunschweig, and Rossler (2006), whose investigation focuses on the attitudes of mental health professionals toward their clients in Switzerland, argue the importance of understanding provider attitudes and beliefs “as it is well known that the actual behavior of psychiatric staff and their respective attitudes toward clients are associated with treatment outcomes” (p. 52).

Other manifestations of provider stigma can be discerned by looking at what clients of mental health services are reporting as barriers to their treatment. In a review of mental health service consumer and family authored personal account literature, my previous research (Charles, 2013) identified five core themes that reflect the client’s experience of provider-based stigma. That these themes are even perceived by clients lends support to the growing body of evidence of the existence of provider-based stigma. These themes include: blame and shame; disinterest, annoyance, and/or irritation; degradation/dehumanization; poor prognosis/fostering dependence; coercion and lack of ‘real’ choice. Briefly, as these themes and manifestations are discussed in greater detail in Chapter 2 of this dissertation, my research argues that the experience of provider stigma includes a client’s perception of blame and shame by mental health providers for the

manifestation and display of mental illness and its symptoms. For example, a provider exhibiting blaming behavior could take the form of chastising a client for not keeping medication appointments and alluding to treatment non-adherence as a cause for the client's symptoms. While these reasons for a client's reemergence of symptoms may actually be valid, the provider's chastisement and blaming are the objectionable qualities. Another expression of provider stigma is the provider's disinterest, annoyance, and/or irritation with their clients and/or families. For example, a client's family may perceive provider annoyance when visiting their loved one on an in-patient psychiatric unit if their questions about status and progress are answered with short, curt replies, inattention, or impatience. Provider stigma also emerges in a provider's degradation/dehumanization of their client, for example, by discussing them and their care without including the client in the discussion or finalizing treatment plans without the client's input. A provider's endorsement of ideas related to client poor prognosis/fostering dependence also reflects the experience of provider stigma. Harboring attitudes of poor prognosis refers to the provider who believes that the likelihood of their client's improvement is low. This can be displayed, for instance, in a provider who encourages a client with schizophrenia to not pursue a college education, for his or her own good, because it could be 'too stressful.' Lastly, according to my previous research, provider stigma is also demonstrated when coercion is employed or the client lacks 'real' choice regarding life and treatment goals. For example, coercion and a lack of 'real' choice are at work when a client struggling with depression is presented with the option of voluntarily signing into an in-patient psychiatric unit or being threatened with mental health court and civil commitment.

A helping relationship with a provider who espouses stigmatizing attitudes and behaviors creates an environment in which the provision of effective or compassionate mental health

services is unlikely. In addition to potentially poorer treatment outcomes, clients who perceive provider stigma may be more likely to avoid mental health services. Bjorkman, Angelman, and Jonsson argue that a client's experience of rejection in the helping relationship "...may lead to them not seeking treatment even when needed" (p. 176). Treatment plan and recommendation non-adherence is also more likely when the client interacts with a provider harboring stigmatizing beliefs, referred to by Bjorkman and colleagues as "additional resistance in taking part of the health care system when needed" (p. 176). This observation is aligned with the warning of Sadow, Ryder, and Webster (2002) who caution that when a provider holds stigmatizing views they may inadvertently interfere with effective treatment, namely by underestimating their client's social and intellectual potential. Harboring stigmatizing beliefs regarding client abilities may be based on the sentiments of poor prognosis and fostering dependence, touched upon by my previous research (Charles, 2013), which likely influences a client's decisions about treatment engagement and termination.

Statement of the Problem

As discussed above, provider stigma may have profound consequences. Therefore the accurate appraisal of its incidence and prevalence is all the more important, to be surely followed by development of prevention and intervention strategies targeting its amelioration. This dissertation describes the development and validation of an instrument intended to tap the construct of provider-based stigma. The measure is for use as a self-assessment for providers, administered in the spirit and context of continued professional education and development. While a more in-depth discussion of self-assessment and professional development is provided in Chapter 2, and measurement basics are touched upon in Chapter 3, the context of the dissertation and the problem to be addressed are specified here, for clarity.

Accurate measurement of provider-based stigma is elusive for reasons discussed in Chapter 2's more detailed review of the literature. However, by identifying limitations in the most used measure of stigma and in recent measures of provider stigma, the opportunity for this dissertation's meaningful contribution to the field of social work stigma research is introduced. Primarily, it appears as though traditional mechanisms of stigma measurement are not appropriate for use with providers. For example, Link, Yang, Phelan, and Collins (2004) cite in their review of stigma measures that the most commonly used method for measuring stigma are methods based on desired social distance. Measures based on social distance "seek to assess a respondent's willingness to interact with a target person in different types of relationships" (p. 519). Two noted limitations of the utility of social distance as an appropriate measure of stigma are the social desirability bias and the inference of behavioral responses from reported intentions, not actual behaviors. These challenges will be addressed in greater detail in Chapter 3. Also, provider-based stigma is most evident in an interpersonal relationship that has special implications, specifically the therapeutic relationship, that has the goal of optimizing mental health well-being, not solely the establishment and maintenance of an interpersonal relationship.

Another example of the limitations of existing measures of stigma, evident even in instruments designed specifically to measure provider-based stigma, include two recent works: one by Wilkins and Abell (unpublished, 2010), the other by Kennedy, Abell, and Mennicke (2014). Wilkins and Abell's measure, the Mental Illness Stigma Scale for Mental Health Professionals is based on Link and Phelan's (2001) social-psychological theory of stigma development. The questionnaire's items are derived solely from an item pool formed by attending to the components that Link and Phelan argue embody stigma – labeling of difference, stereotyping, separating (us and them), and discrimination. These components are useful in

understanding the content of stigma on a basic level, but as used in Wilkins and Abell's instrument, lack the specificity for the development and unique expression of provider-based stigma. For example, Wilkins' and Abell's measure attempts to measure the provider's tendency to label a client as different based on slurs used in common vernacular: lunatic, crazy, and deranged, for example. A measure for use with mental health providers, in contrast, may use alternative labels of difference that include 'resistant,' 'non-adherent,' 'combative,' and 'lacking insight.' In addition, this dissertation assumes that because the client is significantly influenced by provider-based stigma, their experience of the phenomenon seems most relevant, and a fertile ground from which items could be generated. The absence of the client's experience in Wilkins and Abell's item generation is a clear limitation of their instrument.

Kennedy, Abell, and Mennicke's measure of provider stigma, The Mental Health Provider Stigma Inventory (2014) attempts to tap three elements related to provider stigma: attitudes, behaviors, and coworker influence. Like Wilkins and Abell's (2010) measure, the items are worded in a way that is likely to elicit substantial social desirability bias, influencing the validity of the measure. For example, one item "I tell clients that they cause their own problems" is not likely to produce much variability in response from providers, who are unlikely to agree with such a statement. In addition, the items were based on literature that defines and describes two stigma elements, attitudes and behaviors, as well as the influence of coworkers, but does not take into account the client and family experience of provider-based stigma.

As a result of a clear need for accurate assessment of instances and intensity of provider-based stigma and the notable absence of such measurements in the existing literature, this dissertation develops and validates such an instrument. Guided by traditional theories of stigma development, as well as the results of a thematic analysis of consumer and family authored

personal account literature, this measurement seeks to ascertain the incidence and intensity of provider-based stigma based on client experience of the phenomenon.

Significance of the Study and Relevance to Social Work

That mental health providers may also subscribe to the negative attitudes and beliefs about people with mental illness that are held in the general public is a serious impediment to providing effective mental health services, with social justice implications. This topic, therefore, is of the utmost importance to any researcher, educator, or practitioner concerned with the influences of stigma, particularly with a focus on challenging the social injustice it creates as a barrier to effective services. In order to assess the incidence and severity of provider stigma, the profession requires a measure that is reliable, valid, and incorporates the client's experience of the consequences of the phenomenon. There is not, as yet, to the author's knowledge such an explicit and specific measure in existence. This dissertation attempts to fill this gap in scholarship as a challenge to the social injustices imposed by provider stigma, in order to stimulate research and intervention development that will eradicate this stigma. The ultimate outcome is the delivery of more effective and empowering services to those who seek mental health care.

Chapter Two – Literature Review

In Chapter 1, a great deal of information was presented regarding the different manifestations of stigma and accompanying consequences. Included in this discussion, provider-based stigma as the phenomenon of interest was introduced, along with a detailed look at the service context in which it develops. Chapter 2 will begin with a discussion of this dissertation's theoretical underpinnings, a brief look at the theories guiding the chosen approach, methodology, and analytical strategy. The theories of particular interest include symbolic interactionism, particularly the work of Mead (1934) and Goffman (1963), as well as attribution theory, modified labeling theory, a conceptual model developed in another study conducted by the author (Charles, 2013), and measurement theory. Following a discussion of these theories, a review the literature surrounding the use of self-assessment in stigma-attitudes research and professional development is presented, in addition to a brief synopsis of literature about the measurement of public and self-stigma. In particular, attention is given to the utility of these existing measures and instruments, highlighting their limited applicability to provider-based stigma as a different phenomenon. Measures of provider-based stigma, as they are currently available in the literature, are also reviewed with an eye to their limitations and how this dissertation study fills a gap in provider stigma related research. This chapter concludes with a summary of the study's focus and research questions.

Theoretical Foundation

Symbolic interactionism.

Mead. Symbolic interactionism is a social-behaviorist, grand theory initially proposed by George Herbert Mead (1934) that seeks to explain the nature of social interactions and how they shape a person's reality. Basic propositions of symbolic interactionism include the assertion that

humans having the capacity for thought that is shaped by interaction; meaning and reality are socially constructed; individuals are able to alter or change their reality and meaning based on interpretation and experience; people have the capacity to assume the perspective of others in the community (known as *the generalized other*) and judge themselves and their actions accordingly (Mead). Through symbolic interactionism the individual and their actions can be understood “...in terms of the behavior of the whole social group of which [they are] a member, since [their] individual acts are involved in larger, social acts which go beyond [themselves] and which implicate the other members of that group” (Mead, p. 6-7).

Theoretically, symbolic interactionism is useful in understanding why mental health providers have beliefs similar to the general public regarding mental illness. Mental health providers are members of the same social group that consists of the general public, thereby being exposed to the same generalized other, or the attitude of the whole community. The generalized other influences an individual’s behavior (Mead, 1934), so if the community’s attitude is stigmatizing to persons with mental illness, these attitudes would presumably also influence individual behavior, including the behaviors of mental health providers. While this is likely a more complex process, the notion that the provider is a member of the larger society is important at beginning to understand the formation of provider stigma. Also, the generalized other could be the general public’s but it could also be reflective of an organization or agency culture, which undoubtedly has an influence on individual-provider attitudes. The notion that reality and meaning are socially constructed provides the rationale for this study’s investigation of providers’ actions and attitudes that are perceived as stigmatizing by consumers of mental health services. The reality of a client is shaped by their interactions with others, including providers, the community, and with peers. As stigma has been identified as a large barrier for those seeking

mental health services (e.g. U.S. Department of Health and Human Services, 1999), in a society rife with stigmatizing messages about mental illness (e.g., Wahl, 1995), it is not far-fetched to assume that the client's reality is fettered with stigma. Mead's symbolic interactionism therefore provides justification for assessing and measuring the attitudes and actions of providers in the hopes that these can be improved, leading to a less-oppressed reality for mental health service consumers.

Goffman. Particularly relevant for work understanding the influence of stigma on persons living with mental illness is the writing of Erving Goffman who authored a classic piece entitled *Stigma: Notes on the Management of Spoiled Identity* (1963). Goffman extrapolated symbolic interactionism and applied it to understanding the nature of stigma and its influence on 'stigmatized' persons. While persons with mental illness were only one of many stigmatized conditions addressed in his text (including blindness, deafness, race, epilepsy, etc.), the concepts and propositions argued by Goffman are especially relevant to understanding the stigma of mental illness and its influences on the individual.

Key concepts that Goffman identifies include the *social identity* or the socially created range of personal attributes and social statuses that we are likely to encounter in others involved in social situations. The *virtual social identity* is the identity that individuals project or infer about strangers they meet in social situations. These are the attributes, characteristics, and the social status that we anticipate we will encounter when meeting a stranger. An individual's *actual social identity* is the person as they really are, stigmatizing features and all. Incongruence can exist between one's virtual and actual social identity, or what is assumed about them versus what is truly present. If this incongruence is based on a stigmatizing condition, stigmatization may result, due in part if the condition is either a discredited or discreditable stigma. *Discredited* is

when the difference (the stigma) is known or externally visible (shared mental health diagnosis or visible impairment); *discreditable* stigma is when the condition is concealable and/or not known.

In Goffman's symbolic interactionism the key to understanding the influence of stigma on individuals with mental illness lies in conceiving the strategies that one uses to navigate situations in which their stigmatizing condition is known: when their struggles with mental illness are not a secret and they are judged by others based on stereotypic beliefs. Similarly, the dilemmas of one whose stigmatizing condition is concealable includes how they keep it concealed, whether to keep it a secret, and how they might successfully navigate social situations in which their stigmatizing condition is not known, but could become known at any time. Goffman postulates that persons with discredited (unconcealable) stigma use coping strategies like social isolation and withdrawal to protect themselves. Persons with discreditable (concealable) stigmas cope through secrecy (including 'passing'), selective disclosure, and social isolation that include avoiding intimate relationships that may require disclosure. Goffman hypothesized, based on his many interviews with persons with concealable stigmas that a great amount of anxiety and fear are characteristic of these persons and consequences include limited social engagement, less social contact, and feelings of inadequacy.

With respect to the present study, Goffman's symbolic interactionism influences how provider attitudes are conceptualized. For instance, following Goffman's discussion of virtual and actual social identity, the provider who interacts with a mental health service consumer, particularly for the first time, will project onto the stranger a virtual social identity, attitudes and beliefs about that person, based on what they believe they will confront. This is what the dissertation's measure will address, what providers assume about clients. In addition, when there

is a discrepancy between what the provider expects and the client's actual attributes and characteristics, there is incongruence and the potential for stigmatization exists, unconscious and unintended, but destructive nonetheless. Another element of Goffman's symbolic interactionism guiding this study is his proposition about a stigmatized person's social coping strategies. That a person is seeking mental health services, their discreditable stigma, often a concealable condition, is known. Goffman hypothesizes the use of withdrawal and social isolation as coping mechanisms employed by those living with discredited stigma. If the mental health service environment is similar to other social environments where stigmatization of mental illness occurs, then the consumer is likely to withdraw from the service environment, perhaps not seeking needed services or attending treatment, in an effort to avoid stigmatizing situations. In this way, Goffman's symbolic interactionism provides this study's impetus, to destigmatize the service environment, so that clients will actively engage in services, and so that effective programs, services, and treatments can be offered and used by those who need them most.

Attribution theory. The next theory that has guided the proposed dissertation is attribution theory which, in the simplest of terms, refers to the influence of a perceiver's attribution of responsibility for and controllability of a condition on their assessment of a person and even their willingness to help. Initially introduced by Heider (1958) attribution theory's main proposition is that people have an innate motivation to discover causal relationships, reasoned understanding of everyday actions and behaviors (Weiner, 1980). In their attempts to understand their environment, individuals make assessments, or attributions about the stability and controllability of causes of life events and circumstances. These are the two dimensions on which attribution is made: stability of a condition's causality and controllability of causes. Stability of causality refers to the temporal nature of a cause, whether it is stable and unchanging, or whether the cause

is flexible and/or potentially improving (Weiner, 1985; as cited in Corrigan, 2000). This dimension of attribution theory is helpful in understanding provider attitudes and actions, namely if the provider believes that a client's mental health struggles are stable in cause, unlikely to improve or change, then stereotypical beliefs about poor prognosis and paternalism are likely to be endorsed, leading to stigmatizing actions like encouraging a client to limit their life's goals and fostering dependence on the provider and mental health system. If, on the other hand, the provider believes the client's struggles to be temporally limited, capable of improving, then that provider may be more likely to embrace recovery-based ideologies of treatment, moving away from provider stigmatizations.

The second dimension on which attributions are made is the controllability of cause, which refers to the extent to which an individual is able to exert effort and influence over a cause (Weiner, 1985, 1993; as cited in Corrigan, 2000). More blame and responsibility will likely be attributed to an individual if the causes of a predicament are believed to be in the person's control. A further delineation of is made regarding onset and offset controllability. *Onset* controllability is the perception of whether a person had control over contracting an illness or initiating their present difficulty, whereas *offset* controllability refers to the person's perceived ability to cope with a difficulty which they had no fault in initiating (Schwarzer & Weiner, 1991). This second dimension of attribution theory is helpful to understand provider stigmatization. If providers believe that their clients have control over the causation and onset of their mental health difficulties or control over their ability to cope with challenges, attributions of responsibility and blame are likely to be influenced. For example, if a provider believes that their client is experiencing a resurgence of psychotic symptoms because of willfully not adhering to a prescribed medication regimen, it is likely that offset controllability beliefs are at work, that

the provider believes the client's trouble is attributable to their resistance and noncompliance. The decisions that a provider makes about if, when, and how to assist their client will be influenced by their attribution of the client's offset controllability.

Attribution theory is helpful to understanding how provider stigma is formed, in that attributions of causality and controllability are made in a search for understanding one's environment. These attributions will need to be attended to when assembling the item pool from which the proposed measure will be formed. Research has indicated that attributions of causality and controllability influence a helper's decision to help and what help they offer (e.g. Batson, 1975). If attributions are made based on stereotypic beliefs about the person with mental illness, thus flawed, decisions about care are perhaps equally flawed. In an effort to provide services that are truly responsive to mental health service clients, these attributions must be explored, identified, and brought out into the provider development discourse.

Modified labeling theory. Another theory that has informed this dissertation is modified labeling theory, originally formulated in an effort to help understand the phenomenon of self-stigma (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989.) Based in the work of Mead (1934) and symbolic interactionism these authors (Link, et al.) build a framework for understanding the process by which individuals come to personally apply public stigma. It is through socialization that individuals are familiarized with commonly held ideas about what persons with mental illness are like. Regardless of whether or not someone will one day be a psychiatric services consumer, they learn society's stigmatizing beliefs about persons with mental illness (Link, et al.). This socialization is akin to the development and adoption of Mead's *generalized other*, defined above. According to Mead, the individual internalizes the generalized other, without exception, because this is the mechanism through which internal

conversation and self-reflection are possible. When an individual is treated for psychiatric distress, they may receive an official label (a psychiatric diagnosis) or an informal label, like psychiatric patient (Link, et al.). The internalized beliefs, the attitudes of the generalized other (Mead), now become personally relevant (Link, et al.). The individual thus begins to question whether the internalized societal beliefs about mental illness, learned prior to becoming a consumer, apply to oneself (Link, et al.). When these beliefs are deemed to be legitimate and applied to oneself, self-stigmatization develops (Corrigan & Watson, 2002) along with its incumbent detriments to self-esteem, social opportunities, and perceived self-efficacy.

As indicated above, this theory is concerned with the development of self-stigma, but informs this study's rationale in two key ways. From the perspective of the service consumers, if they are seeking services in an environment that is stigmatizing, where employees are reinforcing stigmatizing beliefs already endorsed in the general public and in the socialization of the client themselves, then contact the providers will only reinforce these stigmatizing beliefs. Once reinforced, these beliefs are more likely to be accepted and personally applied by the service consumer, resulting in self-stigmatization. Thus, modified labeling theory confirms that impetus for this study: a less-stigmatizing service environment should be sought, so that when clients seek services the stigmatizing belief that they already hold are not confirmed by the very people from whom they are seeking assistance. If the service setting is free of stigma, then perhaps the stigmatizing beliefs that are brought with the consumer to the service environment will be disconfirmed and discarded.

This theory also informs the present study in another way, from the perspective of the mental health provider. Providers are also socialized with the same attitudes and beliefs about persons who are labeled as having a mental illness. They are also socialized in an environment with the

same stereotypical beliefs about persons who provide services to persons with mental illness (See Chapter 1). Taking this approach, if a mental health provider believes that the negative beliefs about mental health providers are accurate (e.g. mentally unstable, ineffective, unprofessional) then they are more likely to self-apply these stereotypes, and experience a similar detriment in self-esteem and self-efficacy. Understanding the self-stigma that some mental health providers bring to the service setting, and perhaps project onto their clients, will inform conceptualization of the phenomenon of provider stigma and its manifestations in provider attitudes and behaviors. This being so, items related to self-stigmatizing motivations for a provider's attitudes and beliefs were considered for inclusion, but were ultimately not present in the final item pool.

Experience-based model. The final stigma-related theoretical foundation of this dissertation is a conceptual model developed in a personally conducted previous study (Charles, 2013). The model was the main result of a qualitative research study that I conducted as part of my doctoral education. The research study is described as an ethnographic content analysis making use of client and family-authored personal account literature that focused on the service receipt experience. Ethnographic content analysis (ECA) is a qualitative data analysis method introduced by David Altheide (1987) and utilized in other analyses of text-based data (e.g. Besel, Zimmerman, Fruhauf, Pepin, & Banning, 2009; Gormly, 2004). ECA has been used in studies seeking to develop theory, and is also suited for description and definition of phenomena (Gormly). For my study, the published memoirs of mental health service consumers or their families were read, unitized, and analyzed for themes, resulting in a five-theme model of provider-based stigma. This model serves as the guide for this dissertation's instrument item pool development. Before describing the model in detail, this study's method is reviewed,

having been described in detail elsewhere in a published manuscript (Charles, 2013). The following description is meant to provide support for the model's trustworthiness as the framework by which the dissertation's items were generated.

Initially, I began my qualitative research by assembling a purposive sample of client and family-authored books. This sample was generated through a search of Amazon, the largest online retailer of books, using the search terms "mental health services, books, biography." The results of this search were then sorted in order of "Best Selling." This type of search strategy is not uncommon in sampling literature for an ECA. Besel and colleagues (2009), for example, initially used a similar Amazon-based literature search in their ECA of bridal wedding advice literature. Based on a review of each book's description, potential memoirs were next placed in order of probable relevance to the experience of provider-based stigma. Books were identified as appropriate for inclusion if they met the following criteria: published within the last twenty years; the work was either a personal memoir, a collection of stories, or a family account; the principal character described a diagnosis involving a major mental illness (bipolar disorder, schizophrenia spectrum disorder, or major depressive disorder); 'mental health services' was mentioned in the title, abstract, or table of contents. A list of the first 10 books meeting these criteria was assembled as the study's sample, however only seven books were analyzed, because thematic saturation being reached (Charles, 2013). Data collection and analysis were guided by Altheide's (1987) work on ECA, consisting of "reflexive movement between concept development, sampling, data collection, data coding, data analysis, and interpretation" (p.68).

A basic, initial data coding protocol was employed guided by Hayward and Bright's identification of stigma underpinnings, described previously. Primarily responsible for data itemization and coding, I relied on my personal knowledge, professional experience in a public

mental health service setting, including close individual clinical work with clients living with psychotic disorders, in addition to the coursework I completed at the doctoral level that focused on qualitative data-analysis. Each book's narrative text deemed relevant to the study was unitized and coded into existing and emergent themes in a manner described by Silverman (2009) as an iterative process moving between the data and the classification system. As new data emerged that failed to fit into the initial framework, new categories were created. ECA has been referred to as an informal version of the constant comparative method, where new information is compared to already existing information, (i.e Gale & Newfield, 1992, Strauss, 1987, as cited in Smith, Sells & Clevenger, 1994). The categories were reviewed, linked, and recoded. Trustworthiness and dependability of the findings were strengthened through the use of constant comparison, including the use of multiple pieces of literature, and external review via consultation and review of the study's method and findings with a senior social work faculty member.

As a result of employing this method, my research yielded a five-themed model of provider-based stigma. The five themes capture what provider stigma looks like to clients and families. These themes include blame and shame; provider disinterest, annoyance and/or irritation; degradation and dehumanization; poor prognosis/fostering dependence; and coercion and lack of 'real' choice. Each of these themes is briefly described here, as they guide item pool development for the construction of the measure. A graphic to aid understanding is provided below in Figure 3.

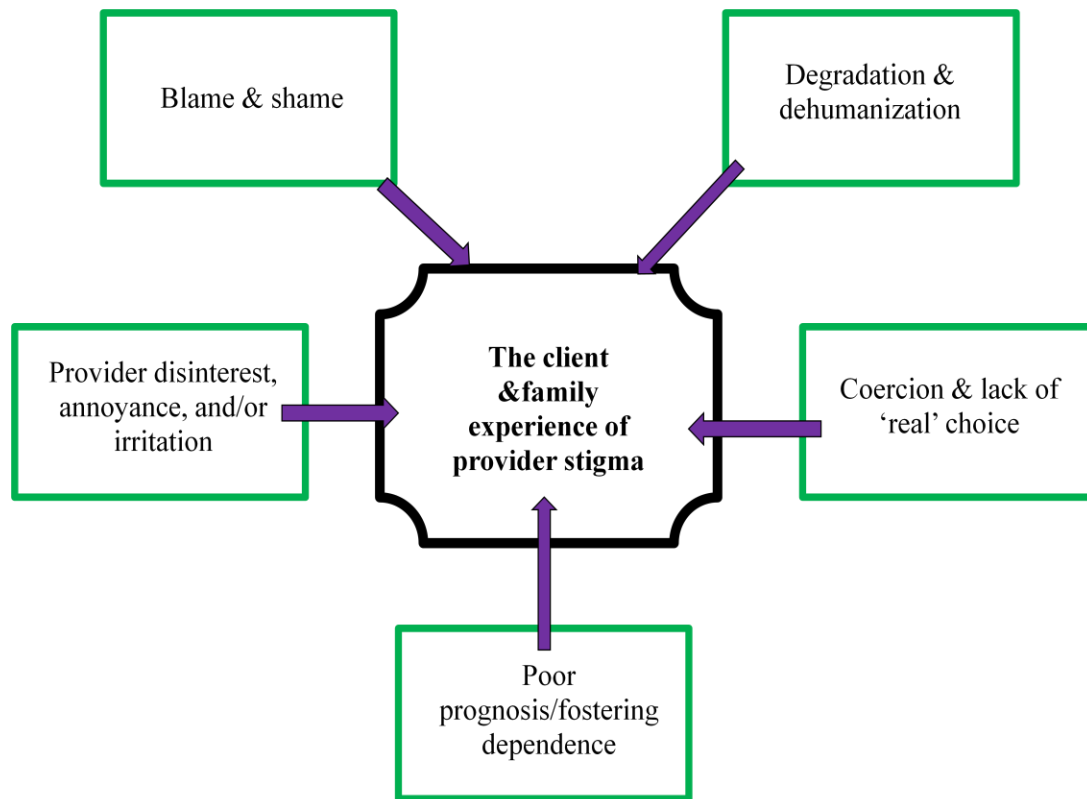


Figure 3. The experience based model of provider-based stigma.

The first theme of the model, *blame and shame*, refers to the experience of clients and families that their provider blames them for their difficulties, the illness they experience, and for less-than-expected progress in treatment – in addition to shaming attitudes as ‘less-than’ as the result of having a mental illness. Underlying the experience of blame is the provider’s perception that the client is somehow behaviorally responsible for the presentation and continued manifestation of symptoms. Next, *provider disinterest, annoyance, and/or irritation*, includes the experience of clients and families of mental health providers as being uninterested in concerns, as well as being annoyed and irritated with requests for information, attention, or assistance. The third identified theme, *degradation and dehumanization*, refers to the experience of clients and families as being treated as if they were of a lower social status or treated in a way

that deprives them of their human qualities, personality, or spirit. Examples of this include instances when providers discuss clients and their care in front of clients, without involving them, thereby placing them in a social position that is lower than the provider, in addition to implying that the client's voice is not as important or accurate as the provider's (Charles, 2013).

The fourth theme of the conceptual model, *poor prognosis/foster dependence*, includes the experience of consumers and families that their mental health providers subscribe to the belief that they (or their loved one) will not recover, improve, or otherwise achieve life goals to which the average person aspires. In addition to the pessimism of poor prognosis, fostering dependence is the perception of clients and families that providers promote dependence on mental health services, support services, and medication. These ideas are interwoven: A provider who endorses ideas of poor prognosis is likely to believe that, for their client's own good, treatment and life goals should not be set too high and the client should not stray too far from the safety of support services. The final theme identified in my model (Charles, 2013) is *coercion and lack of 'real' choice*, which is experienced by clients and families as occurring when the client's choices are externally influenced by the provider and the service provision environment. In addition, lack of 'real' choice reflects the client's experience of making decisions without having access to all possible alternatives. For example, choices about which a client may feel they do not have all available options include medication adherence, voluntary versus involuntary commitment, and utilization of supported housing versus independent living options.

In addition to guiding the item pool generation for the proposed measure, my findings and conceptual model also provide justification for this dissertation. This analysis indicates that a provider's negative attitudes, beliefs, and behaviors toward clients are, in fact, perceived by

clients and their families and harm the helping relationship, decrease satisfaction with the service receipt experience, and perhaps even thwart treatment outcomes.

Measurement theory. As the present study is a measurement development and assessment of initial psychometric values, a review of the basics of measurement theory seems in order, as it guides this dissertation's fundamental task. *Measurement* is defined as the assignment of numerals to objects or events (or people) according to rules (Stevens, 1946). *Measurement theory* is described by Krebs (1987) as the conceptual foundation of all scientific decisions, and is concerned with the rules that influence the assignment of numerals to objects, events, and or people. More specifically, Allen and Yen (1979) describe measurement theory as a branch of applied statistics that describes, categorizes, and evaluates the quality of measurements. The general idea is that measurements can be created, validated, and improved based on these 'rules' in a way that accurately and reliably provides information about a phenomena or object. DeVellis (2003) further clarifies that classical measurement theory is based on the assumption of parallel 'tests,' each item of a measure 'tests' for the variable of interest and reflects the value of that variable in the object or person being tested. As applied to this study, measurement theory guides the basic presumption that the phenomenon of provider stigma can be measured in an individual, based on different tests (items) that each assesses levels of the variable in a respondent, provided appropriate rules for reliability and validity are observed.

Self-assessment. While not a theoretical orientation, the nature of self-assessment measurement requires more in-depth discussion, particularly as it relates to its usefulness in professional development and stigma-related research. Self-assessments include those measures that ask individuals to evaluate and rate their own attributes, such as skills, attitudes, or knowledge (Allen & van der Velden, 2005). Klenowski (1995) further defines self-assessment

as the evaluation or judgment of one's strengths and limitations in an effort to improve one's performance. Self-assessment is frequently used in professional education and continuing training programs, and has been shown to be effective in "improving learning outcomes, future professional development, and lifelong learning..." (Dearnley, & Medding, 2007, as cited in Yoo, Son, Kim, & Park, 2009, p. 585). Across disciplines, *professional development* encompasses learning that serves to maintain and further develop a broad range of competencies, skills, and attitudes across a variety of professional groups (i.e. medicine, social work, law). The use of self-assessment in professional development is supported in the literature (e.g. Beyeler, Westkamper, Villiger, & Aeschlimann, 2004; Yoo, et al.) inclusive of its various forms, such as video-based and multiple choice questions.

An example of a self-assessment instrument used in professional and agency development, specifically targeting attitudes of stigma and discrimination, is the *Self-Assessment Checklist: Stigma and Discrimination* produced by collaboration between the International Council of AIDS Service Organizations and the African Council of AIDS Service Organizations. Specifically, this self-assessment is for use by non-government organizations to assess their agency's effort related to the stigmatization and discrimination against people living with AIDS or HIV. This tool is part of the UK Consortium on AIDS and International Development's initiative, *NGO Code of Good Practice* (2013), and agencies can use this self-assessment to facilitate an appraisal of their efforts to address stigma and discrimination. There are a number of other self-assessments produced by this initiative to facilitate professional and agency development in other areas, like advocacy, harm reduction, and prevention services.

Some of the advantages of a self-assessment measure are argued by Richter and Johnson (2001) and include ease of administration, easily quantifiable data, inexpensive to produce, and

capable for use in multiple administration mechanisms (internet, telephone, paper questionnaire). Additionally, a key advantage of the self-assessment, especially relevant when addressing provider stigma, is that the individual has access to information about themselves to which outside observers are not likely privy (Allen & van der Velden, 2005). In contrast, there are limitations to self-assessment that must be kept in mind when using and developing these measures. Essentially, the greatest limitation is the high likelihood of measurement error, unintentional error resulting from confusing items and intentional error, particularly social desirability bias. Especially relevant in developing a self-assessment of provider stigma, social desirability bias occurs when measurement respondents intentionally alter their responses to items in order to appear more 'normal' or display less of an undesired characteristic (Allen & van der Velden). However, in the context of the proposed measurement, the intention is that this measure will be useful in professional development and continuing education training sessions. A respondent's answer to particular questions and final score is intended to only be used by the individual in self-evaluation of their own practice and levels of stigmatization, not to single them out for discipline. For this reason, the responses may be less susceptible to social desirability bias, especially when compared to a measure whose responses and scoring are to be used for reporting outcomes, program evaluation, and treatment progress monitoring.

With these strengths and limitations in mind, it is important to note that self-assessment as a means of measurement is an often used strategy in research, for example Davis, Mazmanian, Fordis, Harrison, Thorpe, and Perrier's (2006) systematic review of medical research that compared self-assessment to external-assessment. Davis and colleagues describe their data extraction that involved strict inclusion criteria. Prior to exclusion, however, their review initially revealed 198 studies that used self-report and 91 studies that reported on self-assessment

or construct development. While these studies were excluded from Davis and colleague's review as they did not meet their study's objectives, they are indicative of the widespread use and development of this type of instrument. Given the usefulness of self-assessments, the following stigma-related research review is provided, focusing on empirical studies of stigma's incidence, interventions, and developed measures. In addition, keen attention is paid to the utility of these self-assessment measures.

Pertinent Research

This review focuses on studies investigating interventions intended to address public, self, and provider stigma, paying particular attention to existing measures of these stigma sub-types, including the self-assessment format. In addition, the limited applicability of these measures to provider stigma (in the case of public and self-stigma measures) or their shortcomings as existing provider stigma measures will be highlighted.

Key measures of public stigma. As a general type of stigma measure, social distance is identified by Link, Yang, Phelan, and Collins (2004) as one of the most commonly used measures. Essentially, social distance measures seek to assess a respondent's willingness to interact with a target person in different types of social relationships. The social relationships differ in terms of their level of closeness. According to Link and colleagues, Bogardus (1925) was the first to use social distance as a measure of racial attitudes. Cumming and Cumming (1957) were the first to use social distance measuring public attitudes toward persons with mental illness. Key limitations to the use of social distance as a measure of stigma include the propensity for social desirability bias, present when responses are influenced by what the respondent wants people to think they think. Inferring behavioral responses from reported intentions is another notable limitation of social distance. The relationship between a

respondent's intention and actual behavior may be unknown. In addition, social distance as a measure of provider stigma leaves something to be desired; providers are already in social relationships with clients, asking if they would be amenable to closer social relationships asks providers to theoretically cross professional boundaries, introducing a confounding variable. Lastly, social distance does not encompass the unique features already implicit in the helping relationship and does not reflect a client's experience of provider stigma.

As an example of social distance's use in stigma measurement, Brown, Evans, Espenschade, and O'Connor (2010) explore the effectiveness of two brief interventions targeting public stigma, measuring outcomes in terms of desired social distance and negative emotions. The two interventions, filmed contact and simulated hallucinations, were based on elements of contact and education methods of stigma-reduction, respectively. Filmed contact involved the participant viewing a videotaped interview with a person identifying as having a mental illness. The simulated hallucination intervention utilized technology to mimic the experience of auditory hallucinations. The study employed a sample of undergraduate students, so results are not likely generalizable, but the findings are informative. Support was found for the appreciable effects of filmed contact on one's willingness to interact with an individual living with a mental illness – supporting the effectiveness of contact-based interventions at reducing stigma. In contrast, however, the simulated hallucination group expressed higher levels of desired social distance and higher negative emotions *after* the intervention, highlighting the need for contextual development, perhaps coupling the simulation with a contact-based program.

The effectiveness of NAMI's In Our Own Voice (IOOV), both 90 minute and 30 minute versions, has been evaluated in a recent study by Corrigan and colleagues (2010). Effectiveness was measured using Life Story Memory Test (LMST). This measure involves participants

viewing a three-minute videotape in which an actor is labeled “mentally ill” and tells life story. Each video narrative includes 20 items: 10 positive and 10 negative statements reflecting stereotypical attitudes. For example, a positive statement made in the video is “I work as an engineer” (Corrigan, et al., p. 520); a negative statement is “Sometimes I believe I’m George Washington” (p. 520). As an outcome measure, the LMST begins with respondents viewing the three minute video. Next, participants engage in an interference task, described as an unrelated activity that serves as a distraction, providing cognitive distance from the content they just learned. After this interference task, respondents return to the video’s content, and write down as many of the statements from the narrative video that they remember. The ratio of positive versus negative statements recalled is the outcome measure, where more positive statements reflect lower levels of stigma and more negative statements indicate higher stigma. Corrigan and colleagues found that after engaging in an IOOV training, either 30 or 90 minutes in length, participants remembered more positive statements compared to persons in a comparison group, indicating less stigmatizing beliefs.

A specific instrument used frequently in public-stigma focused studies, the Opinions about Mental Illness Scale (Cohen & Struening, 1962; Struening & Cohen 1963), was developed using responses of nearly two-thousand employees of large psychiatric hospitals. Despite being developed using data elicited from mental health providers, this measure is more accurately classified as a public stigma attitude measure, and is frequently used as such (e.g. Rahav, Struening, & Andrews, 1984; Leong & Zachar, 1999). Initially, this instrument included 70-items, but this number was reduced in a subsequent paper to 51 by only including those items that specifically address mental illness. The response mechanism was a Likert format, six-point agreement continuum. Five factors were identified: authoritarianism, benevolence (a kindly

paternalistic view of clients), mental hygiene ideology (a positive orientation endorsing the idea that mental illness is an illness like any other), social restrictiveness (people with mental illness are dangerous and a threat to society and should therefore be restricted in their functioning, during and after hospitalization), and interpersonal etiology (based on the belief that mental illness results from interpersonal experience, particularly deprivation of parental love). The internal consistency statistics of the five-factor's subscales were adequate, coefficients ranging from 0.65 (interpersonal ideology low) to 0.80 (authoritarianism high), with the exception of the mental hygiene ideology subscale, with coefficients ranging from 0.29 – 0.39 (Struening & Cohen, 1963). An exemplar of the scale's items, related to the authoritarianism factor is: "The best way to handle patients in mental hospitals is to keep them behind locked doors." Similarly, related to the benevolence factor, "Patients in mental hospitals are in many ways like children." An example of an item measuring what has been called the mental hygiene factor: "Mental illness is an illness like any other."

This instrument was developed using responses from employees of large mental hospitals, making the potential for application to assessments of provider stigma promising. The scale is a self-assessment, in that providers are asked to rate their agreement with statements about people with mental illness, and composite scores yield indicators of levels of endorsement on different dimensions of stigma. While this measure asks questions intended to elicit attitudes toward persons with mental illness, the scale is very easily used in surveys of the general public. The focus of the scale is not on how stigma can be expressed and perceived in the hospital or the helping relationship, but rather attitudes about people with mental illness in general. Indeed, the attitudes that are assessed are those that could be endorsed by any member of the general public, not specifically the employees of the mental hospitals.

The next measure of public stigma made use of Cohen and Struening's (1962) OMI as a conceptual base. The Community Attitudes Toward the Mentally Ill scale (CAMI), developed by Taylor and colleagues (Taylor, Dear, & Hall, 1979; Taylor & Dear, 1981) intends to assess public attitudes toward mental illness, with a particular focus on assessing attitudes related to community mental health treatment and service users residing in the community. While the OMI has a five-factor structure, the CAMI has only four. The CAMI's four factors include three taken from the OMI: authoritarianism, benevolence, social restrictiveness, (these first three are similar to the OMI) and community mental health ideology. The CAMI scale included 40 items, 10 for each factor. Five of each factor's items were positively worded, five were negatively worded. Only seven of the 40 items were carried over from the OMI. The CAMI assessed attitudes of respondents, with respect to these four factors, by asking for their agreement with declarative statements using a five-point Likert scale. For example, with respect to authoritarianism, the CAMI states "As soon as a person shows signs of mental disturbance, he should be hospitalized." Another example, related to the factor of social restrictiveness, is the statement "I would not want to live next door to someone who has been mentally ill." The four subscales ranged in internal consistency with coefficients falling between 0.68 for the authoritarianism subscale to 0.88 for community mental health ideology (benevolence subscale coefficient = 0.76; social restrictiveness = 0.80).

This measure has limited applicability to the assessment of provider stigma, for many of the same reasons as the OMI, but also because of the scale's focus on attitudes toward community care. It is unlikely that providers would not be in favor of community care, if they are employed in community care. In addition, the attitudes that are assessed are those that are potentially

endorsed by any member of the general public, which is applicable to providers, but neglects to include elements that are unique to the experience of provider-based stigmatization.

Another frequently used measure of public stigma, based on Weiner, Perry, and Magnusson's (1988) investigation of attribution-based reactions to stigma, is The Attribution Questionnaire developed by Corrigan (2003) specifically assessing stigma of mental illness. In contrast, Weiner et al.'s investigation made use of an un-named measure, posing eight questions for each of 10 illnesses/conditions (Alzheimer's disease, blindness, cancer, heart disease, paraplegia, Vietnam War syndrome, AIDS, child abuse, drug abuse, and obesity). Per condition, three questions using nine-point scales to assess responsibility, blame, and changeability and five questions about the liking, pity, anger, charitable donations, and personal assistance to those with each of the conditions. Corrigan's measure, the Attribution Questionnaire comes in one of two forms for adults: the 27-item version and a shortened 9-item version. Initially, respondents review a vignette describing a man, Harry, who lives with schizophrenia. Respondents are then asked to indicate their level of agreement with 27-items designed to assess different stereotypes. Using a 9-point Likert scale, respondents answer questions about Harry and concerns they might have about him. Specifically, six stigma-related constructs were addressed: personal responsibility (alpha coefficient = 0.70); pity (0.74); anger (0.89); fear (0.96); helping (0.88); coercion/segregation (0.89). For example, in response to the declarative statement "Harry would terrify me" respondents indicate on a scale from 1 (not at all) to 9 (very much) their agreement with the statement.

The Attribution Questionnaire, a self-report measure, likely has limited applicability to ascertaining levels of provider stigma, with the exception of those items related to blame and coercion. Specifically, items that address a provider's blame of a client for their difficulties

seem relevant. Also of interest are items assessing the need for and use of coercive methods in treating a person with a serious mental illness. In contrast, the items that are targeting dangerousness, fear, and avoidance seem superficial, mostly useful in assessing attitudes of persons in the general public who do not have frequent contact with persons living with mental illness. It is unlikely that providers will indicate being ‘terrified’ by a client who is exhibiting psychotic symptoms. More likely, this idea of dangerousness will manifest itself in other ways, such as decisions about where and how the provider meets with their client, for example. In addition, the use of a vignette featuring a hypothetical client does not seem necessary for a provider-based survey. Corrigan’s (2003) measure uses the hypothetical Harry, but a measure intended for providers could use a scale directive that asks them to ‘recall a client diagnosed with schizophrenia’ or a similar statement.

As a measure of emotional reactions of the general public toward people living with mental illness, Angermeyer and Matschinger (1996) developed and used the Emotional Reaction to Mental Illness scale. This measure involved the use of a case history vignette, followed by 18 items with responses given on five-point Likert scales. Each of the 18 items assessed a single emotional response to the individual depicted in the case history. The emotional reactions were characterized by three factors: aggressive emotions (i.e., anger, irritation, disgust), prosocial reactions (i.e., desire to help, sympathy, concern, compassion), and feelings of anxiety (i.e., uneasiness, embarrassment, fear).

This scale has dimensions that are useful to measuring provider stigma because provider stigma involves negative emotional reactions that providers experience. However, because emotional reactions, also referred to as prejudices, are only one aspect of stigma, this measure would be incomplete as a stand-alone measure. Angermeyer and Matschinger use this scale in

conjunction with a measure of social distance, perhaps recognizing that emotional reaction is only one element of stigmatization. That being said, it is also possible that the emotional reactions of the general public are not totally representative of the provider, as the provider is also likely to be coping with contextual challenges that further complicate their emotional lives and reactions.

Another measure that is used in public stigma research is Link's (1987) Perceived Devaluation-Discrimination scale for use with the general public. This scale asks respondents about what 'most other people believe' about persons with mental illness. This 12-item scale uses a six-point Likert scale, 1=strongly disagree, 6=strongly agree, where respondents indicate to what extent they agree with statements indicating that most people devalue current and/or former mental health clients. The scale shows adequate reliability ($\alpha = 0.78$). The main limitation of this measure for use with mental health providers is that it does not include elements unique to the helping relationship or the roles of providers that are influenced by provider stigma (i.e. one-sided treatment planning). Answering from the perspective of 'most people' does not seem an adequately personal approach to measuring a mental health provider's attitudes. In addition, attitudes are only one element of provider stigma, with behaviors being an important missing piece of this measure.

A 1999 study by Wahl uses a measure of perceived public stigmatization in a nationwide survey of service consumers. This measure of experienced public stigma, which Wahl titled the Consumer Experience survey, includes three main sections: stigma, discrimination, and demographics/diagnostic information. The Stigma section included nine questions about respondent's interpersonal experiences as consumers of mental health services. Specifically content in this area addressed an individual's treatment by others, negative things seen or heard

about mental illness, and fears and coping strategies regarding disclosure. The extent of the respondent's experience with a particular item was reported on a five-point Likert scale ranging from 'never' to 'very often.' An example of a Stigma sub-section items is: "I have worried that others will view me unfavorably because I am a consumer" (Wahl, p. 471). The Discrimination sub-section included 12-items that explored the extent to which clients experience discrimination in the pursuit of life goals, like getting a job, renting an apartment, and also how they were treated in law enforcement contexts. The same five-point Likert scale is used in this section to record experience frequency. An example of a Discrimination sub-section item is "I have had difficulty renting an apartment or finding other housing when my status as a consumer was known" (Wahl, p. 472).

Wahl's (1999) Consumer Experience survey looks at the client's experience of mental illness related stigma and discrimination. It is concerned with perceived public stigma, not the internalization and self-application of this stigma, so it is not a self-stigma measure. There are items contained in the measure that may inform a measure of provider stigma, but the scale is not sufficient to address the complexities of provider stigma. Examples of useful items include from the stigma sub-scale: "I have been advised to lower my expectations in life because I am a consumer"; and from the discrimination sub-scale: "I have been denied mental health treatment because my health insurance was insufficient for me to pay the cost of treatment." This scale is a self-administered instrument that clients use to report their perceptions of stigmatization. It is not especially useful in provider's self-assessment as the stand-point is the consumers. However, it is possible that these two items above could be used, if reworded to reflect the provider as a survey respondent.

The final public stigma measure reviewed was developed and reported on by Day, Edgren, and Eshleman (2007), The Mental Illness Stigma Scale. Guided by Jones and colleagues (1984) theory of stigma, in which six dimensions are identified as commonly being associated with stigma: (a) concealability - can the ailment be hidden?; (b) course - how will the illness progress over time?; (c) disruptiveness - will the condition disrupt daily living and interpersonal relationships?; (d) aesthetic qualities - is the illness ugly, hard to look at?; (e) origin - what is the disorder's cause?; and (f) peril - is the disorder self or others- destructive? The scale begins with a vignette, describing one of several mental illnesses and their symptoms. The scale asks about the opinions of the respondent about the illness and the person with the illness. Using a seven-point Likert scale, respondents are asked to rate their agreement (1 = completely disagree, 7 = completely agree) to a series of 28 items, each representing one of seven factors: anxiety, relationship disruption, hygiene, visibility, treatability, professional efficacy, and recovery. For example, this item is intended to address relationship disruption: "A close relationship with someone with [a mental illness] would be like living on an emotional roller coaster" (Day et al., p. 2218). The brackets around 'mental illness' indicate where the investigator may substitute in a specific diagnostic label like schizophrenia or major depressive disorder. Another example, intended to address attitudes related to hygiene asks a respondents agreement to this statement: "People with [mental illness] tend to neglect their appearance" (Day et al., p. 2218). After administration to a developmental sample, the authors found that items loaded onto three conceptually distinct factors, resulting in subscales with adequate reliability: Treatability ($\alpha = 0.71$); professional efficacy ($\alpha = 0.86$); and recovery ($\alpha = 0.75$).

The Mental Illness Stigma Scale (Day et al., 2007) measurement is a self-report assessment, asking the respondent to provide answers to the questions based on their own attitudes toward

persons with mental illness. In a study also conducted by the authors, a sample of respondents were asked to complete the survey based on an assumed identity of a person with a mental illness, and how they would answer the questions. In addition, the scale was also employed with a group of mental health service consumers, indicating that it could also be used as a measure of perceived stigmatization.

Specifically regarding the usefulness of this measure for assessment of provider stigmatization, items that are focus on treatability, recovery, visibility and anxiety seem to have the possibility of cross-application. For example, one item “Once someone develops [a mental illness], he or she will never be able to fully recover from it” would be useful in ascertaining whether or not a provider endorses ideas of poor prognosis. However, items that reflect factors of professional efficacy and relationship disruption are less applicable. For example, “Psychiatrists and psychologists have the knowledge and skills needed to effectively treat [mental illnesses]” would be more appropriate in a measure of self-stigma for use with providers. In addition, items related to relationship disruption are about generic interpersonal relationships and do not specifically address the complexities of the helping relationship. Another reason for this scale’s limited applicability for use with providers is that it is theoretically based on elements of stigma. These stigma elements are generic to all stigmatizable conditions, neglecting the unique features of the stigma of mental illness. Ultimately, this scale was not intended for use with providers and does not address the unique features of the client-provider helping relationship.

In light of this review of public stigma interventions and measures it is fairly clear that the existing measures of public stigma have limited utility for application to the measurement of provider stigma. Next, this review returns to another sub-type of stigma, self-stigma, and related

research and measures. Elements of these measures that have bearing on the study of provider stigma will be highlighted, particularly noting the use of self-assessments.

Self-stigma research and measurement. Self-stigma, another well-studied sub-type of mental illness stigma, refers to the negative attitudes and beliefs about people with mental illness that persons living with such illnesses are aware of, accept as valid, and self-apply resulting in detriments to self-esteem, self-efficacy, and social contacts (Corrigan & Watson, 2002). A study by Watson, Corrigan, Larson, and Sells (2007) investigates the relationship between group identification and perceived legitimacy on levels of self-stigma in a group of mental health service consumers. These authors found support for the development of self-stigma, namely that for an individual to develop self-stigmatization they needed to first be aware of the negative stereotypes associated with persons with mental illness. This study made use of the Self-Stigma of Mental Illness Scale (SSMIS), developed by Corrigan, Watson, & Barr (2006) measures self-stigmatization in the mental health service client using four subscales. Each subscale includes 10-items, assessing the extent to which respondents endorse stereotype awareness, stereotype agreement, self-concurrence, and self-esteem decrement, the four stages of self-stigma development. The items are answered by indicating the extent to which the respondent agrees with the statements using a nine-point Likert scale, ranging in values where 1 = I strongly disagree and 9 = I strongly agree. For example, respondents are asked to indicate their agreement on a scale of 1 to 9 their agreement with each of ten declarative statements following the stem “I think the public believes....” For example “I think the public believes... – ‘most persons with mental illness are to blame for their problems.’” Next, respondents indicate their agreement with each of ten declarative statements following the item stem “I think....” As an example, “I think... - most persons with mental illness are to blame for their problems.” The

next subscale asks to what extent respondents agree with the statement “Because I have a mental illness...” followed by one of ten items like “I am to blame for my problems.” The last subscale asks respondents to indicate to what extent they agree to each of ten declarative statements after the stem “I currently respect myself less.” For example “I currently respect myself less... – because I am to blame for my problems.” The internal consistency of the subscales, measured by Cronbach’s alpha, ranged from 0.72 for stereotype agreement to 0.91 for stereotype awareness.

This self-report measure is useful for its intended purpose, measuring self-stigma, but does not present much use in measuring provider stigma. The initial sub-scale, measuring stereotype awareness, makes use of the “what most people” believe model of question. This may have use for provider stigma measures, where the self-assessment intended for professional development may use items beginning with “Most mental health providers...” This may be helpful in reducing social desirability bias, but may also limit the necessary self-appraisal that provider stigma self-assessment measures would hope to produce.

Another investigation regarding the prevalence of self-stigmatization, Brohan, Gauci, Sartorius, Thornicroft, and the GAMIAN-Europe Study Group (2011) measured self-stigma levels in a sample of adults living with bipolar and depressive disorders in European countries. Making use of two scales, the Internalized Stigma of Mental Illness Scale (Ritsher, Ottilingam, & Grajales, 2003; Ritsher & Phelan, 2004) and the Perceived Devaluation and Discrimination Scale (Link, 1987), this study’s results indicate that the experience of self-stigma among adults diagnosed with bipolar disorder or depression is widespread. Over one-fifth of participants reported moderate to high levels of self-stigma. Most respondents reported high levels of perceived discrimination, indicating an awareness of negative public attitudes and behaviors toward persons living with mental illness, and high levels of perceived discrimination were

associated with higher levels of self-stigma. This finding indicates a strong association between perceptions of the outside world and how individuals internally perceive themselves.

The first measure used in this study, the Internalized Stigma of Mental Illness scale (ISMI), was developed by Ritsher, Otilingam, and Grajales in 2003 in collaboration with individuals living with mental illness, and is designed to measure the subjective experience of stigmatization (Rischer & Phelan, 2004). The instrument includes 29 items with responses recorded on a four-point Likert scale, with values ranging from 1 = strong disagree to 4 = strongly agree. Overall, the ISMI possesses good internal consistency with a reliability coefficient of $\alpha = 0.90$. The subscales of this measure, titled Alienation, Stereotype Endorsement, Perceived Discrimination, Social Withdrawal, and Stigma Resistance measure a respondents endorsement of stigmatizing beliefs and resulting alienation and social withdrawal. While this instrument seems to capture the process of self-stigma development and limitations it places on an individual once formed, it does not specifically address the experience of provider-based stigmatization, and is therefore of limited use in the present dissertation.

The second instrument used in Brohan and colleagues' study, Link's (1987) Perceived Discrimination-Devaluation Scale, is also used to measure self-stigma among consumers of services, in addition to public stigma. As mentioned, this measure contains 12-items using a six-point Likert scale, 1=strongly disagree, 6=strongly agree, where respondents indicate the extent they agree with statements indicating that most people devalue current and/or former mental health clients (themselves). This scale has adequate internal consistency reliability, when used with consumers of services, ranging from 0.82 to 0.86 (Link et al., 2004). As applied to provider stigma, limitations to this measure's usefulness exist, namely that the experience of provider

stigma includes elements of devaluation and discrimination that are not addressed in this measure.

Lastly, the Stigma Scale, developed by King et al. (2007) is a brief, self-report scale to measure stigma of mental illness based on service user's qualitative accounts of their feelings and experiences of prejudice and discrimination. This scale is very similar to Ritscher and colleagues' (2003) work, however this scale was presented as an alternative and improvement, based on potentially questionable psychometric properties and a small sample size used in Ritscher et al. and Ritscher and Phelan's (2004) work. The scale by King and colleagues includes 28-items forming three sub-scales, *discrimination*, *disclosure*, and *positive aspects*. The items were formed based on qualitative interviews with consumers of mental health services. The mention of the mental health service environment or provider is limited to one item that asks "I have been discriminated against by health professionals because of my mental health problems." There are other items that are generic in nature, but could be applicable to the experience of provider stigma, like "Sometimes I feel that I am being talked down to because of my mental health problems", which could be reworded to indicate being talked down to by mental health providers because of their mental illness.

This measure is a self-assessment intended for use by consumers, not providers or the general public. In application to provider stigma, this scale is likely not usable as a self-assessment for providers to determine their stigma levels, as it is for consumers. An alternative use could be if the measure was reworded to reflect the mental health service environment and providers, this measure could be administered to client groups and measure a client's perception of provider stigmatization, much like a customer satisfaction survey is used to measure quality of service.

While this review of self-stigma research and measurement is not comprehensive, it provides examples of the types of measures that are in common use. In addition, even though these measures are intended for use with service consumers as measures of self-stigma, it is helpful to find elements of these existing measures that may be useful in assessing provider stigma. In particular, items that address the being talked down to, devalued, or diminished are potentially applicable in a measure of provider stigma.

Provider stigma measures. Provider stigma has been sparingly addressed in the empirical literature, resulting in a similarly small pool of potential measures. Previously, stigmatizing attitudes of providers have been measured in the literature using traditional measures of stigma, for example, desired social distance (Finkelstein, Lapshin, Wasserman, 2008; Covarrubias & Han, 2011), expressed attitude toward individuals living with mental illnesses (Altindag, Yanik, Ucok, Alptekin, & Ozkan, 2006), life story memory tests (Corrigan, Rafacz, Hautamaki, Walton, Rüsçh, Rao, et al., 2010), attribution questionnaires (Corrigan, Larson, Sells, Niessen, & Watson, 2007), and behavioral intention (Chung, 2005). These measures have been used to assess the presence of stigmatizing beliefs with a variety of populations, for example with students, physicians, and nurses; professionals or soon-to-be professionals who may have interactions with individuals with mental illness. However, these measures were designed primarily for use in identifying stigmatizing attitudes in the general public. Literature has indicated that the attitudes of mental health professionals toward their clients may not be significantly different than the attitudes of the general public (Lauber, Anthony, Ajdacic-Gross, Rössler, 2004; Lauber, Nordt, Braunschweig, & Rössler, 2006; Nordt, Rössler, & Lauber, 2006), but it is likely that manifestations of these attitudes, and their resulting stigmatizing behaviors, would be different, especially because of the professional's frequent contact with the stigmatized group. Therefore,

it would be appropriate for studies interested in measuring professional stigma to use an instrument specifically designed for that purpose.

An example of an existing measure targeting attitudes of healthcare providers, in general, is the Mental Illness: Clinicians' Attitudes (MICA) scale developed by Kassam and colleagues (Kassam, Glozier, Leese, Henderson, & Thornicroft, 2010; Gabbidon, Clement, van Nieuwenhuizen, Kassam, Brohan, Norman, & Thornicroft, 2012). This measure was developed with for use with healthcare professionals, including, possibly, mental health providers. MICA is a 16-item scale using 6-point Likert scales as response formats. A response of 1 = strongly agree and 6 = strongly disagree. Internal consistency of MICA has been reported with an alpha of 0.79. There are a few versions of MICA, for example, one for use with physicians or medical students (Kassam et al.) and another for use with providers in health and social services (Gabbidon et al.). For example, both versions ask respondents the extent to which they agree with the declarative statement "People with severe mental illness can never recover enough to have a good quality of life" (Kassam et al., p. 159). Another example asks respondents the extent of agreement to the statement "Being a health/social care professional in the area of mental health is not like being a real health/social care professional" (Gabbidon et al, p. 5). The utility of this measure for assessing attitudes of mental health providers is questionable. While the items were developed using focus groups that included a small number of mental health service consumers and their experiences of stigmatization in the service environment, a significant focus of the measure is on the status of psychiatry, and mental health service provision, with respect to other fields. In addition, the neglect of physical ailments or misattribution of these physical concerns to mental illness is also addressed. These two

elements, professional prestige and detriments to physical health care, are not the consequences of provider stigma with which the proposed measure is concerned.

Another example of an existing measure designed to ascertain levels of provider stigma is a recent, work by Wilkins and Abell (unpublished, 2010), previously described in Chapter 1. This measure, the Mental Illness Stigma Scale for Mental Health Professionals is based on Link and Phelan's (2001) social-psychological theory of stigma development. The questionnaire's items are derived solely from an item pool formed by attending to the components that Link and Phelan argue embody stigma – labeling of difference, stereotyping, separating (us and them), and discrimination and therefore lack the specification for the development and expression of provider stigma in the service delivery environment. The scale begins by directing the respondent to imagine meeting a client who discloses an intense fear of rejection, a history of cutting themselves, prior suicide attempt, and hospitalization. The respondent is then instructed to indicate on a scale of 1 to 7 how likely (1=very unlikely; 7 = very likely) they are to endorse a statement, for example, “As someone who has studied mental health, I would be allowed to judge this person's behavior as nuts.” Next, respondents are asked to consider the person they have labeled as crazy or insane and indicate how likely they are to feel or act in a variety of manners, i.e. “Because of how I would feel around this person, I would consider this client as unpredictable.” These first two examples are intended to tap the labeling and stereotyping elements of Link and Phelan's definition of stigma, respectively. The next two elements of Link and Phelan's definition of stigma, separating and discrimination, are targeted in the last two sections of Wilkins and Abell's scale. To target separation, the scale asks: “Because of how I would feel around this person, I would be unsympathetic to this client because he/she is unlike most.” Addressing discrimination the scale asks: “As someone who has studied mental health, I

would be allowed to actively avoid this person.” As a measure of reliability, this scale’s global stratified alpha was 0.95.

Another measure of provider-based stigma, also briefly described in Chapter 1, is the Mental Health Provider Stigma Inventory, developed by Kennedy, Abell, and Mennicke (2014). The 24-item measure is separated into three sub-scales. The first measures provider’s attitudes; the second, provider behaviors; the third measures the influence of a provider’s coworkers. Survey-takers are given 7-point Likert Scales on which to indicate their level of agreement, where 1 represents complete disagreement and 7 - complete agreement. Examples of items, regarding attitudes, Kennedy and colleague’s scale asks for the respondent’s level of agreement with the following statement: “Clients are crazy.” To address behaviors, Kennedy’s survey gives the statement “I tell clients I am the expert” and asks for level of agreement. Respecting influence of coworkers, level of agreement is indicated to statements such as the following: “If my coworkers talked about how a client was incapable of change I would be more likely to give up on that client.” Reliability as measure via global stratified alpha was 0.95.

When considering the usefulness of Wilkins and Abell’s, as well as Kennedy and colleague’s, scale, the warning of Link and Phelan (2001) highlights the main limitation of these instruments. Namely, that the primary obstacle of those who study stigma, the social scientist who does not belong to the stigmatized group, does so from a theoretical vantage point and not from the lived experience of the mental health service consumer. This dissertation seeks to overcome this very challenge by incorporating a theoretical foundation that includes the lived experience of clients and family members.

Focus of the Study

The focus of the current study is the development of a reliable and valid self-assessment measure of provider stigmatization, centered in the client and family-member's experience of these stigmatizing attitudes and beliefs. A standardized measurement based on the lived experience of clients and families, geared toward assessment of these attitudes and behaviors in mental health providers, would address a gap in the literature that is characterized by a limited supply of mental health provider-focused measures and the absence of such measures based on lived experience. If attitudes and behaviors that are perceived by clients and families as less-than-helpful can be brought to the attention of providers, it is hoped that the mental health service environment and the experience of service receipt can be made as stigma-free as possible, thus allowing for the unimpeded delivery of services. With a clearer path, services are more likely to be effective, efficient, and meeting the needs of the clients and families who so earnestly seek safe haven.

Chapter Three – Methodology

This chapter describes the method by which the measurement of provider stigma was constructed and psychometrically evaluated. Beginning with an exploration of the philosophical assumptions underlying this research, a brief review of the general process of measurement development is provided. Next, the decisions about the development of this measure of provider-based stigma are specified, as well the method by which it has been evaluated.

Scientific Philosophy

Understanding the basic philosophical assumptions of this research project will be helpful in justifying the methodological decisions. This discussion makes use of Burrell and Morgan's (1979) paradigmatic framework to identify and explore the philosophical assumptions underlying the science of a measurement development study. Burrell and Morgan's framework consists of four paradigms, formed by the intersection of two distinct continua; the nature of reality on the horizontal continuum and the nature of society and the goal of scientific inquiry on the vertical. The nature of reality, Burrell and Morgan's horizontal axis, is formed with the idea of an objective reality on the right end and subjective reality on the left. Objective ontology refers to hard facts, 'Truth' external to human cognition, immutable laws that we can come to know through systematic inquiry. Subjective ontology, on the other hand, refers to the nature of reality that does not exist outside of human cognitions. It is socially created and must be experienced first-hand to gain an understanding of it.

On the vertical axis, Burrell and Morgan (1979) have depicted the range in the nature of society and the goals of scientific inquiry. At the bottom of the vertical continuum is "Regulation" which is the idea that society is ordered, if not rule governed, and that science is useful in understanding the status quo, achieving consensus, and knowledge for knowledge's

sake as an appropriate outcome of scientific inquiry. At the top of the vertical axis is “Radical Change” which offers a view of society as conflicted, if not chaotic. The goals of inquiry should focus on emancipation, addressing domination, and be geared to changing the status quo.

The intersection of these two continua, Subjective-Objective and Radical Change-Regulation form four corrals or paradigms. The first paradigm that Burrell and Morgan (1979) propose exists in the lower right hand quadrant of the intersection of the continua. This paradigm is referred to as the *functionalist* paradigm, which embodies an objective view of reality and a scientific process that seeks to understand a regulated society and the status quo. This paradigm is ontologically adheres to realism, where reality is thought to exist outside of human cognition. Epistemologically, how we come to know reality, the functionalist paradigm is positivist, whereby science seeks to understand external reality through systematic inquiry that stresses technique and imposes the methods of natural science onto the social sciences. A viewpoint in the functionalist paradigm maintains that human nature is deterministic, meaning basically that humans beings are defined by their environment and their reality, shaped by it, and react in predictable ways. Methodology in the functionalist paradigm is nomothetic, where natural science methods are preferred, systematic processes, resulting in generalizable findings.

The next paradigm proposed by Burrell and Morgan (1979) that lies at the lower left hand quadrant is termed the *Interpretive* paradigm. This corral is at the subjective end of the ontology continuum and at the regulation end of the goals continuum. Ontologically speaking, Burrell and Morgan argue that science and ideas that emerge from this paradigm view reality in a nominalistic manner, namely that reality exists within the human mind, that nothing really exists outside of our shared understandings of what things mean. Epistemologically, this paradigm produces work that is anti-positivist in that the value of finding permanent, causal relationships

for generalizability is of little use and that the only way to know about what exists is to have first-hand knowledge of it. In terms of views about human nature, inquiry emerging from this paradigm presumes a voluntaristic stance: Humans are active participants of their reality, they are not governed by it, and can alter it according to their needs and experiences. Inquiry emerging from the interpretive paradigm would likely subscribe to a methodology that is ideographic, aimed at coming to know individual's created reality by accessing firsthand knowledge.

Considering the present study, the philosophy of science on which it is based can best be described as emerging from the functionalist paradigm, as defined by Burrell and Morgan (1979). However, the theoretical framework, the conceptual model on which the construct of provider stigma is conceptualized was arrived at by research that more closely resembled inquiry emerging from the interpretive paradigm. The experience-based model personally developed, which is described in detail in Chapter 2 and elsewhere (Charles, 2013), reflects the lived-experience of clients and families regarding the perception of provider-based stigma. The model is used to understand the experience of provider stigma, based on the general notion that provider stigma does not exist outside of the experience of those who perceive it. So while the present research is a scale development, which typically is corralled in the functionalist paradigm because it is based on the assumption that the construct of interest can be observed and measured using methods generally utilized by the physical sciences (empirical evidence), it is based on theory developed out of the interpretive paradigm. Figure 4 illustrates Burrell and Morgan's paradigms and the current study's position within.

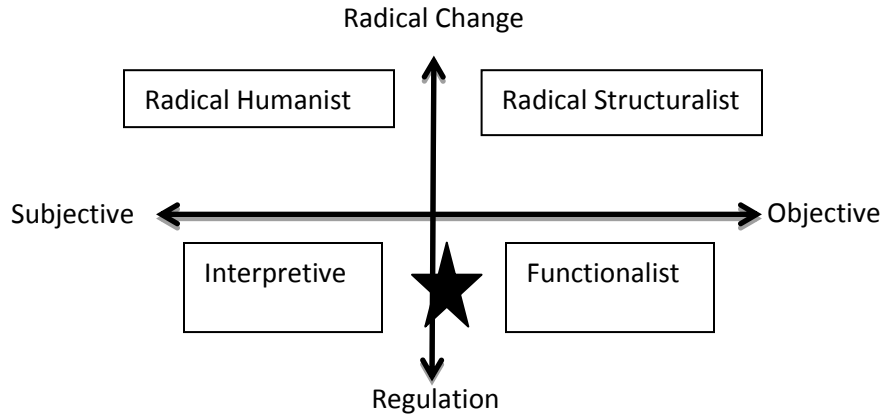


Figure 4. Burrell and Morgan's (1979) paradigmatic perspective and the current study's placement, denoted by ★.

Basics of Measurement Theory and Instrument Development

The argument developed in the previous two chapters can be summarized as follows: Provider stigma is an impediment to the provision of effective and compassionate mental health services and is another avenue through which persons living with mental illness experience oppression, devaluation, and degradation. Furthermore, the measures of mental illness stigma that are currently in use in research are inadequate in specific application to provider-based stigma. Guided by the philosophical assumptions of the functionalist paradigm, provider-stigma is a construct that, if adequately operationalized, can be measured with proper instruments. This is dissertation is the development, construction, and initial validation of a measure of provider-based stigma, based on the experience-based model of provider stigma, and developed in my previous research (Charles, 2013). The development of the measure was guided by DeVellis' (2003) work, who explicates eight steps for measurement development, which include the following:

1. Determining clearly what is to be measured;
2. Generating an item pool;
3. Determining the measurement format;
4. Having the item pool reviewed by experts;
5. Considering the inclusion of validation items;
6. Administering items to a pilot sample;
7. Evaluating the items; and
8. Optimizing the scale's length.

Provider stigma can be defined as a *theoretical variable*, meaning it is an intangible phenomenon, not readily observable by more objective means, based on an understanding of numerous theoretical models of stigma, in general, but a narrowly circumscribed phenomenon (DeVellis, 2003). On the other hand, more concrete and unambiguous variables, like age or years of experience in providing mental health services can be measured by a single question, resulting in an accurate measure of the concept. In order to measure theoretical variables, like provider stigma, scales are more appropriate. A *scale* is composed of a collection of *items* (different questions) targeting the theoretical variable. These items yield values that vary based on the underlying construct – for example, a higher score on a particular item may indicate a stronger effect by provider stigma, whereas a low score would indicate little influence by provider stigma.

Based on the work of Bollen (1989) and Bollen and Lennox (1991) the items of a scale can be referred to as *effect indicators* because they are affected by the latent variable (e.g. provider stigma). When scores on each of the scale's items are totaled, a composite score is yielded, and reveals *levels* of a theoretical variable. For example, the developed measure contains an item that

is intended to ascertain the provider's use of coercive persuasion in admitting clients to an inpatient psychiatric facility (item 25). The author could argue that this item is theoretically caused by provider stigma – the use of coercion to admit a client to an inpatient unit is an effect, or outcome, of provider stigma. It is helpful to note that the term 'effect indicator' does not necessarily describe strict causality, but rather the item is a 'manifestation' of the latent variable (Fayers & Hand, 1997).

Alternately, an *index* is a set of items that are considered *cause indicators*. A cause indicator is a variable that signals the presence or possibility of the underlying construct, but a collection of cause indicators may or may not be associated with one another (Bollen; Bollen & Lennox). For example, an index of provider stigma might include questions related to the provider's education, years of employment in their current position, and the number of clients in their care. Hypothetically, while less education, more or less years of employment, or a larger caseload may indicate a greater likelihood of provider stigma, these aspects are not the effect of provider stigma. Furthermore, these items may not be associated with one another in a linear manner, but they may still be associated with the latent variable of provider stigma.

In light of this overview of measurement basics, the following conclusion can be made: Provider stigma is a theoretical variable that requires indirect means of observation, and may be tapped by a collection of items or questions that will yield a composite score that reflects levels of provider stigma, low to high. The items of the developed scale are intended to serve as effect indicators, or manifestations, of provider stigma: the responses to the various items reflect the presence and intensity of different levels of provider stigma. This measurement can further be classified as a self-assessment, which is defined by its intended target, the providers themselves. Self-assessments and their use in professional development were discussed in Chapter 2's

Review of the Literature, and will be touched upon again in Chapter 5 as an implication or potential use of this study's developed measure. This dissertation begins with the following hypothesis and attempts to answer the accompanying research questions:

1. To what degree is the proposed measure a reliable measure of provider stigma, based on themes of client and family experience of provider's negative attitudes and behaviors?

H1: The proposed measure will be adequately reliable, as evidenced by a suitable Cronbach's alpha, indicating correlation between the measure's items.

2. To what extent is the proposed scale a valid measure of a provider's negative attitudes and behaviors, based on themes of client and family experience?

H1: The measure will possess validity as evidenced by face validity.

H2: The measure will possess validity as evidenced by content validity.

H3: The measure will possess factorial validity based on a five-factor structure indicative of the Experience-based model developed in my previous research (Charles, 2013).

H4: The measure will possess validity as evidenced by construct validity, as measured by the following sub-hypothesis:

Sub-h1: A respondent's reported years of experience in mental health services is predicted to correlate positively to responses on items relating to poor prognosis.

Sub-h2: A respondent's reported years of experience in mental health services is predicted to correlate negatively to responses on items related to blame/shame.

Sub-h3: A respondent's provider status (professional versus paraprofessional) is predicted to correlate with items related to disinterest, annoyance, and irritation.

These sub-hypotheses were predicted in consideration of personal practice experience and review of the literature. The first sub-hypothesis, sub-h1, a positive correlation between years of experience and score on poor prognosis/fostering dependence items is anticipated because of the idea that a provider with more years working with adults living with serious mental illness is in frequent contact with individuals in crisis. As the result of this constant interaction with adults in crisis, the provider may thus have less belief in the likelihood that a client could recover or achieve common life goals like full-time employment, independent housing, and meaningful interpersonal relationships. This explanation for negative attitudes is echoed by Ahmead and colleagues, following their survey of mental health providers in Palestine (Ahmead, Rahhal, & Baker, 2010). These authors posit that perhaps as a result of dealing with patients on a daily basis, attending to their hygiene and safety in inpatient settings, their attitudes about the chances of recovery are perhaps more pessimistic. The second sub-hypothesis, sub-h2, a negative correlation between years of experience and score on blame/shame items is predicted because as a person gains more experience in the field, their understanding of the etiology and course of mental illness likely matures past ideas of personal blame and shame. A survey of mental health nurses conducted by Bjorkman and colleagues found such correlations between years of experience, time since professionally qualifying, and attitudes related to personal blame for difficulties (Bjorkman, Angleman, & Jonsson, 2008).

The third sub-hypothesis, sub-h3, a correlation between professional status and scores on items related to disinterest, annoyance, and/or irritation is predicted based on the belief that the more education a provider receives about mental illness and its treatment, the less likely they are to stigmatize clients. This idea was predicated on the common use of education-based interventions as a method to combat public stigma. The work of Smith and Cashwell (2010)

provides support for the influence of education on stigmatizing beliefs. These authors surveyed both mental health providers in practice and students in training. Their findings indicate that training, education, and experience result in more positive attitudes toward mental illness.

Conceptualization and Operationalization

The first step in scale development, as explicated by DeVellis (2003), is to clearly identify what is to be measured, to conceptualize the construct of interest in such a way that it is neither too simplistic nor too complex. A well-defined construct is the foundation for and an essential element of a useful measurement. The danger in construct over-simplification is developing a measure that is superficial and limited in usefulness and appeal to researchers because the understanding it generates is not meaningful. On the other hand, a conceptualization that is too complex will result in an overly ambitious effort to lump too many concepts into a single construct and measure (Abell, Springer, & Kamata, 2009). Researchers who are conceptualizing an unobservable construct begin by considering how the construct has been understood in the past. In addition, when thinking about a construct meant to be addressed by a developing measure, decisions about dimensions upon which a scale can vary are important to consider. Since a scale can vary in specification of content domain, applicable setting, and population of interest, these same dimensions can be used to further specify the conceptualization of constructs of interest.

Dimensionality of the construct should also be considered at this stage (Viswanathan, 2005). The definition of the construct of interest is either a stand-alone entity or a set of two or more constructs held together conceptually. A one-dimensional measure intends to capture one and only one construct, whereas a multidimensional measure taps two or more factors, and is a collection of one-dimensional measures that are held together conceptually (Springer, Abell, &

Hudson, 2002). For the purposes of this study, the construct of stigma, in general, and provider-based stigma in particular has been considered at length in Chapters 1 and 2. Making note of the limitations of studying stigma from a purely theoretical standpoint, the conceptualization of provider stigma used in this study is based on the conceptual model developed in my previous research (Charles, 2013). This model of the experience of provider stigma, is described in greater detail in Chapter 2, and emerged through an ethnographic content analysis (ECA) of client and family member authored literature. The texts that were analyzed in my study depict a client or family member's experience in the mental health service environments and perceptions of provider stigmatization. The resulting conceptual model is constructed by five emergent themes, listed here, described more fully in Chapter 2 and elsewhere (Charles).

1. Blame and shame.
2. Disinterest, annoyance, and/or irritation.
3. Degradation and dehumanization.
4. Poor prognosis/fostering dependence.
5. Coercion and lack of 'real' choice.

Item development in the current study was guided by my previously described conceptual model and factorial validity of the resulting scale will be based on the degree to which the resulting scale reflects this model. Since the model that conceptually defines the construct of interest, provider-based stigma, contains five themes, it is also hypothesized that the measure will have five dimensions or factors, and is thus a multidimensional measure.

Development of the Item Pool

Relationship of items to latent variable. The second step in developing a scale, according to DeVellis (2003), is to generate a pool of potential items to consider for inclusion in the scale.

This phase of scale development is where the abstract constructs are translated into more specific items intended to capture and describe the underlying variable. It is assumed that the latent construct, or provider-based stigma in the present study, causes the responses to a measure's items (Viswanathan, 2005). While the developed items individually provide a measure of the latent variable's presence, absence, and strength, together they offer a more complete picture of the construct of interest.

Number of items. When developing a scale, there is no set threshold of items that should be generated for the initial item pool. In fact, the generation of more items than could possibly be included is encouraged (DeVellis, 2003). A larger item pool, all else being equal, is better than a smaller pool. Having a large item pool is a safeguard against insufficient internal consistency being discovered at a later time. Items that are unrelated or demonstrate markedly lower internal consistency can be deleted or modified at a later stage of scale development, so beginning with a lot of items to potentially delete or modify is desirable. In addition, the size of the initial item pool will reflect the complexity of the construct of interest.

Similarly, having items that are repetitive or redundant is also acceptable at this stage of scale development. Even slight variations in wording are important in this stage. This small differences are statistically 'put to the test' and only those that most people in the desired population would interpret similarly are retained (Viswanathan, 2005). The items of a scale are intended to capture the construct of interest in a variety of ways. The differentiation of items aside, what the items reveal about the construct of interest is summative. Regardless of how items are worded, what they tap should reveal something different about the phenomenon of interest. For the purposes of this measure, items were generated to tap each of the five themes of the experience-based model (Charles, 2013). Following DeVellis' observation that an item pool

should be is 3 to 4 times larger than the anticipated final measure, and assuming a few items per theme, the initial item pool contained 99 items, with the goal of a final scale containing 15-25 items. This item pool and its refinement are described in greater detail in Chapter 4's discussion of results.

Characteristics of 'good' items. A clear understanding of the qualities of good scale items will be helpful in generating items for the current scale that are truly useful in measuring provider stigma. Items should be concise and clear. DeVellis (2003) cautions scale developers about the dangers of making use of excessively long scale items. As the length increases in a scale item, so too, presumably, does the complexity of the item. Similarly, items should not be too simplistically brief, failing to capture the construct's complexity. Good items also consider reading difficulty and the reading capabilities of anticipated scale respondents. As a general rule, a reading level of between fifth and seventh grades is preferred when writing items for inclusion in a scale intended to be used in the general public. The reading level of a scale item can be quantified by determining the length of sentences and the number of syllables contained. Following the general guiding principle of a fifth to seventh grade reading level in a scale's items would indicate that sentences should be between 14 and 18 words in length and contain 18 to 24 syllables.

In addition to avoiding overly complicated scale items, it is also recommended that multiple negatives be avoided. For instance, a scale item reading "I am not in favor of not treating my clients with an appreciation of their self-determination" is confusing and will likely result in responses that are unintended, failing to accurately depict the underlying construct. A clearer item without multiple negatives, would be, for example, "I am not in favor of treating clients as if they were not able to make self-determined decisions." Another 'bad' scale item is called

double barreled and conveys two or more ideas, so that an affirmative response could indicate affirmation of one or more different ideas. For example, a hypothetical scale item “I object to forcing clients to take medication because the pharmaceutical companies are in cahoots with the physicians.” This question would be objectionable to respondents who are opposed to forcing clients to take medications for reasons other than distrust of the pharmaceutical industry, like human rights, self-determination, and dislike of side-effects. In essence, the items of a scale need to be reviewed for clarity; meaning may be lost when items are confusing.

Current study’s item development. The present study’s items were developed following the method originally proposed by Nunnally and Bernstein (1994) referred to as the *domain sampling model*. Following this approach, the researcher crafts items for possible inclusion in the scale through a process of brainstorming. Items are generated to the point of *theoretical saturation*, a term borrowed from qualitative research, where new items are generated until no more new content is being identified. This approach to item generation assumes that there is an infinite pool of possible scale items, and is effective so long as the pool of potential items is large. Because the goal of this method of item generation is theoretical saturation, the number of items developed is likely to be large and redundancy is inevitable. Redundant items, especially at this stage of item pool generation, are generally preferred, as mentioned above. In the next section, the types of scales will be reviewed, including response options and formats. Based on this review, the structure of the developed measure’s items will be specified.

Measurement Format

Scales. The third step in measurement development described by DeVellis (2003) is determining the format of the scale. The first consideration in deciding on the measurement format is to discern which type of scale is feasible considering the nature of the construct of

interest. Helping developers with this task, DeVellis describes three formats for scales: Thurstone scaling, Guttman scaling, and equally weighted items. Both Thurstone and Guttman scales utilize an ordering system for the scales individual items, with each item reflecting a different intensity of the underlying attribute. The use of these types of scales is difficult, especially when the construct of interest is an unobservable attitude, as opposed to a behavior. Defining and determining the intervals between Thurstone and Guttman scale item's is excessively complicated, and frequently the limitations of these types of measures outweigh potential benefits.

Another type of scale, which assumes equally weighted items, is based on the idea that the measure's items are equal in their ability to address the underlying construct. That is, no item is a better measure of provider stigma than the others. The items of this type of scale are imperfect indicators of an underlying construct; the responses to the scale's items can be quantified, summed, and the resulting numerical score can be used to indicate a level of the underlying variable. Also, the assumptions of a scale consisting of equally weighted items make establishing the scale's reliability and validity by statistical methods like internal consistency via Cronbach's alpha and factor analysis possible. In addition, the response format's possible with equally weighted items is vast, described next, and affords the developer great latitude in designing a measure that meaningfully detects the underlying construct.

There are a few types of scales commonly used in social science research, reviewed by DeVellis (2003), which assume equally weighted items. These include semantic differential, binary options, and the most commonly used, and the one adopted in the present study, is the *Likert scale*. Beginning with a declarative statement, a Likert scale then presents a set of responses which respondents select to indicate the extent to which they agree with or endorse the

declarative statement. The response options vary in the extent to which they convey agreement, and should be worded so that essentially equal intervals are assumed between each level of agreement. For example, 'strongly disagree,' 'mildly disagree,' 'mildly agree,' and 'strongly agree.' Including a neutral midpoint, for example 'no opinion,' 'neither agree nor disagree,' or 'agree and disagree equally' should also be considered. The midpoint occurs when an odd number of response options are presented. This allows the respondents to be uncertain or express a lack of opinion. Without a neutral midpoint, an even number of response options, respondents are able to be uncertain about their level of agreement. Some researchers may choose to include the neutral response option; others may not, depending on the nature of the construct of interest. For example, a researcher may want to force a choice when investigating a construct on which a respondent may select a neutral response to avoid having to make a hard and fast choice.

Response options: Number and time. The items of a scale typically contain two parts: the stem and the response option. Item development, described above, focuses on the generation of the scales item stems. The response options are the means by which respondents indicate their answer to the question posed by the scale. What type of response and how many response options are given will need to be considered jointly with item creation, as the two must be compatible. Providing multiple response options allows for discrimination of differing levels of the underlying variable. How fine the distinction to be made should be considered; the number of options depends on how distinct a differentiation can be made, to the extent that the difference is still meaningful. Too many responses are just as much of a problem as too few. For example, asking respondents to rate their agreement with a statement on a scale from 1 to 100 provides a lot of possible answers, but the differences between specific points, say between 40 and 43,

would have little meaning. In addition, placement of the options and wording of the responses must be considered carefully. Presenting the responses in a range varying from low levels of endorsement to high levels of endorsement helps to convey the meaning of the response options to respondent. In addition, the adjectives used in response wording should be clear and unambiguous. Using adjectives like “somewhat agree” and “agree a little” would be confusing to respondents, who would wonder what the difference between the two actually is.

Another consideration when developing scale items is the time frame in which the researcher is interested. For instance, some scales seek to assess levels of constructs in a temporal manner, say a description of enduring personality traits. Other scales seek to identify attributes during a particular time interval. Many scales do not specify a time frame, and simply imply a time frame that respondents consider. DeVellis (2003) suggests that scale developers be active, rather than passive, when determining the time frame they want to address. Using theory to guide this decision is advocated, particularly in the nature and durability of the variable of interest. For example, is provider stigma an enduring attribute, consistent over time, or is it time-limited or dependent on changing circumstances? Depending on how these questions are answered, the researcher may consider adding a time-specifier to the scale. An example of this type of specifier would be: “In the last six months, in my role of mental health service provider...” followed by the item stems and response options.

Wording of the items. While validity of the scale’s items is described more fully later, key elements of item development are considerations about wording. This section describes how individual scale items could be phrased or developed to prevent bias, thereby increasing scale’s validity. As a preventative measure against acquiescence bias, the use of positively and negatively worded items is suggested (DeVellis, 2003). *Acquiescence bias*, also referred to as

agreement or affirmation bias, occurs when a respondent displays a tendency to answer survey items positively, or to agree with the items, regardless of their content. Positively worded items represent the construct of interest's presence, whereas negatively worded items reflect its absence. Presumably, for example, if a provider endorses ideas reflective of provider stigma, they would endorse positively worded items and disagree with negatively worded items. By including both positive and negatively worded items, scale developers can look at response patterns and detect patterns indicative of those who are responding in the affirmative, regardless of item content. This would signify the presence of acquiescence bias, that the measure is not accurately detecting the construct of interest.

However, there are drawbacks to the use of negatively worded items in survey research. For example, Colosi (n.d.) of the U.S. Census Bureau found that the presence of negatively worded survey items led to more inconsistency and selection of "I don't know" responses. These findings were supported by the research of van Sonderen, Sanderman, and Coyne (2013) that found no evidence that reverse-wording prevented response bias, and actually contributed to confusion and response contamination. Based on these studies, in order to prevent potential confusion and inconsistency in response, the wordings of the developed questionnaire's items were not positively and negatively differentiated.

Another bias that can potentially be remediated by varying the wording of items is that of social desirability bias. *Social desirability bias* is defined as the distortion of a respondent's answers based on how motivated they are to present themselves in a socially prescribed positive manner (DeVellis, 2003). In an effort to reduce the tendency of respondents to give less-than-truthful responses because of social appropriateness, the language of the surveys' items was purposefully varied. More specifically, in traditional measurement development the wording of

survey questions tends to be concrete, allowing the variation of a respondent's agreement to be displayed in their response only. The survey being developed in this dissertation includes items like this, for example: "If my client is not recovering from a relapse, there is something they aren't doing." In contrast, an approach to wording items that is useful in circumventing social desirability bias is called *forgiving wording* or softly worded items. This measure of provider-based stigma includes these items as well, for example: "Even though I try not to, I can sometimes be impatient with my clients."

The use of forgiving or softly worded items has been used in previous research, the work of Naher and Krumpal (2012), for example. However, the effectiveness of using softly worded questions in reducing social desirability bias remains largely unknown or inconclusive. In the present investigation, the developed measure's initial item pool reviewed by expert panel focus groups, in addition to stakeholder consultation, and refined in the administration sample contain both hard and softly worded items, making use of forgiving language. Included in the validation analysis is a comparison of the hard versus soft worded items and their usefulness in measuring provider-based stigma.

Current study's format decisions. The proposed measure will take the Likert scale format, assuming equal weighting of each item, beginning with a declarative statement item stem. The wording of these items is purposefully taking two approaches, a traditionally concrete wording and the use of forgiving terminology. Respondents will indicate a level of agreement with each statement or a frequency of engaging in behaviors. The Likert scale is frequently used in research that investigates attitudes, beliefs, and opinions, (DeVellis, 2003) and therefore is a good fit for investigating the attitudes and beliefs of mental health service providers. The response options for the developed measure's items consist of seven possible levels of agreement

with attitudes or indicators of frequency regarding behaviors. Agreement will be measured by selection of one of the following options: strongly disagree, disagree, somewhat disagree, no opinion, somewhat agree, agree, strongly agree. Frequency of behavior will be indicated by selection of one of the following options: 1 – never, 2, 3, 4-sometimes, 5, 6, 7 – always, and N/A. The use of an odd number of responses includes the neutral median, ‘no opinion,’ allowing respondents to select a position of no opinion or no relevance. According to DeVellis, a neutral position provides an opportunity for equivocation or uncertainty. The time frame in the developed measure is not explicitly stated, but instead reads “reflect on your work in the mental health service delivery setting.” This time frame is open-ended, as the time a respondent has worked in the field varies. A question specifically asking respondents about how long they have been employed in mental health services is included in the survey’s demographic questions.

Refining the Item Pool

Expert panel review. The fourth step in measurement development, as described by DeVellis (2003) is to have the initial item pool reviewed by an expert panel. The expert panel typically consists of a small group with 6-10 members who have backgrounds in and a specialized understanding of the research area of interest. The expert panel reviews and gives feedback about the initial scale, before a full-scale validation with the intended sample (Abell, Springer, & Kamata, 2009). Using an expert panel review, the developing scale can be refined in length and content helping to decrease the burden of data collection to be faced during the validation. Recommended members range from construct experts, like academic faculty specializing in the scale’s content area, but also persons for whom the developed measure is intended, such as clinicians and administrators in the field of interest. Focus groups are

recommended by Springer, Abell, and Hudson (2002) to reality test the researcher's perception and success in capturing the construct on interest.

The present study employed an expert panel format, not only for review of the initial item pool, but also to establish initial face validity of the experience-based model on which item development was based (Charles, 2013). The process and findings from these groups is reviewed in greater detail in Chapter 4. Four separate groups were convened, one including academic researchers specializing in stigma-related topics, a group of mental health service providers, another group consisting of family members of services, and a group of mental health service consumers. Thus, construct experts and intended recipients of the measure were utilized in reviewing the item pool. DeVellis (2003) lists review by an expert panel as one method for determining an individual item's appropriateness for scale inclusion and its relevance to the construct of interest. In addition, expert panel reviewers may offer insight into an item's clarity and conciseness, as well as to possible problems in the chosen approach to the construct of interest.

Questionnaire Design

Once the items have been generated, formatted into appropriate stems and answer options, and reviewed by the expert panel, the questionnaire intended for initial administration takes shape. Decisions about the format of the developed measure needed to be made, specifically, how will the measurement be made available to respondents? The two choices, electronic and paper versions both have risks and rewards. A survey hosted on an internet site is relatively inexpensive, easy to generate, and can be widely disseminated fairly simply. In addition, an electronic version of an instrument, hosted on a well-respected website, can be considered secure and therefore anonymity and confidentiality can be protected. However, the burden to access

and complete the survey is on the respondent, which may result in a lower-than-hoped for response rate. A hard copy, paper version of a scale has benefits too. For instance, removing the extra step required of respondents to get online and go to the online survey, a better response rate is possible. However, cost of materials and time investment to deliver and pick-up completed instruments can be hefty. For the current study, the questionnaire was electronically formatted and electronically disseminated to service providers. Potential respondents were contacted via email and directed to a link to the developed measure, hosted on Surveymonkey.com.

Demographic information. The purpose of this study is to assess the psychometric properties of the developed measure. While demographic variables are useful in ascertaining the qualities of the sample and its representativeness to the population, since this study is not intended for generalization, demographics will be gathered to describe the sample, serve as controls, and to describe relationships among constructs and specific demographics (if any emerge). For the purposes of this investigation, the following descriptive demographics were included in the measurement: gender, highest level of education, discipline or profession with which they identify, length of time employed in mental health services, length of time employed in current role, type of service setting employed, geographical region in which employed, and peer provider status.

Administration of Items to a Developmental Sample

Next in the process of measurement development, according to DeVellis (2003), is to administer the set of items to a sample. Questions about how large a sample should be to properly evaluate an item's ability to measure the construct of interest must be made, bearing in mind several risks inherent in using a sample that is too small. First, developers must be aware that the number of items and the number of scales (or factors) to be extracted influence the

sample size needed. A developmental sample for a new measure must be large enough to eliminate the influence of an individual's subjective variance. If a sample is too small, the patterns of covariation among the items may not be stable, meaning that the correlations among items would not be replicable in other samples. If the ratio of subjects in sample to items in scale is too low, correlations among items are more likely to be influenced by chance, rather than actual relationships. Another concern about a small sample size is that if the sample is too small it may not adequately represent the population for which the measurement is intended. The difference between a small sample and the population may be due to actual differences between sample and population in terms of the construct of interest, or it may be due to the fact that the sample is in some way different, or unusual, from the population. The second difference, a qualitative difference between sample and population, is especially troublesome to scale development efforts, and its application to other samples.

For the present study, the developed item pool was administered to a developmental sample, consisting of persons currently engaging in public mental health service provision. The sample is purposive in nature, specifically targeting providers of mental health services, ranging in discipline (i.e. social work, mental health nursing, psychology, paraprofessional, psychiatry, etc.). The preferred sample size, based on the number of items included in the initial administration of the scale, was approximately 300 respondents. A total of 62 items were tested in this survey, and assuming 5 respondents per item, 310 would be the optimum number of responses.

The sample frame was constructed in the following manner: Contact was made with the Commonwealth of Virginia's Department of Behavioral Health and Developmental Services (VDBHDS). This department provided the researcher with a distribution list of all the executive

directors, clinical directors, and facility directors employed by the Commonwealth in the provision of public mental health services. Contact was made with each person on the distribution list via email, detailing the purpose of the study and its method. In addition, this person was emailed a message to be shared with all employees who have direct contact with clients, both professional and paraprofessionals. This communication was an email, again detailing the study's purpose and method, and providing a link to the measure on SurveyMonkey.com. The email was sent to the agency's contact person, asking the contact person to forward the email 'as is.' In addition, participants were notified that they will be able to register separately from their survey responses to be included in a drawing for one of four \$50 gift cards to Target, as appreciation for filling out the survey. A reminder email was sent to the agency contact after two weeks, to be forwarded 'as is' to service providers, hoping to spur additional participation.

The process by which persons can register for inclusion in the drawing for Target gift cards, while maintaining anonymity and confidentiality of responses to the developed measure was as follows: on the last page of the measure on SurveyMonkey.com a link to another survey was provided. This link could be copied and pasted into another internet browser window, opening another survey in no way linked to the developed measure. On this new page participants indicated whether they wanted to be included in the gift card drawing, providing an email address, and agreeing to be contacted if chosen to arrange delivery. Once the study was completed, the emails gathered through this secondary survey were pooled, from which four were drawn and contacted through email to arrange for gift card delivery.

Risks to human subjects. Respondents who completed the initial scale experienced no more than minimal risk. The scale's items could possibly cause respondents to experience emotional

discontent or discomfort. Care was taken to provide respondents with the possibility for an incentive (i.e. the Target gift cards) that indicates that their time is valuable. The amount of the incentive is not excessive and should not constitute a coercive amount. In addition, to protect human subjects, the Institutional Review Board of Virginia Commonwealth University was consulted with prior to commencing data collection. This study was deemed to be of exempt status (HM20000474), thus precluding the necessity of a full board review.

Evaluation of Items

The last two steps in scale development described by DeVellis (2003) are reviewed next, and include evaluation of scale items and optimization of scale length. The review that follows is about item evaluation and length optimization, in general, with more detailed discussion of what was found in the present investigation to follow in Chapter 4. Evaluation of items involves assessing the individual performance of the scale's items so that appropriate ones can be included in the final measure and others excluded (DeVellis). The scale and its items are evaluated by estimating reliability and validity. The various methods by which these estimations are made are discussed in the sections below.

Reliability estimation. The first quality of the new scale to be assessed is its reliability. *Reliability* of a scale has two dimensions – its stability over time and internal consistency. *Stability over time* or *temporal stability* in a scale is achieved when it performs, that is yields similar scale scores, during repeated use (Springer, Abell, & Hudson, 2002). A measure that is temporally stable produces similar results from one occasion to another (DeVellis, 2003). Conceptually, Spearman (1904) originally proposed that reliability can be understood as the composite of two hypothetical elements: the true score of the latent variable and random error. Thus, a measure taken at different times will be influenced by both the true score and error to

some extent, producing disparate results. If a measure produces similar results at different times, there is less influence of error, and higher reliability. Conversely, if results of a measure are not similar over time, the measure is more influenced by error, and therefore less reliable (Carmines & Zeller, 1979).

Temporal stability is typically estimated using the test-retest method, computed by comparing scores on an instrument administered on two separate occasions. The instrument is administered to the same sample of respondents at two different periods of time. If a measure truly addresses the construct it claims to, it should yield similar results on these two occasions. This assumption is only particularly helpful when the researcher is certain that the construct of interest has remained stable. DeVellis argues that confidence in a construct's stability is not often warranted and thus the proclamation of an instrument's reliability based on test-retest reliability must be made with caution. Differences in scale results over time could be due to one of the following factors, identified by Kelly and McGrath (1988): (a) a real change in the construct of interest, (b) systematic variations of the construct, (c) changes that can be attributed to changes in the subjects or measurement methods (fatigue or the effects of being measured), and (d) actual temporal instability due to an unreliable measurement. The temporal stability dimension of reliability is not addressed in this dissertation and will necessarily be an aspect of future testing of the measure.

Internal consistency. Noting the limitations of assuming a measure's reliability based on temporal stability, another dimension of reliability can be estimated by assessing the correlations among scale items and attending to the measure's internal consistency. *Internal consistency* refers to the homogeneity of the items within a scale (DeVellis, 2003). Items appropriate for inclusion in the scale should be of the highest quality and will have a high correlation with the

true score of the latent variable. However, since the true value of the underlying construct of interest (i.e. provider stigma) cannot be observed or known and compared to item values, this evaluation of item's correlation with true scores can be made through inferences based on correlation among scale items. A scale is internally consistent to the extent that its items are intercorrelated; higher correlations indicate a closer relationship of the items to the construct of interest and its true score. To ascertain intercorrelation, one should inspect the correlation matrix.

Item variance and means. Univariate results can be inspected to inform estimations of a measure's internal consistency. As described by DeVellis (2003), a scale's items should exhibit relatively high variance. For example, a group of respondents who answer a given scale item should not give identical answers. If an item does not discriminate different levels of the construct being measured, answers will be the same, and variance of that item will be 0. In addition to an item's variance, a scale developer should also inspect the mean response value. A desirable mean for a scale item to be included in a measure is one that is close to the center of the range of possible scores. For example, in the present study, a response mean of 3 to 3.5 is desired, with a response option range of six points (neutral option given a value of 0). If the mean falls closer to one extreme of the range or other, the range of variances will be narrow, resulting in skewed data. As a result, these items have lower correlations with one another, thereby reducing the scale's internal consistency (DeVellis)

Cronbach's alpha. The most widely used method for assessing a scale's internal consistency is by computing the reliability coefficient alpha. Most commonly used, Cronbach's coefficient alpha computes the mean of all possible split-half reliabilities (1951). *Split-half* reliability is computed by taking half of the items of a scale to compute a total score and the other half to

compute a second total score. The correlation between these two total scores produces an estimation of reliability (Hudson, 1982). Cronbach's alpha is arrived at by the computation of all possible split-half reliabilities. The resulting statistic is a value that reflects the positive intercorrelations of the scale's items. Essentially, alpha is an indication of the proportion of variance in scale scores that is reflective of the true score of the underlying construct of interest (DeVellis, 2003). Any problems with individual items, like poor variability, non-central mean, and weak inter-item correlations, will result in a lower alpha. After the initial item pool is refined, including and excluding items, decisions made based primarily on inspection of inter-item correlations, and secondarily on item variances and means, scale developers can evaluate how well they have evaluated individual items by computing alpha for the final scale (DeVellis).

The values of alpha, which can readily be computed in commonly used statistical analysis packages, like SPSS, vary between 0.0 to 1.0. The low point, 0.0 indicates no correlation among items; 1.0 indicates perfect correlation. The higher the value of alpha, the higher the internal consistency. DeVellis (2003) proposes the following ranges in which alpha can fall, and the resulting reliability: an alpha below 0.60 is unacceptable, between 0.60 and 0.65 is undesirable; a value between 0.65 and 0.70 is minimally acceptable; between 0.70 and 0.80 is respectable; alphas between 0.80 and 0.90 are very good. The length of a scale that produces an alpha of much above 0.90 should be considered for shortening. Carmines and Zeller argue that widely used scale should have a reliability statistic of at least 0.80 (1979). A new measure should strive for higher values of alpha, to compensate for potential deterioration of the alpha in future research contexts.

In respect to the current study, the initial item pool was evaluated and refined by inspection of the correlation matrix, item variances, and item means. The developed scale's internal

consistency dimension of reliability was assessed by computation of Cronbach's alpha, which is reported in Chapter 4. While these measures of reliability are informative and important, they are but one element of the scale's psychometric properties. Consideration of the items' validity is addressed next.

Validity. Initially, item validity is considered first during item development. These first efforts at ensuring an item's validity are described here first, followed by a discussion of validity estimation of items as administered to a developmental sample. The term *face validity* is used to describe whether or not a scale measures what it appears to measure, on its face (DeVellis, 2003; Rubin & Babbie, 2008). If a measure has face validity, it appears to measure what it claims, and is worth pursuing further. Essentially, while face validity is important, it is not a sufficient, stand-alone criterion for validity. While each individual item can be scrutinized for face validity by the scale developer, the use of an expert panel will provide an extra measure of the scale's face validity. The developer's assessment of face validity may differ from those who are not as invested in the scale or the specific content area.

Similarly, an expert panel can be used to assess a scale's content validity. *Content validity*, which contains elements of face validity (Rubin & Babbie, 2008), refers to the extent to which a specific set of scale items reflect the content area of interest (DeVellis, 2003). Ideally, a scale that is content valid will include items that assess all aspects of the underlying variable, and nothing else. Content and face validity are similar in that they are both determined on the basis of judgments. Specifically, the expert panel makes a judgment about whether the scale or item pool addresses the construct of interest in all possible ways.

There are methods by which the expert panels' judgment of content validity can be assisted statistically. As an example, developers initially provide panel members with the working

definition of the construct of interest. In the present study, the expert panel was provided with the experience-based model (Charles, 2013) as the definition of provider stigma. Next, the expert panel was asked to focus on the fit between the content of the items and the construct definition, and encouraged to provide comments and suggestions for item revisions. This served as a rich source of qualitative data about each item's appropriateness. Alternately, expert panel members could also have been asked to rate the fit on a Likert-like scale: 1 indicating no fit at all between the item and the construct definition, and 5 indicating a really good fit. Based on these ratings, some authors have used statistical methods to quantify content validity, for example the content validity index (CVI; DeVon et al., 2007) which reports the proportion of panelists rating an item as acceptable or the total number of scale items deemed content valid. Inter-rater agreement (IRA; Rubio et al., 2003), another statistical method for determining content validity, involves the computation of agreement among panelist's estimations of fit between items and definition. Lastly, the multi-rater kappa coefficient (Schaefer, Schmidt, & Wynd, 2003) takes IRA a bit further, reporting on the proportion of IRA that remains when chance agreement is controlled. Despite the information being interesting, these tests of content validity are not especially rigorous (Carmines & Zeller, 1979). Whether an item is kept or discarded from the item pool is ultimately the choice of the scale developer. Content validity data, whether qualitative or quantitative, helps to raise flags of concern about specific items that perhaps should be excluded from the final instrument. For this dissertation, qualitative data from expert panel focus groups and stakeholder consultation were used to establish content validity. Quantitative approaches, making use of statistical analysis to establish content validity, were not employed in this study.

Inclusion of validation items. When considering the item and scale validation, scale developers can include items specifically geared at validation of the scale. This is actually the fifth step in scale development described by DeVellis (2003) which involves making decisions about including additional validation items into the scale's package. It will be possible to help determine the validity of the final scale by including additional items, of which, DeVellis describes two types. The first possible inclusion is an item or set of items that detect flaws or problems in the developing measure. For example, one such flaw is the influence of social desirability on a respondent's answer choices. To aid in detection of this bias, developers may consider including a brief measure of social desirability in the measurement package. If this validation item is included, it would be possible for developers to determine how strongly a scale's individual items are influenced by social desirability.

The second type of item that should be considered for possible inclusion is a measure of a related construct of interest, to assist in determining the developing scale's construct validity (DeVellis, 2003). *Construct validity* is defined as the extent to which a measure behaves the way it is supposed to, when considering related constructs, measured by already established measures (DeVellis). Presumably, theory can be consulted to identify constructs related to the latent variable of interest in the developing scale. Already developed and validated scales of these related constructs could be included in order to build the case of the new measure's construct validity.

For the present study, the inclusion of each of the types of validation items that DeVellis (2003) describes, measures to indicate flaws and a related construct measure, were considered. Specifically, a brief social desirability measure developed by Strahan and Gerbasi (1972) and the 9-item short version of Corrigan's (2003) Attribution Questionnaire were considered for

inclusion. Attribution refers to assessments of an observer regarding a person's responsibility and ability to control their mental health challenges. Referring back to the experience-based model of provider stigma (Charles, 2013), perceptions of blame and shame are integral to the experience of provider stigma, or the provider's attributions of a client's responsibility for their presenting difficulties. The Attribution Questionnaire developed by Corrigan (2003), was considered for inclusion as a means of establishing construct validity of the blame and shame factor. Ultimately, however, only the 10-item social desirability measure was included. This decision was made based on the length of the initial survey and concerns about burden to the respondent.

Validity estimation. A scale's validity refers to the extent to which the scale's items address the constructs that it claims. This section describes how the validity of the developed scale's ability to tap the underlying construct, specifically provider stigma as conceptualized by the five themes identified in my experience-based model of provider stigma was assessed (Charles, 2013). The method by which this examination of factor structure will be undertaken is factor analysis. As originally hypothesized, the scale's items are intended to serve as effect indicators, or manifestations, of provider stigma, which conceptually justifies the use of exploratory factor analysis as a means of validity estimation (Fayers & Hand, 1997).

Factor analysis. The best means of determining if a group of items, a scale, or sub-scale represents one construct is factor analysis (DeVellis, 2003). There are three uses for conducting a factor analysis: (a) to determine how many latent constructs, or unobservable phenomena underlie a set of items; (b) to condense information gathered by numerous items into fewer variables; and (c) to define the underlying constructs, thereby interpreting the meaning of a factor. Essentially, according to DeVellis, a factor analysis can be described in the following

terms: Analysis begins with the assumption that there is only one construct underlying the whole group of items and assesses how well this one category explains the association between individual items. Next, the analysis checks to see how well this single construct explains the covariation among items; if one factor does not account for all the covariation, the original premise is rejected and a second underlying factor is identified to explain more of the remaining covariation. This is continued, finding more factors to explain covariance, until the amount of unexplained covariance is small and acceptable to researchers.

Factor analysis as a statistical method can be further specified in terms of exploratory and confirmatory, traditionally referring to the researcher's objective. *Exploratory factor analysis* (EFA) is exploratory in that the number of latent constructs, or the dimensionality of a scale, is explored, rather than specified prior to investigation (Abell, Springer, & Kamata, 2009; Viswanathan, 2007). EFA is also indicated when the relationship between factors is unknown, specifically if the factors are correlated or not (Springer, Abell, & Hudson, 2002). A *confirmatory factor analysis* (CFA) is an analysis that seeks to confirm a factor structure that has been identified through prior research or theory. While this has traditionally been the distinction, DeVellis indicates that CFA more and more refers to investigations making use of structural equation modeling (SEM) methods. For the purposes of this investigation, it is assumed that the analysis of the developed measure will make use of procedures associated with an EFA. Although the five-factor model is hypothesized, based on the experience-based model (Charles, 2013) since this model has not been empirically evaluated, making an assumption that developed items will reflect this model is not strongly merited.

Providing further clarification about the concepts and practices of factor analysis, DeVellis (2003) distinguishes between principle component analysis (PCA) and common factor analysis

(FA). The term *factor analysis*, according to DeVellis, is used sometimes to refer to two different data analytic techniques, that some researchers regard as different and others the same. These terms are often used interchangeably, there are differences between the two methods, but typically, when a scale's items have something meaningful in common, the different methods will support the same conclusions.

Essentially, PCA yields one or more composite variables, or components, that capture most of the information originally contained in the large item pool. The components are also weighted sums, meaning they are linear transformations of the original items, being grounded in the original data and items (DeVellis, 2003). On the other hand, FA yields one or more composite variables, or common factors, that also capture much of the information of the original item set. These common factors, however, as opposed to PCA's components, are hypothetical variables which presumably cause the scale's items to be answered as they are. In addition, PCA is concerned with total variance in the data: shared, unique, and error; whereas FA is concerned only with shared variance. A PCA also assumes that all of the variable's variance will be explained by the resulting component structure. An FA assumes that less than 100-percent of the variance will be explained by the common factors. Despite the differences between PCA and FA, when a set of items has something meaningful in common, either method will yield the same conclusions.

Extraction of factors. In either instance, whether analysis is guided by the assumptions of PCA or FA, factor analysis consists of two procedures: factor extraction and factor rotation. As described, factor analysis will extract as many factors as needed to account for all the covariation, but these factors become less-meaningful at a certain point. This point can be determined in a number of ways, including statistical criterion. These statistical criterions

include those based on maximum likelihood and least squares. However, for the purposes of this discussion, the commonly used methods of Kaiser's (1960) eigenvalue rule and scree test (Cattell, 1966) investigation will be summarized. These are non-statistical, subjective methods that are useful to determine when enough factors to account for covariance have been extracted.

An eigenvalue is understood as the amount of information that is captured by a factor (DeVellis, 2003). When conducting a PCA the information that is potentially covered is equal to the number of items in the scale. For example, a scale with 25 items will have a total of 25 units of information possibly explained by the extracted components. Each factor's eigenvalue represents the portion of information that is accounted for by that factor. If a factor has an eigenvalue of 1, it accounts for the same amount of information as an individual item. Kaiser's (1960) eigenvalue rule is that no factor that the factor analysis derives should be retained if it has an eigenvalue of less than 1 or if it does not account for the same amount of information as a single item would. This is a fairly liberal rule, typically not producing a parsimonious structure. Another means by which the number of factors can be determined is by examining the scree test. The scree test also makes use of eigenvalues, but presents them visually, using relative rather than absolute values as a means to determine their importance. The highest eigenvalues appear higher on the vertical axis, and decrease moving along the horizontal axis. A line drawn between the eigenvalues will decrease steadily at first, and then turn sharply, indicating an 'elbow' which marks the transition from factors that capture a substantial amount of information to those that do not (DeVellis). Those factors that are above the 'elbow' should be retained. The current analysis made use Kaiser's rule, first looking at the number of factors with an eigen value greater than 1. This resulted in a non-parsimonious factor structure (some 18 factors with greater than 1 eigen values), so the approach to factor delineation changed. Theory was used to inform the

number of factors to extract, specifically the five-theme model on which the item pool was based. Many factor analyses procedures were conducted; extracting the number of factors specified by theory (five) as well as other possible solutions (two, three, four, and six factor solutions). The scree plot was also consulted, indicating support for the number of factors suggested by theory.

Factor rotation. While factor extraction is concerned with the number of factors to be examined, *factor rotation* refers to a presentation of already available data in an easy-to-understand manner (DeVellis, 2003). Prior to interpreting factors, a process that is described next, rotating factors is important to increase interpretability by looking at the data from different vantage points. If perfection were possible, rotation procedures would show the data in a way that each scale item correlates with one and only one factor, and does not correlate at all with any other factors, yielding a simple structure. There are two options when considering factor rotation: orthogonal and oblique rotations. *Orthogonal rotation* is useful when it is assumed that factors underlying an item set are uncorrelated with one another. If factors are uncorrelated, their combined effects can be computed by summing their separate effects. Put another way, the amount of information accounted for by one factor can be added to the information that another factor covers to indicate the total information covered by the two factors, together.

Conversely, if the underlying factors are known to be or assumed to be correlated, it is appropriate to make use of *oblique rotation* methods. This rotation approach allows for factors to be correlated with one another, which makes it possible for items to be more strongly identified with one factor versus another. The simple additive feature of uncorrelated dimensions, characteristic of orthogonal rotations, is lost in an oblique rotation, because there is redundancy in the amount of information accounted for by correlated factors. The ideal factor

rotation is the orthogonal rotation, for its simplicity, but if factor correlations are suspected, then orthogonal rotation will likely overestimate factor loadings, resulting in inappropriate item selections. However, DeVellis (2003) notes that when developing measures, the data analyst can first specify the oblique rotation, and inspect the correlations among factors. If these are small, lower than 0.15, than an orthogonal rotation can be conducted.

Interpreting factors. In order to make sense of the extracted factors, the next step in a factor analysis is to examine the items that are strongly associated with each factor. By looking at these items, the general theme of the underlying factor should emerge. This is particularly true when the items are similar and clearly reflective of one latent variable. Interpretation is more difficult when seemingly unrelated items load equally on one factor or when a single item is heavily associated with more than one factor (DeVellis, 2003). Also, it is important to understand that assigning a name to a factor does not establish validity. Validity is established when an item set continues to perform in a manner consistent with its name.

Optimization of Scale Length

The final step in a scale's development, according to DeVellis (2003) is the optimization of its length. In essence, this step is concerned with refining the scale and its included items in light of the analysis and findings of its administration to a developmental sample. Regarding length, Abell, Springer, and Kamata (2009) argue that shorter scales are preferable to longer ones, assuming all things equal. On the other hand, it is important to include enough items to cover all domains of the construct of interest. A risk of a scale that is too brief is that its limited item pool does not include potentially important content, leading to limitations to the construct's definitional complexity. Conversely, a scale that is too long may result in respondents failing to

complete the measure. A scale's ideal length is determined by the predicted burden of using the instrument, desired psychometric strengths, and the construct's complexity (Abell et al.).

When considering items for elimination, DeVellis (2003) suggests first removing items that contribute the least to the scale's internal consistency. In addition, the factor loadings, or how strongly an individual item is associated with an extracted factor, can also be consulted to decide which items to eliminate. Items that are not strongly associated with a one factor, more so than others, can be considered for deletion. Also, items that do not load strongly to a factor, with loading values of less than 0.7, 0.5, or 0.3, can also be considered for exclusion. And finally, if a factor has less than three items associated with it, the factor and its items may be deleted, as the factor structure is not stable.

Thus refined, the end product of this dissertation is a measurement of provider-based stigma, based on the lived experience of mental health service consumers and their families. This measure was assessed for reliability and validity, and decisions about items that compose the scale were made based on these assessments. A revised scale is thus identified, to be used in future studies for confirmation as well as intervention development to address provider-based stigmatization.

Summary of Current Study Decisions

For clarification, a summary of methodological steps are provided here, followed by an outline of the data analysis steps. In developing a measure of provider stigma, the construct of interest is understood as a theoretical variable conceptually understood in terms of the five themes explicated by in my previous research (Charles, 2013). Item generation was guided by Nunnally and Bernstein's (1994) domain sampling method. Items were developed through brainstorming until theoretical saturation was reached. Items took the form of Likert scales,

using a seven-point response format, with a response of 1 indicating strong disagreement with the declarative statement and 7 representing a strong agreement. The initial item pool, once screened for clarity, was reviewed by an expert panel. This panel actually took the form of four separate groups, both focus groups and stakeholder consultation, described more fully in Chapter 4.

Once screened by the expert panel, the measure was formatted electronically, hosted on SurveyMonkey.com. Potential respondents were contacted electronically, via email, and sent a hyperlink to the survey. The following descriptive demographics were included in the measurement: gender, highest level of education, discipline/profession, length of time employed in mental health services, length of time employed in current role, type of service setting employed, geographical region of the Commonwealth, and status as a peer provider.

The developed measure was next administered to a developmental sample, consisting of persons currently engaging in mental health service provision. The sample was purposive, targeting providers of mental health services, ranging in discipline (i.e. social work, mental health nursing, psychology, paraprofessional, psychiatry, etc.). The sample was recruited through contacts with Virginia's DBHDS, the Commonwealth's CSBs and state hospitals. Incentives for participation were offered.

Summary of Data Analysis Steps

The purpose of analyzing data obtained from the developmental sample is to establish the reliability and validity of the developed scale, in addition to exploration of the hypothesized relationships between scale scores, demographic variables, and validation items. First, a factor analysis will be conducted to ascertain the underlying factor structure. As originally noted, the scale's items are intended to serve as effect indicators, or manifestations, of provider stigma,

conceptually justifying the use of exploratory factor analysis as a means of validity estimation (Fayers & Hand, 1997). Based on my experience-based model of provider stigma, multidimensionality is presumed. An exploratory factor analysis is proposed, because my model has not been empirically validated previously.

The researcher made use of IBM – SPSS 21. The factor analysis method included both a principal component analysis and principal axis factoring. In determining how many factors to extract, the current analysis utilized theory to inform the decision of the number of factors to extract, and began with a five-factor solution. In addition, other factor analyses, both PCA and PAF, were conducted, specifying 2, 3, 4, and 6 factor solutions. The decision between extraction methods and factor solutions are described in Chapter 4. Once the factor solution was selected, the results were rotated to assist in interpretation. Although the ideal factor rotation is orthogonal, it is unknown if the five factors underlying the proposed measure are correlated. If the factors are actually correlated, an orthogonal rotation will likely overestimate factor loadings. In order to assess for inter-factor correlation, an oblique rotation was conducted first, followed by an inspection of factor correlations. An orthogonal rotation was also conducted and compared to the oblique rotation's results.

Once rotated, the items' loadings onto each factor should be clearer, allowing for interpretation. Interpretation of factors involves inspecting the items that load strongly onto each factor and finding a general theme among these items. Once the factor structure had been identified, data analysis for this study then turned to item analysis and optimization of scale length.

In terms of item analysis, the first task was to identify those items that were to be excluded from the final measure, based on the identified factor structure and loadings. Items that were not

strongly associated with a one factor, more so than others, were considered for deletion. Also, items that did not load strongly to a factor, with loading values of less than 0.4, were also considered for exclusion. After these deletions were been made, the developed scales reliability will be ascertained via computation of Cronbach's alpha. A detailed discussion of the study's phases and findings is described in the next chapter.

Chapter Four - Results

This chapter presents the results of this dissertation project, the development and psychometric testing of an instrument intended to measure provider-based stigmatization. The project consisted of two main phases: preliminary focus and discussion groups to review the experience-based model of provider stigma and initial item pool review followed by a large-scale dissemination of the initial instrument to a validation sample. Both phases are reviewed here, along with sample demographics, and results.

Initial Item Development

The item pool for this measure was generated using the method described by Nunnally and Bernstein (1994) referred to as the *domain sampling model*. Essentially, items were crafted for possible inclusion in the scale by brainstorming, while focusing on the particular theme the item was intended to tap. Using the experience-based model of provider stigma, described in detail in previous chapters, developed in my previous qualitative research (Charles, 2013), a pool of 99 items was crafted. For each of the five themes of the experience-based model approximately 20 items were crafted. Further specified, each theme was measured by a collection of items that were worded in concrete or hard terms consistent with traditional measurement development. Other items made of ‘forgiving language’ or more softly, tentatively worded prompts. In addition, items intended to question attitudes and beliefs were differentiated from items focusing on behaviors. The initial item pool, separated by theme, language, and attitude/belief versus behavior is provided in Appendix A.

Face and Content Validity of Items

The initial item pool was reviewed by a series of four groups, both focus and stakeholder consultation groups, each serving as an expert panel review. The expert review, according to

DeVellis (2003), is an important step in measurement development. These groups were convened with the goal of establishing face and content validity for both the model on which the items were based, as well as for the items of the developed measure. All four groups were originally intended to take the form of a focus group; however, when convened with consumers of services and family members, these groups are better understood as discussion and consultation groups. The first two convened groups constituted focus groups, gathering feedback about the model and item pool using a structured format to guide discussion. The last two groups, stakeholder consultation groups, were less structured and more focused on the experience of members with the mental health service system. Regardless of type, each group's participants were provided with a description of the experience-based model, a summary of the research from which it was developed, and a description of each of the model's themes. A uniform handout was assembled for use with each of the groups which contained (a) a description of the study from which the experience-based model was developed, (b) a graphic depicting the model, and (c) the initial item pool for the developed measure. A copy of this handout is contained in Appendix B. The groups provided useful feedback on both the model and the item pool.

Academic/researcher focus group and consultation. The first group, comprised of researchers and academics whose work focuses on areas related to mental health services and the stigma of mental illness, was convened via teleconference. A list of potential focus group participants was initially constructed with assistance from Dr. Kia J. Bentley, this dissertation's co-chair, and an email invitation to participate was sent to these 30 individuals. Potential participants were also sent pdf versions of the initial item pool, overview of the experience-based model, and a graphic representation of the model. In total, four researchers participated in the

conference call focus group, two were interviewed independently at another time, and four provided written feedback of both the model and the item pool. All told, the input of ten experts in the field of mental health services and the stigma of mental illness reviewed the experience-based model and the initial item pool for the developed measure. The names and institutional affiliations of these expert participants are provided in Appendix C.

In general, the feedback from the academic focus group and consultation was supportive of the model's comprehensiveness. One participant of the focus group commented that the model "intuitively makes sense." Another voiced the thought that the model seemed to be in keeping with the literature and research with which they were familiar. Having general support for the model, the participants reviewed the item pool, commenting about confusing wording, potential snags that might be addressed with provider and consumer consultation groups, and suggested deletion of at least one item for irrelevance. Specifically, the use of the terms 'recovery' and 'relapse' were questioned, as potentially being confusing due to their similar utilization in substance abuse treatment. This expert panel suggested asking members of the provider focus group, held next, about the potential confusion. In addition, the use of forgiving language, or survey items that were 'softer,' were viewed by the panel as potentially more approachable by respondents and a means by which social desirability bias may be subverted. A suggestion by a few experts in their written feedback was the inclusion of reverse worded items to counteract acquiescence bias. And finally, the potential relationship between burnout and provider-based stigma was questioned in an expert's written feedback, spurring thoughts of including a burnout measure as a validation item. The construct of professional burnout was discussed in Chapter 2 of this dissertation.

Provider focus group. The second focus group was comprised of providers of adult mental health services who are currently employed at a local Community Service Board (CSB), a state funded, community mental health center. Contact was made with a supervisor at a local CSB and, with administration consent, an invitation to participate in the focus group was sent to providers of adult mental health services at that agency. A copy of the recruitment email is provided in Appendix D. The group was held on site in a conference room and lunch was provided to participants. In addition to the researcher, another student in VCU's School of Social Work doctoral program was in attendance serving as a note taker. In total, eight providers of mental health services attended the lunchtime focus group. These participants identified as social workers, counselors, case managers, and a peer provider with years of experience ranging from 5 to 40 years.

The providers participating in the focus group first reviewed the experience-based model, from which the item pool for the self-assessment was initially formed. The group's general consensus was that the model made sense; all the elements or themes seemed to 'fit.' However, the providers did think that the model should take into account the client's living conditions and physical health challenges. Specifically, providers noted that there are things other than a client's presentation of mental illness symptoms that can contribute to holding and enacting stigmatizing attitudes and behaviors. For example, the providers noted that they might avoid clients who are living in environments where there are bed bugs or excessive cat urine.

After reviewing the model, the provider group next looked to the initial item pool for the self-assessment. There was a consensus that the measure would be helpful in a provider's professional practice, in their supervision, and in efforts to improve in professional efficacy. Suggestions were made to change the wording of some items, addressing the issue identified by

the academic/researcher focus group, and clarifying the language between recovery-based terms and substance abuse recovery. In addition, some items that were worded softly, in forgiving language, were noted by provider participants as not being soft enough. The providers also suggested including a measure of burnout. Group members strongly believed that their level of career stress would directly impact their responses to items on the self-assessment of stigma. This suggestion reinforced the importance of assessing the relationship between the construct of professional burnout and provider-based stigma, as suggested by academic/researcher feedback.

Consumers of mental health services stakeholder consultation group. At this point in the planned research, the next scheduled group was to be composed of family members of mental health service consumers. The family group was scheduled, recruited for, and the catering order was submitted. Unfortunately, no participants attended. The next planned stakeholder consultation group consisting of consumers of service had already been scheduled, recruited for, catering order placed, and was therefore ultimately held prior to the family member group. This unexpected change in scheduling conflicted with the original plan, which was to host the consumer group last.

Recruitment for the mental health service consumer stakeholder consultation group began with assistance from the National Alliance on Mental Illness, Virginia. A message recruiting for both family member and consumer discussion groups was distributed through NAMI-Virginia's newsletter and social media page. Interested participants were asked to contact me to RSVP. In addition, a recruitment advertisement was disseminated by Virginia Organization of Consumers Asserting Leadership (VOCAL) through their e-newsletter. These recruitment communications are presented in Appendix D.

The consumer discussion group was held at a community grocery store location, Ellwood Thompson's Community Room, in Richmond, VA. The group was held at lunchtime and lunch was provided. In addition, as incentive for participation group participants were given a selection of personal account memoirs of living with and recovery from mental illness from which to choose. In addition to the researcher, a colleague also attended in order to assist in taking notes. In total, five consumers of mental health services participated in the consultation group. There were two men and three women, ranging in ages from 35 to 60 years. Participants had been consumers of mental health services for varying time frames, spanning from 8 to 27 years.

For much of the group the main focus was on discussion of the experience-based model of provider-based stigma. Since the model was derived through a qualitative analysis of consumer and family authored literature, this stakeholder group provided a real opportunity for the model to be reviewed by consumers of mental health services for face validity. In general, the group of consumers was in agreement with the model, offering their own personal experiences related to each of the themes of the model. One participant indicated that their personal experiences with mental health services were not reflective of the model. Regarding the theme of blame and shame, one participant indicated that it was as if his providers expected him to fail simply because he was not taking medication, as if it were solely his choices that would lead to symptoms. The theme of coercion and lack of 'real' choice particularly resonated with the participants. The consultation group members noted that they were rarely provided with information about other resources to help in their recovery, aside from medication, and that often choices were made about their care without their input or in their absence. As an example of

provider disinterest, annoyance, and/or irritation, one member of the group referred to her therapist falling asleep during a session.

The consultation group of consumers also briefly reviewed the item pool for the self-assessment measure. There were no issues identified by this group as to wording or relevance of specific items. The discussion often returned to their personal experiences that were related to or mirrored the items of the questionnaire. Overall, the group's support of the model's face validity was most evident by their ability to offer numerous experiences from their own lives that were reflective of the themes of provider-based stigma.

Family member stakeholder consultation group. The final stakeholder consultation group serving as an expert panel review of the initial item pool was composed of family members of persons living with mental illness. As previously noted, this group was originally scheduled to be held prior to the consumer group. Due to lack of attendance at the first scheduled meeting this group was ultimately held at a later date. Recruitment for this group was conducted in the same manner as the consumer group, described above, through assistance of NAMI-Virginia, with the addition of the researcher attending NAMI-Central Virginia's monthly meeting and presenting information about the opportunity to participate to the family members in attendance (recruitment materials are in Appendix D). Like the consumer group, the family group was held at Ellwood Thompson's Community Room, with dinner provided, as well as a selection of memoir literature from which participants could choose a book to add to their collection. Attendance at the family group was smaller than the others, with two parents of an individual living with mental illness, the brother of a consumer of services, and a consumer of services in attendance. In total three family members, one consumer, the researcher, and a colleague to assist in recording notes participated in this consultation group.

Most of the group's discussion centered on general experiences with mental health service providers. Dissatisfaction with the 'system' of mental health services was a strong theme of family member's experience. Notably, discussion group participants voiced the belief that there is inadequate communication among providers, such as between the social workers and psychiatrists. In addition, participants voiced the belief that there are limited options for consumers, being mostly relegated to medication management without creating a better standard of living. While this discussion did not center on reviewing the experience-based model, many of the themes of the conversation were reflected in the model. When the stakeholder group did attend to the model, many of the same sentiments were again expressed.

Much of this group's discussion centered on general commentary about dissatisfaction with the mental health service system. Therefore, in order to consolidate the remaining dialogue the experience-based model and items of the proposed survey were reviewed in tandem. For example, items related to the theme of Disinterest, Annoyance, and/or Irritation were read and commented on by participants after they had been introduced to that element of the model. This was different than the structure of the previous groups, during which the model was reviewed in full prior to the items of the survey. With respect to the theme of disinterest, annoyance, and/or irritation, the group equated this theme to their experiences of feeling ignored in their attempts to be involved in their family member's mental health care. Family members supported the theme of degradation and dehumanization, recounting their perception that the services provided to their family member lacked depth, with the focus being medication management, and not adding structure and direction to their loved one's life. This was reiterated when discussion turned to the theme of poor prognosis and fostering dependence. The theme of blame and shame was wholeheartedly endorsed as being relevant to their experience in the mental health services

setting, especially when they were excluded from care decisions for reasons of confidentiality. There was little comment on the theme of coercion/lack of ‘real’ choice by family members, with the exception of the noticed focus on medication and side effect management. Respecting the item pool and elements of the survey, the group voiced agreement and endorsement of a number of the questions, and were especially supportive of the notion that provider-based stigma would be related to provider’s level of professional burnout. No major issues were noted by participants respecting item wording or theme with which the items were associated.

Description of the Disseminated Instrument

Following the focus and stakeholder consultation groups, making use of the notes taken during discussions, the final item pool took shape involving extensive editing, revisions, and the removal of numbers. The measure was named the Mental Health Provider Self-Assessment of Stigma Scale (MHPSASS). The instrument was designed, including crafting demographic questions and validation items. The survey, provided in Appendix E, as disseminated to respondents via SurveyMonkey contained 8 demographic questions: gender, highest level of education, discipline/profession with which respondent identifies, length of employment in mental health services, length of employment in their current role, type of mental health service setting in which they were employed, geographical region of the Commonwealth where they worked, and if they were a peer provider of services. These questions were phrased in a way yielding responses that created nominal (e.g., male/female/other gender identity) and ordinal (e.g. less than 1 year, 1 – 5 years, 6 – 10 years, 11 – 15 years, 16 – 20 years, 21 years or more) level data.

Next, sixty-two items of the MHPSASS’ pool were posed to the respondents, with no more than five on a page, to not visually overwhelm respondents. The majority of the questions

(n=52) asked respondents to consider their level of agreement with statements on a 7-point Likert scale, ranging from 1 = Strongly Disagree, 4 = No Opinion, to 7 = Strongly Agree. Ten questions asked respondents to indicate the frequency with which they engage in the described activity, with responses on a 7-point Likert scale ranging from 1 = Never, 4 = Sometimes, 7 = All of the time, with a separate N/A option. A list of the 62 items of the MHPSASS, along with the associated theme of provider-based stigma as depicted in the experience-based model, the stigma element intended to tap (attitude/belief versus behavior), wording of the items (soft versus hard), and response option (agreement and frequency) is provided in Appendix F.

Following the items being tested for the MHPSASS, validation items were included. A single item, 10-point self-rating scale of burnout was presented. Maslach and Jackson's (1981) definition of burnout was provided, after which respondents were asked to rate "how burnout they perceive [themselves] to be, in [their] current role as a mental healthcare provider." Response options ranged from 0 = Not at all burned out in my current role, 5 = Mildly burned out in my current role, to 10 = Severely burned out in my current role. The inclusion of this validation item was based on focus group feedback that a provider's attitudes, beliefs, and behaviors would likely be significantly related to where they were in terms of burnout. While Maslach has developed a validated instrument for measuring burnout it was not sought for inclusion because of its cost and the current survey already cumbersome length.

The final section of the developed survey contained a 10-item social desirability measure, based on the work of Crowne and Marlowe (1960), shortened and validated by Strahan and Gerbasi (1972). Respondents were asked to respond with True or False to a series of statements. Their responses were scored as 1 or 0, 1 indicating a response influenced by social desirability and 0 indicating a response not reflecting social desirability. The highest possible score on the

measure of 10 would suggest the influence of social desirability, whereas the lowest possible score of 0 would suggest little influence of social desirability.

Taken together, including demographic questions, scale items, and validation items, the disseminated survey contained 81 total items. After the validation items, respondents were thanked again for their participation, and directed to another SurveyMonkey link. Through this other link respondents could enter in their name and email address for entry into a drawing for one of four \$50 gift cards to Target. Since disseminating the survey, the four winners have been selected and cards have been mailed to three of those four; as yet there has been no reply from the fourth winner providing an address. Respondents were assured that their responses on the survey would not be linked to their contact information for the drawing, as the surveys were separate entities.

Sample Construction

With the assistance of a contact at Virginia's DBHDS, a list of email contacts of the Executive and Clinical Directors of each of the Commonwealth's CSBs and state-run mental health facilities was assembled. Forty CSBs and eight facilities were contacted via email to their Executive and/or Clinical Director (ED and CD). Initial emails introducing myself and describing the survey were sent to both the ED and CD, asking for a response to the researcher indicating if the agency would like to participate. The CD was also sent an email of invitation to forward to their staff 'as is,' if the agency chose to participate. If no response was received from the agency, a second contact was made to the both the ED and CD one week later. If the CSB did forward out the invitation to staff, a reminder invitation was sent to these agencies two weeks after the first. Clinical directors were asked to forward out the reminder to staff 'as is' to spur more replies. Most of these email communications were reviewed by the VCU IRB and can be

found in Appendix G. Recruitment, via the email communications described above, took place between September 19, 2014 and October 15, 2014.

Of the 40 CSBs and eight state-run facilities, or 48 total agencies, 21 agreed to participate, for an agency participation rate of 43.75%. All geographical regions of the Commonwealth of Virginia were represented. During data collection a total of 310 attempts at the survey were made. Of the 310, some responses were determined to be ineligible for participation. Despite the request that respondents be employed in mental health service delivery with adults, there were a few responses indicating not being currently employed in the field and serving an infant, child, or adolescent population. Based on ineligibility, eight attempts were deleted. In addition, of the 302 remaining cases, 49 respondents did not complete the survey, stopping at various points. These cases were also deleted for a remaining sample size of $n = 253$. Of those 253 cases, an additional 33 cases were eliminated from the factor analysis procedures because they contained some missing data. As factor analysis requires complete data, the cases containing missing data were not used, leaving a sample size of 220. Demographic data and univariate results are presented for both data sets, the full set of 310 minus the eight ineligible responses ($N = 302$) and for the data set making use of only complete cases ($N = 220$).

Prior to data analysis, there were some noted issues with responses and coding. The first issue was determined to be the result of asking demographic questions in a manner that did not account for all the possible responses. When asked about their highest level of education completed, respondents were given the following choices: high school diploma, bachelor's degree, master's degree, and doctorate/MD. The error was in not including associate's degree as an option. To correct this issue, the data were coded into a categorical variable that included "less than bachelor's degree" to account for those who reported receiving a high school diploma,

as well as those who selected high school, but indicated more education in another field of response. Related to this discrepancy, two respondents selected 'other' as the discipline with which they identified, but indicated receiving an associate's degree or completion of a nursing degree program in the fill-in option. These two respondents were moved from the 'other' discipline to nursing and their education was coded into the less than bachelor's category.

Another coding issue, corrected prior to data analysis, involved responses to the question about the type of mental health service setting in which the respondent was employed. Ten respondents indicated a setting of 'other' but wrote in a setting which was an available option. For example, some respondents wrote they were employed in "state psych hospital" when the "long-term inpatient" response would have been appropriate. These responses were re-categorized into the appropriate category. Another note, quite a few respondents selected 'other' and wrote in 'PACT.' The incidence of this write-in would indicate that not including it as an option was in error.

Sample characteristics. As noted above, of the 310 attempts at the disseminated survey, 49 respondents did not complete the assessment, an additional eight completed surveys were determined to be ineligible, leaving a sample size of $n = 253$. However, another 33 cases were ultimately excluded from the factor analysis because of missing data. The demographic results are presented for two different samples; the first containing $N = 302$ responses, the total data set minus ineligibles; and the second set of $N = 220$, the complete data used in the factor analysis procedures. The purpose in looking at the demographic results of both data sets is to see if there are differences between the groups, to show the characteristics of the sample that chose to begin the survey and the sample that completed the survey. The total number of individuals to which the survey was made available is unknown. Although the survey was sent to all the CSBs and

long-term facilities, it is unknown how many employees at each of these agencies received the invitation. Therefore, a response rate is unknowable. In addition, the total number of mental health providers employed by the Commonwealth of Virginia, particularly those who work with adults, is ever-changing, due to turnover, promotion, and transfer. That, coupled with the division of providers into population, such as child and adolescent services versus adult service providers makes the total population of providers of adult mental health services unknowable. However, the sample size of $N = 220$ is adequate for performing factor analysis procedures, as suggested by Comrey (1973), who stipulates that a sample size of 200 is fair, but a sample size of 300 is good. Thus, this study's sample size of 220 could be characterized as 'fairly good.'

Regarding the data used for the factor analysis ($N = 220$) the majority of respondents were female ($n = 180, 81.8\%$) and just over half held a master's degree ($n = 116, 52.7\%$). Many respondents identified with the social work discipline ($n = 64, 29.1\%$), the next most frequently identified being counseling ($n = 54, 24.5\%$). Respondents indicated having been employed in the mental health field primarily for more than 21 years ($n = 62, 28.2\%$), with the second most indicated time in the field of between 1 and 5 years ($n = 58, 26.4\%$). Conversely, most respondents had been in their current role for between 1 and 5 years ($n = 93, 42.3\%$). Most respondents were employed in outpatient services ($n = 107, 48.6\%$) and were not peer providers ($n = 202, 91.8\%$). Many of the respondents were employed in the central Virginia region ($n = 80, 36.4\%$), Southwest Virginia ($n = 49, 22.3\%$), or Coastal and Tidewater Virginia ($n = 42, 19.1\%$). For all demographic data frequency tables, see below in Table 1 and Table 2.

Table 1

Descriptive Demographic Data

Variable	Response	Total N=302	%	Cumm. %	N=220	%	Cumm. %
Gender	Female	248	81.0	81.0	180	81.8	81.8
	Male	54	19.0	100	40	18.2	100
	Total	302	100		220	100	
Education	Less than Bachelor's Degree	43	14.2	14.2	27	12.3	12.3
	Bachelor's Degree	85	28.1	42.3	67	30.5	42.7
	Master's Degree	159	52.6	94.9	116	52.7	95.5
	Doctorate and/or M.D.	15	5.0	100	10	4.5	100
	Total	302	100		220	100	
Discipline	Social Work	88	29.1	29.1	64	29.1	29.1
	Counseling	69	22.8	51.9	54	24.5	53.6
	Nursing	37	12.3	64.2	24	10.9	64.5
	Human Services	31	10.3	74.5	25	11.4	75.9
	Other	24	7.9	82.4	19	8.6	84.5
	Psychology	22	7.3	89.7	16	7.3	91.8
	Support Staff	17	5.6	95.3	7	3.2	95.0
	Paraprofessional	6	2.0	97.3	5	2.3	97.3
	Medicine	4	1.3	98.6	3	1.4	98.7
	Marriage and Family Therapy	4	1.3	100	3	1.4	100
	Total	302	100		220	100	
Setting	Outpatient services	143	47.4	47.4	107	48.6	48.6
	Long-term inpatient services	62	20.5	67.9	41	18.6	67.2
	Other	38	12.6	80.5	33	15.0	82.2
	Crisis stabilization/acute care	35	11.6	92.1	23	10.5	92.7
	Psychosocial clubhouse	13	4.3	96.4	9	4.1	96.8
	Residential care	10	3.3	99.7	6	2.7	99.5
	Missing	1	0.3	100	1	0.5	100
	Total	302	100		220	100	
Region	Central Virginia	102	33.8	33.8	80	36.4	36.4
	Southwest Virginia	67	22.2	56.0	49	22.3	58.7
	Coastal and	58	19.2	75.2	42	19.1	77.8

	Tidewater Virginia							
	Northern Virginia	47	15.6	90.8	30	13.6	91.4	
	Northwest Virginia	15	5.0	95.8	9	4.1	95.5	
	South central Virginia	11	3.6	99.4	9	4.1	99.6	
	Missing	2	0.7	100	1	.5	100	
	Total	302	100		220	100		
Peer Provider?	No	279	92.4	92.4	202	91.8	91.8	
	Yes	20	6.6	99.0	15	6.8	98.6	
	Prefer not to answer	2	0.7	99.7	2	0.9	99.5	
	Missing	1	0.3	100	1	0.5	100	
	Total	302	100		220	100		

Table 2

Respondent's Length of Time Employed in the Field and in their Role

Length of time employed ...	<i>In the mental health services field</i>						<i>Current role</i>					
	<i>N</i> =302	<i>%</i>	<i>Cum %</i>	<i>N</i> =220	<i>%</i>	<i>Cum %</i>	<i>N</i> =302	<i>%</i>	<i>Cum %</i>	<i>N</i> =220	<i>%</i>	<i>Cum %</i>
Less than 1 year	8	2.6	2.6	5	2.3	2.3	38	12.6	12.6	30	13.6	13.6
1 – 5 years	76	25.2	27.8	58	26.4	28.6	130	43.0	55.6	93	42.3	55.9
6 – 10 yrs.	66	21.9	49.7	42	19.1	47.7	76	25.2	80.8	50	22.7	78.6
11 – 15 yrs.	46	15.2	64.9	33	15.0	62.7	20	6.6	87.4	18	8.2	86.8
16 – 20 yrs.	25	8.3	73.2	20	9.1	71.8	15	5.0	92.4	12	5.5	92.3
More than 21 years	81	26.8	100	62	28.2	100	23	7.6	100	17	7.7	100
Total	302	100		220	100		302	100		220	100	

Comparing the demographic data of the total sample ($N = 302$) with that of the used sample ($N = 220$) there were no major differences noted between the groups. More specifically, the proportion of respondents with given characteristics who completed the survey did not appear to be substantially different from the group that began to take the survey. However, there were some small differences between the starting and finishing samples. For example, with respect to education level, there appear to be small changes in the proportion of the sample of respondents

indicating having less than a bachelor's degree and a bachelor's degree. Initially, 43 respondents having less than a bachelor's degree (14.2% of the sample $N = 302$) and 85 respondents holding a bachelor's degree (28.1% of $N = 302$) began the survey. However, only 27 respondents having less than a bachelor's (12.3% of $N = 220$) and only 67 with a bachelor's degree (30.5% of $N = 220$) finished taking the survey. Compared to those with master's and doctoral degrees, whose proportions remained the virtually the same between the starting and completing samples, it appears that those with less education were slightly less represented in the completed sample. Similarly small differences are present with respect to professional discipline (i.e. counseling starters $n = 69$, or 22.8%; finishers $n = 54$, 24.5%) and service setting (long-term inpatient services starters $n = 62$, 20.5%; finishers $n = 41$, 18.6%). Since the aforementioned differences between starting and finishing samples appear to be insignificant, practically speaking, tests of statistical significance seem superfluous, and were therefore not calculated.

Data analysis

Preliminary analysis.

Missing data. Initially, the frequency distributions for the responses to the 62 items of the item pool were reviewed for missing data. Respondents of the survey were able to skip questions, a decision about which was made by the researcher, so as not to force a response from participants when they desired to skip for any reason. The frequency distributions for each of the questions were reviewed to see if there were any questions that were skipped more frequently than others. One item, number 25 "I would prefer my client to voluntarily admit themselves for emergency psychiatric services, but if they don't, my client knows that I will begin involuntary procedures" was skipped a total of 21 times. All other items were skipped no more than 5 times.

Since this was a significantly higher 'skip' rate, this item was deleted from further analysis. The remaining 61 items of the MHPSASS were used in all further analyses.

In order to see if there were any patterns related to the missing data, that is if missing a particular question was related to the missing of another question, procedures were followed to calculate correlations between missing responses. It is generally preferred that missing data is missing completely at random (MCAR) or missing at random (MAR); that there is little to no relationship between the absence of response on an item to any others. When there is a pattern to the missingness, data are characterized as missing not at random (MNAR). To screen for patterns of missingness in response to any of the initial 61-items of the MHPSASS, data were dummy coded. A value of 1 was used to indicate missing data and 0 for a response of any kind. Next, bivariate correlations were computed in SPSS, and the correlation matrix was inspected, flagging correlations that exceeded 0.50. An evident pattern of missingness was observed, thereby characterizing the missingness as MNAR, not at random. For factor analysis, the most conservative method to address missing data is to not include the whole case in the analysis, which is the approach used in the current study. For this reason 33 cases were removed from further analysis.

Assessment of multivariate assumptions for factor analysis. Next, the data were screened for multivariate assumptions necessary for factor analysis. Namely, it is assumed that there is an absence of outliers. The data were screened for the presence of outliers, which are defined as cases with an extreme value on one variable, as with univariate outliers, or a combination of scores on two or more variables that are so odd they can distort the statistics (Tabachnick & Fidell, 2007). In order to detect possible distortions in the data, the presence of outliers was screened for by the computation of Cook's D. Cook's D essentially provides a measure of the

impact an observation has on the estimated regression coefficient. Since factor analysis does not make use of a dependent variable, as in the case of regression, a random dependent variable was computed using syntax in SPSS. The syntax is as follows:

```
COMPUTE id=$CASENUM.
FORMAT id (F8.0).
EXECUTE.
```

There are several potential thresholds recommended for identification of a Cook's D value that is large enough to indicate an outlier. These criteria are presented below in Table 3.

Table 3

Cook's D Values and Identified Outliers

Criterion	Calculated Value for the Present Study's Data	Outliers Identified by Critical Value of D
Cook's D is greater than $4/(n-k-1)$	$4/(220-61-1) = 0.025$	14
Cook's D is greater than 1	1	0
Cook's D is greater than $4/n$	$4/220=0.018$	22
Average of the above three criteria	0.3477	0

Using the random dependent variable, created for the purpose of computing Cook's D, and the most conservative of critical values of Cook's D ($D = 0.018$) the presence of 22 outliers is indicated. To assess whether the presence of these outliers has an influence on the factor analysis findings, a separate data set was created, one with these 22 outlier cases deleted. The factor analysis procedures, discussed later in this chapter, were conducted with both data sets, the one containing the outliers and the one with outliers deleted. The findings of these factor analyses were not substantially different, indicating that the conservative detection of outliers using the lowest value of Cook's D computed, flagged cases that were not significantly odd

enough to influence the structure of the factor solution. The data set containing outliers, or $N = 220$, was used in the univariate analysis described next.

Univariate analysis. The frequency tables of each of the items were inspected, paying attention to significant ‘missingness,’ for which only one item was determined especially problematic (item 25) and deleted. The responses to the remaining 61 items of the MHPSASS initial pool were coded with the following numerical values, given their respective response options.

Table 4

Coding of Likert Scale Responses

Items	Response options	Coded numerical value
Items 1 through 52 Level of Agreement	1 – Strongly Disagree	1
	2 – Disagree	2
	3 – Somewhat Disagree	3
	4 – No opinion	0
	5 – Somewhat Agree	4
	6 – Agree	5
	7 – Strongly Agree	6
Items 53 through 62 Frequency of Behavior	1 – Never	0
	2	1
	3	2
	4 – Sometimes	3
	5	4
	6	5
	7 – All of the time	6
	N/A	0

A respondent who scored a 6 on either item would indicate an especially high level of agreement with a belief or attitude or a high frequency of a particular behavior. Taken together, the average of responses on each of these items, if they elicited a variety of responses, would tend to cluster

around the mid-point of 3.0. If the item did not bring out a variety of responses, that is different levels of agreement and frequency, the average would cluster toward one extreme of the range.

The majority of the item means clustered toward the lower end of the range, below 3.0. However, 11 items had a mean score of 2.75 or greater (items 1, 2, 9, 10, 13, 14, 17, 22, 39, 43, 48.) Some of the lowest averages were of items 56, 57, 58, and 59 with the means 0.27, 0.48, 0.18, and 0.58 respectively. Inspecting the items' standard deviation gives an indication of the amount of variability in the responses. A larger standard deviation indicates that the distribution of responses varies more from the mean. A smaller deviation signifies little variability of the distribution of scores away from the mean. The standard deviations for the initial 61 items of this scale range from a low of 0.527 (item 58, $M = 0.18$) to a high of 1.585 (item 9, $M = 3.70$). Most of the items have low standard deviations, with notable exceptions. Univariate results for the 61 items are presented below, in Table 5.

Respecting the adequacy of the range of response options, many items (28 of the 61 total) were answered with each of the options, including the minimum and maximum values (between 0 and 6). A sizeable minority, 24 of the 61 items, scored between 0 and 5, without the maximum being selected. There were six items of the 61 total for which respondents only selected options 0 through 4; two of the 61 items only scored a maximum of 3. These last eight items with small ranges correspond to items with very low averages. When considering these univariate results, it is noted that there are some items with significantly low means and standard deviations, which indicates that these particular items are not eliciting a variety of responses from survey-takers. However, at this point, no items were deleted from further consideration based on low variability. The factor analysis procedures are described next, which as a procedure uses the ratio of covariation to standard deviation in computing factor loadings. Univariate statistics were

consulted again, after factor analysis, to assist in selecting items for deletion to make a more parsimonious measure.

Table 5

Univariate Statistics for 62-items of MHPSASS

Item	Missing from N = 253	Mean score (N = 220)	Standard Deviation	Minimum value	Maximum value
1	1	3.08	1.304	0	5
2	0	3.00	1.370	0	6
3	1	1.36	1.218	0	5
4	1	2.33	0.995	0	5
5	0	2.18	0.999	0	5
6	0	2.21	1.040	0	6
7	0	2.42	1.212	0	6
8	0	1.70	0.829	0	4
9	1	3.70	1.585	0	6
10	0	3.02	1.497	0	6
11	0	2.36	1.179	0	5
12	0	2.50	1.22	0	5
13	1	3.24	1.557	0	6
14	1	2.87	1.416	0	6
15	1	2.14	1.073	0	5
16	0	2.17	1.193	0	5
17	0	2.90	1.367	0	6
18	2	2.20	1.117	0	5
19	1	2.09	1.155	0	5
20	1	2.47	1.156	0	5
21	0	2.33	1.294	0	5
22	2	2.78	1.384	0	6
23	0	2.03	1.009	0	5
24	0	2.28	1.499	0	6
25	21	DELETED	---	---	---
26	1	2.62	1.250	0	6
27	3	2.25	1.269	0	6
28	0	2.04	1.035	0	4
29	0	2.20	1.121	0	6
30	0	2.45	1.232	0	5
31	0	1.35	0.656	0	4
32	0	2.20	1.157	0	5
33	1	1.90	1.305	0	6
34	2	2.36	1.188	0	5
35	0	2.47	1.339	0	6

36	1	1.95	1.076	0	4
37	1	1.95	1.403	0	6
38	0	2.25	1.406	0	6
39	1	3.52	1.441	0	6
40	1	2.10	1.144	0	5
41	0	2.00	1.141	0	6
42	0	1.95	1.359	0	5
43	1	3.18	1.450	0	6
44	0	2.66	1.374	0	5
45	1	1.96	1.061	0	6
46	1	2.44	1.388	0	6
47	2	1.76	1.246	0	5
48	1	3.21	1.470	0	6
49	3	2.03	1.186	0	5
50	3	1.85	1.172	0	5
51	4	2.63	1.413	0	6
52	3	2.62	1.514	0	6
53	0	1.53	1.343	0	5
54	0	1.10	1.512	0	6
55	0	1.43	1.289	0	6
56	1	0.27	0.588	0	3
57	0	0.48	0.847	0	4
58	3	0.18	0.527	0	3
59	3	0.58	0.931	0	4
60	3	1.27	1.166	0	5
61	4	1.19	1.395	0	6
62	3	1.25	1.161	0	5

Factor analysis. A series of exploratory factor analyses were performed using IBM SPSS 21. The analyses varied based on factor-extraction method, number of factors specified, and the inclusion of outliers in the procedure. Varimax rotation was exclusively employed in these analyses after it was determined that orthogonal rotation was the optimal selection. To determine if the orthogonal rotation was the appropriate method, the recommendation of DeVellis (2003) was followed. Namely, a principal component analysis (PCA) with a four factor solution was conducted, specifying Oblimin rotation, after which, the component correlation matrix was inspected. If the correlations of this matrix are “quite small (e.g. less than .15)...” (p.

124) then the analyst could opt for an orthogonal rotation. For this data, the component correlations were quite low: Factor 2's correlation with Factor 4 was $-.139$, less than $.15$. The other correlations were less than $.195$. The only exception was Factor 3's correlation with Factors 1 and 2, with correlations of $-.307$ and $-.241$ respectively. Overall, these component correlations were low and therefore the orthogonal rotation seemed to be the best option. Indeed orthogonal rotation is preferred, as uncorrelated subscales of a final measure are desired. Table 6 lists the factor analysis procedures conducted with each of the two data sets, using varimax rotation for all. In total, 20 exploratory factor analyses were computed and compared.

Table 6

Factor Analysis Procedures Performed

Dataset with outliers retained ($N = 220$)	Dataset with outliers deleted ($N = 198$)
Principal Component Analysis (PCA) – two factors Principal Axis Factoring (PAF) – two factors	PCA – two factors PAF – two factors
PCA – three factors PAF – three factors	PCA – three factors PAF – three factors
PCA – four factors PAF – four factors	PCA – four factors PAF – four factors
PCA – five factors PAF – five factors	PCA – five factors PAF – five factors
PCA – six factors PAF – six factors	PCA – six factors PAF – six factors

The outputs for the factor analysis were inspected, first attending to the influence of outliers on a resulting factor solution. The factor structure, respective item loadings, and the amount of variability accounted for were not significantly different between the data set containing outliers and the set with outliers deleted. Specifically, the total variance explained by the resulting factor

structure, regardless of number of factors specified and method of extraction, were within one or two points (i.e. variance explained with outliers, PCA, two factors = 23.684%; without outliers, PCA, two factors = 25.037%). This indicates that the conservative approach to detecting outliers, detailed above, flagged values that while statistically 'odd' were not exerting an influence on the data that merited deletion. Outliers were retained and the factor analysis outputs of both PCA and PAF extraction methods were next inspected. As the result of PCA's assumption of communalities that equal one, which PAF does not assume, the total variance accounted for by the factor structure was higher with the PCA compared to PAF, regardless of the number of factors specified. For example, with the three factor model, the variance explained with PCA extraction was 28.357%, in contrast to PAF extraction with variance explained value of 24.882%. The higher variance explained is desirable in a meaningful scale and therefore, a PCA solution was pursued. Next, the factor loadings for each of the PCA outputs were inspected.

The five factor solution was examined first because of the five factor model used to craft the item pool; the hypothesized factor structure was five. Although the variance accounted for by this solution was the largest of all (35.808%), the factor loadings made a five-factor solution impractical. The fifth factor did not have any items loading solely on it, and the threshold for a viable factor is that it must have at least 3 items loading on it alone. In adequate items loadings was also the case with the six factor solution. Therefore, the five and six factor PCA solutions were eliminated from consideration because of insufficient item loadings. Of the three remaining PCA solutions, the four factor model had the highest variance accounted for (32.454%) and seemingly readable factor loadings. The two factor and three factor solutions had

significantly lower variance accounted for values, 23.648% and 28.357% respectively. For this reason, the four factor PCA solution was selected to be used for scale refinement.

The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy provides an indicator of the extent to which the variables of a construct belong together. While there are no 'gold' standards for interpretation of the KMO measure, Kaiser and Rice (1974) suggest the following guidelines for interpreting the results: KMO larger than 0.9 is marvelous, larger than 0.8 is meritorious, larger than 0.7 is middling, larger than 0.6 is mediocre, larger than 0.5 is miserable, and below 0.5 is unacceptable. For this data, the KMO measure value is 0.799, which is larger than 0.7, or middling, by Kaiser and Rice's suggestion, but if rounded up to 0.8, is meritorious.

The rationale for selecting the principal component analysis (PCA) extraction with varimax rotation and a specified four factor solution, as described above, was supported by consulting the data's scree plot, contained in Figure 5. As can be seen, a distinct 'rubble' effect occurs after the fourth factor.

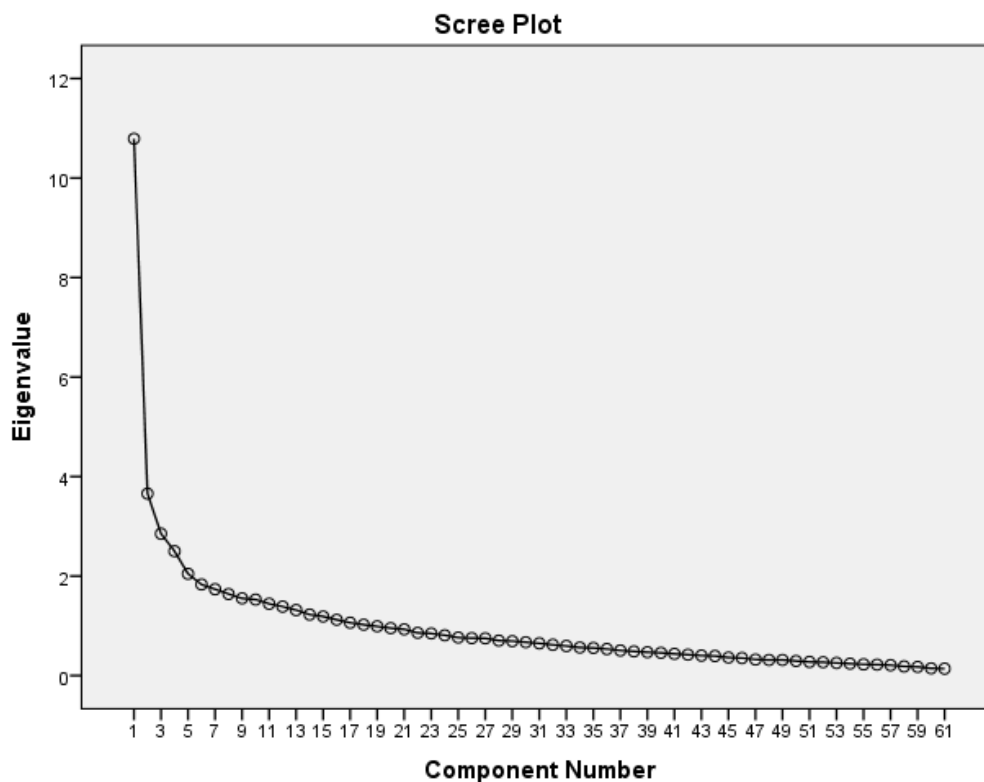


Figure 5. Scree plot for MHPSASS data, PCA extraction, varimax rotation.

These four factors explained 32.454% of the variance in the correlation matrix for these data.

The variance accounted for by each of the four factors was fairly equal: Factor 1 accounted for 8.988% of the variance, Factor 2 = 8.594%, Factor 3 = 8.029, and Factor 4 = 6.844%. The SPSS output is replicated below in Table 7.

Table 7

Total Variance Explained for Exploratory Factor Analysis, Principal Component Extraction with Varimax Rotation of the Mental Health Provider Self-Assessment of Stigma Survey

Component	Total Variance Explained								
	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	10.790	17.689	17.689	10.790	17.689	17.689	5.483	8.988	8.988
2	3.657	5.995	23.684	3.657	5.995	23.684	5.243	8.594	17.582
3	2.850	4.673	28.357	2.850	4.673	28.357	4.897	8.029	25.611
4	2.499	4.097	32.454	2.499	4.097	32.454	4.175	6.844	32.454

Extraction Method: Principal Component Analysis.

In Appendix H the solution's communalities and factor loadings are provided. Communality represents the proportion of the variance in an item that is explained by the factor solution. Communality values range from 0.0 to 1.0 with values closer to 1.0 representing a greater proportion of variance accounted for by the factor structure. As can be seen in the highlighted communality values in the table of Appendix H, there are 14 items of the original 61 items for which the factor solution accounts for 40% or more of the variance. In general, the communalities for these items is fairly low, with no proportion of variance accounted for by the factor structure greater than 0.546 (item 44).

Next, the rotated factor matrix, which contains the correlations between the items and each factor, was examined. A higher factor score represents a stronger correlation between the item and the factor. The level at which a meaningful association is achieved will vary depending on the purposes of the investigation. Typically a threshold of 0.3, 0.5, or 0.7 is used. For these data, the threshold of 0.3 results in a large number of items qualifying for retention, but also a

high number of split-loadings, or items that are loading at a level of 0.3 to more than one factor. However, at the 0.5 threshold few items were identified for retention. Therefore, for these data the threshold of 0.4 was used to identify items for retention. Based on this level, 19 items did not load onto any of the four factors and were flagged for deletion. These items are indicated in Appendix H with [*]. In addition, the loading was to be on only one factor. For example, item 60 loaded at a level of 0.498 onto Factor 4, but also 0.439 onto Factor 2. Due to the split loading, item 60 was flagged for deletion and is flagged in Appendix H with [**]. Using the recommendation of Worthington and Whittaker (2006) the factor loadings of the items were also inspected to ensure a substantial difference in loadings onto a factor. These authors recommend that items which do not produce factor loadings with more than a 0.15 difference should be deleted. Using this guidance, items 20 (loading 0.457 on Factor 1 and 0.309 on Factor 3) and 46 (loading 0.473 on Factor 3 and 0.342 onto Factor 4) were deleted from further consideration, and noted in Appendix H with [***].

After factor analysis, there were 39 items of the MHPSASS remaining, with 11 items loading onto Factor 1; 11 items onto Factor 2; nine items onto Factor 3; and eight items loading onto Factor 4. Next, the remaining 39 items were evaluated with attention to the individual item's performance and reliability.

Item analysis and reliability. The initial measure of internal consistency, Cronbach's alpha, was computed for the remaining 39 items of MHPSASS. Cronbach's alpha measures how much the covariance between items influence the variance of the total scale score (Abell, Springer, & Kamata, 2009). The computed Cronbach's alpha for this remaining group of 39 items is 0.876. The level is within the range which DeVellis (2003) describes "very good." Cronbach's alpha is not only influenced by the covariation of the items, but also increases with the addition of more

items. The Cronbach's alpha if the item were deleted from the scale values were reviewed next and compared to the alpha level of the total 39 items. If the value for 'alpha if deleted' was higher than the alpha for the 39 items, that is, if the scale's reliability would be increased if the item were deleted, that item would be deleted from further consideration. Item 9, if deleted would result in a scale with an alpha of 0.880, higher than the computed alpha for the total of 0.876. Also, the deletion of item 13 would produce a scale with an alpha of 0.878, also higher than the overall scale's reliability. These two items were deleted and a second item-analysis and Cronbach's alpha computation were conducted.

The remaining 37 items of the MHPSASS resulted in a computed alpha of 0.882, very good reliability according to DeVellis (2003) and all 'if item were deleted' values were less than the reliability with all included. Next, decisions were made about specific items' retention on the basis of duplication, taking into consideration item means and standard deviation. The researcher chose to further refine the MHPSASS because of the burdensome length of a 37 item measure and the redundant items that remained. Specifics of the decisions about deletion made on the basis of univariate statistics (mean less than 2.0) and duplication (if there are duplicates, the one with the highest mean was selected) are presented below in Table 8.

Table 8

Item Deletion Decisions

Deleted item # and stem	Stigma element Language	Item mean (s.d.)	Duplicate item # and stem	Dup. stigma element Language	Dup. mean (s.d.)	Deletion Rationale
8 - When a client wants to explore their medication options, I try to decrease their expectations: they don't really have that many choices.	Behavior Soft	1.70 (0.829)	n/a	n/a	n/a	Low mean (less than 2.0) and s.d.
11 - I occasionally have a hard time hiding my irritation with some clients.	Behavior Soft	2.36 (1.179)	2 - It's hard not to sometimes be irritated with clients who have serious mental illnesses.	Attitude/ Belief Soft	3.00 (1.370)	Lower mean and s.d. when compared to duplicate
30 - If a client doesn't take prescribed medication, they lack insight into their illness.	Attitude/ Belief Hard	2.45 (1.232)	22 - If my client isn't taking the medication they are prescribed, it is most likely because they lack insight into their illness	Attitude/ Belief Soft	2.78 (1.384)	Lower mean and s.d. when compared to duplicate
33 - Sometimes I make decisions for my client, for their own good.	Attitude/ Belief Hard	1.90 (1.305)	24 - In some instances it may be necessary to make decisions for my client, without their collaboration, for their own good.	Attitude/ Belief Soft	2.28 (1.499)	Low mean (less than 2.0) and s.d. Lower mean and s.d. when compared to duplicate
36 - When my client's family asks a lot of questions I find it difficult to not be annoyed.	Attitude/ Belief Soft	1.95 (1.076)	10 - When my client's family calls too many times, I can become irritated	Attitude/ Belief Soft	3.02 (1.497)	Low mean (less than 2.0) and s.d. Lower mean and s.d. compared to duplicate
42 - When considering options for housing, I try to highlight the options that I think they will benefit from	Behavior Soft	1.95 (1.359)	n/a	n/a	n/a	Low mean (less than 2.0) and s.d.
45 - When my client is very symptomatic, I don't need to fully explain my actions to them.	Attitude/ Belief Hard	1.96 (1.061)	29 - When my client is very symptomatic, I sometimes do not need to fully explain my actions to them	Attitude/ Belief Soft	2.20 (1.121)	Low mean (less than 2.0) and s.d. Lower mean and s.d. compared to duplicate
47 - I may not inform my client of possible options for independent housing, because they likely won't do well in those situations.	Attitude/ Belief Soft	1.76 (1.246)	n/a	n/a	n/a	Low mean (less than 2.0) and s.d.

Item # and stem	Stigma element Language	Item mean (s.d.)	Duplicate item # and stem	Dup. stigma element Language	Dup. mean (s.d.)	Deletion Rationale
50 - If my client's family is over-involved in my client's life, I am less likely to include them in treatment planning.	Behavior Soft	1.85 (1.172)	n/a	n/a	n/a	Low mean (less than 2.0) and s.d.
52 - When a client with a serious mental illness asks if they will always require medication, I will often tell them yes, because I believe they will.	Behavior Soft	2.62 (1.514)	39 - My client, diagnosed with a serious mental illness, will probably always need to take medication to function.	Attitude/Belief Soft	3.52 (1.441)	Lower mean and s.d. when compared to duplicate
53 - I often discourage clients with a serious mental illness from setting goals that are too 'out of reach.'	Behavior Hard Freq.	1.53 (1.343)	41 - My client's treatment plan may not reflect their goals, but rather goals that I think are realistic, to make sure they are successful in achieving these goals.	Behavior Soft	2.00 (1.141)	Low mean (less than 2.0) and s.d. Lower mean and s.d. compared to duplicate
54 - In my role as service provider I have made 'deals' with clients to get them to take prescribed medications, even if they really didn't want to.	Behavior Soft Freq.	1.10 (1.512)	n/a	n/a	n/a	Low mean (less than 2.0) and s.d.
55 - When my client is experiencing psychotic symptoms, I find myself more detached in our interactions.	Behavior Soft Freq.	1.43 (1.289)	n/a	n/a	n/a	Low mean (less than 2.0) and s.d.
59 - I frequently refer to clients by diagnoses they have, not their name.	Behavior Hard Freq.	0.58 (0.931)	38 - In the past, I have occasionally made reference to a client using a diagnostic label they have, instead of their name.	Behavior Soft	2.25 (1.406)	Low mean (less than 2.0) and s.d. Lower mean and s.d. compared to dup.
61 - When considering options for housing, I only let my client know about the options that I think they will benefit from.	Behavior Hard Freq.	1.19 (1.395)	15 - When I review treatment options with my client, I find myself sometimes emphasizing what I would prefer, setting aside the other options available.	Behavior Soft	2.14 (1.073)	Low mean (less than 2.0) and s.d. Lower mean and s.d. compared to duplicate
62 - When I am irritated with my client's neediness, I attempt to avoid them.	Behavior Hard Freq.	1.25 (1.161)	n/a	n/a	n/a	Low mean (less than 2.0) and s.d.

Based on duplication and univariate statistics, another 16 items of the MHPSASS were deleted, resulting in a further refined measure containing 21 items. Cronbach's alpha computed for the further refined 21-items was 0.816. This value is lower than the alpha computed for the 37 items, but the difference in reliability is likely accounted for by the different number of items. Also, an alpha of 0.816 is still considered 'very good' by DeVellis' (2003) recommendations. The item-analysis 'if item were deleted' alphas were also inspected, which identified item 22, if deleted would result in a scale with a higher alpha than if it were included. Therefore, item 22 was deleted. The final reliability and item assessment for the refined 20-item MHPSASS is contained in Appendix I, showing a scale alpha of 0.817, 'very good' according to DeVellis' recommendations.

In addition to the overall scale's reliability, each factor's subscale reliability was also assessed. These values are as follows: Factor 1 subscale Cronbach's alpha = 0.758; Factor 2 subscale Cronbach's alpha = 0.660; Factor 3 subscale Cronbach's alpha = 0.663; Factor 4 subscale Cronbach's alpha = 0.553. According to the suggestions of DeVellis (2003) these subscale reliability statistics span the range from 'unacceptable' (Factor 4's alpha 0.553), 'minimally acceptable' (Factors 2 and 3 alphas = 0.660 and 0.663 respectively), and 'respectable' (Factor 1's alpha = 0.758). The full reliability assessment is included in Appendix I.

Interpretation of the factors

Using the 20-items refined MHPSASS, a second look at the factor scores from the principal component factor analysis was taken to review the strength and relationship of the items to their respective factors. Again, the factor loadings and communalities for all 61 items of the MHPSASS are provided in Appendix H. For the discussion of factor interpretation, the factor

loadings and communalities of the 20-item MHPSASS are separated out from the total report in Appendix H and are provided below in Table 9.

Table 9

Factor Loadings and Communalities of the 20-Items of MHPSASS

20-item MHPSASS						
	Original theme	Factor 1	Factor 2	Factor 3	Factor 4	Communality
Item 2 - It's hard not to sometimes be irritated with clients who have serious mental illnesses.	DAI	.502	-.041	.181	.060	.290
Item 10 - When my client's family calls too many times, I can become irritated.	DAI	.544	.163	-.097	.093	.341
Item 17 - Even though I try not to, I can sometimes be impatient with my client.	DAI	.491	.043	.101	.131	.270
Item 21 - If a client is behaving in an annoying manner, I find that I am less likely to return their calls.	DAI	.630	.215	-.167	-.100	.480
Item 27 - Sometimes, I wish my client would hurry up when speaking with me.	DAI	.545	-.069	.061	.306	.400
Item 28 - Because I sometimes find it hard to hide my irritation, I can be short with my clients.	DAI	.442	.247	.051	.236	.315
Item 35 - When a client isn't trying hard enough in their recovery I may not go out of my way to help them.	Blame/ Shame	.430	.182	.129	.071	.240
Item 44 - When a client calls me too often, I get irritated with their neediness.	DAI	.676	.290	.056	.050	.546
Item 15 - When I review treatment options with my client, I find myself sometimes emphasizing what I would prefer, setting aside the other options available.	C/LORC	.329	.520	.071	-.015	.384
Item 19 - When families ask if their loved one will achieve common life goals, I may try to minimize expectations, so they aren't disappointed.	PP/FD	.191	.441	.094	.128	.256
Item 40 - When a family member of a client diagnosed with a serious mental illness asks if their loved one will ever get better, I try to minimize their expectations, so they aren't disappointed.	PP/FD	.248	.490	.073	.205	.349

Item 41 - My client's treatment plan may not reflect their goals, but rather goals that I think are realistic, to make sure they are successful in achieving these goals.	C/LORC	.067	.650	.183	.182	.494
Item 48 - If I think my client would benefit from a particular service, I find myself continuing to suggest this to them, even if they've declined.	C/LORC	.109	.439	.161	.042	.232
	Original theme	Factor 1	Factor 2	Factor 3	Factor 4	Communality
Item 12 - When a client of mine is not taking prescribed medication, they are probably resistant to being treated.	D&D	.120	.140	.545	.099	.340
Item 14 - Clients with serious mental illnesses have a hard time making good choices for themselves, so service providers need to help them.	C/LORC	.053	.028	.592	.195	.392
Item 26 - If a client is relapsing with symptoms of mental illness, there is likely some part of their treatment plan they haven't been following.	Blame/Shame	.160	.136	.515	.043	.311
Item 39 - My client, diagnosed with a serious mental illness, will probably always need to take medication to function	PP/FD	-.017	.075	.645	.170	.451
Item 24 - In some instances it may be necessary to make decisions for my client, without their collaboration, for their own good	C/LORC	.155	.073	.165	.473	.280
Item 29 - When my client is very symptomatic, I sometimes do not need to fully explain my actions to them.	D&D	.306	.058	.093	.515	.370
Item 38 - In the past, I have occasionally made reference to a client using a diagnostic label they have, instead of their name.	D&D	.225	.072	-.081	.538	.352

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.^a

a. Rotation converged in 7 iterations.

Abbreviations: DAI = Disinterest, Annoyance, Irritation; C/LORC = Coercion/Lack of REAL choice; PP/FD = Poor Prognosis/Fostering Dependence; D&D = Degradation & Dehumanization

Communalities of the items suggest that the derived four factor solution explains no less than 23.2% (item 48) of the variance and no more than 54.6% (item 44). The items load strongly onto

one and only one factor, with factor loadings shaded. The items of the MHPSASS were then grouped according to common factor with which they are associated. The themes on which the items were originally based, taken from the five-factor model of provider-based stigma (Charles, 2013), were listed alongside the items. Next, the items and associated themes were reviewed for similarities for the purposes of factor labeling.

For the first factor, seven of the eight items were originally based on the theme of provider disinterest, annoyance, and/or irritation. The last item was based on the theme of blame and shame. The seven items reflecting disinterest, annoyance, and/or irritation were reviewed, and it was noted that these items were related to provider irritation and impatience, rather than items reflecting disinterest, which had been removed from the scale in previous refinement.

Reviewing the final item based on blame and shame, the underlying construct could quite well reflect impatience. This first factor, fairly readable and interpretable, was labeled *Irritation and Impatience*.

The second factor was also fairly simple to interpret. Three of the five items were based on the original theme of coercion/lack of ‘real’ choice and the remaining two were based on poor prognosis/fostering dependence. After reviewing the five items, the common theme of these items seemed to be related to matters of client’s choices and their capacity to make these choices, as well as their capacity to have a meaningful recovery. For this reason, this second factor was labeled *Choice and Capacity*.

The third factor was a bit harder to interpret, with all four of its associated items initially based on four separate themes. These themes are degradation and dehumanization, coercion/lack of ‘real’ choice, blame and shame, and poor prognosis/fostering dependence. However, reading the individual items reveals an underlying thread. Items 12, 26, and 39 each are related in some

way to medication and treatment adherence. Item 14 is concerned with providers needing to help clients make decisions, because they are unable to do so themselves. Each of these items is also indicative of the perception of clients' necessity to remain active in treatment, or dependence-enforcing. This factor was labeled *Adherence and Dependence*.

The fourth factor was also complex in its interpretation with only three items. These items were based on the original themes of coercion/lack of 'real' choice and degradation and dehumanization. Item 24 refers to making decisions for clients, but it is different than the items of Factor 2 or Factor 3, because item states more concretely that a provider might need to make a decision for a client, without their collaboration, for the client's own good. In essence, this devalues the client's right and ability to participate in their treatment. Similarly, item 29, in reference to a provider not needing to fully explain their actions to their clients, reflects devaluation of the client's right and ability to engage in their treatment and recovery. The final item, item 38, reflects the use of diagnostic labels when referring to clients, rather than their names. Underlying this item could be the construct of depersonalization, or a provider's cognitive discounting of their client's humanity. While a challenge to interpret, Factor 4 was labeled as *Devalue and Depersonalize*.

Revised Scale

The final version of the MHPSASS contains 20 items. The items, factors, stigma element, wording approach, and response option was contained in Appendix J. Eight of the items represent Factor 1, labeled *Irritation and Impatience*; five items were contained in the second factor, titled *Choice and Capacity*; four items represent the third factor, *Adherence and Dependence*; the remaining three items compose the fourth factor's subscale labeled *Devalue and Depersonalize*. For the total 20-item scale, the responses were coded such that there were a

total of 6 points possible for each item, for a maximum possible score of 120. The minimum score was 0. The MHPSASS scores for this sample range from 16 to 80. The mean score was 50.450 with a standard deviation of 12.308.

Each of the four subscales contains a different number of items, making the comparison of their means and variances troublesome, however these data are provided below in Table 10 because the information is still meaningful.

Table 10

Subscale Descriptive Statistics

	Total points Possible	Minimum Possible	Minimum Scored	Maximum Scored	Mean	Standard Deviation
Irritation and Impatience Subscale	48	0	3	35	20.67	6.454
Choice and Capacity Subscale	30	0	0	20	11.55	3.921
Adherence and Dependence Subscale	24	0	3	21	11.51	3.768
Devalue and Depersonalize Subscale	18	0	0	18	6.72	2.945

With respect to the different language or wording approaches, the final 20 items of the MHPSASS only contain one item crafted in a ‘hard’ way. The other 19 items use ‘soft’ wording, or forgiving language, as described in Chapter 3, a finding that is discussed in more detail in Chapter 5. In addition, only items with agree/disagree response options were used in the refined MHPSASS. Ten items (items 53-62) of the original 62 were responded to with a level of frequency. None of these items were retained, due to inadequate or split factor loadings, exceptionally low mean and variation, or lower mean and variation when compared to a redundant item.

Assessment of Validity

Construct validity: Hypotheses. In order to establish construct validity, three sub-hypotheses were proposed in Chapter 3, which are reiterated here:

H4: The measure will possess validity as evidenced by construct validity, as measured by the following sub-hypothesis:

Sub-h1: A respondent's reported years of experience in mental health services is predicted to correlate positively to responses on items relating to poor prognosis.

Sub-h2: A respondent's reported years of experience in mental health services is predicted to correlate negatively to responses on items related to blame/shame.

Sub-h3: A respondent's provider status (professional versus paraprofessional) is predicted to correlate with items related to disinterest, annoyance, and irritation.

To test these hypotheses, new variables were created in SPSS 21. Specifically, variables were created by computing scores of on all items initially intended to tap the theme of poor prognosis contained in the 61-item pool and another variable representing all the items related to the theme of poor prognosis contained in the final 20-item version of the MHPSASS. The same variables were created with respect to items related to the theme of blame/shame and disinterest, annoyance, and irritation. The decision to use both the total items and only those in the MHPSASS was made because of the small number of blame and shame-based items in the final instrument, of which there were only two. In addition, a dummy variable was created to dichotomize the profession or discipline the respondent identified with, to parse out the professionals from paraprofessionals.

With respect to sub-hypothesis 1, correlation between the score on all poor prognosis items ($N = 12$) in the 61-item pool and level of years of experience in mental health services by computing

Gamma. The demographic question about how many years a respondent was employed in mental health services elicited a range or ordinal level data. Specifically, the responses were as follows: less than one year, between 1 and 5 years, 6 – 10 years, 11 – 15 years, 16 – 20 years, and 21 years or more. Due to the independent variable being measured on an ordinal level, correlation was assessed by computing Gamma. The correlation between level of years employed in mental health services and score on all poor prognosis items ($N = 12$), resulted in Gamma value of 0.022, an approximate t value of 0.405 ($p = 0.686$), not statistically significant. In addition, the correlation computation between level of years of experience in mental health services and score on the poor prognosis items included in the 20-item MHPSASS ($n = 3$) resulted in a Gamma value of 0.006, an approximate t-value of 0.102 ($p = 0.919$), also not statistically significant. These non-statistically significant correlations indicate that the sub-hypothesis 1, a relationship between scores on poor prognosis items and years of experience in mental health services cannot be supported.

To address sub-hypothesis 2, the correlation between level of years of experience in mental health service delivery and scores on all items related to blame and shame ($N = 12$) was measured by computation of Gamma, due to the ordinal nature of the independent variable. The computed Gamma value of 0.018, approximate t-value of 0.297 ($p = 0.766$) indicates the relationship is not statistically significant. The correlation between level of years in the mental health field and the score on only those blame and shame items included in MHPSASS' 20-items ($n = 2$), produced a gamma value of -0.035, approximate t-value of -0.541 ($p = 0.589$) also not statistically significant. Based on computation of gamma, the hypothesis of a negative correlation between level of years of experience in mental health services and score on total blame and shame, as well as MHPSASS items only, cannot be supported.

For sub-hypothesis 3, the independent variable of professional status (paraprofessional or professional) is nominal in nature. For this reason, the correlation between professional status and score on all items intended to measure provider disinterest, annoyance, and irritation, as well as only those items included in the final 20-item MHPSASS was ascertained by computation of Cramer's V. The correlation between professional status and all the items related to disinterest, annoyance and irritation ($N = 13$), indicated a statistically significant, strong positive relationship (Cramer's $V = 0.521$, $p = 0.029$). In addition, the correlation between professional status and only the MHPSASS provider disinterest, annoyance and irritation items ($n = 7$) indicated a statistically significant, strong relationship (Cramer's $V = 0.412$, $p = 0.111$). There is caution with interpreting these results, however, due to the disparate sample sizes of the professional versus paraprofessional group ($n = 208$ and 12 respectively). The statistically significant relationship between professional status and items related to provider disinterest, annoyance, and irritation provides support for the construct validity of the MHPSASS. Again, the first two sub-hypothesis were not supported and the third was supported with much caution due to disparate sample sizes and a small sample of paraprofessional.

Without confirmation of two of the three sub-hypothesis, and a cautiously supported third sub-hypothesis, the validity of the refined measure is still in question. However, other relationships were hypothesized through the inclusion of the social desirability bias and burnout self-rating validation items, lending support to the MHPSASS' construct validity.

The concept of social desirability is measured on the ratio level, the scale scores range from 0, indicating no influence of social desirability on the participant's responses, and 10, signaling a high level of influence of social desirability bias. For these data, of which only 209 participants completely responded to each of the 10 items of the scale, the full range of responses were

utilized, with a minimum score of 0 and a maximum of 10, mean = 5.36, standard deviation = 2.258. Pearson's r , intended to measure the correlation between two interval/ratio level variables, was computed for the respondent's total MHPSASS score and their level of social desirability bias. For these data, Pearson's $r = -0.169$ ($p = 0.015$) indicating a significant negative relationship between the variables.

In addition to social desirability, a validation item related to perceived level of professional burnout was included in the dissemination of the survey. A direct relationship between self-rating of burnout and MHPSASS score was hypothesized. Initially, respondents were provided with the following directive:

One element of mental health service provision as a career that has a significant influence on a provider's attitudes, beliefs, and behaviors toward clients is that of professional burnout. *Burnout* is defined as "a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind. A key aspect of the burnout syndrome is increased feelings of emotional exhaustion" Maslach & Jackson (1981, p. 99) (p. 12 of Appendix D).

Respondents were then asked to use the definition to rate on a 10-point scale how burnout they perceived themselves to be (0 = not at all burned out in current role, 5 = mildly burned out in current role, and 10 = severely burned out in current role). It was anticipated that there would be a positive correlation between self-rating of burnout and scores on the MHPSASS. Pearson's r was computed to measure the association between these two variables. Pearson's r value = 0.235, ($p = 0.001$) indicating a statistically significant, positive relationship between self-rating of burnout and MHPSASS scale score. The relationships between these validation items and MHPSASS score are addressed in more detail in Chapter 5.

Factorial validity. The factor analysis results arrived at in this study deviate from what was anticipated based on my prior research. Contrary to the hypothesized five-factor model of provider-based stigma, described in-depth in Chapter 2, this analysis reveals an underlying four factor model of provider-based stigma. There are a number of possible reasons for this discrepancy, which will be discussed in Chapter 5. With respect to the measure’s factorial validity, it may be helpful to reconcile the five themed model of provider-based stigma with the four factor model that emerged from this data. The following figure superimposes the four factors onto a variation of the experience-based model of provider-based stigma that was provided in Chapter 2’s Figure 3.

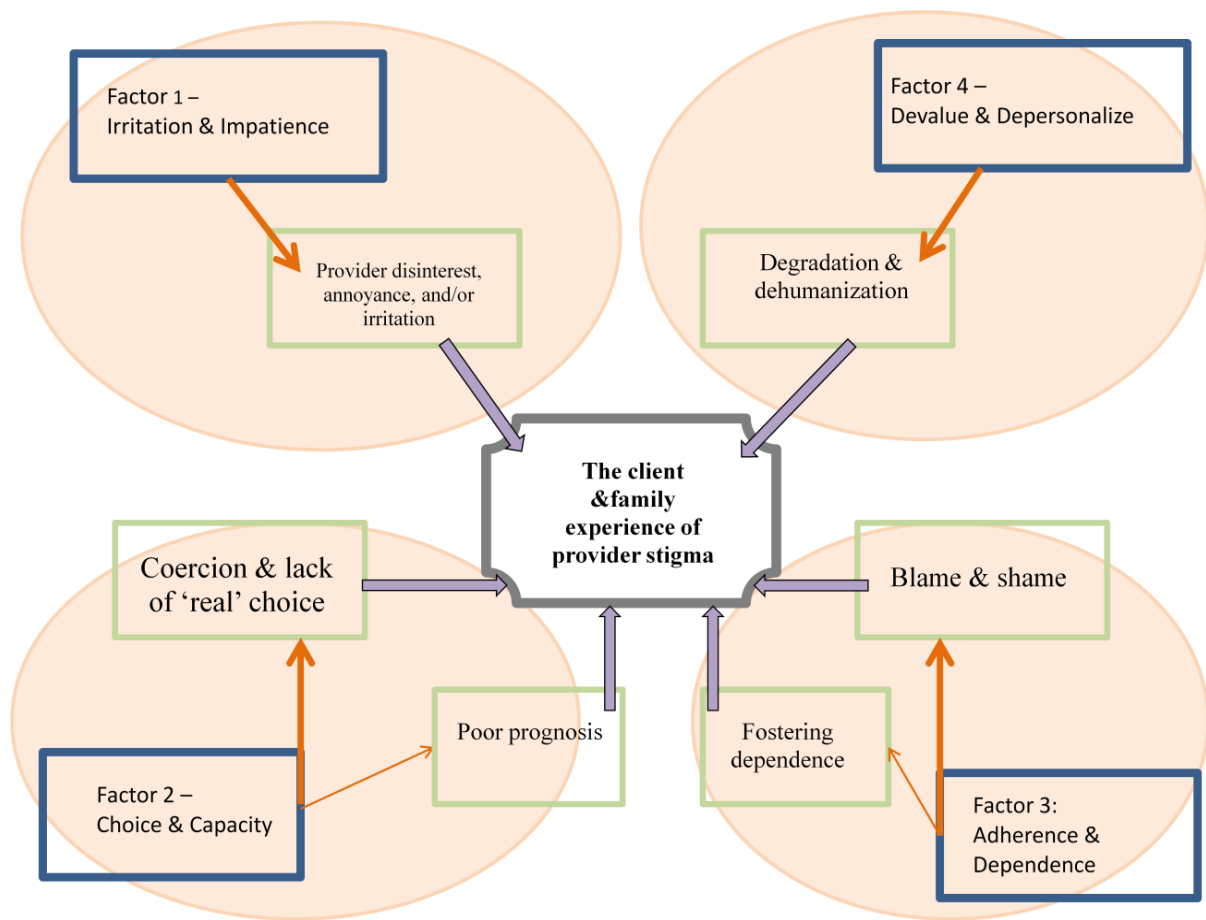


Figure 6. Reconciling the four factor solution with the five-themed model of provider-based stigma.

Summary of Findings

At the outset, this dissertation's purpose with the development of a scale intended to address elements related to provider-based stigma and the initial testing of this scale's reliability and validity. A large 99-item pool was initially developed, with approximately 20 items generated to address each of the five themes of the experience based model of provider stigma, described in Chapter 2. This initial item pool was reviewed by a series of four focus or stakeholder consultation groups, along with the experience-based model, to serve as both an expert panel reviewing the item pool and establishing face validity of the underlying model. These groups, composed of academic/researchers, providers of mental health services, consumers of mental health services, and another group of family members helped to refine the item pool to the 62-item MHPSASS disseminated to all the CSBs and state-run facilities in the Commonwealth of Virginia. With a respectable sample size, response to the 62 items and 11 validation items were evaluated. Initially, one item, item 25, was found to have been skipped by 21 respondents, and was thus eliminated from further consideration.

A four-factor principal component analysis with varimax rotation was selected from a lengthy series of analyses as the most informative solution, explaining over 32% of the items' variance, and interpretability. Using factor loadings as a guide, another 22 items were deleted. Next, reliability assessment and item-analysis along with consultation with the univariate item statistics led to the deletion of another 19 items, leaving a final MHPSASS of 20 items. The 20 items of the MHPSASS can be found in Appendix J. The refined version of MHPSASS demonstrated an adequate level of internal consistency. Although only two of the three sub-hypotheses concerning construct validity were supported, the validation items regarding social desirability bias and professional burnout did demonstrate their hypothesized relationship, lending evidence

to the scale's validity. Additionally, while a five-factor solution was not supported, contrary to the five themes of the experience-based model on which the items were based, there are potential explanations for why factorial validity may have been compromised, which will be described in Chapter 5. In summary, based on the initial assessments of the MHPSASS' reliability and validity, the 20-item scale is an adequate initial measure of provider-based stigma, informed by the experience of clients and families, which will be useful in future research around the construct.

Chapter Five – Discussion

Study Synopsis

Emerging in a context that is strained by social and bureaucratic influences, including frequent exposure to clients in the most serious of crises, ever-growing caseloads, tight resources, and the difficult navigation of interdisciplinary communication for effective collaboration, the existence of provider-based stigma is not wholly surprising. Mental health providers are human, not immune to the stigmas of the general public concerning mental illness, despite their training and experience. One of the most serious consequences of receiving services from a provider who endorses stigmatizing beliefs is a fractured therapeutic relationship, absent of the essential elements of acceptance, empathy, and unconditional positive regard (Rogers, 1994). Based on the idea that a positive, helping relationship between the consumer of services, their family, and their mental health provider is an essential element to recovery from mental illness, provider-based stigma has the potential to negatively influence a client's engagement with, commitment to, and outcomes associated with treatment. Indeed, previous research suggests that negative attitudes and beliefs of mental health providers can have a direct effect on the quality of the helping relationship and service outcomes (Eack & Newhill, 2008; O'Connell & Stein, 2011; Scheyett & Kim, 2004; Schulze, 2007). A client may avoid seeking mental health services due to feelings of rejection in the helping relationship and may be less likely to follow a provider's recommendations (Bjorkman, Angelman, and Jonsson, 2008d). Even more importantly, when a client's treatment outcomes are negatively influenced by a provider's attitudes, beliefs, and behaviors, this may translate into the client's inability to realize important treatment and life goals, like symptom stabilization, avoiding hospitalization, unemployment, and achieving independent housing. With such steep costs of provider-based

stigma and its influence on the therapeutic relationship, the need for accurate assessment of its presence and severity is clear.

In order to meet this need, this dissertation's goal was to develop and initially test the psychometric properties of a self-assessment of mental health provider-based stigma. As a self-assessment, the intent is that this measure will be used in the spirit of continuing education and development for providers of mental health services. In contrast to other measures of provider-based stigma (i.e., Wilkins & Abell, unpublished, 2010), discussed in Chapter 2, this dissertation made use of client and family experiences of the phenomena to inform item generation. Building off personally conducted qualitative research and the resulting experience-based five-themed model of provider stigma, the developed item pool for the Mental Health Provider Self-Assessment of Stigma Scale (MHPSASS) took shape.

Originally consisting of just fewer than 100 item stems, each of the five themes were addressed by approximately 20 items, which focused on a provider attitude and belief or a provider behavior, and varied by the use (or non-use) of forgiving language. That is, some items took the approach used in traditional measurement development, which use statements containing little room for equivocation in the stem, but assumed all variance of endorsement would be evident in the response options. Alternatively, many items used forgiving language, or were more softly worded, so as to temper the influence of the question on the response, not to induce defensiveness in respondents. Both item pool and the five-themed experience-based model were next introduced to a series of focus and stakeholder consultation groups for expert panel review of the item pool and initial face validation of the model. Following the four groups, composed of academics/researchers with specialization in stigma and mental health, providers of

services, families of consumers, and service consumers, the item pool was refined to 62 items and general support for the five-theme model was indicated.

As electronically disseminated to a purposive sample of mental health service providers, the survey included eight demographic questions, 62 items of the MHPSASS, a one-item burnout validation measure, and a 10-item social desirability validation scale, for a total length of 81 items. Response to sample recruitment was substantial; approximately 50% of the agencies contacted forwarded out the email invitation to employees resulting in a responding sample of 302 providers of adult mental health services. After data cleaning, deleting cases with missing values for the MHPSASS items, a remaining sample size of 220 remained. Next, a series of factor analyses were conducted, exploratory in nature, making use of two data sets; one with outliers deleted and the other with outliers retained. The presence of outliers did not significantly influence the factor solutions or loadings, and so further analyses made use of the data set that contained the outlier cases. Both principal component analysis and principal axis factoring extraction methods were performed, specifying 2, 3, 4, 5, and 6 factor solutions. The PCA, varimax rotated, four factor solution was chosen as the most useful and informative. The items of the MHPSASS were refined based on factor loadings. Reliability assessment and item-analysis followed, leading to more deletions. Finally, the univariate statistics and items stems were consulted to determine which items should be removed, resulting in more item deletions for a refined MHPSASS of 20 items.

The 20 item MHPSASS was then reviewed by factor, including which items loaded most strongly onto each of the four factors. In this way, the four factors were named: *Irritation and Impatience* (eight items); *Choice and Capacity* (five items); *Adherence and Dependence* (four items); *Devalue and Depersonalize* (three items). The final factor-solution accounted for a

sizeable proportion of the variance in the items (32.454%), lending support to the scale's validity. In addition, reliability analysis indicated good reliability of the 20-items, as measured by Cronbach's alpha = 0.817. The performance of the subscales, measuring each factor, ranged from less than desirable to respectable.

In addition to the performance of the measure, the 20 item MHPSASS scores were computed and univariate statistics indicated an average provider-based stigma score of 50.45 ($SD = 12.31$), minimum scored 16 and highest 80 (out of possible 120). When correlations were computed with pre-specified demographic variables, to test the sub-hypotheses related to construct validity, there were no statistically significant relationships observed. More specifically, years of employment in mental health services were not significantly correlated with respondent scores on items related to disinterest, annoyance and/or irritation, or poor prognosis/fostering dependence. Also, no significant correlation between professional status (versus paraprofessional) and scores on items related to blame and shame. However, when examining the relationship between MHPSASS 20-item scale scores with the validation items measuring professional burnout and social desirability bias, the anticipated relationships were observed. That is, respondent's score on the MHPSASS was negatively correlated with their scores on the social desirability measure and positively correlated with the burnout self-rating. Said another way, the more influenced by social desirability a respondent was the lower their levels of provider-based stigma. The more burnout a respondent perceived themselves to be, the higher their level of provider-based stigma, and vice versa.

Aside from the data about the scale's development and psychometric properties, there were key differences noted in the way survey-takers responded to questions that were more softly or tentatively worded, as opposed to those posed in a more rigid manner, as well as items that

elicited a frequency-based response rather than level of agreement. In general, questions that were written with forgiving language evoked more variation in the responses of participants, in contrast to the hard-worded questions which produced responses that were of lower average and variability. For example, item 16, written in a hard manner, states: “If my client is not recovering from a relapse, there is something they aren’t doing.” This item’s mean score = 2.17, $SD = 1.193$, with the minimum 0 and a maximum of response option 5 selected. In contrast, item 26, written with forgiving-language, states: “If a client is relapsing with symptoms of mental illness, there is likely some part of their treatment plan they haven’t been following.” This item had a mean score of 2.62, $SD = 1.250$, with the full range of responses selected (0 to 6). The softly written item 26 had a higher mean and standard deviation than the hard-worded item 16, in addition to evoking the whole range of response options. In addition, frequency-based questions elicited little variability, as well, and were not included in the final measure.

All-in-all, the project produced an initial measure of provider stigma, with respectable construct validity and good reliability. Importantly, the measure is grounded in the client and family member experience of provider-based stigma. The results of this dissertation, namely the scale’s four-factor solution, the inter-play of social desirability and professional burnout, and results regarding the use of forgiving wording in measurement development are next discussed, attending to how they are situated within the context of previous research.

Meaningful Findings

Differences between hypothesized model and factor solution. Construction of the item pool for the MHPSASS was guided by a model developed in personally conducted qualitative research, described in detail in Chapter 2 (Charles, 2013). The experience-based model consisted of five themes related to client and family member’s perception of provider-based

stigma. Focus and stakeholder consultation groups conducted in the first phased of this project lent support to the face validation of the five-themed model. However, the groups' were convenience sampled, small in numbers, and data was loosely collected through field notes. Therefore, sweeping conclusion of the model's validity cannot be made. Instead, this support served simply as an indication that the model on which the self-assessment's item pool is based was reflective of the experience and expertise this group of academic researchers, mental health providers, service consumers, and family members. It was thus hypothesized that the five themes of the model guiding the item pool generation would likely result in a five-factor solution for the MHPSASS. However, this was not the case, as no items loaded onto a fifth factor; rather, a four-factor solution was indicated.

That there are many different ways in which clients and families may feel stigmatized by providers of mental health services is supported by the findings of other qualitative studies. For example, Schulze and Angermeyer (2003) revealed through focus groups with mental health service consumers that not only did clients feel stigmatized by providers of services, but also by different aspects of care. These aspects of stigmatization included the provider's disinterest in them as people or their history of mental health problems, but also on the focus of the providers on medication as the standard psychiatric treatment. These authors also report clients feeling stigmatized by providers who share with clients their clinical diagnoses with a poor prognosis for recovery, or by not sufficiently informing the clients of the varying options for treatment, or potential medication side effects. Other authors' findings were similar, but also included other elements of provider-based stigma, like a provider not including the client and family in a shared-decision making process regarding treatment (Pinfold, Byrne, & Toulmin, 2005). These findings, the conclusions of my previous research, and the initial face validity provided by the

focus and stakeholder consultation groups convened as part of this dissertation's method, support the notion that the experience of provider-based is multi-faceted. In addition, the perception of provider-based stigma is also subjective, as experienced by clients and families, and therefore can shift and change.

In addition, the differences between the factor solution of the refined MHPSASS and the experience-based model of provider stigma could be a reflection of the distinction between the perceptions of clients and families with those of providers. Because the MHPSASS is a self-assessment for use by providers, the underlying factor structure is the result of the provider's level of agreement with an item that is intended to measure an element of provider-based stigma, as experienced by clients and families. The four-factor model could more accurately be referred to as a model reflecting the provider's assessment of their stigmatizing attitudes, beliefs, and behaviors toward clients and families. The discrepancy between the provider's and the client's perception of the service environment and the helping relationship is not necessary surprising. The experience-based model is not necessarily invalid, or not reflective of provider-based stigma, as the result of the MHPSASS' factor structure. Rather, it is more likely that what a provider will endorse is a bit different than what the client and family experience. The themes of the experience-based model of provider stigma were thus refined and reconceptualized as themes of provider-based stigma, informed by experience, and endorsed by providers. How these themes were refined and conceptualized is described more, next. The figure from Chapter 4, reconciling the two perspectives of provider-based stigma, is again presented below, to aid understanding.

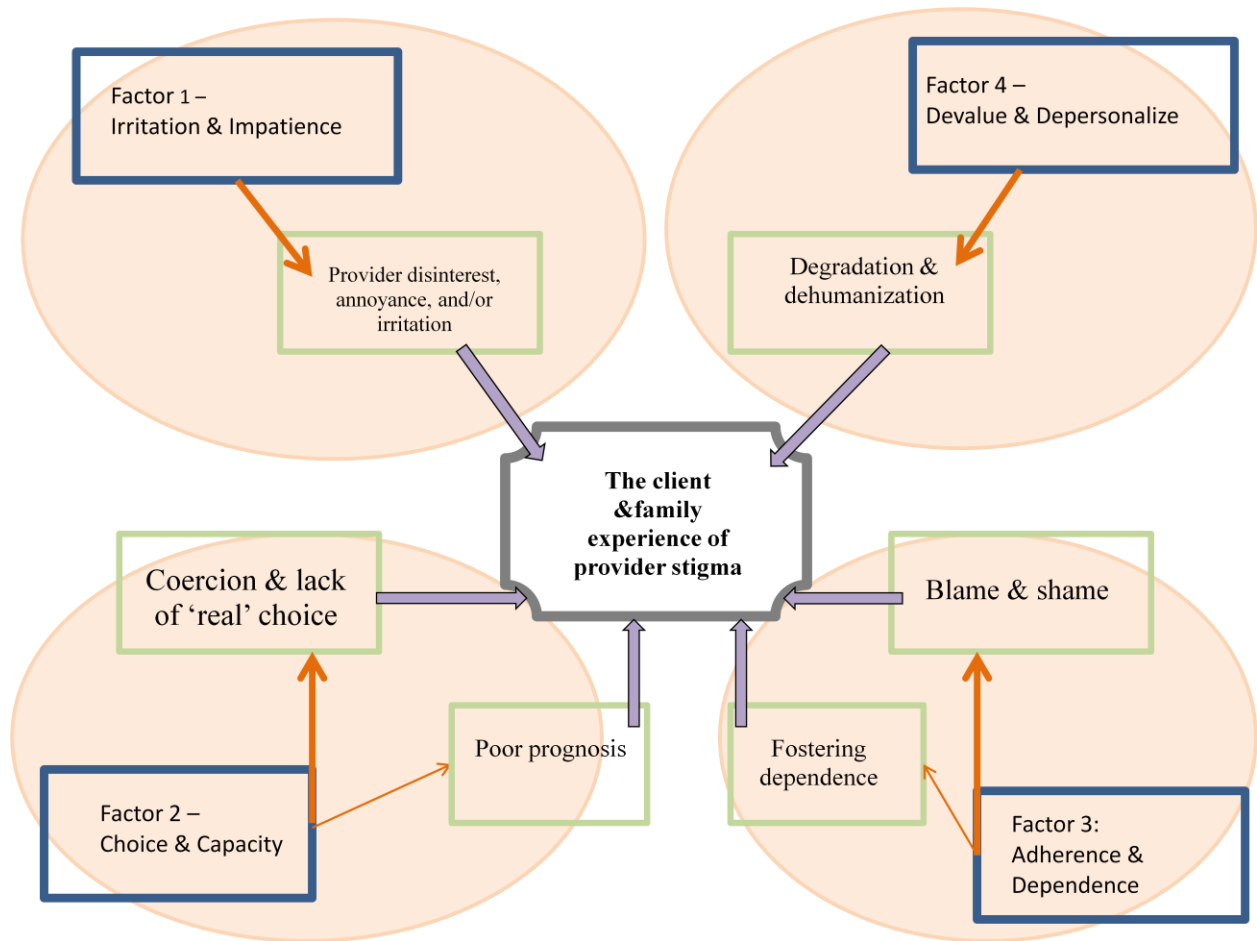


Figure 6. Themes of provider-based stigma: Client experience and provider-informed.

Refinement of the model.

Irritation and impatience. The first factor, Irritation and Impatience, was measured by eight items, seven of which were initially crafted to tap the theme of disinterest, annoyance, and/or irritation; the last item reflected the theme of blame and shame. However, upon review of the items, the underlying theme for these items was that of irritation and impatience, specifically concerned with a provider's irritation and impatience with clients, impatience likely being the result of their irritation. Disinterest seems less relevant to the provider's perception of their

engagement with clients. Clients and families may perceive an uninterested provider, but a provider is more likely to express irritation and impatience with their client than a lack of engagement – since engagement with the client is, in fact, a key element of their job. Therefore, the theme of provider disinterest, annoyance, and/or irritation was refined to the more concise irritation and impatience.

The validity of this theme as reflecting the construct of provider-based stigma is supported by the responses of this sample of mental health providers. More specifically, stigmatizing attitudes, beliefs, and behaviors of mental health providers that reflect irritation and impatience are evident in the factor solution. This finding is in keeping with previous work and research. For example, Watkins (2007) in his guide for recovery-informed practice notes that acceptance of all clients is often very challenging. Echoing the notion of provider irritation and impatience, Watkins warns that “prejudicial attitudes colour our interaction, feelings of disapproval, irritation or antipathy surface into consciousness or lurk on the edge of our awareness” (p. 143). As previously noted, a key aspect of successful and nurturing therapeutic relationships is the provider’s acceptance of their client. Acceptance has been described as the absence of judgment, as well as respect and affirmation of one’s clients (Watkins). Provider irritation and impatience could possibly erode the client’s feeling of being accepted by their provider, thus harming the therapeutic relationship.

Choice and capacity. The second factor of the four-factor solution was labeled Choice and Capacity, and is composed of five items. Of these five items, three were crafted with the intention of capturing the client’s experience-based theme of coercion and lack of ‘real’ choice. Two of the five items were developed in relation to poor prognosis/fostering dependence. The items of this factor, when reviewed, reflected the notion that client’s available and achievable

choices and capacity to improve and recover were inherently limited by mental illness. Providers endorsed these ideas by indicating the need to help clients set goals that were achievable, only describing or especially encouraging some of the options available to clients, and minimizing expectations of the client and family regarding the client's capacity to improve in symptoms and functioning. These five remaining items of this factor were the least divisive, with respect to the use of coercion or control in mental health treatment, likely reflecting the perspective of providers rather than their clients. When making decisions about naming the factors of the provider-informed model, the use of pejorative words was avoided. 'Coercion' is especially objectionable, particularly when used with providers of mental health services, an issue described more below.

The tendency of providers to encourage a client to set goals they believe are more realistically achievable may be viewed, as Thornicroft (2006) suggests, in a more charitable way. Namely, mental health providers may have a strong sense of personal responsibility for ensuring that their clients do not experience a relapse of symptoms or psychiatric distress. In that effort, providers may be reluctant to encourage a client to set a goal, like full-time employment, that may be stressful or anxiety-provoking, possibly leading to a worsened state. In addition, the pessimism of mental health providers about their client's capacity to recover is supported by research, like the work of Hugo (2001) whose study in South Australia revealed that mental health providers were generally less optimistic about a client's chances of recovery than the general public, and that providers made their conclusions about a client's likelihood to recovery based on their personal experience in treating individuals living with mental illness. Thornicroft refers to this pessimism as 'physician bias.' Providers are often in contact with individuals experiencing crises or exacerbated symptoms and therefore, their clinical repertoires are filled with numerous

examples of clients who have not had good results. The bias is caused by the provider's lack of contact with individuals who have substantially improved or recovered, who have not returned for more treatment. When influenced by physician bias, messages that voice disbelief in a client's capacity to improve are transmitted and perceived by clients and families. For instance, quoting a service user participating in a focus group conducted by Schulze and Angermeyer (2003), "You've got schizophrenia, you will be ill for the rest of your life" (p. 304). This pessimism seems to be reflected in this factor of the MHPSASS.

Coercion.

Originally, the experience-based model's theme of coercion and lack of 'real' choice was expressly concerned with the use of coercion and control in the service environment, most clearly evident with involuntary hospitalizations. Thornicroft (2006), in his synopsis of recent research, describes the dilemma faced when clients are technically admitted voluntarily to an inpatient facility, but most understand that they are not fully free to engage in treatment, or stay or leave as they wish. Item 25, which was originally in the MHPSASS pool to address this particular issue states: "I would prefer my client to voluntarily admit themselves for emergency psychiatric services, but if they don't, my client knows that I will begin involuntary procedures." This item was ultimately eliminated from consideration because it was skipped by 21 provider respondents. This item skip-rate was more than five times larger than any other item. This is perhaps an indication of what Thornicroft describes as a difficult point for providers to accept. While most providers work day-to-day, trying their best to help their clients, the experience of the power differential, notably in the provider's ability to deprive a person of their liberty, no matter how good the intention, is experienced by clients as stigmatizing. More specifically, "those receiving such treatment find that the basis of this 'therapeutic' relationship (blending

care, concern and threat) is at best a mixed blessing, and at worst a dishonest amalgam of both help and control” (p. 153).

Adherence and dependence. The third factor, labeled Adherence and Dependence, was measured by four items. Each of these four items was originally intended to measure a different theme of the experience-based model of provider stigma, making interpretation and naming difficult. Specifically, the themes of degradation and dehumanization, coercion and lack of ‘real’ choice, blame and shame, as well as poor prognosis/fostering dependence served as guides in creating these items. While they were originally intended to tap different themes, commonalities between the four items were evident upon review. Namely, these items are concerned with the provider’s perception of the importance of a client’s adherence to medication and treatment recommendations as well as the dependence of clients on providers to help them make good decisions. The medication focus of mental health services and on acute symptom reduction has been experienced by clients as stigmatizing (Schulze & Angermeyer, 2003). These sentiments were echoed in this dissertation’s family and consumer stakeholder consultation groups, who indicated that they had not learned of peer services or other community opportunities from their contact with mental health services, but from their own investigations. As one focus group participant stated “It is almost criminal the lack of information that you get. We need ways of coping other than just handing us pills.”

Devalue and depersonalize. Finally, the fourth factor, Devalue and Depersonalize, consists of three items. Two items represent the experience-based model’s theme of degradation and dehumanization, while the final item was intended to tap the theme of coercion/lack of ‘real’ choice. These items were particularly concerned with a provider’s propensity to depersonalize their clients based on symptoms and diagnostic labels, as well devaluing a client’s ability to

make decisions for themselves. Referred to as dehumanization in the experience-based model, depersonalization was chosen as the label for this factor because the item more closely reflected depriving clients of their personhood rather than their humanity. Also, depersonalization is a term used when describing the phenomenon of professional burnout (Maslach & Jackson, 1981). The findings of this study indicate a correlation between the level of provider-based stigma and a provider's self-rated perception of burnout (Cronbach's alpha = 0.235; $p = 0.001$). In addition, although dehumanization is a common theme of the *client's* experience of provider-based stigma (Hinshaw, 2007), the term is pejorative and likely to produce defensiveness in use with *providers*. Since the MHPSASS is intended for providers, and the four-factor model is based on provider's endorsement, the less inflammatory term of depersonalize was selected.

Blame and shame.

Notably absent from the four factor solution were items related to the theme of blame and shame. In fact, only five of the original 12 items aimed at measuring provider blame and shame loaded onto any one of the four factors. Items 9 and 26 loaded onto Adherence and Dependence; items 20 and 35 loaded onto Irritation and Impatience; Item 50 loaded onto Choice and Capacity. In the end, only two of the original 12 items were retained in the refined measure, and blame and shame were not indicated in the labeling of the factor solution. Inspecting the total data set, The score on all items related to blame and shame, or 12 items, the average score was 26.6 ($SD = 6.76$) with score possibilities ranging from 0 to 72. This mean is fairly low, indicating a clustering of scores below the midpoint, corresponding to consistent disagreement with the blame and shame-based stems. The highest score by a respondent on these items related to blame and shame was 42. When compared to other themes, the variation produced by items related to blame and shame was quite low.

The absence of provider's endorsement of attitudes, beliefs, and behaviors related to blame and shame is in sharp contrast to the client and family experience. Not only were elements of provider blame and shame evident in the development of the experience-based model, but were also supported by the consultation groups conducted in the first phase of this dissertation. The focus and consultation groups, conducted prior to the dissemination of the MHPSASS to mental health providers, indicated general support for the five-themed model. Families and consumers gave examples of feeling blamed and shamed by their providers, in addition to feeling as if they had limited life choices, a bleak outlook for recovery, short-tempered providers, and dehumanized by aspects of their treatment and the service environment. These issues have been recently discussed with respect to parents of children struggling with co-occurring disorders (Cohen-Filipic & Bentley, 2015). However, the perceptions of providers, both in the focus group and in the factor solution to the MHPSASS, indicate an absence of support for attitudes, beliefs, and behaviors based on blaming and shaming.

There are a few possible explanations as to why providers did not express a substantial level of agreement with the items related to blame and shame. First, the items crafted may not have had construct validity; these items may not have measured provider blame and shame, but rather some other underlying construct. Specifically for the two items retained for the 20-item MHPSASS, it appears that these two were better represented by themes related to provider's impatience and/or the provider's belief in the necessity of the client to diligently adhere to treatment recommendations. Another possible reason for the lack of provider-endorsement of blame and shame is that perhaps providers do not perceive themselves as holding these attitudes and beliefs. They may have not agreed with blame and shame items because they really did not agree with the statements, but their actions and countenance during interactions with clients and

families conveys a different message. This again, is an example of the difference between the client and family's perception of services and the provider's. Another possibility is that providers did, in actuality, hold beliefs of blame and shame, but did not answer the blame and shame items truthfully, because it was socially undesirable or unacceptable for them to answer honestly. And finally, another potential rationale for this finding is that providers do not actually harbor attitudes, beliefs, or behaviors based in elements of blame and shame. If providers do not actually have ideas based on blame and shame, then the perception of clients and family members inaccurately attributes provider attitude and actions to blaming and shaming.

Answering the research questions, study hypotheses, and sub-hypotheses. There were research questions, hypotheses, and sub-hypotheses associated with this project, mostly related to the measure's reliability and validity. The developed 20-item MHPSASS possesses good internal consistency, as evidenced by a Cronbach's alpha of 0.817. The MHPSASS also displayed suitable face and content validity, based on the feedback of expert panel review and the connection of the items to literature and experience. The measure's factorial validity, while not supportive of the predicted five-factor model, does reflect four factors, which contain elements of each of the original five. The discrepancy between the predicted five-factor model and the four factor solution were reconciled by review of the items and understanding that the perceptions of providers will differ from the perceptions of clients and families. Regarding construct validity, two of the three sub-hypotheses of predicted relationships between scores on theme-related items to specific demographic variables, were not supported. Namely, no relationships were observed between a respondent's reported years of experience in mental health services and score on all items related to poor prognosis/fostering dependence, or items

related to blame and shame. These relationships were predicted in consideration of personal practice experience and review of the literature.

Specifically, a positive correlation between years of experience and poor prognosis/fostering dependence items was anticipated because as a provider has more experience working with clients coping with serious mental illness, it was assumed that the general idea of improvement would not be endorsed. Essentially, this thought was based in the idea that a provider with more experience working with adults living with serious mental illness, frequently in contact with individuals in crisis, may have less belief in the likelihood that a client would achieve common life goals like full-time employment, independent housing, and meaningful interpersonal relationships. It was hypothesized that providers with more experience in the field would have less hope of their client's ability to improve in functioning and even to recover. Conversely, a negative correlation between years of experience and blame/shame items was predicted because it was hypothesized that as a person gained more experience in the field, their understanding of the etiology and course of mental illness might mature past ideas of personal blame and shame. A survey of mental health nurses conducted by Bjorkman and colleagues found such correlations (Bjorkman, Angleman, & Jonsson, 2008).

As described in Chapter 4, the statistics computed investigating these relationships were not statistically significant (Gamma = 0.022, $p = 0.686$; Gamma = 0.018, $p = 0.766$, respectively). There are a few potential reasons as to why these predicted relationships were not observed. It is possible that these predictions were in error, and therefore the relationships were not found because they do not exist, with this sample. Another possibility is that the relationship does exist, but that the influence of social desirability has skewed responses in such a way that a correlation could not be found. This is particularly plausible with the sub-hypothesis related to

years of experience and blame and shame ideas. As indicated by the lack of blame and shame items in the final measure due to low variability and factor loadings, providers were hesitant to agree with the blame and shame items, regardless of years of experience in the field. A decrease in agreement with blame and shame items could not be observed, even as years of experience increased, because there was not a substantial level of agreement to begin with.

The third sub-hypothesis, a predicted relationship between the professional status of the provider (paraprofessional versus professional) and items related to annoyance, irritation, and/or disinterest was found, but interpreted cautiously due to a small paraprofessional sample ($n = 12$) (Cramer's $V = 0.521$, $p = 0.029$). This relationship was hypothesized because it was predicted that the more education a provider had received about mental illness and its treatment, the less likely they were to stigmatize clients. This idea was predicated on the common use of education-based interventions as a method to combat public stigma. In addition, the work of Smith and Cashwell (2010) supports this relationship, whose survey findings indicate that training, education, and experience result in more positive attitudes toward mental illness. For this dissertation, more education and training than was predicted to be reflected in less agreement with items related to annoyance, irritation, and impatience. Although this sub-hypothesis was supported with a statistically significant relationship between professional status and level of agreement with items related to annoyance, irritation and/or disinterest, the results should be accepted with caution. Since the sample size of the paraprofessional sample was small ($n = 12$), especially in comparison to the professional sample ($n = 208$), the likelihood of erroneously rejecting a true null hypothesis is greater. Therefore, more investigation is needed, which should be included in future replication studies, described more in research implications.

Relationship of MHPSASS score to validation variables. Lack of confirmation for two of three predicted sub-hypothesis was surprising, although they were not the only validation mechanisms. During the MHPSASS' development, validation items were included for the initial survey's dissemination, with establishing the instrument's construct validity in mind. In particular a brief 10-item social desirability scale and a self-rating of professional burnout were included in the delivery of the MHPSASS. The intent was to describe the relationship between a respondent's level of social desirability bias, self-rating of professional burnout, and MHPSASS score. It was hypothesized that the scores on the developed measure would correlate inversely to social desirability and directly to burnout. These relationships were indeed found.

Initially, social desirability bias was hypothesized to be inversely correlated to scores on the MHPSASS after reflection of DeVellis' (2003) recommendations. Namely, DeVellis suggests that "if an individual is strongly motivated to present [themselves] in a way that society regards as positive, item responses may be distorted" (p. 87). If this is the case, a validation measure of the bias should be considered for inclusion. Providers of mental health services, whose job is to work with people living with mental illness, providing effective and compassionate services, would likely seek to present themselves in a way consistent with their career choice. If their presentation, or response to survey items, differs from their actual attitudes and behaviors, social desirability has influenced the response and thus skewed the validity of the measure. In addition, inclusion of a measure of social desirability bias was encouraged by the academic/researcher focus group and the provider focus group, convened during the first phase of this dissertation. Both groups voiced the belief that an inverse relationship between provider stigma and social desirability bias was likely.

To measure the relationship between provider-based stigma and social desirability bias, Pearson's r was computed for MHPSASS score and respondent's scores on a brief, 10-item social desirability measure. The computed value of Pearson's $r = -0.169$ ($p = 0.015$) indicating a significant negative relationship. This indicates that the influence of social desirability bias was clearly at work in the responses of survey participants. More specifically, when the influence of social desirability increases, the total MHPSASS score decreases. Put another way, if a provider is more influenced by social desirability, they report lower levels of agreement with items of the MHPSASS.

A relationship between MHPSASS score and self-rating of burnout was predicted, as informed by the provider focus group, conducted in the first phase of this dissertation. The participants of the provider focus group voiced a belief that their level of professional burnout would likely influence how they interact with their clients. In addition, elements of the conceptualization of burnout are akin to aspects of provider stigma. For example, Maslach and colleagues' (1981; 1993) understanding of burnout includes depersonalization, emotional exhaustion, and personal accomplishment. More specifically, depersonalization involves negative and cynical attitudes toward one's clients and/or one's work in general. Emotional exhaustion refers to feeling depleted and fatigued. Lastly, the personal accomplishment dimension of burnout is better understood as the perception of one's professional efficacy and competence. Provider-based stigma, as conceptualized by the experience-based model's five themes, includes perceptions of clients and families being depersonalized, including interactions with providers who exhibit negative demeanors and cynicism. It is because of this commonality that the relationship between burnout and MHPSASS score was predicted.

Testing the relationship between burnout and MHPSASS score, Pearson's r was computed to measure the association. Pearson's r value = 0.235, ($p = 0.001$) indicating a statistically significant, positive relationship between self-rating of burnout and MHPSASS scale score. More specifically, a higher burnout rating was related to higher levels of provider-based stigma; lower burnout ratings were associated with lower levels of provider stigma. Additionally, the correlation between the level of burnout and social desirability was computed using Pearson's r , which was not statistically significant ($r = -0.061$, $p = 0.390$). Said another way, a provider's self-rating of their burnout was not associated with the level of influence of social desirability. Therefore, although two of the three sub-hypotheses that were intended to establish this measure's construct validity were not supported, other hypothesized relationships between MHPSASS score and validation measures were endorsed, lending evidence to the argument of the new measure's construct validity.

Differences in language used for survey questions. Another topic of interest in the development of this measure was the type of language used to craft items for the scale. Specifically, in traditional measurement development items are written in a concrete manner, very rigid statements, allowing for the variability of agreement or frequency to be indicated by the response selected. However, with topics that are prone to the influence of social desirability bias, such as provider-based stigma, the use of proxy language (i.e. what 'most' people would think) or forgiving language (also referred to as soft-wording) is often used. In essence, forgiving language is a loading strategy, or a wording of the items in such a way that encourages respondents to answer more truthfully (Sudman & Bradburn, 1982; Groves, Fowler, Couper, Lepkowski, Singer, & Tourangeur, 2004). For the MHPSASS, the items were crafted using forgiving language, taking two approaches: first, the 'everyone does it' approach and second, by

taking the tone that the attitude or behavior exists for comprehensible reasons. The differences between the softly worded items and hard wording were clearly evident in the survey's responses. In particular, the final 20 items of the MHPSASS only contain one item crafted in a 'hard' way. That is, the remaining 19 items use 'soft' wording, or forgiving language. In addition, when comparing a softly worded item to a near duplicate item with hard wording, the variability of the soft item was evident. The soft items had higher means and larger standard deviations, indicating more variation in the responses of survey-takers. Based on this, the utility of softly worded items in producing a scale that identifies some variation in responses with a sample that is hesitant to vary is indicated. Indications for future research, based on this finding, are described in later sections.

Limitations

Sample response. Although the results of this study are informative and quite promising, they are not without limitations. First, the agency response rate, those CSBs and facilities that disseminated the initial invitation for staff participation was fairly low. Approximately 50% of the agencies who could have participated in the study chose to do so. These agencies did not communicate their reason for non-participation, but rather simply did not respond to email inquiries. Relatedly, an individual-level response rate is unknowable. The sampling protocol for this project included sending an email invitation to the clinical directors of Virginia's CSBs, requesting they forward out the invitation to their staff members who engage in adult mental health service provision. There is no way to know how many staff members were included in the email's forwarding. Not knowing the total sampling frame from which this sample is drawn results in uncertainty as to the sample's representativeness of the population. However, because

the sample was purposively assembled, not randomly selected, generalizability of the findings cannot be assumed, regardless of knowing the response rate.

Scale length and missing data. Initially, 309 persons began to respond to the survey. However, only 261 saw the survey through to its completion, with only some items missing. The other 48 respondents stopped answering questions at some point of the survey. This coupled with a pattern of missing data at the end of a certain type of questioning indicates that respondent fatigue or the burdensome length of the instrument may have been an issue. The disseminated survey contained a total of 81 items. An evident pattern of missingness was observed, notably, the missingness of items 49, 50, and 51 were correlated with one another, as were non-responses to items 58, 59, 60, 61, and 62. A likely explanation for these clusters of missingness is related to the length of the instrument package and respondent fatigue. Items 49-51 were the last items with the 7-point strongly disagree to strongly agree response options. Skipping these questions indicates that perhaps respondents were tired of this type of questioning. Thus, when presented with the new answer response format focusing on ‘frequency’ in question 53, respondents were then prompted to begin replying again. However, still fatigued by the length of the survey, respondents then skipped questions 58-62, despite the changed response option of frequency, because they were ‘done’ answering questions with Likert scale responses. The incomplete survey submissions were not included in data analysis, so the refined MHPSASS does not include data from respondents who became fatigued by the length of the survey. This may have influenced the results, particularly if those who were more likely to be fatigued by a survey’s length were in more or less agreement with the items of the scale. There is, however, no way to know if this subsample of non-completers is somehow different than those who did complete.

This adds to the evidence that replication studies for the refined 20-item MHPSASS, to determine if the underlying factor structure remains consistent, are needed.

Self-assessment. The use of a self-assessment or self-rating versus the observation of actual behavior or actual client's perceptions of stigma in the service environment is a limitation in the interpretation of this study's findings. Self-assessment's greatest disadvantage is the greater chance of measurement error (Allen & van der Velden, 2005). The source of error can be intentional, as in social desirability bias, or unintentional. Unintentional error can arise when respondents do not understand the question or when they do not remember circumstances or events. For this measure, the items were reviewed by expert panel for comprehensibility and were worded carefully to ensure understanding; however it is impossible to know if all respondents truly understood what they were being asked. In addition, respondents may have forgotten events in their practice history or times when they did engage in behaviors reflecting stigma, and reported inaccurate agreement or frequency levels as a result. The items of the refined MHPSASS were responded to by indication of level of agreement. This is a self-assessment, not an actual measure of behaviors as the result of stigmatizing attitudes. A key question is if and how these attitudes and beliefs translate into stigmatizing behaviors of providers.

Social desirability. An intentional source of measurement error and a key limitation to the use of self-report and self-disclosure of attitudes as a measure of provider-based stigma is the influence of social desirability bias on responses. As mentioned previously, one of the key findings of this dissertation is the association between a respondents MHPSASS score and the level of social desirability influencing their responses, as measured by a 10-item scale. The influence of social desirability was anticipated in these responses, but it is still a limitation in the

interpretation of results. The overall levels of provider-based stigma, as measured by the 20-item MHPSASS were relatively low (mean=50.45, s.d.=12.308), which could indicate actually low-levels of provider-based stigma, or that providers were unwilling to indicate agreement with the statements, despite actual endorsement. The clear association between the MHPSASS score and the social-desirability measure indicate that the interpretation of MHPSASS scores should be made cautiously as they are likely underestimating the provider's actual level of agreement.

Implications for Practice

Practice implications of the self-assessment and other findings. The findings of the present study are a contribution toward the larger goal of improving mental health services and the service receipt experience of clients and families. The goal of improving of services is based on the idea that effective and compassionate services are unlikely when the attitudes, beliefs, and behaviors of mental health providers are interpreted by service users and families as stigmatizing. The implications for practice, addressing provider-based stigma, can take a multi-level approach. This includes a single practitioner changing his or her attitudes, beliefs, or behaviors, or it could be the implementation of a continuing education program of training for an agency to address provider-based stigma. The outcome of this dissertation, a reliable and valid measure for providers to use in the self-assessment of their individual levels of provider stigma, can be used by providers to ensure that they are engaging in practice that is absent of stigmatizing attitudes, beliefs, and behaviors. Furthermore, the model on which this measure was based reflects the client and family experience of provider stigma. This model is different from the factor solution of the measure, indicating a discrepancy between perceptions of clients with those of providers. Given this discrepancy between client and provider perceptions, the MHPSASS begins to reconcile these differences, sensitizing providers to the potentially

stigmatizing nature of their attitudes, beliefs, and behaviors. Even if a provider does not harbor provider-based stigma, providers should be aware of the possibility that their clients may have interacted with providers in the past who were stigmatizing, which may influence the current helping relationship. The influence of provider stigma, its enactment or perception, should be anticipated by provider and skills should be developed in order to recognize its presence.

An agency-level practice intervention that makes use of the MHPSASS could be in the form of continuing education or in-service training opportunities for mental health providers in public service. The intervention could begin with the administration of the self-assessment, stressing that responses would be for the provider's own development, not shared with anyone else or used with issues respecting their employment. After providers score their assessments, discussion or classroom content could be delivered around the experience of provider-based stigma, what it means to clients and families, and ways that practitioners could address this in their practice. The experience-based model of provider-based stigma and the four-factor MHPSASS solution could also be useful in highlighting the discrepancy between the perceptions of clients and providers.

This measure was created with participation from providers of many different disciplines, and its use by these different providers is thus encouraged. Many of the respondents of the developmental sample were social workers, and social work professionals do represent a significant proportion of providers in mental health services (National Association of Social Workers, 2015). Therefore, the MHPSASS' use by social workers engaged in mental health service delivery is also encouraged. Regardless of professional identification, a practitioner may use the measure, individually, in supervision, or in group training. Utilizing the measure in supervision, the MHPSASS may generate conversation regarding provider-based stigma,

including the unintentional nature of some of the attitudes and beliefs that are addressed. The conversation generated by the MHPSASS could then evolve into constructive dialogue of how to counteract these stigmatizing messages sent by providers that are perceived by clients and families.

In general, the use of a self-assessment such as MHPSASS to evaluate one's practice is aligned with the NASW's Code of Ethics for professional social workers. Specifically, the Code of Ethics, in reference to a social worker's cultural competence and social diversity, states that workers "should obtain education about and seek to understand the nature of social diversity and oppression with respect to ...mental or physical disability" (Section 1.05, para. 3). In addition, the Code of Ethics prohibits workers from practicing, facilitating, or condoning discrimination based on any factor, including mental disability. The use of a self-assessment of provider-based stigma would constitute an effort to understand the diverse perspectives of clients and families, ensuring that one is practicing in a manner free of discrimination. While not all for whom the MHPSASS is intended are social workers, their inclusion on many mental health teams and centers situates them to be agents of change, influencing interdisciplinary coworkers, helping to make the receipt of mental health services a stigma-free experience. This is also in alignment with the NASW Code of Ethics, which notes that social workers should draw on perspectives, values, and experiences of the social work profession when working on interdisciplinary teams, using appropriate channels to navigate disagreements.

The finding of this study regarding the relationship between MHPSASS score and self-rating of burnout also has implications for practice. The direct relationship between burnout and provider-stigma suggests that professional burnout may be related to endorsement and enactment of provider-based stigma. As such, it could be argued that providers have an ethical obligation to

attend to their self-care, physically, professionally, and emotionally, in order to provide the most effective and compassionate services. Stebnicki (2008) summarizes the approaches taken by self-care strategies for mental health providers in the treatment of professional fatigue syndromes. In general, these strategies involve preventing, managing, reducing, and coping with the provider's stress and anxiety levels. These professional fatigue treatments may make use of mind-body behavioral health, or focus on increasing the professional's capacity for self-awareness and mindfulness, with the intention of exploring stress, anxiety, potential over-identification with clients. In addition, wellness and lifestyle approaches are employed, along with a focus on cultivating and embracing peer and mentorship support, including professional supervision and associations. More specifically for individual providers, Pearlman and MacIan (1995) outline activities that trauma workers can engage in to mitigate professional burnout and embrace wellness, which may be relevant to other mental health providers. These activities include: (a) discussing clients with colleagues; (b) attending workshops or professional development seminars; (c) spending time with family and friends; (d) traveling, taking vacation, pursuing hobbies; (e) talking with colleagues between sessions or contacts with clients; (f) socializing; (g) physical exercise; (h) reducing or limiting their caseload; (i) attending to their spiritual life; (j) and engaging in supervision. Regardless of the approach or techniques used, taking care of oneself is an important task for mental health providers, which may well have implications for the development and enactment of provider-based stigma.

Specific practice implications based on the MHPSASS' four factors. In addition to the usefulness of the MHPSASS itself, the underlying factor structure of the measure may also have important implications for social work practice. Several recommendations are made here, in anticipation of the possibility that a provider endorses any of the factors underlying the

MHPSASS. Counteracting provider irritation and impatience, providers might first want to acknowledge the very trying nature of service delivery, and that their irritation and impatience are not completely irrational. Providers might be more forthcoming and open with clients regarding the reasons for their frustration, consistent with authenticity in practice and reciprocal relationships with clients, as suggested by both the strengths and empowerment approaches to practice (Lee, 2001; Saleebey, 2006). A client may assume that their provider is impatient or irritated with them for one reason, but the true cause may be a backlog of paperwork or a headache. In addition, a provider who is emotionally exhausted, a dimension of professional burnout, may be more irritable in their interactions. Provider self-care is essential to remediate the influence of irritation and impatience. Also, being able to discuss irritations with both peers and supervisors would also help providers to deliver services that are as free as possible of irritation and impatience. This is consistent with the notion that workplace support, opportunities for professional development, including supervision, are necessary in reducing what Acker (2012) refers to as negative work outcomes.

To address provider attitudes and behaviors related to choice and capacity, a truly collaborative approach to decision-making and treatment planning must be taken. For example, the strengths perspective to social work practice, developed by notable scholars and researchers, including Saleebey (2006) and Rapp (1998), is one such approach. A strengths perspective to practice counteracts false limitations on a client's available choices and capacity to improve. Notably, as Rapp suggests, taking a strengths-based approach to practice involves a 'can do' attitude in all aspects of care, because all clients can learn, grow, and change (1998). Saleebey argues that clients are best served when their provider collaborates with them, instead of taking the vantage point of 'expert' (2006). Linhorst, Hamilton, Young, and Eckert (2002) note that

empowerment through collaborative treatment planning is possible when people with mental illness have a minimal level of psychiatric stability and decision making-skills, in addition to an agency culture that promotes the practice. For providers, the first step for collaborative decision-making is presenting clients with their options. More specifically, clients should be provided with a description of every option for service and help available to them, at the agency and in the community. Providing this information to client empowers them to make their own choices with full knowledge of alternatives. If a provider has a preference for which option that a client should choose, a housing opportunity for instance, the provider might indicate what their professional opinion is, giving reasons why, but voicing support for the client's decision, regardless. The unconditional positive regard necessary for an effective therapeutic relationship still extends to clients despite a provider's disagreement with their choices.

Also related to providing mental health services in a way that embraces a client's choices and capacity, a provider may seek out, respect, and encourage clients to complete psychiatric advance directives. (PAD). A PAD, as defined by the National Alliance on Mental Illness, is a legal document written by a person who lives with a mental illness, competent and of full knowledge of their decisions at the time of writing, which specifies preferences and directions for their psychiatric care at times when they are unable to make their own decisions (2014). In addition, a PAD might name a proxy or agent who the client gives the power to make decisions about their care during these times of crisis. As noted, elements of provider-based stigma that are represented by the choice and capacity factor reflect the provider's belief that clients lack substantial capacity for improvement and recovery, and that their available and achievable choices for life and treatment are limited. The PAD, conversely, is the voice of the client, exercising their capacity to make these treatment decisions. PADs have the potential to

minimize the experience of coercion and support client empowerment (Khazaal, Manghi, Delahaye, Machado, Penzenstadler, & Molodynski, 2014).

Providers in practice can embrace the client's capacity for improvement and their available choices by encouraging the completion of advance directives. In Virginia, consumers of mental health services can make use of the support offered by facilitators, or individuals who help others complete advance directives (Virginia Advance Directives, 2015). Putting clients in contact with facilitators or programs providing facilitation like the Wellness Recovery Action Plan (WRAP) program offered by Virginia Organization of Consumers Asserting Leadership (VOCAL), is an action that providers can take to support the client's choices in care. In addition, practitioners can be certain to ask all clients with whom they interact if they have a PAD. Just by asking, the provider signals that they are aware that clients are able to make choices for themselves and their treatment. If one's client does have a PAD, a provider should do their best to adhere to the preferences and, according to the law, follow the instructions when not illegal or unethical (NAMI, 2014).

The practice suggestions advocated by Bentley and Walsh (2014) for social workers who are collaborating with clients prescribed to psychotropic medications fit well into the practice implications for responding to the MHPSASS' factor of adherence and dependence. To reiterate, the adherence and dependence factor concerns the importance a provider places on medication as the focus of treatment, the client's adherence to medication and treatment recommendations, as well as the client's dependence on providers to help them make good decisions. Conversely, Bentley and Walsh argue that social workers should embrace a partnership model of practice, with the goal of forming an alliance and mutually sharing expertise. Providers who approach practice from the perspective of partnership building would counteract attitudes and beliefs that

too heavily focus on the importance of medication and treatment adherence, and dependence on support services. Bentley and Walsh further specify the principles of a partnership model, which include involving the client in decision-making, being forthright with treatment options and decisions, and paying keen attention to the client's strengths and limitations.

In addition, related to the MHPSASS' factor of adherence and dependence, a provider focusing solely on medication as a treatment option can be experienced as stigmatizing by clients and families. To counteract this, the perspective toward medication advocated by Bentley and Walsh (2014) is relevant. Namely, these authors suggest social workers maintain a balanced perspective about the costs and benefits of psychotropic medication. Practically speaking, social workers can approach the use of medication in a client's treatment using a partnership model of practice. As argued by Bentley and Walsh, the goals of medication treatment are inherently different within the partnership model of care, compared to traditional models of care. Namely, from a partnership perspective, the goal of medication treatment is to improve the client's quality of life, not simply to reduce symptoms.

Working against issues associated to the factor of adherence and dependence, it is important for providers to understand that a client's adherence to medication is complex and likely influenced by many factors. Providers may increase their ability to understand and assist their clients by learning more about the client's experience with medication. Many individuals perceive medications to be helpful, some are skeptical, while others are stigmatized, thus making the act of taking a medication much more meaningful than simple 'adherence.' In their study of the meaning of antidepressant medication for clients living with depression, Garfield, Smith, and Francis (2003) found that clients believed themselves to be helped by medications, but this help did come with consequences, including losing the feeling of normality and a sense of

inadequacy. Bentley's (2010) study on the meaning of psychiatric medication found complex reflections, best understood by interlocking and overlapping themes. Bentley argues that taking medication is not a benign act, but something that "incites meaning, influences identity, and impacts life" (p. 488). For instance, study participants describe taking medication as a protection of their humanness and a preventative measure against a relapse, but also as a symbol of differentness, dependency, and a tolerated fact of life. And so, as Donovan and Blake (1992) have argued, from the physician's perspective the client's non-adherence to medication is an irrational act, while simultaneously, but conversely, it is entirely rational from the client's perspective. Often medication prescription, maintenance, and adherence are the focus of mental health services. It is this focus that can sometimes be perceived by clients and families as stigmatizing. A provider who understands that the act of taking medication is a multi-faceted phenomenon would likely be better able to empathize with clients who wrestle with these tough decisions. The provider who simply labels a client who is non-adherent to medications 'resistant' or 'lacking insight' may be making a complex reason too simple.

A practice implication, based on the MHPSASS' devalue and depersonalize factor, is the importance of a provider's commitment to the idea that each client possesses inherent dignity and worth. For social workers, this sentiment is codified in the NASW's Code of Ethics (2008), which states "social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity" (Ethical Principles, para. 3). Without this commitment to the dignity and worth of the individual, the emergence of attitudes and beliefs representative of devaluation and depersonalization become more likely. Attitudes, beliefs, and behaviors indicative of provider devaluation and depersonalization include not

valuing the input of one's client, describing or discussing a client by using a diagnostic category rather than a name, and not fully explaining one's actions or treatment decisions to their client. For a social worker or any other mental health provider to counteract attitudes and behaviors based in devaluation and depersonalization they must be committed to the worth and value of each individual with whom they interact.

One key way that a provider can actively show that they value a client's personhood is by paying close attention to the language that they use and rely on person-first language. Person-first language is based on the basic concept that a mental health condition, or any other condition, is only one aspect of a person, not the defining characteristic (American Psychiatric Association, 2014). For example, to say that a client is a person "diagnosed with schizophrenia" is a properly phrased use of person-first language. Alternatively, a non-person-first reference would be to say the client is "schizophrenic." A client's personhood is very important and referring to clients by a psychiatric label deprives them of their humanity. It is important that providers use person-first language not only during interactions with clients and families, but also in their record keeping, as well as in team and colleague meetings.

Implications for Social Work Education

The findings of this dissertation also have important implications for the education of social work students, especially those poised to enter the field as mental health providers. Consulting with the Council on Social Work Education's (CSWE) Educational Policy and Accreditation Standards (EPAS), it is clear that the self-assessment of one's attitudes and behaviors in practice is a supported goal of social work education (2008). Specifically, CSWE EPAS codify a core competency of professional social workers, that of engaging diversity and difference in practice. To be competent in this area, social work students must, through their education and professional

socialization, “gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups” (Section 2.1.4). In connection with suitable self-awareness, social workers should have the necessary self-reflective skills to practice self-correction, assuring continual professional development. Additionally, a goal of social work education is the instillation of the notion that students will be life-long learners, and to engage their clients as informants to better their practice. To facilitate this goal, the MHPSASS could be used in field education or mental health practice coursework, especially noting the consultation with clients and families that took place in its development. By first making use of a formalized self-assessment during one’s professional education, the likelihood that it may be used again, or even influence attitudes and practice behaviors, is greater.

In addition, to sensitize students to the discrepancy between the client and families perception of the service environment with that of providers is also an important implication for social work education. Both conceptual models of relevance to this dissertation, the experience-based model and the model endorsed by providers, could be used in mental health practice courses, illustrating the differences and similarities. The notion that what is intended is not always what is conveyed or perceived is an important lesson for a developing practitioner. This sensitivity would serve them well in better understanding the experience of the clients and families with whom they work.

Educational content making use of the MHPSASS itself could also be useful. Existing interventions in the literature that address provider stigma have generally been introduced with medical students or general practitioners in mind. These interventions include educational programming that highlight stigma-related content (Üçok et al., 2006) and programs combining education and contact with persons living with mental illness (i.e. Altindag, Yanik, Uçok,

Alptekin, and Ozkan, 2006; Chung, 2005). More explicitly related to social work, the work of Scheyett and Kim (2004) and Mason and Miller (2006) describe educational interventions with MSW students. Mason and Miller in particular argue for both classroom and field interventions.

Mental health practice courses in social work should focus on those approaches which are in common use in the field, that also reflect the ethics and values espoused by the profession. In particular, social work education should continue to pay a great deal of attention to the recovery-based approach to practice. The ten components of recovery practice include: self-direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, responsibility, and hope (SAMHSA, 2006). These components are commonly touched upon in social work classrooms and practitioners are uniquely qualified to enact the vision of the recovery paradigm (Carpenter, 2002). CSWE (2011), in their report on the integration of recovery principles to practice, indicates that social work education has taken significant strides incorporating recovery content into the classroom, but there are challenges in the efforts to do more. Specifically, even though social work students and practitioners may readily accept the principles of a recovery-approach to practice, the dominance of the medical model makes implementation difficult. The medical model of mental health practice mimics medical science in that it involves the use of observation, identification, diagnosis, and the prescription of treatment for pathology that is thought to arise from an objective disease process (Coppock & Dunn, 2010). The CSWE report describes the medical model as a paradigm that extinguishes the hope necessary for recovery and inconsistent with social work values. Even still, the medical model is in common use and despite a social worker's value alignment with recovery, their actions may indicate another philosophy of care. Social work students should be prepared for the elements of the service environment that are in contrast to the ideal practices

that they learn in the classroom. To counter this dominance and inconsistency between recovery and the medical model, CSWE suggests that the remedy is in education of social work students with careful definitions, examples, exercises, and practice tools. Findings of this dissertation also indicate that, for example, linking the dominance of a medication focus to elements of provider-based stigma may help students make the connection between how their practice can help or harm clients, even without intention.

Educational content on psychiatric medication should also be taught to social work students, as medication is an element in many clients' recovery plans. The social worker's unique role in using medication in treatment should be highlighted. Also, students should be instructed on the basics of psychopharmacology, along with a critical perspective, including the multidimensional meaning that medication can have for many clients, as described by Bentley (2010). In addition, Bentley (1993) encourages social workers to stand for balance and common sense with respect to psychotropic medications. Although these medications are helpful for many clients, it is important that social workers not ignore the experience of adverse effects "or the sociopolitical aspects of their use" (Bentley & Walsh, 2014, p. 35). Critically thinking about the use of psychiatric medication is advocated by Cohen (2004) who also argues that students should be educated in a way that leads to questions and social work-generated answers about the legitimacy of medication's dominance as the go-to treatment. It is important for students to be educated in a way that encourages critical thought toward the use of medication and not blind acceptance of something that holds so much meaning for our clients.

In addition, education should focus on practice approaches that stress the client's involvement and their expertise in their own care. Strengths-based practice and the empowerment approach, for example, really engage the client in setting their own treatment goals and plan. To educate

students in a way to prevent negative attitudes and beliefs reflecting a client's capacity to improve, the prognosis of mental illnesses should be given attention in education, but learning activities should also employ contact-based interventions. For example, Scheyett and Kim (2004) argue for the use of facilitated dialogues in MSW curriculum to bring together consumers of mental health services and social work students. In their review of one such dialogue held at the University of North Carolina, student attitudes toward consumers had a significant positive shift, as measured by need for social distance, perceived dangerousness, and affective response (Scheyett & Kim). Facilitated dialogues are consistent with the recommendation of Zellmann, Madden, and Aguiniga (2014), who suggest inviting guest speakers into the classroom to provide social work students an opportunity to ask questions and address their own fears and misconceptions regarding mental illness. Zellmann and colleagues advocate for inviting both individuals living with mental illness and mental health providers to serve as guest speakers in social work classrooms, to dispel myths about the service environment. In addition, utilizing personal and family narratives may help to facilitate awareness and sensitivity to the client experience, a practice advocated by Hinshaw (2007). Classroom or homework assignments making use of memoirs may also be useful in highlighting client's capacity to improve and the individuality of experience.

A key finding of this dissertation was the distinct relationship between a respondent's score on the MHPSASS and their level of social desirability bias. This finding may also have implications for social work education. Since social workers are educated in a way that encourages self-reflection as a necessary exercise and skill for social work practice, students need to be made aware of the role social desirability bias has on what they share in professional supervision. Despite the taboo associated with providers harboring negative attitudes and beliefs

about their clients, it is sometimes a reality. These attitudes and beliefs are often not shared with others, including supervisors, for fear of being disciplined or thought of as less-competent. However, if the student/practitioner is to be able to grow, they must believe that honestly sharing of themselves is vital to being an effective and compassionate social worker, and it is also the right thing to do for their clients. Therefore, social work education has a clear imperative to prepare students to engage in self-reflective practice that involves discussing the uncomfortable, sometimes hard-to admit aspects of their practice in supervision.

One important way of making sure that students feel that they are able to discuss what may seem to be a taboo topic is to remove the taboo by beginning a discourse. By starting the discussion students are granted 'permission' to talk about an uncomfortable topic. This is akin to the process of therapeutic group work that touches on taboo topics. Once the group enters the taboo-zone, other members perceive themselves to be free to enter the zone too and discuss the taboo topic (Shulman, 2006). Educators may normalize the experience of providers being frustrated, impatient, and sometimes irritated with one's clients, stressing that it does happen, because providers are human with emotions. This normalization would make discussing these attitudes and behaviors more acceptable. In addition, equipping social work students with strategies and skills with which to cope with interpersonal stress are also important goals of education. To this end, the importance of and the rationale for the use of person-first language should also be emphasized in the classroom, particularly in classes teaching mental, emotional, and behavioral disorders. The use of person-first language should be strongly encouraged, even when in supervision or other professional communications, to ensure that depersonalization is avoided.

The direct correlation between self-rating of professional burnout and provider-based stigma, a key finding of this dissertation, may also have implications for social work education. Due to this correlation, the relationship of burnout to provider stigma indicates that attending to professional burnout is likely an important element of any activities intended to ameliorate the presence of provider-based stigma. As mentioned, professional burnout is understood as a multidimensional phenomenon that includes a provider's emotional exhaustion, depersonalization, and feelings of low professional achievement (Maslach, 1993). In order to prevent or remediate provider burnout, social work education should include instruction in common mechanisms by which burnout is overcome. More specifically, students should be taught about the methods by which they could engage in self-care from the beginning of their careers. In addition, students can be encouraged to cultivate nurturing peer communities and engage in supervision in a meaningful way. By providing this introduction to addressing provider burnout in the student's professional education and socialization, they are more likely to begin these activities in their field assignments and early career, starting a habit or pattern of self-care.

Implications for Research

This dissertation's findings also have implications for future research. First, the MHPSASS displays generally adequate internal consistency as well as face, content, and construct validity. Since this was an initial administration, however, more testing is obviously needed. Not only should studies be conducted to see if the findings replicate, the psychometric properties are consistent, but also to see if the underlying factor structure remains intact with other samples. In addition, further refinement of the MHPSASS is warranted. Specifically, this refinement is likely to include the reintroduction of several items related to the experience-based model theme

of blame and shame. The current study's findings indicate that providers are hesitant to endorse items related to blame and shame, but their conceptual and practical importance to the phenomenon merits revisiting their inclusion. Also, the function and numeric value assigned to the middle "no opinion" response option and alternative response options such as "NA" will necessarily be considered and perhaps changed for use in future studies. A next step, with the further refined measure, when the psychometric properties of the MHPSASS have been replicated, would be cross-sectional studies using larger samples of mental health providers to ascertain the prevalence of mental health provider-based stigma. A large study would give clear indications about how widespread the problem of provider-based stigma is, based on the client and family conceptualization offered by the MHPSASS.

The finding of this dissertation about the use of forgiving, or 'soft,' wording in measurement development also has implications for future research. Namely, this study found that when items were worded either in a 'hard' manner, consistent with traditional measurement development, or more 'softly' worded items, reflecting a forgiving approach, that the softly worded items elicited more variability in response, with higher averages and greater standard deviations. Also, the final instrument only contained one item using the hard wording approach. This may indicate that when surveying about a topic likely to produce responses skewed to one extreme or the other, or creating a self-assessment tool in particular, that the use of forgiving wording may be a better method to elicit response variance. Investigators who are developing or refining measures of typically taboo topics might consider using soft wording as a method to increase the likelihood that the whole spectrum of responses would be selected.

Another implication, or a next step in research that could make use of the MHPSASS, is the development of interventions for providers and educational content for students. Earlier, in the

discussion of practice implications, several approaches for remediation of provider-based stigma were offered that can directly inform intervention research. Unfortunately, there is a gap in the literature with regard to stigma reduction efforts geared specifically to mental health providers. Intervention research, making use of the MHPSASS and its relevant conceptual models is indicated. Furthermore, studies that investigate the effectiveness of these interventions would also be necessary, to see if a reduction in provider-based stigma actually occurs. However, prior to these intervention effectiveness studies, if they make use of the MHPSASS as an outcome measure of stigma reduction, the MHPSASS necessarily requires further refinement.

Further research that uses the MHPSASS could involve comparing the provider's scores on the MHPSASS with a similar measure or some other survey completed by clients. This would give further information about the difference between the client and the provider's perspective and the reciprocal impact of attitudes and beliefs. In addition, the relationship between provider-based stigma, as measured by the MHPSASS, and other variables of client outcomes, like quality of life, likelihood of rehospitalization, symptom severity, and the like could be topics of investigation. Also, more research around the differences between sub-groups of mental health providers and their levels of provider-based stigma could be useful. For example, the relationship between professional status (professional versus paraprofessional) and MHPSASS scores could be incorporated into future studies. The relationship that was found in this study, while significant, should be noted with caution because of the small sample of paraprofessionals (n=12). A study with a larger sample would be informative in either replicating or refining the findings of this dissertation.

Conclusion

The stigma of mental illness poses additional and important challenges for persons living with mental illness, adding to the burden many feel in conjunction with the symptoms of illness. Provider-based stigma, the negative attitudes, beliefs, and behaviors of mental health providers, pose a special and significant impediment to an individual's recovery. For this reason the accurate appraisal of the presence of provider-based stigma is of great importance. In that effort, this dissertation is the development and initial psychometric testing of an instrument designed as a self-assessment of provider-based stigma, making use of the client and family's experience of the phenomenon. The use of the client and family experience as the foundation for this self-assessment for providers uses the client voice in addressing an issue that most greatly influences the client. The self-assessment developed here, the 20-item Mental Health Provider Self-Assessment of Stigma (MHPSASS) exhibits adequate reliability and initial measures of validity. Future research is needed to replicate the findings, support the underlying factor structure, and to further refine the distinction between the client and provider's perspective. In future efforts to address provider-based stigma, the MHPSASS will likely be useful, especially in its reflection of the client and family experience.

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Appendix A

Initial Item Pool for the Developing MHPSASS

Blame and shame

Attitudes and beliefs influenced by Blame and Shame (soft).

1. If one of my clients begins to experience an increase in symptoms of mental illness, I tend to think that they are probably non-adherent to prescribed medication.
2. If my client is having psychotic symptoms, I think that they most likely haven't been taking medication as prescribed.
3. If a client is relapsing with symptoms of mental illness, there is likely some part of their treatment plan they haven't been following.
4. If my client is not recovering from a relapse, there is probably something that they aren't doing.
5. If my client is not achieving realistic treatment goals, it is most likely because they aren't really trying.
6. When my client has a relapse of symptoms, I tend to look at possible problematic behaviors they engage in as the cause of the setback.
7. My client's family members are often to blame when their treatment goals aren't achieved.
8. Conflict between my client and their family members tends to initiate symptom relapses.

Attitudes and beliefs influenced by Blame and Shame (hard).

9. If my client is having psychotic symptoms, they obviously haven't been taking medication as prescribed.
10. If my client is not recovering from a relapse, there is something that they aren't doing.
11. My clients family members are to blame when treatment goals aren't achieved.

Behaviors toward clients caused by Blame and Shame (soft).

12. Because my client isn't taking their medication, I may not give them a lot of attention during our interactions.
13. If my client is not following their treatment plan, I sometimes find myself returning their calls less.
14. When a client isn't trying hard enough in their recovery I may not go out of my way to help them.
15. It is sometimes hard to be empathic with my client who is experiencing increased symptoms of mental illness, because they haven't been taking prescribed medications.
16. Because my client's family is to blame for the relapse, I find it difficult to want to include them in status updates.
17. If my client's family is over-involved in their life, I try to discourage this unhealthy dynamic, and am less likely to include them in treatment planning.

Behaviors toward clients caused by Blame and Shame (hard).

18. If my client is not following their treatment plan, I return their calls less.
19. If my client isn't taking their medication, I don't give them a lot of attention during our interactions.
20. Since my client's family is to blame for the relapse, I do not include them in status updates.

Disinterest, annoyance, and/or irritation

Attitudes & Beliefs influenced by disinterest, annoyance, and/or irritation (soft).

1. I occasionally have a hard time hiding my irritation with some clients.
2. When a client calls me a lot, I tend to get irritated with their neediness.
3. It's hard not to sometimes be irritated with clients who have serious mental illnesses.
4. Even though I try not to, I can sometimes be impatient with my clients.
5. A client who wants a lot of my attention can sometimes be annoying.
6. There are some clients whose lives I'm not really that interested in.
7. When some of my clients tell me about life situations, I find it hard to pay attention.
8. Sometimes, I wish my client would hurry up when speaking with me.
9. When my client's family calls and asks for an update too many times, I can become irritated.

Attitudes & Beliefs influenced by disinterest, annoyance, and/or irritation (hard).

10. I have a hard time hiding my irritation with some clients.
11. I am frequently impatient with clients.
12. When a client calls me too often, I get irritated with their neediness.

Behaviors toward clients because of disinterest, annoyance, and/or irritation (soft).

13. Because I sometimes find it hard to hide my irritation, I can occasionally be short with my clients.
14. If I get irritated with my client's neediness, I may sometimes attempt to avoid them.
15. When I am irritated with a client, I may be less helpful.
16. If a client is behaving in an annoying manner, I find that I am less likely to return their calls.
17. Because I'm not that interested in the lives of some of my clients, I may not pay them attention at first when I see them in a practice setting.
18. When family members visit my client, I may not acknowledge them right away, but finish what I'm doing first.

Behaviors toward clients because of disinterest, annoyance, and/or irritation (hard).

19. When I am irritated with my client's neediness, I avoid them.
20. If my client is annoying, I will not return their calls.

Degradation and dehumanization

Attitudes & Beliefs influence by degradation and dehumanization (soft).

1. If a client does not follow our agency's rules, it is probably because they are resistant to being treated.
2. If my client isn't taking the medication they are prescribed, it is most likely because they lack insight into their illness.
3. If my client isn't following our agency's guidelines, it is probably because they lack significant insight into their illness.
4. Many of my clients don't take prescribed medications because they lack insight into their illness.
5. When a client of mine is not taking prescribed medication, they are probably resistant to being treated.
6. When my client is very symptomatic, I sometimes do not need to fully explain my actions to them.
7. Even though I may not really believe this, I sometimes have thoughts that perhaps there is something different about my clients compared to me.
8. Admittedly, I am grateful I do not live with a serious mental illness.

Attitudes & Beliefs influenced by degradation and dehumanization (hard).

9. If a client doesn't take prescribed medication, they lack insight into their illness.
10. When my client is very symptomatic, I don't need to fully explain my actions to them.
11. If a client is not following agency rules, they are resistant to treatment.

Behaviors toward clients because of degradation and dehumanization (soft):

12. It is often necessary to figure out a way to not have a client's signature on paperwork, since I'm not always able to get in touch with my client.
13. When a client is experiencing psychotic symptoms, I sometimes find myself more abrupt in our interactions.
14. When my client is experiencing psychotic symptoms, I find myself more detached in our interactions.
15. In order to finish paperwork requiring a client's signature, I may not be able to get in touch with them, so I figure out a way to omit their signature.
16. Sometimes, to save time and for convenience, I might discuss the status of clients with other staff members, in front of clients, without their input.
17. Sometimes when talking about a client with other staff, I have referred to a client by their diagnostic label rather than their name.
18. Sometimes I talk about clients with other staff members, in the presence of those clients, and don't include them in the conversation.
19. In the past, I have made reference to a client by a diagnostic label they have, instead of their name.

Behaviors toward clients because of degradation and dehumanization (hard):

20. I discuss the status of clients with other staff members, in front of clients, without my client's input.
21. I refer to clients by diagnoses they have, not their name.
22. I am not fully engaged during my interactions with a client who is experiencing psychotic symptoms.

Poor prognosis/fostering dependence

Attitudes & Beliefs influenced by poor prognosis/fostering dependence (soft).

1. When a client is really symptomatic, I sometimes find it difficult seeing them any other way (not symptomatic).
2. When working with a client who lives with a serious mental illness, I have some doubt that they will ever really improve.
3. I am concerned about my client's continued well-being when they wish to decrease their contact or relationship with mental health support services since they likely need these services in order to function well.
4. I sometimes doubt that my clients with serious mental illnesses will ever really get better.
5. My client, diagnosed with a serious mental illness, will probably always need to take medication to function.
6. I generally do not believe clients with serious mental illness should terminate support services; they will likely need them in the future.
7. Clients with serious mental illnesses will almost always require intensive community support services.

Attitudes & Beliefs influenced by poor prognosis/fostering dependence (hard).

8. When working with a client who lives with a serious mental illness, I doubt that they will ever improve in symptoms.
9. Clients with serious mental illness will always require intensive community support services.
10. I do not believe that my clients should end support services; they will need them in the future.

Behaviors toward clients because of poor prognosis/fostering dependence (soft).

11. When a client says they have a goal that I think is really unlikely they will achieve, I subtly discourage them from setting this goal, for their own good.
12. In my practice, I try not to encourage clients with a serious mental illness from setting goals that are 'out of reach', so they won't be disappointed.
13. When a client with a serious mental illness asks if they will always require medication, I will often tell them yes, because I believe they will.
14. When a family member of a client diagnosed with a serious mental illness asks if their loved one will ever get better, I try to minimize their expectations, so they aren't disappointed.
15. When families ask if their loved one will achieve common life goals, I may try to minimize expectations, so they aren't disappointed.

Behaviors toward clients because of poor prognosis/fostering dependence (hard).

16. I discourage clients with a serious mental illness from setting goals that are too 'out of reach.'
17. When families ask if their loved one will achieve common life goals, I try to minimize expectations.

Coercion and lack of ‘real’ choice

Attitudes & Beliefs influenced by coercion and lack of ‘real’ choice (soft).

1. My client wants to have a full time job, but may not really be an option for them because they will lose their disability income or other needed resource(s).
2. Clients with serious mental illnesses have a hard time making good choices for themselves, so service providers need to help them.
3. I may not inform my client of possible options for housing, because they likely won’t do well in those situations.
4. Sometimes I may need to make decisions for my client, for their own good.
5. In some instances it may be necessary to make decisions for my client, without their collaboration, for their own good.

Attitudes & Beliefs influenced by coercion and lack of ‘real’ choice (hard).

6. Clients with serious mental illnesses are unable to make good choices for themselves, so I need to help them in my role as a service provider.
7. Sometimes I make decisions for my client, for their own good.

Behaviors toward clients because of coercion and lack of ‘real choice (soft).

8. If I think a client needs to be admitted to an inpatient psychiatric facility, I ask for them to admit themselves, but they also understand that I will have to start involuntary procedures if they don’t.
9. When a client wants to explore their medication options, I try to decrease their expectations: they don’t really have that many choices.
10. My client’s treatment plan may not necessarily reflect their goals, but rather goals that are realistically attainable.
11. My client’s treatment plan may not reflect their goals, but rather goals that I think are realistic, to make sure they are successful in achieving these goals.
12. In my role as service provider I have made ‘deals’ with clients to get them to take prescribed medications, even if they really didn’t want to.
13. If I think my client would benefit from a particular service, I find myself continuing to suggest this to them, even if they’ve declined.
14. When my client has a relapse in symptoms, I can’t help but remind them of the suggested services that they previously declined, in hopes that they will now accept the services I think they need.
15. When I review treatment options with my client, I find myself sometimes emphasizing what I would prefer, setting aside the other options available.
16. I would prefer my client to admit themselves for emergency psychiatric services, but if they don’t, my client knows that I will need to begin involuntary procedures.
17. When considering options for housing, I try to highlight only the options that I think they will benefit from.

Behaviors toward clients because of coercion and lack of ‘real choice (hard).

18. If I think my client would benefit from a particular service, I will repeatedly suggest this to them, even if they decline.
19. When my client has a relapse in symptoms I remind them of the suggested services that they declined.
20. When considering options for housing, I only let my client know about the options that I think they will benefit from.

Appendix B

Focus and Consultation Group Handout

In an effort to understand the client and family experience of provider-based stigmatization, I conducted an ethnographic content analysis (ECA) of client and family member authored literature. The published memoirs, which described the client and/or family member's experience in the mental health service setting, were read, unitized, and analyzed for themes, resulting in the five-theme model of provider stigma:

1. Blame and shame
2. Disinterest, annoyance, and/or irritation
3. Degradation and dehumanization
4. Poor prognosis/fostering dependence
5. Coercion and lack of 'real' choice.

The first theme, *blame and shame*, is the client or family's belief that their provider blames them for their difficulties, the illness they experience, or for less-than-expected progress in treatment. Additionally, clients and families may feel shamed by their providers, that they are of less value as a human as the result of having a mental illness.

The second theme *provider disinterest, annoyance, and/or irritation* is the client or family's perception of their mental health providers as being uninterested in their concerns, being annoyed and irritated with requests for information, attention, or assistance.

Next, *Degradation and dehumanization*, clients and families experience provider stigma in being treated as if they were of a lower social status or treated in a way that deprives them of their human qualities, personality, or spirit. For example, instances where providers discuss clients and their care in front of clients, without involving them, thereby placing them in a social position that is lower than the provider, in addition to implying that the client's voice is not as important or accurate as the provider's.

Poor prognosis/foster dependence, reflects the perception that one's provider believes that they (or their loved one) will not recover, improve, or otherwise achieve life goals that the average human aspires. Related to the notion that a client won't recover, *Fostering dependence* is the perception of clients and families that providers promote over-dependence on mental health services, support services, and medication.

Coercion and lack of 'real' choice occurs when the client's choices are externally influenced by the provider and the service provision environment. Lack of 'real' choice reflects the client's experience of making decisions without having access to all possible alternatives. For example, choices about which a client may feel they do not have all available options include medication adherence, voluntary versus involuntary commitment, and utilization of supported housing versus independent living options.

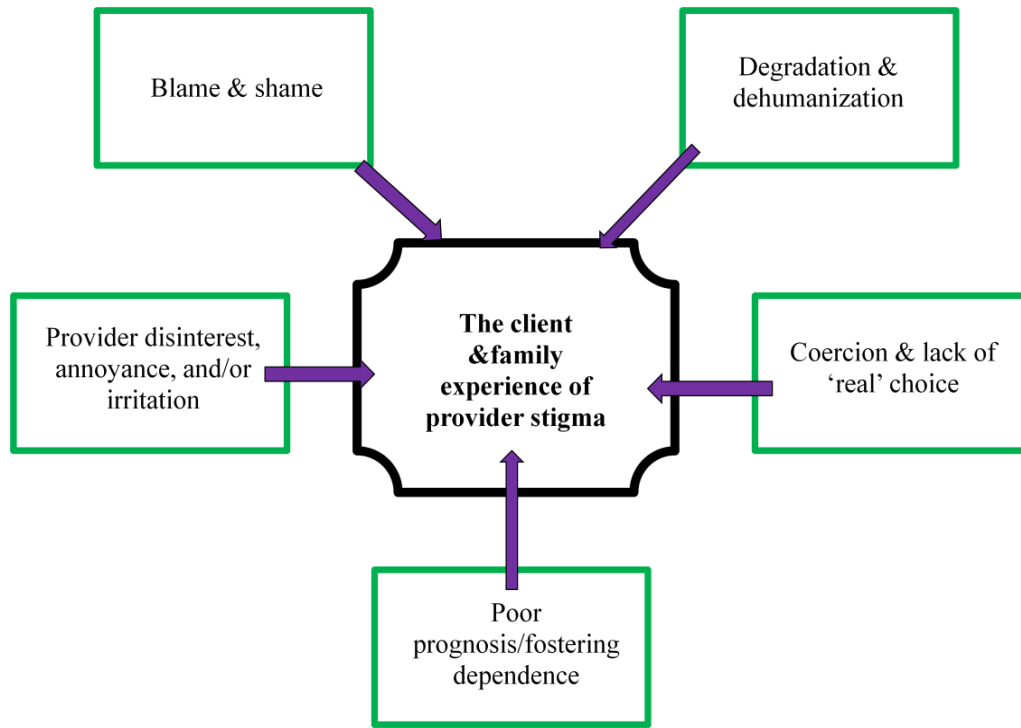


Figure B1. *The experience-based model of provider stigma.*

15-20 items PER theme for a total of 50-75 items.

Blame and shame

“blaming them for their difficulties, the illness they experience, and for less-than-expected progress in treatment (responsibility and controllability?)”

Attitudes and beliefs influenced by Blame and Shame (soft).

21. If one of my clients begins to experience an increase in symptoms of mental illness, I tend to think that they are probably non-adherent to prescribed medication.
22. If my client is having psychotic symptoms, I think that they most likely haven't been taking medication as prescribed.
23. If a client is relapsing with symptoms of mental illness, there is likely some part of their treatment plan they haven't been following.
24. If my client is not recovering from a relapse, there is probably something that they aren't doing.
25. If my client is not achieving realistic treatment goals, it is most likely because they aren't really trying.
26. When my client has a relapse of symptoms, I tend to look at possible problematic behaviors they engage in as the cause of the setback.
27. My client's family members are often to blame when their treatment goals aren't achieved.
28. Conflict between my client and their family members tends to initiate symptom relapses.

Attitudes and beliefs influenced by Blame and Shame (hard).

29. If my client is having psychotic symptoms, they obviously haven't been taking medication as prescribed.
30. If my client is not recovering from a relapse, there is something that they aren't doing.
31. My clients family members are to blame when treatment goals aren't achieved.

Behaviors toward clients caused by Blame and Shame (soft).

32. Because my client isn't taking their medication, I may not give them a lot of attention during our interactions.
33. If my client is not following their treatment plan, I sometimes find myself returning their calls less.
34. When a client isn't trying hard enough in their recovery I may not go out of my way to help them.
35. It is sometimes hard to be empathic with my client who is experiencing increased symptoms of mental illness, because they haven't been taking prescribed medications.
36. Because my client's family is to blame for the relapse, I find it difficult to want to include them in status updates.
37. If my client's family is over-involved in their life, I try to discourage this unhealthy dynamic, and am less likely to include them in treatment planning.

Behaviors toward clients caused by Blame and Shame (hard).

38. If my client is not following their treatment plan, I return their calls less.
39. If my client isn't taking their medication, I don't give them a lot of attention during our interactions.
40. Since my client's family is to blame for the relapse, I do not include them in status updates.

Disinterest, annoyance, and/or irritation

“uninterested in client and family concerns, as well as annoyance with requests for assistance or information. In addition, irritation was perceived by clients and/or families in response to requests for service, attention, or information.”

Attitudes & Beliefs influenced by disinterest, annoyance, and/or irritation (soft).

21. I occasionally have a hard time hiding my irritation with some clients.
22. When a client calls me a lot, I tend to get irritated with their neediness.
23. It's hard not to sometimes be irritated with clients who have serious mental illnesses.
24. Even though I try not to, I can sometimes be impatient with my clients.
25. A client who wants a lot of my attention can sometimes be annoying.
26. There are some clients whose lives I'm not really that interested in.
27. When some of my clients tell me about life situations, I find it hard to pay attention.
28. Sometimes, I wish my client would hurry up when speaking with me.
29. When my client's family calls and asks for an update too many times, I can become irritated.

Attitudes & Beliefs influenced by disinterest, annoyance, and/or irritation (hard).

30. I have a hard time hiding my irritation with some clients.
31. I am frequently impatient with clients.
32. When a client calls me too often, I get irritated with their neediness.

Behaviors toward clients because of disinterest, annoyance, and/or irritation (soft).

33. Because I sometimes find it hard to hide my irritation, I can occasionally be short with my clients.
34. If I get irritated with my client's neediness, I may sometimes attempt to avoid them.
35. When I am irritated with a client, I may be less helpful.
36. If a client is behaving in an annoying manner, I find that I am less likely to return their calls.
37. Because I'm not that interested in the lives of some of my clients, I may not pay them attention at first when I see them in a practice setting.
38. When family members visit my client, I may not acknowledge them right away, but finish what I'm doing first.

Behaviors toward clients because of disinterest, annoyance, and/or irritation (hard).

39. When I am irritated with my client's neediness, I avoid them.
40. If my client is annoying, I will not return their calls.

Degradation and dehumanization – The experience of degradation is described as being treated as if they were of lower social status. This concept is related to the experience of dehumanization, which is to deprive one of human qualities, personality or spirit.

Attitudes & Beliefs influence by degradation and dehumanization (soft).

23. If a client does not follow our agency's rules, it is probably because they are resistant to being treated.
24. If my client isn't taking the medication they are prescribed, it is most likely because they lack insight into their illness.
25. If my client isn't following our agency's guidelines, it is probably because they lack significant insight into their illness.
26. Many of my clients don't take prescribed medications because they lack insight into their illness.
27. When a client of mine is not taking prescribed medication, they are probably resistant to being treated.
28. When my client is very symptomatic, I sometimes do not need to fully explain my actions to them.
29. Even though I may not really believe this, I sometimes have thoughts that perhaps there is something different about my clients compared to me.
30. Admittedly, I am grateful I do not live with a serious mental illness.

Attitudes & Beliefs influenced by degradation and dehumanization (hard).

31. If a client doesn't take prescribed medication, they lack insight into their illness.
32. When my client is very symptomatic, I don't need to fully explain my actions to them.
33. If a client is not following agency rules, they are resistant to treatment.

Behaviors toward clients because of degradation and dehumanization (soft):

34. It is often necessary to figure out a way to not have a client's signature on paperwork, since I'm not always able to get in touch with my client.
35. When a client is experiencing psychotic symptoms, I sometimes find myself more abrupt in our interactions.
36. When my client is experiencing psychotic symptoms, I find myself more detached in our interactions.
37. In order to finish paperwork requiring a client's signature, I may not be able to get in touch with them, so I figure out a way to omit their signature.
38. Sometimes, to save time and for convenience, I might discuss the status of clients with other staff members, in front of clients, without their input.
39. Sometimes when talking about a client with other staff, I have referred to a client by their diagnostic label rather than their name.
40. Sometimes I talk about clients with other staff members, in the presence of those clients, and don't include them in the conversation.
41. In the past, I have made reference to a client by a diagnostic label they have, instead of their name.

Behaviors toward clients because of degradation and dehumanization (hard):

42. I discuss the status of clients with other staff members, in front of clients, without my client's input.
43. I refer to clients by diagnoses they have, not their name.
44. I am not fully engaged during my interactions with a client who is experiencing psychotic symptoms.

Poor prognosis/fostering dependence - The belief of poor prognosis refers to the idea that persons with mental illness will not recover, improve, and/or achieve life goals to which the average person aspires. Fostering dependence -is the desire to promote in individuals with mental illness dependence on mental health services, support services, and medication.

Attitudes & Beliefs influenced by poor prognosis/fostering dependence (soft).

18. When a client is really symptomatic, I sometimes find it difficult seeing them any other way (not symptomatic).
19. When working with a client who lives with a serious mental illness, I have some doubt that they will ever really improve.
20. I am concerned about my client's continued well-being when they wish to decrease their contact or relationship with mental health support services since they likely need these services in order to function well.
21. I sometimes doubt that my clients with serious mental illnesses will ever really get better.
22. My client, diagnosed with a serious mental illness, will probably always need to take medication to function.
23. I generally do not believe clients with serious mental illness should terminate support services; they will likely need them in the future.
24. Clients with serious mental illnesses will almost always require intensive community support services.

Attitudes & Beliefs influenced by poor prognosis/fostering dependence (hard).

25. When working with a client who lives with a serious mental illness, I doubt that they will ever improve in symptoms.
26. Clients with serious mental illness will always require intensive community support services.
27. I do not believe that my clients should end support services; they will need them in the future.

Behaviors toward clients because of poor prognosis/fostering dependence (soft).

28. When a client says they have a goal that I think is really unlikely they will achieve, I subtly discourage them from setting this goal, for their own good.
29. In my practice, I try not to encourage clients with a serious mental illness from setting goals that are 'out of reach', so they won't be disappointed.
30. When a client with a serious mental illness asks if they will always require medication, I will often tell them yes, because I believe they will.
31. When a family member of a client diagnosed with a serious mental illness asks if their loved one will ever get better, I try to minimize their expectations, so they aren't disappointed.
32. When families ask if their loved one will achieve common life goals, I may try to minimize expectations, so they aren't disappointed.

Behaviors toward clients because of poor prognosis/fostering dependence (hard).

33. I discourage clients with a serious mental illness from setting goals that are too 'out of reach.'
34. When families ask if their loved one will achieve common life goals, I try to minimize expectations.

Coercion and lack of ‘real’ choice - Coercion occurs when a mental health service client’s choices are externally influenced by the provider and the service provision environment. The thematic element of the lack of a real choice reflects the client’s experience of making decisions about their treatment and lives without having access to all possible alternatives

Attitudes & Beliefs influenced by coercion and lack of ‘real’ choice (soft).

21. My client wants to have a full time job, but may not really be an option for them because they will lose their disability income or other needed resource(s).
22. Clients with serious mental illnesses have a hard time making good choices for themselves, so service providers need to help them.
23. I may not inform my client of possible options for housing, because they likely won’t do well in those situations.
24. Sometimes I may need to make decisions for my client, for their own good.
25. In some instances it may be necessary to make decisions for my client, without their collaboration, for their own good.

Attitudes & Beliefs influenced by coercion and lack of ‘real’ choice (hard).

26. Clients with serious mental illnesses are unable to make good choices for themselves, so I need to help them in my role as a service provider.
27. Sometimes I make decisions for my client, for their own good.

Behaviors toward clients because of coercion and lack of ‘real choice (soft).

28. If I think a client needs to be admitted to an inpatient psychiatric facility, I ask for them to admit themselves, but they also understand that I will have to start involuntary procedures if they don’t.
29. When a client wants to explore their medication options, I try to decrease their expectations: they don’t really have that many choices.
30. My client’s treatment plan may not necessarily reflect their goals, but rather goals that are realistically attainable.
31. My client’s treatment plan may not reflect their goals, but rather goals that I think are realistic, to make sure they are successful in achieving these goals.
32. In my role as service provider I have made ‘deals’ with clients to get them to take prescribed medications, even if they really didn’t want to.
33. If I think my client would benefit from a particular service, I find myself continuing to suggest this to them, even if they’ve declined.
34. When my client has a relapse in symptoms, I can’t help but remind them of the suggested services that they previously declined, in hopes that they will now accept the services I think they need.
35. When I review treatment options with my client, I find myself sometimes emphasizing what I would prefer, setting aside the other options available.
36. I would prefer my client to admit themselves for emergency psychiatric services, but if they don’t, my client knows that I will need to begin involuntary procedures.
37. When considering options for housing, I try to highlight only the options that I think they will benefit from.

Behaviors toward clients because of coercion and lack of ‘real choice (hard).

38. If I think my client would benefit from a particular service, I will repeatedly suggest this to them, even if they decline.

39. When my client has a relapse in symptoms I remind them of the suggested services that they declined.
40. When considering options for housing, I only let my client know about the options that I think they will benefit from.

Response format(s):

Strongly Agree Agree Neither agree or disagree Disagree Strongly Disagree

Often Sometimes Not applicable to my role Rarely Never

Appendix C

Academic/Research Focus Group Participants

Participants of the researcher and academic expert focus group:

A. Suzanne Boyd, Ph.D., Associate Professor – University of North Carolina at Charlotte
David Kondrat, Ph.D., Associate Professor – Indiana University
Phyllis Solomon, Ph.D., Professor – The University of Pennsylvania
Patrick Sullivan, Ph.D., Professor – University of Indiana

Experts providing feedback via one-to-one interview:

Jeffrey Lacasse, Ph.D., Assistant Professor – Florida State University
Anna Scheyett, Ph.D., Dean and Professor – University of South Carolina

Experts providing feedback via email, after review of scale materials:

John Brekke, Ph.D., Professor – University of Southern California
Kevin Corcoran, Ph.D., Professor – University of Alabama
Melissa Floyd-Pickard, Ph.D., Professor – University of North Carolina at Greensboro
Layne Stromwall, Ph.D., Associate Professor – Arizona State University

Appendix D

Provider, Family, and Consumer Stakeholder Consultation Group Recruitment Materials

Recruitment of family member consultation group participants. Flyer used on page 261. ListServ and Facebook requests:

Listserve and Facebook request:

As part of a doctoral dissertation research project, NAMI members, particularly family members and caregivers of consumers of mental health services are invited to take part in a small discussion group focusing on their experience of stigma in mental health service settings. This focus group for family members is hosted by Jennifer Keast Charles, MSW, a doctoral candidate in the VCU School of Social Work, under the supervision of Dr. Kia J. Bentley. The group will meet at Ellwood Thompson's Community Room on March 27, 2014 at 12:00 p.m. Ellwood Thompson's is located at 4 North Thompson Street, Richmond, VA 23221. The group will last approximately one to 1 ½ hours. Lunch will be served. In addition, participants will be entered into a drawing to win a recent, popular mental health consumer and family personal account book. If interested in learning more or to participate, contact Jennifer via email at keastjl@vcu.edu

Recruitment of client consultation group participants. ListServ and Facebook requests:

Listserve and Facebook request:

As part of a doctoral dissertation research project, NAMI members, particularly consumers of mental health services are invited to take part in a small discussion group focusing on their experience of stigma in mental health service settings. This focus group for consumers is hosted by Jennifer Keast Charles, MSW, a doctoral candidate in the VCU School of Social Work, under the supervision of Dr. Kia J. Bentley. The group will meet at Ellwood Thompson's Community Room on April 3, 2014 at 12:00 p.m. Ellwood Thompson's is located at 4 North Thompson Street, Richmond, VA 23221. The group will last approximately one to 1 ½ hours. Lunch will be served. In addition, participants will be entered into a drawing to win a recent, popular mental health consumer personal account book. If interested in learning more or to participate, contact Jennifer via email at keastjl@vcu.edu

Recruitment of provider focus group participants – email to by clinical supervisor at Chesterfield County CSB:

Subject line: Focus Group Pre-Recruitment

Body:

Dear [CSB contact person],

Thank you again for being willing to let me recruit and host a small focus group of adult mental health service providers at Chesterfield County CSB.

For my dissertation project, I am attempting to develop a scale to measure the attitudes, beliefs, and behaviors of mental health providers toward the clients they serve. I have developed a thematic understanding of provider-based stigmatization and an initial pool of survey items that may be useful in measuring provider attitudes. Now I would like to invite Chesterfield County CSB staff members to engage in a small focus group to review the model and the measure's item pool and offer feedback to help me refine the tool.

The focus group will be held on-site, if possible. A date and time are TBD - Although, lunch time would probably allow for the most participation. The focus group should take about an hour to complete, and I will provide lunch for convenience and as an incentive to participate.

I will follow this email with an email invitation for staff members of your agency. This email can be forwarded to frontline staff "as is" to the adult mental health service workers at Chesterfield County CSB.

Thank you so much for helping me with this study. If you have any questions or concerns about this study, please feel free to contact me at keastjl@vcu.edu or 410-707-5396

Thanks you,
Jennifer Keast Charles, MSW

Recruitment of provider focus group participants – email to be forwarded to staff by clinical supervisor at Chesterfield County CSB:

Subject line: Please help me develop a scale to measure provider attitudes?

Body:

Hello. My name is Jennifer Keast Charles and I am a Ph.D candidate at the VCU School of Social Work. For my dissertation project, I am attempting to develop a self-assessment to measure provider attitudes, beliefs, and behaviors that are perceived by clients and families as stigmatizing. To develop this measure, I'm using a model of provider-based stigma that was derived by analyzing the experiences of clients and families in the mental health service environment.

I'd like to invite you to a focus group, hosted at Chesterfield County CSB, to help make this research useful. During this one-hour discussion we will be reviewing the experience-based model of provider stigma as well as evaluating proposed items of the final measure. I need your help determining if the model and the measure are relevant to current mental health practice.

The focus group will be held during the lunch hour, and I will provide a catered lunch, and guide our discussion.

If you have any questions about this project or to RSVP to participate, please contact me at keastjl@vcu.edu or 410-707-5396

If you have any questions about your rights as a participant in this study, please contact:

Office for Research Subjects Protection
Virginia Commonwealth University
800 East Leigh Street, Suite 114
P.O Box 980568
Richmond, VA 23298

804-828-0868

Thank you,
Jennifer Keast Charles, MSW

Study on attitudes, beliefs, and behaviors of mental health service providers



We are conducting a focus group with family members of consumers of mental health services.

Participation in this focus group will take approximately 1 hour to 1 and ½ hours, in-person, at Ellwood Thompson's Community Room.

~ Heavy refreshments will be served~

If you are interested in participating, or would like more information about this study, please contact Jennifer Keast Charles at keastjl@vcu.edu or 410-707-5396

This study is being conducted by the VCU School of Social Work. Dr. Kia J. Bentley is the Principal Investigator (kbentley@vcu.edu)

Mental Health Provider Self-Assessment of Stigma

Thank you for helping with my dissertation research!

My name is Jennifer Keast Charles, MSW and I am a doctoral candidate in the School of Social work at Virginia Commonwealth University, in Richmond, Virginia. Formerly, I practiced as a social worker in a community mental health center crisis stabilization unit and as a member of a mobile crisis team.

My dissertation research is the development of a self-assessment survey, intended for use by those providing mental health services. The following survey is an initial attempt to measure provider-based stigmatizations: subtle, often unintended negative attitudes, beliefs, and behaviors of mental health service providers. Your answers to the following questions will help to refine this survey, making it more valid and potentially useful for future providers to use in reflection of their own practice.

This survey is completely voluntary, confidential, and anonymous. Your answers on this survey are not linked to your identity in any way, thus it would be impossible for your responses to effect your job. The results of this administration of the survey will chiefly be used to help choose the best items for inclusion and to begin to validate the scale. When finalized, this survey and its results are intended for use in self-reflective practice and supervision, not performance review.

At the completion of the survey, you will be directed to another SurveyMonkey link, where you will have the opportunity to enter your contact information. **This will enter you into a drawing for one of four \$50 gift cards to Target, as a way of saying "Thank you!" for participating.**

The VCU office of Research Subjects Protection has granted IRB approval for this study [Study #HM20000474]. In addition, this survey has been reviewed by the VACSB Data Management, Survey Sub-committee. This research is being supervised by Drs. Kia J. Bentley and Dr. Patrick Dattalo, Professors in the School of Social Work at Virginia Commonwealth University. Should you have any questions or concerns regarding this survey, please feel free to email me at keastjl@vcu.edu

Demographic information

Please answer the following demographic and experience-related questions by selecting a response from each drop-down menu.

1. What is your gender?

2. What is your highest level of education?

3. To which discipline/profession do your most closely identify?

4. How long have you been employed in mental health services?

Mental Health Provider Self-Assessment of Stigma

5. How long have you been employed IN YOUR CURRENT ROLE?

6. In what type of mental health service setting do you work?

7. Which of the following geographical locations within the Commonwealth best describes where you are employed?

8. Are you a peer provider?

****Peer provider is defined as a mental health service provider who publicly identifies as living with a mental health issue, who uses their experience in recovery, in addition to skills learned in formal training, to deliver services (SAMHSA-HRSA Center for Integrated Health Solutions).**

Self-Assessment

For the following items, reflect on your work in the mental health service delivery setting. Please indicate your level of agreement with the following statements regarding your attitudes, beliefs, and behaviors toward clients with whom you interact.

When asked about "my client," "a client," or "clients" - please think about your experience with clients *in general*. If the statement is not applicable to your role or you do not have an opinion of the statement, select the neutral "No Opinion."

9. If one of my clients begins to experience an increase in symptoms of mental illness, I tend to think that they are probably non-adherent to prescribed medication.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. It's hard not to sometimes be irritated with clients who have serious mental illnesses.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. When family members visit a client, who is in an inpatient setting, I may not acknowledge them right away, but finish what I'm doing first.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Mental Health Provider Self-Assessment of Stigma

12. If a client does not follow our agency's rules, it is probably because they are resistant to being treated.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate your level of agreement with the following statements. If the statement is not applicable to your role or you do not have an opinion of the statement, select the neutral "No Opinion."

13. When a client is really symptomatic, I sometimes find it difficult seeing them any other way (not symptomatic).

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. When a client says they have a goal that I think is unlikely they will achieve, I subtly discourage them from setting this goal, for their own good.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. When my client who lives with a serious mental illness wants a full time job I think it may not be an option for them because they likely will not be able to cope with the demands of employment.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. When a client wants to explore their medication options, I try to decrease their expectations: they don't really have that many choices.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17. Conflict between clients and their family members tends to initiate symptom relapses.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate your level of agreement with the following statements. If the statement is not applicable to your role or

Mental Health Provider Self-Assessment of Stigma

you do not have an opinion of the statement, select the neutral "No Opinion."

18. When my client's family calls too many times, I can become irritated.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. I occasionally have a hard time hiding my irritation with some clients.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20. When a client of mine is not taking prescribed medication, they are probably resistant to being treated.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. I generally do not believe clients with serious mental illness should terminate support services; they will likely need them in the future.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. Clients with serious mental illnesses have a hard time making good choices for themselves, so service providers need to help them.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate your level of agreement with the following statements. If the statement is not applicable to your role or you do not have an opinion of the statement, select the neutral "No Opinion."

23. When I review treatment options with my client, I find myself sometimes emphasizing what I would prefer, setting aside the other options available.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

24. If my client is not recovering from a relapse, there is something that they aren't doing.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Mental Health Provider Self-Assessment of Stigma

25. Even though I try not to, I can sometimes be impatient with my clients.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

26. When a client is experiencing psychotic symptoms, I sometimes find myself more abrupt in our interactions.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

27. When families ask if their loved one will achieve common life goals, I may try to minimize expectations, so they aren't disappointed.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate your level of agreement with the following statements. If the statement is not applicable to your role or you do not have an opinion of the statement, select the neutral "No Opinion."

28. It is sometimes hard to be empathic with my client who is experiencing increased symptoms of mental illness, because they haven't been taking prescribed medications.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. If a client is behaving in an annoying manner, I find that I am less likely to return their phone calls.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

30. If my client isn't taking the medication they are prescribed, it is most likely because they lack insight into their illness.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

31. When working with a client who lives with a serious mental illness, I have some doubt that they will ever really improve in functioning

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Mental Health Provider Self-Assessment of Stigma

32. In some instances it may be necessary to make decisions for my client, without their collaboration, for their own good.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate your level of agreement with the following statements. If the statement is not applicable to your role or you do not have an opinion of the statement, select the neutral "No Opinion."

33. I would prefer my client to voluntarily admit themselves for emergency psychiatric services, but if they don't, my client knows that I will begin involuntary procedures.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

34. If a client is relapsing with symptoms of mental illness, there is likely some part of their treatment plan they haven't been following.

1	2	3	4	4	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

35. Sometimes I wish my clients would hurry up when speaking with me.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

36. Because I sometimes find it hard to hide my irritation, I can be short with my clients.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

37. When my client is very symptomatic, I sometimes do not need to fully explain my actions to them.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate your level of agreement with the following statements. If the statement is not applicable to your role or you do not have an opinion of the statement, select the neutral "No Opinion."

Mental Health Provider Self-Assessment of Stigma

38. If a client doesn't take prescribed medication, they lack insight into their illness.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

39. Sometimes, for convenience, I might discuss the status of my client with other staff members, in front of my client, without my client's input.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

40. I sometimes doubt that my clients living with serious mental illnesses will ever really get better.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

41. Sometimes I make decisions for my client, without their input, for their own good.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

42. If my client is not achieving realistic treatment goals, I wonder if it is because they aren't really trying.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate your level of agreement with the following statements. If the statement is not applicable to your role or you do not have an opinion of the statement, select the neutral "No Opinion."

43. When a client isn't trying hard enough in their recovery I may not go out of my way to help them.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

44. When my client's family asks a lot of questions I find it difficult to not be annoyed.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Mental Health Provider Self-Assessment of Stigma

45. Even though I may not really believe this, I sometimes think that perhaps there is something inherently different about my clients compared to me.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

46. In the past, I have occasionally made reference to a client using a diagnostic label they have, instead of their name.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

47. My client, diagnosed with a serious mental illness, will probably always need to take medication to function.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate your level of agreement with the following statements. If the statement is not applicable to your role or you do not have an opinion of the statement, select the neutral "No Opinion."

48. When a family member of a client diagnosed with a serious mental illness asks if their loved one will ever get better, I try to minimize their expectations, so they aren't disappointed.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

49. My client's treatment plan may not reflect their goals, but rather goals that I think are realistic, to make sure they are successful in achieving these goals.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

50. When considering options for housing, I try to highlight the options that I think my client will benefit from - perhaps not mentioning other options.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Mental Health Provider Self-Assessment of Stigma

51. When my client has a relapse of symptoms, I tend to look at problematic behaviors they engage in as the cause of the setback.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

52. When a client calls me too often, I get irritated with their neediness.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate your level of agreement with the following statements. If the statement is not applicable to your role or you do not have an opinion of the statement, select the neutral "No Opinion."

53. When my client is very symptomatic, I don't need to fully explain my actions to them.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

54. Clients with serious mental illness will always require intensive community support services.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

55. I may not inform my client of possible options for independent housing, because they likely won't do well in those situations.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

56. If I think my client would benefit from a particular service, I find myself continuing to suggest this to them, even if they've declined.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate your level of agreement with the following statements. If the statement is not applicable to your role or you do not have an opinion of the statement, select the neutral "No Opinion."

Mental Health Provider Self-Assessment of Stigma

57. My client's family members are often to blame when treatment goals aren't achieved.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

58. If my client's family is over-involved in my client's life, I am less likely to include them in treatment planning.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

59. When I am irritated with a client, I may be less helpful.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

60. When a client with a serious mental illness asks if they will always require medication, I will often tell them yes, because I believe they will.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Somewhat Disagree	No Opinion	Somewhat Agree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The next 10 questions ask you about different behaviors.

For the next 10 questions please indicate how often you engage in each behavior by selecting a response on the scale below each item.

The scale ranges from:

1 = "I never do this," to

4 = "I do this sometimes," to

7 = "I do this all of the time."

If the behavior is not applicable to your experience or your role, select **"N/A"** to indicate *not applicable*.

When asked about "my client," "a client," or "clients" - please think about your experience with clients *in general*.

Self-Assessment

Please indicate how often you engage in each behavior by selecting a response on the scale below each question. If the behavior is not applicable to your experience or your role, select N/A.

61. I discourage clients who live with serious mental illness from setting goals that are too 'out of reach.'

1	2	3	4	5	6	7	N/A
Never			Sometimes			All of the time	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Mental Health Provider Self-Assessment of Stigma

62. In my role as a service provider I have made ‘deals’ with clients to get them to take prescribed medications, even if they really didn’t want to.

1	2	3	4	5	6	7	N/A
Never			Sometimes			All of the time	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

63. When my client is experiencing psychotic symptoms, I find myself more detached in our interactions.

1	2	3	4	5	6	7	N/A
Never			Sometimes			All of the time	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

64. I have difficulty staying awake in therapy sessions because I am not interested in what my client is saying.

1	2	3	4	5	6	7	N/A
Never			Sometimes			All of the time	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

65. Since my client’s family is to blame for my client’s relapse, I do not include them in status updates.

1	2	3	4	5	6	7	N/A
Never			Sometimes			All of the time	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Assessment

Please indicate how often you engage in each behavior by selecting a response on the scale below each question. If the behavior is not applicable to your experience or your role, select N/A.

66. If my client is not following their treatment plan, I do not return their phone calls.

1	2	3	4	5	6	7	N/A
Never			Sometimes			All of the time	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

67. I make reference to clients by diagnoses they have, not their name.

1	2	3	4	5	6	7	N/A
Never			Sometimes			All of the time	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

68. When families ask if their loved one will achieve common life goals, I try to minimize expectations.

1	2	3	4	5	6	7	N/A
Never			Sometimes			All of the time	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Mental Health Provider Self-Assessment of Stigma

69. When considering options for housing, I only let my client know about the options that I think they will benefit from.

1	2	3	4	5	6	7	N/A
Never			Sometimes			All of the time	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

70. When I am irritated with my client's neediness, I will try to avoid them.

1	2	3	4	5	6	7	N/A
Never			Sometimes			All of the time	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Validation Items

One element of mental health service provision as a career that has a significant influence on a provider's attitudes, beliefs, and behaviors toward clients is that of professional burnout.

Burnout is defined as "a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind. A key aspect of the burnout syndrome is increased feelings of emotional exhaustion" (Maslach & Jackson, 1981, p.99).

71. Using the above definition of burnout, indicate on the 10-point rating scale below how 'burnout' you perceive yourself to be, in your current role as a mental healthcare provider.

0					5						10
Not at all					Mildly						Severely
burned out	1	2	3	4	burned out	6	7	8	9		burned out
in my current					in my current						in my current
role.					role.						role.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Validation items

Thinking about yourself in general - and not solely with respect to your mental health practice- consider the following statements. Indicate whether these statements are TRUE or FALSE for you.

This page contains a scale created by Strahan & Gerbasi (1972).

72. I'm always willing to admit it when I make a mistake.

- True
- False

73. I always try to practice what I preach.

- True
- False

Mental Health Provider Self-Assessment of Stigma

74. I never resent being asked to return a favor.

- True
- False

75. I have never been irked when people expressed ideas very different from my own.

- True
- False

76. I have never deliberately said something that hurt someone's feelings.

- True
- False

77. I like to gossip at times.

- True
- False

78. There have been occasions when I took advantage of someone.

- True
- False

79. I sometimes try to get even rather than forgive and forget.

- True
- False

80. At times I have really insisted on having things my own way.

- True
- False

81. There have been occasions when I felt like smashing things.

- True
- False

Thank you!

Mental Health Provider Self-Assessment of Stigma

That completes the [Mental Health Provider Self-Assessment of Stigma Survey](#) and validation items.

Thank you so very much for your participation!

Please click "Done," after which a link will be provided directing you to another SurveyMonkey survey where you can enter into a drawing for one of four \$50 gift cards to Target, as a "THANK YOU" for your time and effort.

Your contact information is NOT linked, in anyway, to your responses on the present survey. You will be contacted via your provided contact information should you win the the drawing, at which time shipment of the gift card can be arranged (at my cost, of course).

Thank you, again! Please click "Done."

Appendix F
Original 62-Items of the MHPSASS

Item #	Stem	Theme intended to tap	Stigma element	Wording	Response Options
1	If one of my clients begins to experience an increase in symptoms of mental illness, I tend to think that they are probably non-adherent to prescribed medication.	Blame/ Shame	Attitude/ Belief	Soft	Agree
2	It's hard not to sometimes be irritated with clients who have serious mental illnesses.	Disinterest/ Annoyance/ Irritation	Attitude/ Belief	Soft	Agree
3	When family members visit my client, who is in an inpatient setting, I may not acknowledge them right away, but finish what I'm doing first.	Disinterest/ Annoyance/ Irritation	Behavior	Soft	Agree
4	If a client does not follow our agency's rules, it is probably because they are resistant to being treated.	Degradation & Dehumanization	Attitude/ Belief	Soft	Agree
5	When a client is really symptomatic, I sometimes find it difficult seeing them any other way (not symptomatic).	Poor Prognosis/ Fostering Dependence	Attitude/ Belief	Soft	Agree
6	When a client says they have a goal that I think is unlikely they will achieve, I subtly discourage them from setting this goal, for their own good.	Poor Prognosis/ Fostering Dependence	Behavior	Soft	Agree
7	My client who lives with a serious mental illness wants to have a full time job, I think it may not be an option for them because they likely will not be able to cope with the demands of employment.	Coercion/ Lack of REAL choice	Attitude/ Belief	Soft	Agree
8	When a client wants to explore their medication options, I try to decrease their expectations: they don't really have that many choices.	Coercion/ Lack of REAL choice	Behavior	Soft	Agree
9	Conflict between my client and their family members tends to initiate symptom relapses.	Blame/ Shame	Attitude/ Belief	Soft	Agree
10	When my client's family calls too many times, I can become irritated.	Disinterest/ Annoyance/ Irritation	Attitude/ Belief	Soft	Agree
11	I occasionally have a hard time hiding my irritation with some clients.	Disinterest/ Annoyance/ Irritation	Behavior	Soft	Agree

Appendix F
Original 62-Items of the MHPSASS

Item #	Stem	Theme intended to tap	Stigma element	Wording	Response Options
12	When a client of mine is not taking prescribed medication, they are probably resistant to being treated.	Degradation & Dehumanization	Attitude/Belief	Soft	Agree
13	I generally do not believe clients with serious mental illness should terminate support services; they will likely need them in the future.	Poor Prognosis/ Fostering Dependence	Attitude/Belief	Soft	Agree
14	Clients with serious mental illnesses have a hard time making good choices for themselves, so service providers need to help them.	Coercion/ Lack of REAL choice	Attitude/Belief	Soft	Agree
15	When I review treatment options with my client, I find myself sometimes emphasizing what I would prefer, setting aside the other options available.	Coercion/ Lack of REAL choice	Behavior	Soft	Agree
16	If my client is not recovering from a relapse, there is something that they aren't doing.	Blame/ Shame	Attitude/Belief	Hard	Agree
17	Even though I try not to, I can sometimes be impatient with my client.	Disinterest/ Annoyance/ Irritation	Attitude/Belief	Soft	Agree
18	When a client is experiencing psychotic symptoms, I sometimes find myself more abrupt in our interactions.	Degradation & Dehumanization	Behavior	Soft	Agree
19	When families ask if their loved one will achieve common life goals, I may try to minimize expectations, so they aren't disappointed.	Poor Prognosis/ Fostering Dependence	Behavior	Soft	Agree
20	It is sometimes hard to be empathic with my client who is experiencing increased symptoms of mental illness, because they haven't been taking prescribed medications.	Blame/ Shame	Behavior	Soft	Agree
21	If a client is behaving in an annoying manner, I find that I am less likely to return their calls.	Disinterest/ Annoyance/ Irritation	Behavior	Soft	Agree
22	If my client isn't taking the medication they are prescribed, it is most likely because they lack insight into their illness.	Degradation & Dehumanization	Attitude/Belief	Soft	Agree

Appendix F
Original 62-Items of the MHPSASS

Item #	Stem	Theme intended to tap	Stigma element	Wording	Response Options
23	When working with a client who lives with a serious mental illness, I have some doubt that they will ever really improve in functioning.	Poor Prognosis/ Fostering Dependence	Attitude/ Belief	Soft	Agree
24	In some instances it may be necessary to make decisions for my client, without their collaboration, for their own good.	Coercion/ Lack of REAL choice	Attitude/ Belief	Soft	Agree
25	I would prefer my client to voluntarily admit themselves for emergency psychiatric services, but if they don't, my client knows that I will begin involuntary procedures.	Coercion/ Lack of REAL choice	Behavior	Soft	Agree
26	If a client is relapsing with symptoms of mental illness, there is likely some part of their treatment plan they haven't been following.	Blame/ Shame	Attitude/ Belief	Soft	Agree
27	Sometimes, I wish my client would hurry up when speaking with me.	Disinterest/ Annoyance/ Irritation	Attitude/ Belief	Soft	Agree
28	Because I sometimes find it hard to hide my irritation, I can be short with my clients.	Disinterest/ Annoyance/ Irritation	Behavior	Soft	Agree
29	When my client is very symptomatic, I sometimes do not need to fully explain my actions to them.	Degradation & Dehumanization	Attitude/ Belief	Soft	Agree
30	If a client doesn't take prescribed medication, they lack insight into their illness.	Degradation & Dehumanization	Attitude/ Belief	Hard	Agree
31	Sometimes, for convenience, I might discuss the status of my client with other staff members, in front of my client, without my client's input.	Degradation & Dehumanization	Behavior	Soft	Agree
32	I sometimes doubt that my clients with serious mental illnesses will ever really get better.	Poor Prognosis/ Fostering Dependence	Attitude/ Belief	Soft	Agree
33	Sometimes I make decisions for my client, for their own good.	Coercion/ Lack of REAL choice	Attitude/ Belief	Hard	Agree

Appendix F
Original 62-Items of the MHPSASS

Item #	Stem	Theme intended to tap	Stigma element	Wording	Response Options
34	If my client is not achieving realistic treatment goals, I wonder if it is because they aren't really trying.	Blame/ Shame	Attitude/ Belief	Soft	Agree
35	When a client isn't trying hard enough in their recovery I may not go out of my way to help them.	Blame/ Shame	Behavior	Soft	Agree
36	When my client's family asks a lot of questions I find it difficult to not be annoyed.	Disinterest/ Annoyance/ Irritation	Attitude/ Belief	Soft	Agree
37	Even though I may not really believe this, I sometimes think that perhaps there is something inherently different about my clients compared to me.	Degradation & Dehumanization	Attitude/ Belief	Soft	Agree
38	In the past, I have occasionally made reference to a client using a diagnostic label they have, instead of their name.	Degradation & Dehumanization	Behavior	Soft	Agree
39	My client, diagnosed with a serious mental illness, will probably always need to take medication to function.	Poor Prognosis/ Fostering Dependence	Attitude/ Belief	Soft	Agree
40	When a family member of a client diagnosed with a serious mental illness asks if their loved one will ever get better, I try to minimize their expectations, so they aren't disappointed.	Poor Prognosis/ Fostering Dependence	Behavior	Soft	Agree
41	My client's treatment plan may not reflect their goals, but rather goals that I think are realistic, to make sure they are successful in achieving these goals	Coercion/ Lack of REAL choice	Behavior	Soft	Agree
42	When considering options for housing, I try to highlight the options that I think they will benefit from.	Coercion/ Lack of REAL choice	Behavior	Soft	Agree
43	When my client has a relapse of symptoms, I tend to look at problematic behaviors they engage in as the cause of the setback.	Blame/ Shame	Attitude/ Belief	Soft	Agree
44	When a client calls me too often, I get irritated with their neediness.	Disinterest/ Annoyance/ Irritation	Attitude/ Belief	Hard	Agree

Appendix F
Original 62-Items of the MHPSASS

Item #	Stem	Theme intended to tap	Stigma element	Wording	Response Options
45	When my client is very symptomatic, I don't need to fully explain my actions to them.	Degradation & Dehumanization	Attitude/Belief	Hard	Agree
46	Clients with serious mental illness will always require intensive community support services.	Poor Prognosis/ Fostering Dependence	Attitude/Belief	Hard	Agree
47	I may not inform my client of possible options for independent housing, because they likely won't do well in those situations.	Coercion/ Lack of REAL choice	Attitude/Belief	Soft	Agree
48	If I think my client would benefit from a particular service, I find myself continuing to suggest this to them, even if they've declined.	Coercion/ Lack of REAL choice	Behavior	Soft	Agree
49	My client's family members are often to blame when treatment goals aren't achieved.	Blame/ Shame	Attitude/Belief	Hard	Agree
50	If my client's family is over-involved in my client's life, I am less likely to include them in treatment planning.	Blame/ Shame	Behavior	Soft	Agree
51	When I am irritated with a client, I may be less helpful.	Disinterest/ Annoyance/ Irritation	Behavior	Soft	Agree
52	When a client with a serious mental illness asks if they will always require medication, I will often tell them yes, because I believe they will.	Poor Prognosis/ Fostering Dependence	Behavior	Soft	Agree
53	I often discourage clients with a serious mental illness from setting goals that are too 'out of reach.'	Poor Prognosis/ Fostering Dependence	Behavior	Hard	Freq
54	In my role as service provider I have made 'deals' with clients to get them to take prescribed medications, even if they really didn't want to.	Coercion/ Lack of REAL choice	Behavior	Soft	Freq
55	When my client is experiencing psychotic symptoms, I find myself more detached in our interactions.	Degradation & Dehumanization	Behavior	Soft	Freq

Appendix F
Original 62-Items of the MHPSASS

Item #	Stem	Theme intended to tap	Stigma element	Wording	Response Options
56	I have difficulty stay awake in therapy sessions because I am not interested in what my client is saying.	Disinterest/ Annoyance/ Irritation	Behavior	Hard	Freq
57	Since my client's family is to blame for the relapse, I do not include them in status updates.	Blame/ Shame	Behavior	Hard	Freq
58	If my client is not following their treatment plan, I do not return their phone calls.	Blame/ Shame	Behavior	Hard	Freq
59	I frequently refer to clients by diagnoses they have, not their name.	Degradation & Dehumanizati on	Behavior	Hard	Freq
60	When families ask if their loved one will achieve common life goals, I try to minimize expectations.	Poor Prognosis/ Fostering Dependence	Behavior	Hard	Freq
61	When considering options for housing, I only let my client know about the options that I think they will benefit from.	Coercion/ Lack of REAL choice	Behavior	Hard	Freq
62	When I am irritated with my client's neediness, I attempt to avoid them.	Disinterest/ Annoyance/ Irritation	Behavior	Hard	Freq

Appendix G

Administration Recruitment Materials

Email for Executive Directors

Subject: Provider attitudes research project

Body:

Dear [Executive Director],

My name is Jennifer Keast Charles and I am a PhD candidate in the School of Social Work at Virginia Commonwealth University. Prior to my doctoral academic studies I worked as a social worker in a community mental health center and as a member of a crisis stabilization team.

For my dissertation project I am seeking to develop a self-assessment measure, for use by mental health service providers, which focuses on attitudes, beliefs, and behaviors toward their clients. It is my hope that a standardized measure of provider attitudes will allow for further study into an often overlooked topic. The ultimate goal is, of course, to provide clients with the most effective services, improving quality of life, by efficient means.

In this effort, I have developed a draft assessment, based on previously completed exploratory research and an extensive review of relevant research. I have also reviewed the items for this questionnaire with multiple focus groups consisting of researchers, providers, family members, and consumers of services. Now, I would like to invite the providers of adult mental health services in your agency to complete the draft survey, both professional and paraprofessional employees. This will help me to refine and improve this self-assessment of provider attitudes.

The VCU Office of Research Subjects Protection has granted IRB approval for this study [Study #HM20000474]. In addition, this survey has been reviewed by the VACSB, Data Management, survey sub-committee. I was provided with the needed contact information to reach all the CSBs in the Commonwealth by the Department of Behavioral Health and Developmental Services. If you have any questions or concerns about this study, please feel free to email me at keastjl@vcu.edu or my dissertation supervisor, Dr. Kia J. Bentley at kbentley@vcu.edu

As Executive Director of the ((CSB TARGETED)) I wanted to be sure you were aware that this survey was being sent to the ((Mental Health Director)), along with a request that an email invitation to participate be forwarded out to your agency's providers of adult mental health services. The email to be sent to employees contains a web-link to the survey. I have asked the ((Mental Health Directors)) to email this to all employees who have interpersonal contact with consumers of services – professional and paraprofessionals, administrators and supervisors. As an incentive for participation, participants will have an opportunity to enter into a drawing for one of four \$50 gift cards to Target. Participation is completely voluntary and should take 20-25 minutes to complete.

Here is a link to the survey: <https://www.surveymonkey.com/s/HCRN3QG>

Thank you very much for your help! I will be following-up in a couple of weeks with the ((TARGETED POSITION)) and asking them to forward another email to providers at your

agency, as a reminder to participate. If you do not want to invite the providers at your agency to participate in this study, please let me know that as well.

Thank you,
Jennifer Keast Charles, MSW

Email for Mental Health or Facility Directors

Subject: Provider attitudes research project

Body:

Dear [MH or Facility Director],

My name is Jennifer Keast Charles and I am a PhD candidate in the School of Social Work at Virginia Commonwealth University. Prior to my doctoral academic studies I worked as a social worker in a community mental health center and as a member of a crisis stabilization team.

For my dissertation project I am seeking to develop a self-assessment measure, for use by mental health service providers, which focuses on attitudes, beliefs, and behaviors toward their clients. It is my hope that a standardized measure of provider attitudes will allow for further study into an often overlooked topic. The ultimate goal is, of course, to provide clients with the most effective services, improving quality of life, by efficient means.

In this effort, I have developed a draft assessment, based on previously completed exploratory research and an extensive review of relevant research. I have also reviewed the items for this questionnaire with multiple focus groups consisting of researchers, providers, family members, and consumers of services. Now, I would like to invite the providers of adult mental health services in your agency to complete the draft survey, both professional and paraprofessional employees. This will help me to refine and improve this self-assessment of provider attitudes.

The VCU Office of Research Subjects Protection has granted IRB approval for this study [Study #HM20000474]. In addition, this survey has been reviewed by the VACSB, Data Management, survey sub-committee. I was provided with the needed contact information to reach all the CSBs in the Commonwealth by the Department of Behavioral Health and Developmental Services. If you have any questions or concerns about this study, please feel free to email me at keastjl@vcu.edu or my dissertation supervisor, Dr. Kia J. Bentley at kbentley@vcu.edu

An email to forward out to your agency's adult mental health service providers will follow this email, which will contain a web-link to the survey. Please email this to all employees who have interpersonal contact with consumers of services – professional, peer, paraprofessionals, administrators, and supervisors. As an incentive for participation, participants will have an opportunity to enter into a drawing for one of four \$50 gift cards to Target. Participation is completely voluntary. The survey should take approximately 20-25 minutes to complete. Here is a link to the survey: <https://www.surveymonkey.com/s/HCRN3QG>

Thank you very much for your help! I will follow-up with you in a couple of weeks and ask you to forward another email to providers at your agency, as a reminder to participate. If possible, please send me a quick email when you forward out the survey invitation. Also, if you do not want to invite the providers at your agency to participate in this study, please let me know that as well.

Thank you,
Jennifer Keast Charles, MSW

Follow-up one week later, if no reply:

Dear {BOTH MH director/Executive},

I wanted to follow-up with you at {Targeted Agency} about the information and invitation to participate in my dissertation research project sent to you last week.

I am seeking to develop a self-assessment measure, for use by mental health service providers, which focuses on attitudes, beliefs, and behaviors toward their clients. It is my hope that a standardized measure of provider attitudes will allow for further study into an often overlooked topic. I would like to invite the providers of adult mental health services in {TARGET AGENCY} to complete the draft survey, both professional, paraprofessional, and peer employees. This will help me to refine and improve this self-assessment of provider attitudes. As an incentive for participation, participants will have an opportunity to enter into a drawing for one of four \$50 gift cards to Target. Participation is completely voluntary. The survey should take approximately 20 minutes to complete.

Last week I sent a description of my project and an invitation to forward to providers at your agency, if you decided you would be able to help. This survey has been sent out to all the CSBs in the Commonwealth of Virginia in addition to the mental health facilities and I have begun to receive completed surveys from many different areas. I am eager to have the feedback from providers of adult mental health services at {YOUR AGENCY}. If you have any questions, concerns, or need additional information in order to make a decision about your agency's participation, please let me know. If you would like me to resend the invitation to forward out to your employees, I can do that as well.

Thank you,
Jennifer Keast Charles, MSW

Email to employees and peer providers:

(Forwarded out by Mental Health and Facility directors)

Subject: Will you help me develop a self-assessment of mental health service provider attitudes?

Body:

Hi, my name is Jennifer Keast Charles and I am a PhD candidate at the School of Social Work at Virginia Commonwealth University. Prior to my doctoral academic studies I worked as a social worker in a community mental health center and as a member of a crisis stabilization team.

For my dissertation research project I am developing a self-assessment measure for use by mental health service providers to assess and reflect on their attitudes, beliefs, and behaviors. Currently, I have a draft of the provider self-assessment, but I need assistance from mental health service providers, like you, to improve the measurement and to determine how well it works.

The draft is currently hosted online at Survey Monkey, to collect input from providers, and I truly hope you will choose to participate. Completion should take approximately 20 minutes. Participation is completely voluntary and your responses will not be linked to your identity.

After you complete the survey you will have the opportunity to provide your email address to be entered into a drawing to win one of four \$50 Target gift cards. Where I ask for your email address is not linked to your survey responses in any way, but you may, of course, choose not to enter this drawing, thereby not providing your email address.

Here is a link to the survey: <https://www.surveymonkey.com/s/HCRN3QG>

If you have any questions about this project, please feel free to contact me at keastjl@vcu.edu or my dissertation supervisor, Dr. Kia J. Bentley at kbentley@vcu.edu

If you have any questions about your rights as a participant in this study, please contact:

Office for Research Subjects Protection
Virginia Commonwealth University
800 East Leigh Street; Suite 114
PO Box 980568
Richmond, VA 23298

804-828-0868

Thank you,
Jennifer Keast Charles, MSW

Follow-up to Mental Health or Facility Directors, 2 weeks after initial invite was forwarded:

Subject: Could you send a reminder to your agency's providers of adult mental health services?

Body:

Dear [Mental Health or Facility Director],

Thank you for your help in completing my dissertation project, the creation of a self-assessment measure of mental health service provider attitudes. I have received completed questionnaires from a number of providers and would love more, to make sure that the measure is the best it can be!

Here is a link to the survey: <https://www.surveymonkey.com/s/HCRN3QG>

Please help me in forwarding out a follow-up, reminder email to providers of adult mental health services at ****YOUR AGENCY**. That reminder email will follow this email, shortly, and can be forwarded 'as is.'

If you have any questions or concerns about this study, please feel free to contact me at keastjl@vcu.edu or my dissertation supervisor, Dr. Kia J. Bentley at kbentley@vcu.edu

Thank you again!
Jennifer Keast Charles, MSW

Follow-up to be sent to employees and peer providers

(Forwarded 2 weeks after initial invitation, by the mental health/facility director)

Subject: A reminder about the service provider attitude self-assessment project

Body:

Hello. Two weeks ago you received an email requesting your help to develop a self-assessment measure for providers of mental health services. Thank you so much to those who have already taken a moment to participate! If you would still like to respond to the survey, you still have time to do so. Completion of the online questionnaire should only take about 20 - 25 minutes. Participation is absolutely voluntary.

Here is a link to the survey: <https://www.surveymonkey.com/s/HCRN3QG>

Your participation is really important to making the self-assessment truly useful to providers of mental health services. As a 'thank you' to those who participate, at the survey's completion you will be given the opportunity to enter into a drawing for one of four \$50 gift cards to Target.

If you have any questions about this project, please feel free to contact me at keastjl@vcu.edu or my dissertation supervisor, Dr. Kia J. Bentley at kbentley@vcu.edu.

If you have any questions about your rights as a participant in this study, please contact:

Office for Research Subjects Protection
Virginia Commonwealth University
800 East Leigh Street, Suite 114
PO Box 980568
Richmond, VA 23298

804-828-0868

Thank you,

Jennifer Keast Charles, MSW

Appendix H

Factor Loadings and Communalities for the 61-items of the MHPSASS

Rotated Component Matrix^a

	Factor 1	Factor 2	Factor 3	Factor 4	Communality
*Item 1	-.029	.135	.350	.026	.142
Item 2	.502	-.041	.181	.060	.290
*Item 3	-.086	.126	.065	.293	.113
*Item 4	.351	-.020	.348	.043	.247
*Item 5	.353	.164	.271	.059	.228
*Item 6	.254	.359	.104	.035	.206
*Item 7	.203	.350	.390	-.071	.321
Item 8	.096	.472	.138	.025	.252
Item 9	.145	-.007	.407	-.322	.291
Item 10	.544	.163	-.097	.093	.341
Item 11	.540	-.008	.001	.156	.316
Item 12	.120	.140	.545	.099	.340
item 13	-.110	-.136	.561	.124	.361
Item 14	.053	.028	.592	.195	.392
Item 15	.329	.520	.071	-.015	.384
*Item 16	.108	.276	.255	-.380	.298
Item 17	.491	.043	.101	.131	.270
*Item 18	.174	.144	.131	.282	.148
Item 19	.191	.441	.094	.128	.256
***Item 20	.457	.106	.309	.283	.396
Item 21	.630	.215	-.167	-.100	.480
Item 22	-.003	.087	.666	-.083	.458
*Item 23	.315	.201	.343	.097	.267
Item 24	.155	.073	.165	.473	.280
Item 26	.160	.136	.515	.043	.311
Item 27	.545	-.069	.061	.306	.400
Item 28	.442	.247	.051	.236	.315
Item 29	.306	.058	.093	.515	.370
Item 30	.076	.071	.600	.075	.377
*Item 31	.213	.357	.042	.326	.281
*Item 32	.327	.117	.329	.270	.302
Item 33	.229	.239	.103	.515	.385
*Item 34	.333	.263	.379	.068	.328
Item 35	.430	.182	.129	.071	.240
Item 36	.521	.328	.078	.123	.400
*Item 37	.074	.025	.202	.297	.135

Item 38	.225	.072	-.081	.538	.352
Item 39	-.017	.075	.645	.170	.451
Item 40	.248	.490	.073	.205	.349
Item 41	.067	.650	.183	.182	.494
Item 42	-.115	.692	.058	.092	.505
*Item 43	.280	.319	.363	-.033	.313
Item 44	.676	.290	.056	.050	.546
Item 45	.159	.139	.201	.637	.490
***Item 46	-.028	.056	.473	.342	.344
Item 47	-.059	.691	.099	.092	.499
Item 48	.109	.439	.161	.042	.232
*Item 49	.344	.385	.108	-.029	.279
Item 50	.149	.454	-.021	-.062	.233
*Item 51	.260	.046	.089	.322	.181
Item 52	-.066	.206	.588	.197	.431
Item 53	.098	.468	.186	.248	.324
Item 54	-.119	.251	.242	.441	.330
Item 55	.277	.033	.169	.473	.330
*Item 56	.315	.243	-.035	.202	.200
*Item 57	.069	.326	-.029	.127	.128
*Item 58	.340	.212	-.109	.079	.179
Item 59	.243	.060	-.113	.459	.286
**Item 60	.211	.439	.118	.498	.500
Item 61	-.031	.587	.098	.360	.485
Item 62	.571	.008	.034	.299	.417

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.^a

a. Rotation converged in 7 iterations.

Appendix I
Reliability Assessment

Total Mental Health Provider Self-Assessment of Stigma Survey (alpha = 0.817)

	Subscale Item to Total Statistics		Total Score to Total Statistics	
	Subscale Corrected Item-Total Correlation	Subscale Cronbach's Alpha if Item Deleted	TOTAL MHPASS Corrected Item-Total Correlation	Total MHPASS Cronbach's Alpha if Item Deleted
<i>Factor 1 Subscale (alpha = 0.758)</i>				
2 - It's hard not to sometimes be irritated...	.411	.741	.387	.809
10 - When my client's family calls too many times, I can become irritated.	.432	.738	.395	.809
17 - Even though I try not to, I can sometimes be impatient with my clients.	.451	.733	.417	.808
21 - If a client is behaving in an annoying manner...	.477	.729	.349	.811
27 - Sometimes I wish my clients would hurry up when speaking with me.	.473	.730	.412	.808
28 - Because I sometimes find it hard to hide my irritation, I can be short with my clients.	.474	.732	.469	.806
35 - When a client isn't trying hard enough in their recovery....	.313	.758	.357	.811
44 - When a client calls me too often, I get irritated with their neediness.	.642	.696	.632	.795

Appendix I
Reliability Assessment

<i>Factor 2 Subscale (alpha = 0.660)</i>				
15 - When I review treatment options with my client, I find myself sometimes emphasizing what I would prefer...	.371	.627	.388	.809
19 - When families ask if their loved one will achieve common life goals, I may try to minimize expectations....	.423	.604	.409	.808
40 - When a family member of a client diagnosed with a serious mental illness asks...	.469	.584	.457	.806
41 - My client's treatment plan may not reflect their goals...	.532	.555	.417	.808
48 - If I think my client would benefit from a particular service, I find myself continuing...	.315	.671	.329	.329

Appendix I
Reliability Assessment

<i>Factor 3 (alpha = 0.663)</i>				
12 - When a client of mine is not taking prescribed medication...resistant...	.446	.596	.364	.810
14 - Clients with serious mental illnesses have a hard time making good choices...	.501	.554	.307	.814
26 - If a client is relapsing with symptoms of mental illness, there is likely some part of their treatment plan...	.417	.613	.364	.810
39 - My client, diagnosed with a serious mental illness, will probably always need to take medication...	.418	.616	.285	.815
<i>Factor 4 (alpha = 0.553)</i>				
24 - In some instances it may be necessary to make decisions for my client...	.364	.458	.379	.810
29 - When my client is very symptomatic, I sometimes do not need to fully explain my actions to them.	.379	.447	.373	.810
38 - In the past, I have occasionally made reference to a client using a diagnostic label...	.364	.451	.304	.814

Appendix J
Finalized MHPSASS 20-Items

Factor 1 - Irritation and Impatience				
Original Item #	Stem	Stigma element	Wording	Resonse option
2	It's hard not to sometimes be irritated with clients who have serious mental illnesses.	Attitude/ Belief	Soft	Agree
10	When my client's family calls too many times, I can become irritated.	Attitude/ Belief	Soft	Agree
17	Even though I try not to, I can sometimes be impatient with my client.	Attitude/ Belief	Soft	Agree
21	If a client is behaving in an annoying manner, I find that I am less likely to return their calls.	Behavior	Soft	Agree
27	Sometimes, I wish my client would hurry up when speaking with me.	Attitude/ Belief	Soft	Agree
28	Because I sometimes find it hard to hide my irritation, I can be short with my clients.	Behavior	Soft	Agree
35	When a client isn't trying hard enough in their recovery I may not go out of my way to help them.	Behavior	Soft	Agree
44	When a client calls me too often, I get irritated with their neediness.	Attitude/ Belief	Hard	Agree
Factor 2 - Choice and Capacity				
15	When I review treatment options with my client, I find myself sometimes emphasizing what I would prefer, setting aside the other options available.	Behavior	Soft	Agree
19	When families ask if their loved one will achieve common life goals, I may try to minimize expectations, so they aren't disappointed.	Behavior	Soft	Agree
40	When a family member of a client diagnosed with a serious mental illness asks if their loved one will ever get better, I try to minimize their expectations, so they aren't disappointed.	Behavior	Soft	Agree
41	My client's treatment plan may not reflect their goals, but rather goals that I think are realistic, to make sure they are successful in achieving these goals	Behavior	Soft	Agree
48	If I think my client would benefit from a particular service, I find myself continuing to suggest this to them, even if they've declined.	Behavior	Soft	Agree

Appendix J
Finalized MHPSASS 20-Items

Factor 3 - Adherence and Dependence				
Original Item #	Stem	Stigma element	Wording	Resonse option
12	When a client of mine is not taking prescribed medication, they are probably resistant to being treated.	Attitude/ Belief	Soft	Agree
14	Clients with serious mental illnesses have a hard time making good choices for themselves, so service providers need to help them.	Attitude/ Belief	Soft	Agree
26	If a client is relapsing with symptoms of mental illness, there is likely some part of their treatment plan they haven't been following.	Attitude/Belief	Soft	Agree
39	My client, diagnosed with a serious mental illness, will probably always need to take medication to function.	Attitude/ Belief	Soft	Agree
Factor 4 - Devalue and Depersonalize				
24	In some instances it may be necessary to make decisions for my client, without their collaboration, for their own good.	Attitude/ Belief	Soft	Agree
29	When my client is very symptomatic, I sometimes do not need to fully explain my actions to them.	Attitude/ Belief	Soft	Agree
38	In the past, I have occasionally made reference to a client using a diagnostic label they have, instead of their name.	Behavior	Soft	Agree

Vita

Jennifer Louise Keast Charles was born August 30, 1981 in Howard County, Maryland, and is a citizen of the United States of America. She graduated from Oakland Mills High School in Columbia, Maryland in 1999. Jennifer received her Bachelor of Arts degree in Communication Studies from Virginia Polytechnic Institute and State University (Virginia Tech), Blacksburg, Virginia in 2005. She earned a Masters degree in Social Work from Barry University, Miami Shores, Florida in 2008. Jennifer was employed for about one year post-MSW as a psychiatric social worker. She served in a variety of positions, including on a crisis stabilization unit, as well as maintaining a small case load of clients in outpatient therapy, and as an intake and evaluation specialist for outpatient services at South County Mental Health Center, Delray Beach, Florida.