

Challenging Psychiatric Stigma in Mental Health Professionals

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DEDICATION

To L. H.

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ABSTRACT

This study was undertaken to (a) determine whether diagnostic labels influence the beliefs, attitudes, and clinical judgments of psychologists-in-training; and to (b) test the efficacy of a cognitive intervention intended to reduce psychiatric stigma. Participants included 402 doctoral students in U.S. clinical and counseling psychology programs. All were asked to read a case vignette and report their reactions to it. Some participants were presented with a clinical vignette that specified a previous diagnosis of a personality disorder (PD); others were given a vignette that did not include a PD diagnosis. The presence or absence of an anti-stigma intervention preceding the vignette was also randomized. Following the vignette, trainees were questioned about their emotional reactions, their likelihood of helping such a client, their beliefs about the client's control over his condition, their willingness to avoid such a person, and their anticipated clinical behaviors. Trainees reacted to PD cases with more stigmatizing responses overall. In particular, they anticipated fewer helping behaviors and reported more discriminatory clinical behaviors. When prompted with an anti-stigma message prior to reading the vignette, trainees' reactions were less stigmatizing overall. Specifically, they reacted with less negative emotions, attributed less responsibility for portrayed problems, and were less likely to anticipate distancing themselves from the individual personally and professionally. The present findings contribute to the growing corpus of research indicating that psychiatric labels carry pejorative connotations even for mental health professionals. Clinicians-in-training appear less likely to help a client when presenting problems are described by diagnoses rather than by symptoms alone. While students may not be immune from implicit biases about mental illness, results demonstrate that they are

responsive to intervention. Thus, graduate school may represent a sensitive period when clinicians are particularly open to anti-stigma interventions.

Keywords: stigma, attitudes, stereotypes, mental illness, mental health professionals, personality disorders, anti-stigma campaign

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CHAPTER I

Introduction

Research suggests that human beings have a fundamental need for belongingness (Baumeister & Leary, 1995). Despite the importance social acceptance has for us, social rejection remains part of the human experience. Sometimes exclusion occurs based on idiosyncratic interactions between two individuals. In other cases, certain individuals are systematically excluded because they possess particular characteristics or are members of a certain group – a process known as stigmatization. Throughout history, individuals with mental illness have experienced stigmatization, and this continues today (Phelan, Link, Stueve, & Pescosolido, 2000). This mental illness stigma, also known as psychiatric stigma, creates serious obstacles for affected individuals as they attempt to navigate an intolerant social environment. Thus, individuals with mental illness have not only the symptoms of the illness to contend with but also the effects of what Finzen (1996) refers to as a “second illness” – stigmatized reactions from others.

Bachelor (1995) showed that clients seeking psychotherapeutic services consider respect and a nonjudgmental attitude to be the most important therapist characteristics underlying a good therapeutic relationship. While creating an accepting and non-judgmental environment remains an important goal for all mental health professionals, it is one that is undoubtedly aspirational in nature. Clinicians are members of society too, and are likely to inherit, as products of socialization processes, many of the ideas of the cultural milieu, including stigmatizing beliefs and attitudes. Prior studies found that psychologists and social workers held negative and biased attitudes towards individuals with Acquired Immune Deficiency Syndrome (AIDS; Crawford, Humfleet, Ribordy, Ho,

& Vickers, 1991). Young and Powell (1985) demonstrated that client obesity can actually influence a clinician's decision-making. And Farina et al. (1977) found that physically unattractive psychiatric clients are given more severe diagnoses, are hospitalized for longer durations, and receive fewer doctor visits than attractive clients, even when other influential variables are controlled. Therefore, there is reason to believe that mental health professionals are not immune to stigmatizing beliefs, attitudes, and behaviors that exists in society at large.

There is also evidence that despite their clinical training, or perhaps because of it, clinicians possess *mental illness* stigma as well. Research in this area suggests that a closer examination of psychiatric stigma within providers is warranted. Stigma is expected to negatively impact empathy, an essential component of the therapeutic alliance (Feller & Cottone, 2003). The therapeutic alliance, in turn, is a well-known and consistent predictor of psychotherapy outcome (Martin, Garske, & Davis, 2000). Therefore, if psychiatric stigma exists within providers, then client care depends on confronting this issue. This study examined psychiatric stigma present within mental health professionals and explored possible ways to counter it.

Review of the Literature

Psychiatric Stigma

Stigma is a public mark of disgrace or discredit based on some attribute that sets a person aside from others (Byrne, 2001) and results in a "spoiled identity" (Goffman, 1963, p. 19). Psychiatric stigma, also known as mental illness stigma, is the process of setting apart individuals with psychiatric illness. The history of social responses to mental illness describes a long record of rejection, punishment, isolation, and stigmatization

(Hinshaw, 2008). Unfortunately, psychiatric stigma still remains widespread in Western (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000) and non-Western (Chung & Wong, 2004) societies. Therefore, it remains an important social problem.

The Process of Psychiatric Stigmatization

Link and Phelan (2001) propose that the process of stigmatization is characterized by people distinguishing and labeling human differences, linking individuals to undesirable characteristics, placing labeled persons in distinct categories to achieve an us-versus-them separation, and the experience of some degree of status loss and discrimination for labeled persons. Weiner's (1986) *attribution theory* helps to organize these different components of stigma. Attribution theory describes a causal process whereby discriminative stimuli act as signals that are given meaning by mediating knowledge structures, which influence affect and behavior. The attributions that a person makes are important because they influence the attitudes he or she comes to have. These attitudes are likewise important because they, in turn, shape other emotional and behavioral responses. Attribution theory provides a model that binds these cognitive, emotional, and behavioral domains together in a causal process. Corrigan and Lee (2013) have called this the *cognitive behavioral model of stigma*.

Cognitive components of psychiatric stigma. The process of stigma begins with the perception of discriminative stimuli – that is, the distinguishing and labeling of human differences (Link & Phelan, 2001). While there are many human differences, the vast majority of them are ignored and considered socially irrelevant (e.g., shoe size, book preferences). Nevertheless, some are determined to be socially salient (e.g., skin color, sexual preference, mental health). While some sources of stigma are readily apparent and

cued by physical signs, other stigmas are hidden and must be inferred (Goffman, 1963). Mental illness appears to be inferred on the basis of psychiatric symptoms, social inappropriateness, personal appearance, and diagnosis (Corrigan, 2000).

Once human differences are labeled, a basis for separation exists. Labels contribute to the salience of groupness (Link & Phelan, 2001) – the degree to which a collection of people is perceived as a unified or meaningful entity (Campbell, 1958; Hamilton & Sherman, 1996). People presume that groups are distinguished by definable boundaries, and a rationale is in place for treating group members with a sense of fundamental differentness (Corrigan, 2007). Further contributing to this sense of us-versus-them separation is the fact that people tend to resort to categorization biases when they encounter highly complex objects with uncertain attributes (Bruner, Busiek, & Minturn, 1952; Jones & Gerard, 1967; Linville & Jones, 1980), as is the case for psychiatric diagnoses (Gjerde et al., 1979).

Accordingly, groups are subject to stereotypes – popular beliefs that associate a whole group of people with certain traits (Kassin, 2001). While stereotypes may exist to provide quick and convenient summaries of groups, they can also result in inaccurate and negative portrayals (Greenwald & Banaji, 1995). Stereotyping often imputes a wide range of deficiencies on the basis of an original one (Goffman, 1963). Common malefic stereotypes about those with mental illness maintain that they are dangerous, violent, unpredictable, and disruptive (Feldman & Crandall, 2007; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Reavley & Jorm, 2012).

Other aspects of labeling include persistence and stability. When an individual is associated with a label, this shapes others' expectations, is not easily overridden, and

often continues to govern others' perceptions regardless of ensuing behavior (Langer & Abelson, 1974; Rosenhan, 1973; Temerlin, 1968). Furthermore, people tend to see groups as stable (Kashima, 2000). Indeed, myths exist that people with mental disorders do not recover (Corrigan et al., 2000). As people feel reduced to a label, especially one that separates, stigmatizes, and persists, it is no small wonder that many choose not to seek clinical services in an effort to avoid the diagnostic label (Corrigan, 2007).

Emotional components of psychiatric stigma. Prejudice is a closely related but different concept to stereotyping. While stereotypes refer to epistemological processes, prejudice refers to attitudes, evaluations, and affect. Social psychologists view prejudice as attitudes that are based on stereotypes and facilitate the efficient creation of heuristic impressions and expectations for behavior (Hamilton & Sherman, 1994). As people evaluate their social environments, these attitudes provide valenced appraisals that allow for quick decision-making (Fazio, 1986). Therefore, prejudice goes beyond just *thinking* about others and reflects how we *feel* about the social groups we encounter.

Research has found anger, fear, anxiety, aggression, and disgust to be elevated in people encountering individuals with mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Thornicroft, Rose, Kassam, & Sartorius, 2007). Graves, Cassisi, and Penn (2005) also discovered physiological measures of stress, such as brow muscle tension, palm skin conductance, and heart rate, tend to be elevated during encounters with individuals with mental illness. To understand this trend, researchers have looked to Weiner's (1986) attribution theory.

According to attribution theory, emotional reactions are influenced by one's attributions. The theory posits that individuals believed to be in control of a negative

outcome are more likely to be seen as responsible and reacted to angrily, whereas individuals viewed as not in control are more likely to be reacted to with pity (Rush, 1998; Weiner, Graham, & Chandler, 1982). Consistent with this hypothesis, studies on mental illness have shown controllability attributions predicting anger and pity in this way (Menec & Perry, 1998; Schwarzer & Weiner, 1991). Individuals with a mental illness are seen as responsible for their pathologies and as having personal control over their conditions – both in terms of how they contract the disorder (*onset controllability*) and how they cope with and overcome it (*offset controllability*; Corrigan, River, et al., 1999; Crandall & Moriarty, 1995).

Behavioral components of psychiatric stigma. The process of stigmatization culminates in discrimination and status loss. Discrimination refers to the unequal treatment of individuals based on their membership, or perceived membership, in a certain group or category (Pager & Shepherd, 2008). Social distance, or people's interest in avoiding individuals with a certain trait, is the most frequently employed measure of stigma (Corrigan, Edwards, Green, Diwan, & Penn, 2001). Significant associations have been demonstrated between attitudinal social distance and actual behavioral social avoidance, lending credence to its validity as a proxy of discrimination (Crandall & Warner, 2005). Social distancing towards individuals with mental illness has been discovered by many researchers (Link, Yang, Phelan, & Collins, 2004). To understand this phenomenon, researchers have once again looked to attribution theory.

Studies of public attributions have shown that the public sees persons with mental illness as somewhat or very likely to become violent (Link et al., 1999) and views mental illness as stable over time (Norman, Windell, & Manchanda, 2010) and very rare (Sofres,

2003). While epidemiological studies have shown that these beliefs are exaggerated and inconsistent with reality (Kessler, Merikangas, & Wang, 2010; Swanson, Holzer, Ganju, & Tsutomu Jono, 1990), these distortions nevertheless succeed in prompting exclusion. Studies have established that perceptions of dangerousness (Link et al., 1999), prognosis (Norman et al., 2010), and rarity (Feldman & Crandall, 2007) are good predictors of the desire to maintain social distance.

Unfortunately, these attitudinal predictions are corroborated by the actual experiences of individuals with mental illness. Individuals with mental illness tend to experience more social isolation than the average person (Perese & Wolf, 2005), which in turn is a well-established risk factor for reduced psychological well-being (Kawachi & Berkman, 2001). In Wahl's (1999) survey of individuals with severe mental illness, 60% of respondents reported experiences of being shunned or avoided, and 26% indicated that such rejection was frequent. Evidence also suggests that social distancing occurs not only in personal settings, but in professional settings as well (Angermeyer, 2004). Thus, psychiatric stigma affects individuals not only personally, but vocationally as well.

Attribution theory predicts that beliefs influence emotional reactions, and these in turn influence behavior. Corrigan (2000) hypothesized that pity will predict helping behaviors, anger will predict punishing behaviors, and fear will predict avoidance, and later found support for these hypotheses, demonstrating that responsibility beliefs and emotional responses mediate the effects of controllability on helping (Corrigan et al., 2003). Subsequent research, however, has suggested that beliefs concerning causation may not be as powerful as beliefs about social appropriateness, danger, and prognosis in mediating social distance (Norman et al., 2010).

It is also possible for differential treatment to appear in more subtle, indirect ways. Mullen, Salas, and Driskell (1989) showed how unacquainted individuals placed in groups and asked to perform a task will automatically create fairly stable social hierarchies, and use external statuses to do so, even when the external statuses have no bearing on task proficiency. Thus, stigma may be tied to the natural human tendency to organize hierarchies and to use undesirable characteristics to inform organization. Unfortunately, once put in place, these hierarchies can take on lives of their own and create disabling environments that perpetuate stigmatization and disadvantage (Link & Phelan, 2001). This is known as structural discrimination. When stigma has affected the structure around a person, negative outcomes can be expected whether or not any one individual has directly treated them in a discriminatory way.

Status loss, or downward placement in the status hierarchy, occurs following individual and structural discrimination (Link & Phelan, 2001). To the extent that this occurs, a whole range of negative outcomes may be associated (Hatzenbuehler, Phelan, & Link, 2013). Individuals with a mental illness have a more difficult time obtaining and keeping jobs (Link, 1987; Wahl, 1999), leasing safe housing (Page, 1995; Wahl, 1999), and obtaining medical services (Desai, Rosenheck, Druss, & Perlin, 2002; Druss, Bradford, & Rosenheck, 2000). They also earn less income and are more likely to be underemployed compared to an equally impaired but unlabeled group (Link, 1982).

Unfortunately, this is probably just the beginning, as stigmatized individuals are often disadvantaged in a broad range of life domains. This may help explain why stigma is such a persistent predicament: even if one is able to escape or overcome unfortunate outcomes in one domain, another is still present to perpetuate the struggle (Link &

Phelan, 2001). Given the many disadvantages this population is already likely to face, it is regrettable that approach and helping behaviors are likely to be attenuated in people who come to interact with them.

Psychiatric Stigma within Mental Health Professionals

Many people seek the counseling of a therapist because of the safe environment therapy attempts to create – a haven free of judgment, prejudice, and discrimination. Therapeutic benefits may be derived from interacting with experts who possess more accurate knowledge about mental illness than the regular population and being able to openly discuss issues normally considered too taboo for ordinary conversation. Benefits may also come from receiving empathy and acceptance not typically provided by other members of society (Rogers, 1957). However, the assumption that providers are free of the judgments that afflict the rest of the population may be presumptuous.

Mental health professionals, as members of the culture, are likely to inherit many of the stereotypes and prejudices of the milieu. Therefore, a barrier of stigma may exist within providers as well. Although there is a dearth of research assessing the attitudes of mental health professionals towards people with mental illness, initial research supports this sentiment by and large (e.g., Byrne, 1999; Keane, 1990; Lauber, Nordt, Braunschweig, & Rossler, 2004; Lyons & Ziviani, 1995; Reidy, 1994; Sadow, Ryder, & Webster, 2002). Nearly three-quarters of the relevant publications report that beliefs of mental health providers do not differ from those of the population, or in some cases are even more negative (Hugo, 2001; Jorm et al., 1999; Schulze, 2007).

Research also supports the idea that mental health professionals possess pejorative attitudes towards certain types of clientele that are idiosyncratic to the field. Lewis and

Appleby (1988) reported that psychiatrists differentially form judgmental and rejecting attitudes towards individuals given a diagnosis of a personality disorder. Similarly, a survey of Australian mental health nurses revealed negative attitudes towards clients with borderline personality disorder (Deans & Meocevic, 2006). Farrell and Lewis (1990) demonstrated that psychiatrists held significantly more negative attitudes towards clients with a history of alcohol dependence. Finally, Mirabi, Weinman, Magnetti, and Keppler (1985) revealed that a majority of mental health professionals found working with chronically mentally ill clients to be unrewarding, considered them an undesirable population to work with, and agreed that most clinicians prefer to avoid contact with such clients and refer them whenever possible.

It is one thing to say that mental health professionals may not differ from the population in terms of stereotypes and prejudices, but quite another to suggest that their behaviors may also be harmful. Sadly, research to date suggests that professionals not only possess stigmatizing attitudes, but that their clients are affected by them as well. A survey of individuals with schizophrenia and their families revealed that exclusion and discrimination not only occurred in the context of the client's everyday social relationships, but also in contact with mental health providers (Schulze & Angermeyer, 2003). In fact, nearly one-quarter of all stigma experiences reported were accounted for by encounters with providers. In another study of individuals with severe mental illness, 28% of the interviewees saw their mental health caregivers as contributors to stigma via disparaging remarks, rejection behavior, and discouraging advice (Wahl, 1999).

Numerous qualitative studies echo these findings (Pinfold, Byrne, & Toulmin, 2005;

Schulze & Angermeyer, 2003). Therefore, the routine practices of mental health workers may be experienced as stigmatizing.

Both explicit and implicit biases exist that can influence behavior in subtle ways. Therefore, clinicians may underestimate the degree to which their own prejudices still operate. The social psychology literature states that explicit bias predicts deliberative judgments and behaviors that people monitor closely, whereas implicit bias predicts nonverbal behavior and behaviors that people do not monitor closely (Dovidio, Kawakami, Johnson, Johnson, & Howard, 1997; Fazio, Jackson, Dunton, & Williams, 1995). Therefore, some of the most damaging aspects of stereotypes may come from implicit processes associated with them. This is particularly problematic because implicit processes typically operate outside of awareness.

While psychiatric stigma within clinicians can be expected to result in numerous deficiencies in treatment, such as communication failures (Byrne, 2000; Uçok, Polat, Sartorius, Erkoç, & Ataklı, 2004), the most problematic effect is likely to be its impact on the strength of the therapeutic relationship. In order to foster better therapeutic alliances, it is vital that individuals suffering from stigmatization and shame not receive the same judgment from their therapists. Clinicians can only hope to assist in the reorganization of their clients' expectations of others provided that, when emotionally engaged, their attitudes challenge detrimental cultural norms rather than implicitly reinforce them.

Challenging Psychiatric Stigma in Mental Health Professionals

The resilience of stigma. Reducing stigma and shame surrounding mental illness is essential to improving the quality of life for people with mental illness. However, research has shown that the processes underlying stigmatization are resistant to change.

For example, Devine (1989) has shown that activation of stereotypes is a relatively automatic cognitive process, and therefore one that may be difficult to alter. Activated stereotypes tend to bias information processing, which makes disconfirming stereotypes during encounters difficult. In passive situations, experiments have shown that people tend to recall and encode social information that is consistent with stereotypes (Fyock & Stangor, 1994; Stangor & McMillan, 1992), especially when distracted or tired (Macrae, Hewstone, & Griffiths, 1993). In engaged situations, even when incentivized to be active in information seeking, people evince tendencies to seek out only information that confirms stereotypes (Bodenhausen & Wyer, 1985) and override information that would counter stereotypes (Krueger & Rothbart, 1988).

Overturing prejudices may be just as difficult, if not harder. Our prejudices are seated in complex psychophysiological systems that may not be easily changed. Wilson's *dual model* of attitudes states that people can hold two different evaluations of the same object at the same time, one being an explicit attitude which exists at a controlled, conscious level, and the other being an implicit attitude that exists at an automatic, habitual level and can be activated and used quickly and non-consciously in social judgment (Wilson, Lindsey, & Schooler, 2000). Neuroscience research supports this model and explains how sensory information is processed through subcortical pathways in a rather crude form long before higher-order cortical structures have time to analyze it in a more deliberative fashion (LeDoux, 1996). As a result of this partiality, control may be especially difficult in cases where time pressures exist or latent attitudes are particularly strong. Studies have linked prejudices to amygdala activity and suggest that emotional biases may be rooted in amygdala-based memories and, as such, may be harder

to unlearn than cognitive associations (Hart et al., 2000; Phelps et al., 2000). Finally, because underlying processes operate outside of awareness, individuals may underestimate the degree to which their own prejudices function.

Overcoming discrimination is not easy. While educational and legislative efforts have helped to reduce acts of discrimination in many different areas and there is increasing pressure to condemn inequality, there are obvious cultural benefits for people who deny endorsement of stereotypes in public yet still treat individuals differentially in private. Hence, people may say they do not agree with stigma, but later discriminate when private opportunities present themselves (Gaertner & Dovidio, 1986).

Strategies for challenging psychiatric stigma. Research on strategies to combat psychiatric stigma is currently limited and conflicted. While attempts to reduce stigma through educational efforts have been touted as successful by some (Brockington et al., 1993; Penn et al., 1999), others cite mixed results (e.g., Devine, 1995). Researchers have also been wary of efforts protesting inaccurate and hostile representations of mental illness by advocacy groups, calling attention to the little empirical evidence for their effectiveness (Corrigan & Penn, 1999) and sharing concerns about priming and rebound effects that commonly accompany stereotype suppression (Macrae et al., 1994; Wegner, Schneider, Carter, & White, 1987).

However, borrowing from the social and cognitive psychology literature may offer more hopeful possibilities. For example, Kawakami, Dovidio, Moll, Hermsen, and Russin (2000) have demonstrated that stereotype activation can be reduced with training. Similarly, Blair and Banaji (1996) showed how stereotype priming can be eliminated when there is an intention in place to process counter-stereotypic information and

sufficient cognitive resources available. Relatedly, Monteith (1993) showed that training people to slow down and think carefully about their responses when implicit biases may be operating is very effective at reducing prejudiced responses. Therefore, activating explicit, conscious processes may be an effective way to override implicit, unconscious ones like those found in psychiatric stigma (Weiner et al., 1988).

Rationale for reducing psychiatric stigma. Reducing the effects of stigma within the therapeutic setting may positively impact clients in several ways. First, reducing stigma in the therapeutic relationship will reduce stigma as a whole in each client's interpersonal world since the therapist constitutes part of this world. Second, reduced stigma is likely to increase empathy towards clients and promote stronger alliances, known to lead to improved outcomes (Martin et al., 2000). Although empathy was originally conceptualized as a static, enduring characteristic of the therapist, more recently researchers have found greater support for the notion that accurate empathy is more like a back-and-forth interpersonal interaction characterized by mutual exploration and collaboration than a stable trait, and hence something that therapists can work on and improve with their clients (Barkham & Shapiro, 1986; Teyber & McClure, 2011). Third, holding an attitude of acceptance is likely to have positive therapeutic effects as it is internalized by clients. Many theoretical orientations, especially client-centered and interpersonal approaches, contend that clients will only be able to accept themselves if they have the genuine acceptance of their therapist (Rogers, 1957; Teyber et al., 2011).

However, it is unrealistic to expect clinicians to remain emotionally dispassionate throughout treatment. In fact, research on relational psychotherapy has shown that clients actually have better outcomes when their clinicians are emotionally engaged and

demonstrate emotional flexibility, rather than emotional homogeneity (Holmqvist & Armelius, 2006). For some clients, it may even be important to engage therapists emotionally in their maladaptive interpersonal patterns and hook them into destructive and negative roles (Holmqvist, 2000). Thus, it is not necessary for mental health professionals to have impeccably positive attitudes, but rather for them to be able and willing to extricate themselves from negative countertransferential positions.

Similarly, it is unrealistic to ask that clinicians possess none of the negative stereotypes or prejudices that are ambient in our culture. What *is* important is for them to be able to identify and challenge their beliefs so that they can encounter their clients authentically and still treat them impartially (Lauber et al., 2004). As a set of rigid cultural beliefs, psychiatric stigma needs to be examined within providers and further research into strategies for overriding it needs to be conducted. Clinicians cannot expect the culture to change without participating in the process of change themselves. Therapists must dispel their own myths, challenge their own prejudices, and scrutinize their own behaviors if they expect their clients and others to do the same.

Statement of the Problem

For better or worse, we all possess stereotypes and stigmatizing attitudes as artifacts of socialization. These are deeply woven into the fabric of our being. They exist in complex cognitive-affective structures that perform social regulatory functions (Amodio, Devine, & Harmon-Jones, 2007) and may well have evolved to maintain hierarchy and social order within our species (Kurzban & Leary, 2001). Since stigmatization has detrimental effects for those with psychiatric disorders, it is important that people who work with them understand their own contributions to this stigma.

It is possible that, as a byproduct of their education or professional training, mental health professionals do, by and large, overcome the shaming and blaming attitudes towards individuals with mental illness that regularly accompany socialization. However, initial evidence suggests that this is not likely to be the case, that covert stigma still exists within the field, and that it negatively impacts therapeutic work, particularly with individuals diagnosed with Axis II and substance abuse disorders (Deans & Meocevic, 2006; Lewis & Appleby, 1988).

Although over 65 studies assessing attitudes about mental health have been conducted in the past 15 years (Angermeyer & Dietrich, 2006), only nine surveys of mental health professionals' attitudes have been completed, and only four meet rigorous methodological criteria (Schulze, 2007). Additionally, a majority of the studies have been performed outside of the United States and focus on schizophrenia, thereby limiting external validity. Therefore, there is insufficient knowledge about mental illness stigma within the mental health professions today.

Lewis and Appleby (1988) employed a vignette-based experimental design to assess if the presence or absence of a former diagnosis of serious mental illness would affect the attitudes of the 240 British psychiatrists. The study used a brief case history vignette that was modified only slightly to either mention or restrict information about a previous diagnosis of personality disorder. The authors noted that this case vignette method not only allows for a fully-controlled experimental study, but also typically produces results consistent with real-world behavioral observations.

Following a reading of the case history, participants were asked to fill out a questionnaire about the assessment and management of the case, consisting of 22

semantic differentials on a 6-point scale. Their results confirmed the hypothesis that when a former diagnosis of a personality disorder was given, attitudes towards the client were less favorable. In their study, a third experiment group was told ahead of time about the detrimental effects of psychiatric labeling and asked participants to try to remain uninfluenced by these labeling effects. Curiously, results indicated that the attitudes of psychiatrists in this group remained unfavorable.

This latter result appears to be inconsistent with the prediction that training individuals to consciously hold stigmatizing attitudes in check as they become activated will succeed in reducing stigma. One possible explanation is that the statement prefacing the vignette was demanding and unhelpful, asking participants to remain fair and unbiased but offering no perspective or guidance in doing so – something known to be problematic when retraining social judgment (Lord, Pepper, & Preston, 1984). Another possibility is that the participants, whose average time in practice was 16.5 years, were not open to the suggestion, perhaps as a result of their substantial professional experience. Indeed, several studies have shown that medical students exhibit more adaptable attitudes earlier in their medical career and became more cynical, less empathic, more stigmatizing, and less open to intervention later on (Mahood, 2011; Neumann et al., 2011; Roman, Popritkin, Borges, & Somusetty, 2013).

To address these concerns and see if psychiatric stigma can, indeed, be reduced by coaching young clinicians to consciously override their implicit biases with explicit processes, it is necessary to conduct new research. This study investigated the presence of psychiatric stigma in an understudied segment of mental health professionals – psychologists-in-training – and examined whether this group is responsive to

intervention. If psychiatric stigma can be countered, then there may be critical periods in professional development when motivation is especially high to allow for relatively simple training to be effective.

Statement of Hypotheses

The following hypotheses were proposed:

Group A:

- 1) It was hypothesized that a diagnostic label would be associated with more stigmatization, such that participants presented with a clinical vignette that included a diagnosis of a personality disorder would report more overall stigma than participants whose vignette did not include the diagnostic label.
- 2) It was hypothesized that a diagnostic label would be associated with more stigmatization, such that participants presented with a clinical vignette that included a diagnosis of a personality disorder would attribute more personal responsibility and greater controllability to portrayed problems than participants whose vignette did not include the diagnostic label.
- 3) It was hypothesized that a diagnostic label would be associated with more stigmatization, such that participants presented with a clinical vignette that included a diagnosis of a personality disorder would report more negative emotions and fewer positive emotions than participants whose vignette did not include the label.
- 4) It was hypothesized that a diagnostic label would be associated with more stigmatization, such that participants presented with a clinical vignette that included a diagnosis of a personality disorder would report fewer helping behaviors and more rejecting behaviors than participants whose vignette did not include the label.

- 5) It was hypothesized that a diagnostic label would be associated with more stigmatization, such that participants presented with a clinical vignette that included a diagnosis of a personality disorder would report higher levels of personal social distancing than participants whose vignette did not include the diagnostic label.
- 6) It was hypothesized that a diagnostic label would be associated with more stigmatization, such that participants presented with a clinical vignette that included a diagnosis of a personality disorder would report higher levels of professional social distancing than participants whose vignette did not include the diagnostic label.

Group B:

- 7) It was hypothesized that educating participants about psychiatric stigma and encouraging them to consciously challenge their implicit biases would be associated with less stigmatization, such that participants presented with an anti-stigma passage prior to a clinical vignette would report less overall stigma than participants whose vignette was not preceded by an anti-stigma passage.
- 8) It was hypothesized that educating participants about psychiatric stigma and encouraging them to consciously challenge their implicit biases would be associated with less stigmatization, such that participants presented with an anti-stigma passage prior to a clinical vignette would attribute less personal responsibility and less controllability to portrayed problems than participants whose vignette was not preceded by an anti-stigma passage.
- 9) It was hypothesized that educating participants about psychiatric stigma and encouraging them to consciously challenge their implicit biases would be associated with less stigmatization, such that participants presented with an anti-stigma passage

- prior to a clinical vignette would report less negative emotions and more positive emotions than participants whose vignette was not preceded by such a passage.
- 10) It was hypothesized that educating participants about psychiatric stigma and encouraging them to consciously challenge their implicit biases would be associated with less stigmatization, such that participants presented with an anti-stigma passage prior to a clinical vignette would report more helping behaviors and less rejecting behaviors than participants whose vignette was not preceded by such a passage.
- 11) It was hypothesized that educating participants about psychiatric stigma and encouraging them to consciously challenge their implicit biases would be associated with less stigmatization, such that participants presented with an anti-stigma passage prior to a clinical vignette would report lower levels of personal social distancing than participants whose vignette was not preceded by an anti-stigma passage.
- 12) It was hypothesized that educating participants about psychiatric stigma and encouraging them to consciously challenge their implicit biases would be associated with less stigmatization, such that participants presented with an anti-stigma passage prior to a clinical vignette would report lower levels of professional social distancing than participants whose vignette was not preceded by an anti-stigma passage.

CHAPTER II

Methods

Materials

Survey. A survey was generated to collect demographic information and additional subject data germane to the research study (see Appendix B). Demographic information gathered included the participant's age, gender, ethnicity, type of doctoral program, type of doctoral degree, year in the program, and amount of prior clinical experience. In addition, participants were asked to specify their primary theoretical orientation. Further, participants were asked to identify their clinical interests, indicating which settings/populations they have and would like to work with in the future and what type of professional position they are most interested in pursuing. Participants were also questioned about their degree of personal experience with mental illness, which Angermeyer and Matschinger (1997) have shown to be related to attitudes.

Vignette. One clinical vignette adapted from Lewis and Appleby (1988) was presented to the participants of this study (see Appendix D). The case depicted a 34-year-old man who endorses depressed mood, suicidal ideation and plan, financial problems, and sleep difficulty being treated pharmacologically with nitrazepam. Minimal changes were made to the original vignette created by Lewis and Appleby. Since graduate students may have more contact with outpatient populations during their training, the vignette was modified such that the individual is seeking *treatment*, whereas the original vignette portrays an outpatient seeking *admission*, ostensibly to inpatient care. Additionally, since psychology graduate students, in contrast to practicing psychiatrists, may not recognize nitrazepam as a benzodiazepine, the general drug class was used to

describe the medication rather than its specific name. Further, the vignette was altered to leave out the type of professional who previously diagnosed the depicted client. This was done to generalize the vignette. Finally, the term “GP” was replaced with “general practitioner” to eliminate ambiguity. All other details remained unchanged.

As in the original study, information in the vignette was deliberately restricted to encourage participants to draw inferences based on their pre-existing beliefs and attitudes. As written, the case is diagnostically ambiguous, and the experimental manipulation takes advantage of this. In the experimental condition, the depicted client was given a previous diagnosis of a personality disorder. In the control condition, no previous diagnosis was provided.

The personality disorder category was chosen to diagnostically describe the individual in the experimental condition because multiple studies have already shown mental health professionals to hold negative attitudes towards clients in this category (Deans & Meocevic, 2006; Lewis & Appleby, 1988). Therefore, the likelihood of eliciting latent stigma within participants was believed to be greater with this category. Furthermore, personality disorders are not rare. Modern epidemiological studies have shown that approximately 1 in every 10 individuals suffers from a diagnosable personality disorder (Lenzenweger, 2008). Therefore, the implications of these findings are broad. The gender of the depicted individual as male was not altered because perceptions of dangerousness are expected to be greater with a male client, especially among female clinicians (Elbogen, Williams, Kim, Tomkins, & Scalora, 2001), further increasing the probability of latent stigma being activated by the vignette.

Training intervention. Superimposed on the diagnostic manipulation was a second experimental manipulation. This independent variable manipulated the presence or absence of an anti-stigma intervention. Participants in the experimental condition read a concise but persuasive argument about the known presence of psychiatric stigma within mental health professionals, the detrimental effects it has on client care, the phenomenon of implicit biases giving rise to psychiatric stigma, and the power clinicians have to override these implicit processes with explicit ones (see Appendix C). Participants in the control condition were asked to read an unrelated scientific passage.

Questionnaire. Following the vignette, participants were instructed to answer a series of questions (see Appendix E), randomized within each composite category. These questions were developed from a review of the existing literature on stigma and aimed to cover cognitive, affective, and behavioral domains. Since some components of stigma operate outside of conscious awareness and may be difficult or impossible to self-report, implicit measures – that is, instruments designed to capture psychological attributes without requiring participants to provide a subjective assessment of these attributes – were strongly considered (Gawronski & De Houwer, 2014). However, the goal of reaching many graduate students across North America and the exploratory nature of this study ultimately restricted the search to explicit measures that could be presented in an internet-based self-report survey at little cost. Whenever possible, items were carefully selected to reduce the face validity of the task and minimize social desirability biases to attempt to address these concerns, at least in part. The specific questions chosen and the rationale for their use are outlined below.

Cognitive measures. Attribution theory posits that cognitive attributions affect other cognitions, affect, and behavior (Weiner, 1986). For example, the theory predicts that initial cognitive perceptions of controllability and responsibility for psychological symptoms will predict negative stereotyping, prejudice, and discrimination. Specifically, a condition seen as controllable will be met with anger and punishing actions whereas a condition seen as uncontrollable will be met with pity and helping behaviors. Questionnaire items to assess initial attributions were included in an attempt to reveal cognitive components of psychiatric stigma.

Items were adapted from Corrigan et al.'s (2003) Attribution Questionnaire (AQ) to assess personal responsibility and controllability beliefs. The three original items representing this construct were modified grammatically and adjusted to use an 8-point Likert-type scale, ranging from *Not at all* (1) to *Very much* (8). These items were shown to have good reliability in Corrigan et al. (2003; $\alpha = .70$). There is some evidence in the literature for the validity of items in this scale. Studies have shown that psychiatric disorders are seen as more controllable than physically-based disorders, and are reacted to with less liking, pity, and assistance (Corrigan, River et al., 1999; Weiner et al., 1988).

Similarly, Corrigan (2003) showed that perceived controllability of mental illness is related to avoidance and withholding help. Further, Corrigan et al. (1999) found that participants who rated individuals with mental illness as less blameworthy were more likely to perform actual helping behaviors. Therefore, Corrigan et al.'s (2003) measures show evidence of construct validity by correlating with relevant concepts in ways that attribution theory would predict. One additional item that also assesses responsibility and controllability was taken from Angermeyer and Matschinger (1996) and aligned with the

abovementioned response formatting. The final controllability/responsibility beliefs composite contained 4 items, had a mean of 2.97 ($SD = 1.09$) across participants, and demonstrated acceptable internal consistency with a Cronbach alpha value of .69.

Affective measures. Attribution theory further holds that psychological processes that identify human differences, link those differences to undesirable attributes, and assign different others into an outgroup are likely to be associated with emotions of anger, fear, pity (Corrigan et al., 2003), anxiety (Graves et al., 2005), and hostility and disgust (Thornicroft et al., 2007). Attribution theory also contends that evaluations that give rise to negative emotions are expected to result in fewer helping behaviors, and initial evidence supports this (Corrigan et al., 2003). Therefore, a subset of the self-report questions attempted to assess stigma by examining participants' emotional reactions.

Self-report items measuring emotional responses were taken directly from the AQ developed by Corrigan et al. (2003). The constructs of pity (three items), anger (three items), and fear (four items) were assessed using an 8-point Likert-type scale, ranging from *Not at all* (1) to *Very much* (8). Minimal grammatical adjustments were made to these questions. Corrigan et al. (2003) showed good to excellent internal consistency for these measures (pity, $\alpha = .74$; anger, $\alpha = .89$; fear, $\alpha = .96$). Evidence for the construct validity of this scale has already been discussed. Two additional items were taken from Angermeyer and Matschinger's (1996) Emotional Reaction to Mental Illness (ERMI) Scale and adjusted to conform to the aforementioned response formatting. This instrument demonstrated good reliability in Link et al. (2004) and Van Brakel (2006). With regards to construct validity, it has also been used to demonstrate that increased exposure to individuals with mental illness is correlated with less anxiety, less desire for

social distance, and more prosocial reactions, as would be anticipated by attribution theory (Angermeyer & Matschinger, 1996; Link et al., 2004).

Ten additional items were added to help assess for internal reliability, and to balance out positive and negative emotions and their approximate valences (e.g., “I am made to feel anxious by John,” “I feel fondness towards John”). The final emotional reactions composite contained 22 items and had a mean of 3.54 ($SD = 0.45$) across participants. This composite demonstrated acceptable internal consistency with a Cronbach alpha value of .62.

Behavioral measures. An additional set of items attempted to survey helping/rejecting behaviors and examine discrimination components of stigma. Two items were borrowed from measures of prosocial reactions put forth in the ERMI Scale (Angermeyer & Matschinger, 1997). One item was drawn from Corrigan et al.’s (2003) AQ scale. These questions were modified grammatically and adjusted to an 8-point Likert-scale, ranging from *Not likely* (1) to *Very likely* (8). The psychometric properties of these scales have already been discussed previously. One new item was added in order to increase the number of questions within this category (“How likely are you to be helpful to John?”). The final helping behaviors composite contained 4 items, had a mean of 2.46 ($SD = 0.88$) across participants, and demonstrated acceptable internal consistency with a Cronbach alpha value of .66.

Two final sets of items measured different types of social distancing. Social distancing can be conceptualized on interactive, normative, and affective dimensions, but in all cases the concept refers to the degree of closeness sought after between groups or individuals. Questions about social distancing are among the most commonly used

measures to assess stigma (Link et al., 2004). The first set of items covered *personal* social distancing and the second set *professional* social distancing. To assess personal social distancing, five questions were taken from Link et al.'s (1999) study and fitted to an 8-point Likert-style, ranging from *Not likely* (1) to *Very likely* (8). Three questions were taken from Link et al.'s (1987) study and converted to the 8-point response format. Another three items were adapted from a helping behaviors scale found in Corrigan et al. (2003) which are better categorized as measuring social distancing. The final personal social distancing composite contained 11 items, and had a mean of 4.74 ($SD = 1.47$).

To assess professional social distancing, fourteen new questions were generated to have particular clinical relevance. Questions were created to examine the therapist's desire for varying degrees of closeness or distance with a patient (e.g., "How likely are you to refer John to someone else?" and "How likely are you to feel comfortable taking on John as a client?"). Each of these questions followed the same 8-point Likert-style response format. The final professional distancing composite contained 14 items, and had a mean of 3.53 ($SD = 0.75$).

Generally speaking, scores on social distance scales tend to show good to excellent internal-consistency ranging from .75 to greater than .90 (for a review see Link et al., 2004). In this study, the personal social distancing measure demonstrated excellent internal consistency with a Cronbach alpha value of .94. The professional social distancing composite showed acceptable internal consistency with a Cronbach alpha value of .67. Evidence for the construct validity of these scales comes from studies showing that individuals with no prior exposure to mental illness and individuals who perceive individuals with mental illness as dangerous are more likely to desire social

distance from a person described as having a mental illness (Link et al., 1987; Link et al., 1999; Martin, Pescosolido, & Tuch, 2000). However, several limitations to the validity of social distance scales exist (Link et al., 2004). First, although behavioral intentions like social distance items are often good predictors of actual behavior, it is important to note that responses can be contaminated by social desirability biases. Because of this limitation, the social distancing scales were placed last within the questionnaire in an attempt to minimize the degree to which social desirability biases were operative during the questionnaire as a whole.

Procedures

The experiment was conducted on the internet through PsychData Surveys (www.psychdata.com). Participants were provided an informed consent agreement (see Appendix F) which discussed the study's confidential and anonymous nature. After providing consent, participants were asked to fill out the initial survey. Once completed, participants were asked to read an introductory passage followed by a vignette. Participants were randomly assigned to one of four conditions which determined which introductory passage and which vignette they were presented with: (1) Anti-stigma Intervention and Diagnostic Label ($N = 87$); (2) No Intervention and Diagnostic Label ($N = 108$); (3) Anti-stigma Intervention and No Diagnostic Label ($N = 99$); and (4) No Intervention and No Diagnostic Label ($N = 105$).

After reading the vignette, participants were instructed to answer a questionnaire about the vignette just presented. The questionnaire contained 55 total items, grouped into five separate categories. Ordering of the items was randomized within each category. Each question was designed to be answered using an 8-point Likert scale (e.g., "Not at

all” to “Very much”). After confirming their submission, participants were debriefed such that the purpose and methods of the study were explained (see Appendix G).

Participants were then thanked for their participation. Participants were also offered the opportunity to request a summary of the results upon the study’s completion. This study was approved by Loyola University Maryland’s Institutional Review Board and all participants were treated in accordance with the American Psychological Association’s ethical guidelines (see Appendix A).

Participants

To determine how many participants to recruit, a power analysis was conducted. In a study examining pejorative attitudes in psychiatrists, a medium to large effect size on a measure of clinician sympathy was found when a previous diagnosis of personality disorder was experimentally manipulated ($f = .33$; Lewis & Appleby, 1988). However, this constitutes only part of the picture given that this study includes two independent variables rather than just one. Since the effect size of an anti-stigma training intervention is currently unknown, a conservative estimate was used for the experiment’s total anticipated effect size. With a medium effect size chosen, a power analysis was run in G*Power version 3.1.2 (Faul, Erdfelder, Buchner, & Lang, 2009) for a factorial analysis of variance (ANOVA) model including the main effects of two independent variables and their interaction. The target sample size was estimated to be 128 participants ($f = .25$, $\alpha = .05$, $\beta = .80$, *Numerator df* = 1, *Groups* = 4).

Requests for participation were sent via e-mail to 300 training directors of clinical and counseling psychology doctoral programs in the United States and Canada. Contact information for these programs was compiled from Sayette, Mayne, and Norcross (2010).

Training directors were asked to distribute a link to all doctoral students in his/her program via e-mail. Students were asked to participate in a 10-15 minute online study. In order to encourage participation, students were informed that each study completed would result in US \$1 being donated to the Leukemia and Lymphoma Society.

A total of 510 survey responses were received. Responses from students not currently enrolled in a Ph.D. or Psy.D. program for clinical or counseling psychology were excluded. Incomplete surveys and surveys completed in less than 5 minutes or greater than 25 minutes were also excluded. Uniform responding on questionnaire items (e.g., having all “Very Likely” responses) also resulted in omission from analysis. As a result of exclusion criteria, 104 surveys were removed. Of the remaining responses, six univariate outliers were found and removed using the outlier labeling rule and a k value of 2.2 (c.f. Hoaglin, Iglewicz, & Tukey, 1986; Hoaglin & Iglewicz, 1987). One multivariate outlier was identified and removed using Mahalanobis’ Distance at a significance level of .001.

ANOVAs and Chi-squared tests showed that the eliminations did not produce meaningful differences in any demographic variable (gender, $\chi^2(2, N = 909) = 0.08$, $p = .962$; age, $F(1,907) = 0.39$, $p = .531$; race/ethnicity, $\chi^2(5, N = 909) = 1.55$, $p = .907$; degree, $\chi^2(1, N = 909) = 0.03$, $p = .873$; program, $\chi^2(2, N = 909) = 0.90$, $p = .639$; year in program, $\chi^2(7, N = 909) = 2.20$, $p = .948$; years of experience, $\chi^2(8, N = 909) = 1.258$, $p = .996$; theoretical orientation, $\chi^2(6, N = 909) = 0.42$, $p = .999$; personal exposure to mental illness, $\chi^2(7, N = 909) = 2.59$, $p = .920$).

The following characteristics describe the remaining sample ($N = 399$; see Table 1). The average respondent age was 27.98 years old ($SD = 5.23$). For gender,

82.0% of the participants identified as female, 17.8% identified as male, and 1 respondent identified as other. With regards to race/ethnicity, 80.5% of the sample described themselves as Caucasian (non-Hispanic), 6.3% as Hispanic/Latino, 6.0% identified as African-American/Black, 5.8% as Asian/Pacific Islander, 2.8% identified as multiracial, 1.0% as American Indian/Alaskan Native, and 3.0% as other. These demographics were highly similar to the Association of Psychology Postdoctoral and Internship Centers (APPIC)'s reported applicant demographics for the 2012 Match (Keilin, 2014). In this match year, 79% of applicants identified as female and 20% identified as male. For race/ethnicity, 77% of the sample described themselves as Caucasian (non-Hispanic), 4% identified as multiracial, 6% identified as African-American/Black, 7% as Asian/Pacific Islander, 8% as Hispanic/Latino, 1% as American Indian/Alaskan Native, and 3.0% as other. This high degree of similarity to the match statistics suggests that this study's sample was representative of the current student population in graduate programs.

Clinical psychology students comprised 83.5% of the respondents, and counseling psychology students comprised the remaining 16.5%. Ph.D. students represented 57.4% of the sample, while Psy.D. students represented 42.6%. By comparison, the 2012 APPIC match applicants were comprised of 79% clinical psychology and 12% counseling psychology students, and the breakdown of Ph.D. and Psy.D. students was 57% and 42%, respectively (Keilin, 2014). A high degree of similarity can also be seen on these metrics. More participants came from university-housed training programs (73.7%) than professional schools or other programs (26.1%). Three years was the median time spent in a doctoral program. Four years was the median time spent working face-to-face with a clinical population in any setting. Respondents were most influenced by behavioral,

Table 1

Descriptive Statistics for the Sample of Training Psychologists

	Frequency	Percentage	Minimum	Maximum	Mean	Standard Dev.
Age (in years)			21	60	27.98	5.23
Gender						
Female	327	82.0				
Male	71	17.8				
Other	1	0.3				
Race/ethnicity						
African American/Black	24	5.8				
American Indian/Alaskan Native	4	1.0				
Asian/Pacific Islander	23	2.8				
Caucasian	321	80.5				
Hispanic/Latino	25	6.3				
Multiracial	11	2.8				
Other	12	3.0				
Program Type						
Ph.D./Ed.D.	229	57.4				
Psy.D.	170	42.6				
Degree Type						
Clinical Psychology	333	83.5				
Counseling Psychology	66	16.5				
Program Setting						
University Department	294	73.7				
University-housed Prof. School	61	15.3				
Free-standing Professional School	43	10.8				
Other	1	0.3				
Year in Program						
1	83	20.8				
2	71	17.8				
3	87	21.8				
4	70	17.5				
5	58	14.5				
6	21	5.3				
7	5	1.3				
8+	4	1.0				
Years of Clinical Experience						
0	32	8.0				
1	60	15.0				
2	88	22.1				
3	77	19.3				
4	51	12.8				
5	40	10.0				
6	17	4.3				
7	11	2.8				
8+	23	5.8				
Theoretical Orientation						
Cognitive/Behavioral/CBT/REBT	226	56.6				
Humanistic	66	16.5				
Psychodynamic	39	9.8				
Systems	30	7.5				
Interpersonal	25	6.3				
Behavioral analysis	4	1.0				
Other	9	2.3				
Assigned Condition						
Diagnosis, Anti-stigma	87	21.8				
Diagnosis, Control	108	27.1				
No Diagnosis, Anti-stigma	99	24.8				
No Diagnosis, Control	105	26.3				

Note. $N = 399$.

cognitive, cognitive-behavioral, rational-emotive, acceptance and commitment therapy, or dialectical behavior therapy (56.6%); followed by humanistic, client-centered, existential-phenomenological, or Gestalt approaches (16.5%); followed by psychodynamic, psychoanalytic, or object relations orientations (9.8%); followed by systems, family systems, or attachment theory approaches (7.5%); followed by interpersonal or interpersonal process psychotherapy (6.3%); followed by other (2.3%) and applied behavioral analysis/clinical behavior analysis approaches (1.0%).

CHAPTER III

Results

Preliminary Analyses

Random assignment. To ensure that random assignment did not unevenly distribute participant variables, ANOVA and Chi-squared tests were run. Results indicated that demographics did not differ across conditions (gender, $\chi^2(6, N = 399) = 4.58, p = .598$; age, $F(3, 395) = 0.71, p = .549$; race/ethnicity, $\chi^2(15, N = 399) = 17.23, p = .306$; degree, $\chi^2(3, N = 399) = 3.54, p = .316$; program type, $\chi^2(3, N = 399) = 1.66, p = .647$; year in program, $\chi^2(21, N = 399) = 27.98, p = .141$; years of clinical experience, $\chi^2(24, N = 399) = 16.00, p = .888$; theoretical orientation, $\chi^2(18, N = 399) = 20.32, p = .315$; personal exposure to mental illness, $\chi^2(21, N = 399) = 12.90, p = .912$).

MANOVA Assumptions. To determine if the assumptions of the MANOVA procedure were upheld, preliminary analyses were conducted. Kolmogorov-Smirnov (K-S) tests on the dependent variables revealed that none of the five composites evidenced univariate normality (personal responsibility beliefs, $D = .067, df = 399, p < .001$; helping behaviors, $D = .112, df = 399, p < .001$; personal social distancing, $D = .054, df = 399, p = .007$; professional social distancing, $D = .045, df = 399, p = .052$) except emotional reactions ($D = .045, df = 399, p = .055$). However, the overall stigma score computed by the grand composite did evidence univariate normality according to a K-S test ($D = .032, df = 399, p = .200$), and a visual examination of the Q-Q plots revealed only minimal deviation from normality. Therefore, it is likely that the large sample size, which increases the power to detect differences from a normal distribution, contributed to the quantitative suggestion of non-normality. Nonlinear transformations

were unsuccessful in creating normal distributions for all of the dependent variables, largely due to the fact that some composites were positively skewed while others were negatively skewed. Although the assumption of multivariate normality was not met, the MANOVA is known to be more robust to violating this assumption with larger sample sizes (i.e., when cell size is greater than 20-30; Hair, Anderson, Tatham, & Black, 1992; Tabachnick & Fidell, 1996).

Another MANOVA assumption is that of linearity, or linear relations among pairs of dependent variables. Pearson correlations were calculated for all ten composite pairs and the average bivariate correlation was found to be .25 ($SD = 0.13$). These results, along with an examination of scatterplots, did not indicate signs of gross nonlinearity between composite pairs. However, because the relations were not perfectly linear, some power loss was expected in the analysis. The MANOVA procedure works best when variables are moderately correlated and is not suitable when the dependent variables are very high or very low in correlation (French et al., 2002). Small to medium correlations indicated that multicollinearity assumptions were not violated and that using a MANOVA procedure was indeed appropriate.

MANOVA also requires both variance and intercorrelations to be homogeneous across cells (French et al., 2002). Levene's test was non-significant for all composites (personal responsibility beliefs, $F(3, 395) = 1.09, p = .352$; emotional reactions, $F(3, 395) = 0.56, p = .639$; helping behaviors, $F(3, 395) = 1.66, p = .175$; personal social distancing, $F(3, 395) = 0.55, p = .648$; professional social distancing, $F(3, 395) = 0.26, p = .856$), suggesting homogeneity of error variances. A non-significant result to Box's test confirmed that the homogeneity of variance-covariance matrix assumption was

upheld (*Box's* $M = 40.70$, $F = 0.88$, $p = .692$). The experimental design and online survey implementation ensured that the independence of observations assumption was also met.

Primary Analyses

Hypothesis 1. The first hypothesis posited that adding a diagnostic label of personality disorder to a clinical vignette would be associated with more overall stigmatization. With assumptions of the test upheld, a two-way MANOVA was run and revealed a significant multivariate main effect for diagnostic label on stigma scores, Wilks' $\lambda = .948$, $F(5, 391) = 4.25$, $p = .001$, partial $\eta^2 = .05$ (see Table 2). Power to detect the effect was .96. Thus, this hypothesis was supported by the results. Participants provided significantly more stigmatizing responses when a personality disorder diagnosis was specified ($M = 3.52$, $SD = 0.61$) than when no personality disorder diagnosis was given ($M = 3.39$, $SD = 0.58$).

Hypothesis 2. The second hypothesis posited that by adding a diagnostic label of personality disorder to a clinical vignette, respondents would attribute more personal responsibility and greater controllability to portrayed problems. Significant univariate main effects for diagnostic label were not obtained for responsibility/controllability items, $F(1, 395) = 0.27$, $p = .606$, partial $\eta^2 < .01$, power = .08. As such, this hypothesis was not supported by the results. Participants did not attribute significantly more responsibility/controllability to portrayed problems when a personality disorder diagnosis was provided ($M = 3.01$, $SD = 1.05$) than when a personality disorder diagnosis was not provided ($M = 2.94$, $SD = 1.13$).

Hypothesis 3. The third hypothesis posited that adding a diagnostic label of personality disorder to a clinical vignette would be associated with more negative

Table 2

Analysis of variance results for Psychiatric Stigma by Diagnostic Label and Intervention

Diagnostic Label	Wilk's λ	<i>df</i> 1	<i>df</i> 2	<i>F</i>	<i>p</i>	Partial η^2	Power
Overall	.948	5	391	4.25	.001*	.05	.96
Responsibility Beliefs		1	395	0.27	.606_	.00	.08
Emotional Reactions		1	395	3.23	.073_	.01	.43
Helping Behaviors		1	395	7.87	.005*	.02	.80
Personal Social Distancing		1	395	1.74	.188_	.00	.26
Professional Social Distancing		1	395	7.60	.006*	.02	.79
Intervention	Wilk's λ	<i>df</i> 1	<i>df</i> 2	<i>F</i>	<i>P</i>	Partial η^2	Power
Overall	.949	5	391	4.24	.001*	.05	.96
Responsibility Beliefs		1	395	6.62	.010*	.02	.73
Emotional Reactions		1	395	9.21	.003*	.02	.86
Helping Behaviors		1	395	0.76	.383_	.00	.14
Personal Social Distancing		1	395	13.19	< .001**	.03	.95
Professional Social Distancing		1	395	7.61	.006*	.02	.79
Interaction	Wilk's λ	<i>df</i> 1	<i>df</i> 2	<i>F</i>	<i>p</i>	Partial η^2	Power
Overall	.980	5	391	1.59	.163_	.02	.55

Notes.

* $p < .01$, ** $p < .001$

emotional reactions and fewer positive emotional reactions. Given the significance of the overall MANOVA model, univariate main effects were examined for each dependent variable (i.e., composite). Significant univariate main effects for diagnostic labeling were not obtained for emotional reactions, although the effect approached significance, $F(1, 395) = 3.23, p = .073$, partial $\eta^2 = .01$, power = .43. Participants did not endorse significantly more negative emotional reactions when a personality disorder diagnosis was provided ($M = 3.51, SD = 0.44$) than when a personality disorder diagnosis was not provided ($M = 3.58, SD = 0.46$).

Hypothesis 4. The fourth hypothesis posited that adding a diagnostic label of personality disorder to a clinical vignette would be associated with respondents anticipating fewer helping behaviors and more rejecting behaviors. Significant univariate main effects for diagnostic label were obtained for helping/rejecting behaviors,

$F(1, 395) = 7.87, p = .005$, partial $\eta^2 = .02$, power = .80. Thus, this hypothesis was supported by the results. Participants endorsed significantly more rejecting behaviors when a personality disorder diagnosis was provided ($M = 2.60, SD = 0.95$) than when a personality disorder diagnosis was not specified ($M = 2.33, SD = 0.79$).

Hypothesis 5. The fifth hypothesis posited that adding a diagnostic label of personality disorder to a clinical vignette would be associated with higher levels of personal social distancing. Significant univariate main effects for diagnostic label were not obtained for personal social distancing, $F(1, 395) = 1.74, p = .188$, partial $\eta^2 < .01$, power = .26. Therefore, this hypothesis was not supported by the results. Participants did not endorse significantly higher levels of personal social distancing when a personality disorder diagnosis was provided ($M = 4.84, SD = 1.43$) than when a personality disorder diagnosis was not provided ($M = 4.64, SD = 1.49$).

Hypothesis 6. The sixth hypothesis posited that adding a diagnostic label of personality disorder to a clinical vignette would be associated with higher levels of professional social distancing. Significant univariate main effects for diagnostic label were obtained for professional social distancing, $F(1, 395) = 7.60, p = .006$, partial $\eta^2 = .02$, power = .79. Hence, this hypothesis was supported by the data. Participants endorsed higher levels of professional social distancing when a personality disorder diagnosis was provided ($M = 3.64, SD = 0.75$) than when a personality disorder diagnosis was not provided ($M = 3.42, SD = 0.73$).

Hypothesis 7. The seventh hypothesis posited that presenting clinicians with an anti-stigma intervention prior to a clinical vignette would be associated with less overall stigmatization towards the individual depicted in the vignette. With assumptions of the

test upheld, a two-way MANOVA revealed a significant multivariate main effect for intervention on stigma scores, Wilks' $\lambda = .95$, $F(5, 391) = 4.24$, $p = .001$, partial $\eta^2 = .05$. Power to detect the effect was .96. Thus, this hypothesis was supported by the results. Adding an anti-stigma intervention resulted in significantly less stigmatized responding overall ($M = 3.31$, $SD = 0.60$) than presenting participants with an unrelated educational passage ($M = 3.57$, $SD = 0.57$).

Hypothesis 8. The eighth hypothesis posited that clinicians presented with an anti-stigma intervention prior to reading a clinical vignette would attribute less personal responsibility and less controllability to portrayed problems. Significant univariate main effects for intervention were obtained for responsibility/controllability items, $F(1, 395) = 6.62$, $p = .010$, partial $\eta^2 = .02$, power = .73. Thus, this hypothesis was supported by the data. Participants educated on mental illness stigma and encouraged to challenge their implicit biases reported significantly less personal responsibility and controllability beliefs towards the individual in the vignette ($M = 2.82$, $SD = 1.03$) as compared to control group participants ($M = 3.10$, $SD = 1.12$).

Hypothesis 9. The ninth hypothesis posited that clinicians given an anti-stigma intervention prior to receiving a clinical vignette would report less negative emotional reactions towards the individual depicted in the vignette. Given the significance of the overall MANOVA model, univariate main effects were examined. Significant univariate main effects for intervention were obtained for emotional reactions, $F(1, 395) = 9.21$, $p = .003$, partial $\eta^2 = .02$, power = .86. Significantly less stigmatizing emotional responses were reported by participants who were educated on psychiatric stigma and encouraged to consciously challenge their implicit biases ($M = 3.47$, $SD = 0.43$) as

compared to participants who were given an unrelated educational passage to read ($M = 3.61, SD = 0.46$).

Hypothesis 10. The tenth hypothesis posited that presenting clinicians with an anti-stigma intervention prior to reading a clinical vignette would be associated with less stigmatization in terms of helping/rejecting behaviors. Significant univariate main effects for intervention were not obtained for helping/rejecting behaviors, $F(1, 395) = 0.76$, $p = .383$, partial $\eta^2 < .01$, power = .14. Therefore, this hypothesis was not supported by the data. Participants presented with an anti-stigma intervention did not endorse significantly less rejecting behaviors ($M = 2.42, SD = 0.87$) than participants given an unrelated educational passage to read ($M = 2.50, SD = 0.89$).

Hypothesis 11. The eleventh hypothesis posited that clinicians presented with an anti-stigma intervention prior to a clinical vignette would report less personal social distancing towards the individual depicted in the vignette. Significant univariate main effects for intervention were obtained for personal social distancing, $F(1, 395) = 13.19$, $p < .001$, partial $\eta^2 = .03$, power = .95. As such, this hypothesis was supported by the data. Participants who were given an anti-stigma intervention prior to receiving a clinical vignette reported significantly less personal social distancing towards the portrayed individual ($M = 4.45, SD = 1.49$) than participants who were given an unrelated educational passage to read ($M = 4.99, SD = 1.40$).

Hypothesis 12. The final hypothesis posited that clinicians presented with an anti-stigma intervention prior to reading a case vignette would report less professional social distancing towards the depicted client. Significant univariate main effects for intervention were obtained for professional social distancing, $F(1, 395) = 7.61$, $p = .006$, partial $\eta^2 =$

.02, power = .79. Thus, this hypothesis was supported by the data. Participants presented with an anti-stigma intervention prior to encountering a case reported significantly lower levels of anticipated professional social distancing towards the portrayed individual ($M = 3.41$, $SD = 0.72$) than control group participants ($M = 3.63$, $SD = 0.76$).

Other Analyses

Interactions. Running a two-way MANOVA revealed no significant interaction effects between anti-stigma intervention and diagnostic label, Wilks' $\lambda = .980$, $F(5, 391) = 1.59$, $p = .163$, partial $\eta^2 = .02$. Power to detect the effect was .55. Because the main effects are independent of each other, it can be said that the addition of a personality disorder diagnosis resulted in more stigmatized responding, without having to further qualify the effect of diagnostic labeling on the basis of the anti-stigma manipulations. Similarly, it can be said that the addition of an anti-stigma intervention resulted in less stigmatized responding, without having to speak about how this intervention interacted with the diagnostic labeling manipulation.

Post-hoc Analyses

Covariates. Exploratory analyses were run to examine the influence of other factors upon stigma. No significant differences in overall stigma were anticipated nor detected between program type ($F(2, 397) = 1.18$, $p = .278$), theoretical orientation ($F(6, 392) = 1.87$, $p = .084$), or interest in inpatient work ($F(1, 397) = 1.13$, $p = .288$). Although women were expected to maintain less stigmatizing attitudes and be more open to intervention based on previous research (e.g., Martinez-Zambrano et al., 2013; Pinfold et al., 2003; Rusch, Evans-Lacko, Henderson, Flach, & Thornicroft, 2011), no gender differences were detected (overall stigma, $F(2, 396) = 1.66$, $p = .191$; intervention

responsiveness, $F(1, 394) = 1.37, p = .24$). Two positive results were notable, however. Participants with more personal experience with mental illness exhibited reduced overall stigma scores ($R^2 = .011, F(1,397) = 4.48, p = .035$), and Ph.D. students reported lower overall stigma scores by comparison to Psy.D. students ($F(1, 397) = 4.77, p = .030$, partial $\eta^2 = .01$, power = .59).

The intervention's effectiveness for personality disorders. In order to assess if the anti-stigma intervention used in this study is effective not just for the general case, but specifically for the case of an individual labeled with a personality disorder, a test was performed to see if an interaction existed between the diagnostic label manipulation and the personality disorder manipulation. Because no significant interaction effect was discovered ($F(5, 391) = 1.59, p = .163$), the intervention was successful across all conditions. Therefore, it can be said that the anti-stigma intervention used in this study was even effective for personality disorders.

Individual item analysis. In two cases, there were rationales in place for conducting further post-hoc analyses. Because numerous studies in the literature have suggested the important role that perceptions of dangerousness have in instigating stigma, a closer examination of questionnaire items relating to perceptions of danger and safety was conducted. Second, given that participants endorsed higher levels of professional social distancing when a personality disorder was provided and less professional social distancing when encountering an anti-stigma intervention, it was important to examine which aspects of professional behavior in particular appear most subject to change. Accordingly, individual item analyses were also performed on questionnaire items relating to professional social distancing.

Dangerousness. Participants did not endorse significantly more negative emotional reactions as a whole when a personality disorder diagnosis was provided, and an individual item analysis did not suggest that diagnostic labeling affected perceptions of dangerousness in particular. However, ANOVA calculations indicated that participants exposed to an anti-stigma intervention were less likely to see the portrayed client as dangerous ($F(1, 397) = 29.25, p < .001$), more likely to feel safe around him ($F(1, 397) = 12.16, p < .001$), and less likely to feel frightened by him ($F(1, 397) = 5.33, p = .021$). When this client was specifically given a personality disorder label, the intervention remained successful at reducing perceptions of dangerousness ($F(1, 193) = 10.02, p = .002$). Therefore, the intervention was effective at reducing perceptions of dangerousness, regardless of diagnostic labeling.

Professional social distance. When training clinicians were presented with a personality disorder case, they were less comfortable taking the individual as a client ($F(1, 395) = 4.16, p = .042$) and more likely to refer the client ($F(1, 395) = 5.10, p = .025$). They also anticipated being less likely to inform the client of his diagnosis ($F(1, 395) = 5.81, p = .016$) and being less likely to give out a number where they could be reached after hours ($F(1, 395) = 7.96, p = .005$). Fortunately, clinicians exposed to an anti-stigma intervention were generally more comfortable taking on clients ($F(1, 395) = 6.21, p = .013$), more likely to give out their number to clients for after-hours support ($F(1, 395) = 12.02, p = .001$), and more likely to inform the client of his diagnosis ($F(1, 395) = 5.70, p = .017$).

CHAPTER IV

Discussion

Summary of results

Psychiatric stigma exists within psychologists-in-training. The present study investigated the presence of mental illness stigma in a previously unexplored subgroup of mental health professionals: psychologists-in-training. Through use of a between-subjects experimental design, this study demonstrated that mental health trainees are prone to bias. This finding is consistent with a growing research corpus indicating that mental health professionals do not have any special immunity against psychiatric stigma (e.g., Lauber et al., 2004; Nordt, Rossler, & Lauber, 2006; Schulze, 2007). Those with more personal experience with mental illness exhibited reduced overall stigma scores. This is also consistent with previous literature (for a review see Corrigan & Penn, 1999).

While prior studies have shown that women tend to hold more positive attitudes towards the mentally ill (Roberts et al., 2008; Rusch et al., 2011), gender differences in overall stigma were not discovered in this sample of mental health professionals. It may be that men who elect to enter this profession have overcome some of the masculinity scripts that lead to greater degrees of stigmatization in the lay population. Differences were found, however, between Ph.D. and Psy.D. students, with Ph.D. students reporting reduced stigma scores. It may be that variation in training accounts for these differences observed in overall stigmatization.

Diagnostic labels increase psychiatric stigma. This study also investigated factors that increase stigmatization among clinicians and which domains (e.g., cognitive, emotional, behavioral) are most susceptible to influence. This study, through the use of

an experimental design, was successful in positively identifying psychiatric labeling as one such factor. Results indicated that diagnostic labeling of a personality disorder increases stigmatizing responding in clinicians. In particular, clinicians reported being less likely to engage in helping behaviors and more likely to engage in professional social distancing towards individuals who had been diagnosed with a personality disorder relative to those who had the same symptoms but were unlabeled. The study reproduced the findings of others suggesting that diagnostic labeling can have iatrogenic effects (e.g., Corrigan, 2004; Corrigan, 2007; Link, 1987; Link et al., 1989; Sartorius, 2002), and that individuals labeled as personality-disordered may be a group at particular risk for stigmatization by providers (Deans & Meocevic, 2006; Lewis & Appleby, 1988). This study also showed that stigmatization may be most likely to manifest in greater discomfort accepting individuals with a personality disorder as clients, as well as differential behavior in handling referrals, after-hours support, and transparency.

One finding that was unexpected was that labeling did not appear to negatively influence cognitive (personal responsibility/controllability attributions) or affective domains (self-reported emotional reactions) as much as it negatively impacted behavioral measures (willingness to engage in helping behaviors, likelihood of engaging in professional social distancing). Weiner's (1986) attribution theory posits that attributions influence attitudes, which in turn influence behaviors, and there is support for this cognitive-behavioral model in the psychiatric stigma literature (Corrigan, 2003; Corrigan et al., 1999; Crandall & Moriarty, 1995; Weiner et al., 1988). Consistent with this causal process, significant differences in cognitive and affective measures were expected if,

indeed, significant differences in behavioral measures were found. However, this was not the case, and so results seem inconsistent with previous literature in this area.

Why might this be? It is important to note that the majority of stigma studies have been conducted with non-professional samples. Therefore, one possibility is that controllability beliefs, emotional reactions, and personal social distancing are good proxies for psychiatric stigma when used in the lay population, but are not as strong when used with a sample of mental health professionals. Clinicians-in-training may, in fact, be stigmatizing in these domains, but common measures may not be sensitive enough to accurately detect these dimensions of stigma within this sample. For this population, other measures may be needed to identify latent stereotyping and prejudice.

Perhaps mental health professionals *possess* the same stereotypes and prejudices as the general population, but do not *endorse* them. Social desirability may be particularly active in this population, and self-reported controllability attributions, emotional reactions, and personal social distancing measures may be differentially affected by this bias. Evidence already exists suggesting that measures of personal social distancing are especially vulnerable to contamination by social desirability (Link et al., 2004). The same may be true for controllability attributions and self-reported emotional reactions. It is easy to imagine trainees – across all experimental conditions – being particularly prone to overstating their tolerance for individuals with mental illness during this stage of the professional lifecycle.

This may account for the unexpected attenuation of stigmatized responding seen in the cognitive and affective domains in response to labeling. But why would the same suppression effect not also influence the behavioral domain? One possibility is that

reduced helping behaviors and increased professional social distancing are artifacts of training. It may be that novice clinicians have been taught to view personality disorders as difficult to treat and themselves as unlikely to help affected individuals. If such partialities are indeed learned during undergraduate education or graduate training, then curricula should be re-examined.

Psychiatric stigma can be reduced. The present study also investigated the effect that anti-stigma interventions can have on psychiatric stigma within clinicians, and successfully demonstrated that encouraging student clinicians to consciously challenge their implicit biases can indeed reduce stigmatization. In particular, interventions like the one used in this study have the ability to diminish beliefs about personal responsibility and controllability of symptoms, decrease negative emotional responses, and reduce both personal and professional social distancing. Thus, it appears that interventions can reduce stigma across cognitive, emotional, and behavioral domains.

These results are in agreement with previous research from cognitive and social psychology literature demonstrating that training people to slow down and think carefully about their responses when implicit biases may be operating is effective in reducing prejudicial responding (Blair et al., 1996; Kawakami et al., 2000; Monteith, 1993). Results are also in support of Weiner's attribution theory (Weiner et al., 1988) which holds that changes in cognition will cascade into changes in emotion and behavior.

However, these results are inconsistent with Lewis and Appleby's (1988) study which failed to demonstrate effective anti-stigma interventions with experienced psychiatrists. What might account for these divergent results? One possibility is that the anti-stigma intervention preceding the Lewis and Appleby (1988) vignette was overly

terse and ineffective. In this statement, participants “were told that [the experimenters] were interested in the labelling effect of certain psychiatric diagnoses and were asked not to let themselves be influenced by previous labels” (p. 45). Lord, Pepper, and Preston (1984) demonstrated that if you would like people to be less biased, do not simply ask them to be less biased; instead, ask them to consider the opposite point of view and give them strategies on how they can be more impartial. The Lewis and Appleby intervention may have failed because people were essentially given *be-unbiased* orders (“Bias can happen. Don’t be biased.”), rather than *consider-the-opposite* instructions (“This is how bias happens, this is how it affects others, and this is how you can avoid it.”).

It is also possible that this study’s participants differ in important ways from the Lewis and Appleby sample. Because Lewis and Appleby did not report details of their sample (e.g., age, gender, theoretical orientation), significant demographic differences between the two studies cannot be ruled out. It may also be that trainees are at a unique stage of professional development that sets them apart from other clinicians. Perhaps being ensconced within an atmosphere of education contributes to a unique openness to intervention, while practicing in the field for many years leaves one less so. There may also be important distinctions between psychiatry and psychology training that account for the observed differences.

Although successful in the cognitive, affective, and behavioral domains, the intervention did not reduce stigmatization in all of its forms. The intervention failed to significantly increase helping behaviors. One potential explanation for this is that the language used in items may have elicited socially desirable responding in participants across conditions, leading to a poor measure of the true likelihood of helping or rejecting

behaviors. Of course, it is also possible that the potency of the intervention was simply not strong enough to elicit significant change in the helping domain.

Stigma towards personality disorders can be reduced. This study also presented interventions that were not only successful in reducing stigmatized responding in general, but were also powerful enough to counter the effects of a personality disorder label specifically. This study provides evidence that clinicians-in-training can succeed at reducing their psychiatric stigma, even when working with individuals with personality disorders. These results, however, run contrary to the Lewis and Appleby (1988) study which failed to demonstrate reduction of stigmatization towards individuals with a personality disorder after exposure to an intervention. In addition to the reasons already mentioned, the dated nature of the Lewis and Appleby study may also be relevant. Attitudes associated with personality disorders and their treatment today may be very different from those present in 1988, and may account for the observed differences.

Limitations and Future Directions

While this study was primarily interested in assessing training clinicians within doctoral psychology programs, it is important to qualify results in light of this circumscribed sample. This sample is not representative of all mental health providers, and this limits the generalizability of this study's findings. Because this study's positive results differ from Lewis and Appleby's (1988) study which did not succeed in reducing stigma in experienced clinicians, it may be prudent to examine the effects of interventions on mental health workers at various stages of the professional lifecycle. In addition to examining graduate and post-graduate cohorts, comparisons to undergraduates and to the general population may also bear interesting results. Because differences were observed

between this sample of psychologists and Lewis and Appleby's (1988) sample of psychiatrists, it also seems prudent to examine differences across mental health disciplines and across different fields as this may shed more light on the effects of training on attitudes and responsiveness to intervention.

In addition to being young, this sample was also North American. The nuances of stigma and responsiveness to intervention may well vary across age and culture. Therefore, it is also important for future research to compare Western and non-Western samples and to study age effects cross-sectionally and longitudinally. In previous research, psychiatric stigma has been shown to vary across gender, with women generally holding more positive attitudes towards those with mental illness (Rusch et al., 2011) and being more responsive to intervention (Pinfold et al., 2003), but these phenomena were not found in this study. Future studies may consider using a more even balance of men and women to compare gender directly, as this sample was predominantly female.

The findings of this study are also limited by the parameters of the vignette. The hypothetical case used in this study depicts a 34 year-old male client with a history of suicidality requesting treatment for depression. Many participants were also told that he was previously diagnosed with a personality disorder. Whether this study's findings generalize to other clients and other presenting problems remains to be seen. Future research may benefit from examining clinician cognitions, attitudes, and behaviors across different client demographics. Clinicians may regard a female client with similar presenting problems very differently, for example. Experimental manipulation of gender and other client variables may lead to other important findings.

Internal validity concerns also merit discussion. While some composite groupings and questions were informed by previous research, others were newly introduced in this study. As such, concern for construct validity is only reasonable. Given the experiment's design, it can be argued that differences observed across groups represent prejudicial responding. However, it also seems sensible to question whether, say, refusal to give out an after-hours phone number to a client is really a measure of stigma. Further research is needed to establish more evidence for the validity of the measures used.

Another limitation of this study is its exclusive use of explicit measures. Explicit measures require individuals' subjective participation and tap into their conscious processes (Gawronski et al., 2014). This is problematic when what is being measured is either inaccessible or resides outside of conscious awareness. It is also problematic if the act of introspection somehow interferes with the underlying process, or if there is motivation in place for individuals to intentionally modify their responses. Because some components of stigma operate outside of awareness, future studies should validate the present findings using implicit measures. In so doing, concerns about measurement distortions due to social desirability or self-presentation interests will also be addressed.

Conclusions

Previous research has found that mental health professionals are not immune to psychiatric stigma. The results of this study provide additional evidence in support of this discovery. However, this study also demonstrates that stigma can be countered. These outcomes have important policy implications. The findings suggest that it may be better to describe clients' presenting problems in terms of symptoms rather than by diagnostic labels. According to this study, doing so is likely to diminish the discrimination that

individuals with mental illness experience from mental health professionals. Results also suggest that reminding clinicians to consider the negative impact of psychiatric stigma and incentivizing them to challenge their own implicit biases is also likely to reduce the stereotyping, prejudice, and discrimination that providers may unknowingly perpetuate. Furthermore, the results imply that training may be a particularly sensitive period during which anti-stigma interventions are likely to be effective.

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APPENDIX A

Institutional Review Board Approval Letter



LOYOLA UNIVERSITY MARYLAND

— 1852 —

July 17, 2012

Mr. Douglas M. Girard
8 Clear Skys Court, Apt. T2
Baltimore, MD 21209

Dear Mr. Girard:

IRB Log Number: **3159**
Proposal Title: **Challenging Psychiatric Stigma in Mental Health Professionals**

This letter is to officially notify you of the approval of your project by the Loyola University Maryland Institutional Review Board (IRB) on Human Subjects Research. It is the Board's opinion that you have provided adequate safeguards for the rights and welfare of the participants in the study. Your proposal seems to be in compliance with the DHHS Regulations for the Protection of Human Subjects (45 CFR 46) and has been classified as eligible for **expedited review**.

You are authorized to implement this study beginning on the Date of Final Approval: 7/17/2012. This approval is Valid Until: 7/16/2013.

This project should be conducted in full accordance with all applicable sections of the Loyola University Maryland *Policies and Procedures for Research Involving Human Participants*, and the IRB must be notified immediately of any proposed changes that may affect the status of your research project. You are required to report any unanticipated problems involving risks to the participants or others to the Board.

A copy of the *Policies and Procedures for Research Involving Human Participants* can be located at: inside.loyola.edu/academics/research/orsp/compliance/human_subjects/HSpoliciesandprocedures.pdf

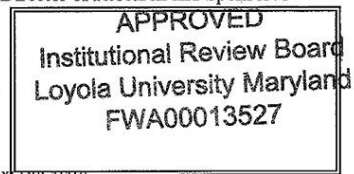
For projects that continue beyond one year from the starting date, the IRB will request continuing review and update of the research project. Your study will be due for continuing review as indicated above.

You are required to retain copies of documents related to the use of human participants in your research project including but not limited to all signed consent and assent documents and complete records of any adverse incidents that occurred during the research as well as any follow-up correspondence or actions taken in response to the adverse incident. You are also responsible for maintenance and retention of such records for a minimum of three years after the completion of the research. If you leave Loyola University Maryland within this period, all records must be provided to your department so that they can be retained for the required three-year period. If you are a student, complete copies of these records must be provided to your faculty sponsor. Your advising faculty sponsor is responsible for maintenance and retention of such records for a minimum of three years after the completion of the research.

If you have any further questions, please contact Stacey Bass, Assistant Director of Research and Sponsored Programs, at (410) 617-2188 or sbass1@loyola.edu.

cc: Matthew Kirkhart, Ph.D.

THE UNIVERSITY'S GENERAL REQUIREMENTS FOR THE PROTECTION OF HUMAN PARTICIPANTS APPLY TO ALL RESEARCH, WHETHER OR NOT IT HAS BEEN DECLARED EXEMPT.



APPENDIX B

Survey

Please answer each of the following questions about your background.

1. Gender: Male Female Other
2. Age: years
3. Which of the following best describes you? (Check all that apply.)
 - African-American/Black
 - American Indian/Alaskan Native
 - Asian/Pacific Islander
 - Caucasian, not Hispanic
 - Hispanic/Latino
 - Other
 - Multiracial
4. Type of psychology graduate program you are enrolled in: Ph.D.
Psy.D. Other
5. Type of program: Clinical Psychology Counseling Other
6. Where is your graduate program housed?
 - University department
 - Free-standing professional school
 - University-housed professional school
 - Other
7. Year in program: 1 2 3 4 5 6 7 8+
8. Are you currently on your pre-doctoral internship? Yes No
9. Have you completed your pre-doctoral internship? Yes No

10. To date, how many years of clinical experience have you had in total:

0 1 2 3 4 5 6 7 8+

11. What type of clinical/counseling work do you plan on doing after graduating?

(Check all that apply.)

Psychotherapy

Assessment

School psychology

Research

Teaching/Professorship

Other

12. What populations have you worked with within the field of psychology? (Check

all that apply.)

Children

Adolescents

Adults

Geriatric

None

13. What populations do you plan to work with after graduating? (Check all that

apply.)

Children

Adolescents

Adults

Geriatric

None

14. What settings have you worked in within the field of psychology? (Check all that apply.)

College Counseling Center/Student Mental Health Center

Outpatient Psychiatric Clinic/Community Mental Health Center/Private Practice

Inpatient Psychiatric Hospital

Correctional Facility/Forensic Setting

Medical Clinic/Hospital

Schools

Nursing home/Assisted Living

Other - Please specify: _____

None

15. What settings do you plan to work in after graduating? (Check all that apply.)

College Counseling Center/Student Mental Health Center

Outpatient Psychiatric Clinic/Community Mental Health Center/Private Practice

Practice

Inpatient Psychiatric Hospital

Correctional Facility/Forensic Setting

Medical Clinic/Hospital

Schools

Nursing home/Assisted Living

___ Other - Please specify: _____

___ None

16. Please check the ONE category of theories that you have found to MOST influence your theoretical perspective/conceptualization of clients:

___ Behavioral/Cognitive/Cognitive-Behavioral/Rational-emotive/Acceptance & Commitment Therapy/Dialectical Behavior Therapy

___ Psychodynamic/Psychoanalytic/Psychoanalysis (classic)/Object Relations

___ Humanistic/Client-centered/Existential/Phenomenological/Gestalt

___ Systems/Family Systems/Attachment Theory

___ Applied Behavioral Analysis/Clinical Behavior Analysis

___ Interpersonal Psychotherapy (IPT)/Interpersonal Process

___ Other

17. How much exposure have you had to mental illness outside of your professional life (e.g., self, family, friend, roommate, stranger)?

(Not at all)

(Very much)

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8

APPENDIX C

Training Intervention

Experimental Condition: Anti-stigma Intervention

Individuals with mental illness continue to experience stigmatization today. This mental illness stigma, also known as psychiatric stigma, can create real obstacles for affected individuals as they attempt to navigate an intolerant social environment.

Unfortunately, research shows that mental health professionals are not immune to cultural stereotypes about mental illness and possess psychiatric stigma themselves (e.g., Deans & Meocevic, 2006; Farrell & Lewis, 1990; Jorm et al., 1999; Hugo, 2001; Lauber et al., 2004; Lewis & Appleby, 1988; Nordt et al., 2006; Schulze, 2007). This is reasoned to impact client care.

Biases exist at both explicit and implicit levels. Because implicit processes operate outside of awareness, individuals may underestimate the degree to which their own prejudices still function. Implicit bias has been shown to be fairly resilient to extinction. Fortunately, research suggests that given sufficient motivation, time, and cognitive resources, individuals can override implicit attitudes with explicit ones (Kawakami et al., 2000; Monteith, 1993; Wilson, Lindsey, & Schooler, 2001). Therefore, training people to slow down and think carefully about their responses has been shown to be very effective at reducing prejudiced responses. This is especially important in situations where control is needed because implicit biases may be operating.

If psychiatric stigma exists within providers, and research suggests that it does, then client care depends on confronting this issue and engaging in deliberate efforts to reduce this stigma.

Control Condition: Unrelated Scientific Passage

Boredom is a common experience in healthy individuals and may be elevated in various neurological or psychiatric conditions. Described as an “unpleasant, transient affective state, in which the individual feels a pervasive lack of interest” (Fisher, 1993, p. 396) in an activity, the subjective experience of boredom has been examined in the context of its relationship to attention, work practices and personality factors.

An individual’s ability to cope with the experience of boredom has also been related to various personality factors and the degree of vulnerability to psychopathology (Hamilton, 1981; Kass, Wallace, & Vodanovich, 2003; Seel & Kreutzer, 2003).

Numerous studies have demonstrated a relationship between attention or attentional failures and the experience of boredom. Indeed, the experience of boredom itself can be altered by virtue of manipulations of attention. A significant relationship may also exist between the perception of the passage of time and boredom (Danckert & Allman, 2005).

APPENDIX D

Vignette

Experimental Condition: Previous diagnosis of personality disorder given

Please read the following:

Table 1

John, a 34-year-old man, complains of feeling depressed, and says he has been crying on his own at home. He is worried about whether he is having a nervous breakdown, and is requesting treatment. He has thought of killing himself by taking an overdose of some tablets he has at home. He has taken one previous overdose, 2 years ago. At that time he was given a personality disorder diagnosis. He has recently gone into debt and is concerned about how he will repay the money. He is finding it difficult to sleep and his general practitioner has given him a benzodiazepine. He thinks these have helped a little and is reluctant to give them up.

Control Condition: No previous diagnosis mentioned

Please read the following:

Table 1

John, a 34-year-old man, complains of feeling depressed, and says he has been crying on his own at home. He is worried about whether he is having a nervous breakdown, and is requesting treatment. He has thought of killing himself by taking an overdose of some tablets he has at home. He has taken one previous overdose, 2 years ago. He has recently gone into debt and is concerned about how he will repay the money. He is finding it difficult to sleep and his general practitioner has given him a benzodiazepine. He thinks these have helped a little and is reluctant to give them up.

APPENDIX E

Questionnaire

compassion towards John.*								
I am made to feel confident by John.*								
I think that John is safe.*								

Note: Emotional reactions

Please answer the following questions based on the previous vignette:

	1 (Not likely)	2	3	4	5	6	7	8 (Very likely)
How likely are you to feel the desire to help John?*								
How likely are you to be helpful to John?*								
How likely are you to feel the desire to keep out of John's business?								
How likely are you to feel that you would help John?*								

Note: Helping/rejecting behaviors, Prosocial behavior

Please answer the following questions based on the previous vignette:

	1 (Not at all)	2	3	4	5	6	7	8 (Very much)
I think it is John's own fault that he is in his present condition.								
I think John is responsible for his present condition.								
I think John's current condition is within his control.								
I think John has exercised unsound judgment.								

Note: Personal responsibility and controllability beliefs

likely would you be to interview John for a job?*								
How likely are you to feel comfortable carpooling to school every day with someone like John?*								
How likely are you to spend an evening socializing with someone like John?*								
How likely are you to become friends with someone like John?*								
How likely are you to feel comfortable working closely at a job with someone like John?*								

Note: Personal social distancing

How likely are you to return someone else's phone call before John's?								
How likely are you to spend more time than average preparing for a session with John?*								
How likely are you to refer John to someone else?								
How likely are you to adjust your schedule if John were to ask you to reschedule his appointment?*								
How likely are you to inform John of his diagnosis?*								

Note: Professional social distancing

APPENDIX F

Informed Consent Agreement

INFORMED CONSENT AGREEMENT

Dear Participant:


My name is Douglas Girard, and I am a doctoral student at Loyola University Maryland. The study you are being asked to participate in is being used to assist with the completion of my doctoral dissertation. This study is being conducted under the supervision of Matthew Kirkhart, Ph.D., Associate Professor of Psychology, 4501 N. Charles St., Baltimore, MD 21210, (410) 617-5498.

As a participant in this study, you will be asked to answer a number of demographic questions, read a brief vignette, and respond to some questions about what you have read. You may find your participation in this study to be interesting and enjoyable. There are no anticipated risks or side effects from this study. After completing all questions, you will be debriefed on the purpose of the study. All of the information obtained in this study will be confidential and anonymous. No identifying information will be gathered, and therefore no identifying information will be associated with responses to the survey. Data will be retained for a minimum of three (3) years, and only the investigators (Douglas Girard and Matthew Kirkhart) will have access. The data will be stored in a secure computer within a locked room, and the data files will be secured and password protected using encryption best practices.

Participation in this study is completely voluntary. You have the right to decline participation or withdraw at any point in time. From start to finish, the study should take approximately 10-15 minutes to complete. Completion of this study is an indication of your free and informed participation in this research. Results may be published, but your identity will not be revealed. This study has approved by the Loyola University Maryland

Institutional Review Board. In order to encourage participation in the study, we will donate \$1 to the Leukemia and Lymphoma Society for each submission received to help fund lifesaving research and provide support to individuals affected by cancer. If you have questions or concerns regarding this research, please feel free to call Douglas Girard at (203) 645-3327 or Matthew Kirkhart at (410) 617-5498. Thank you in advance for your time and consideration.

Sincerely,



Douglas M. Girard, M.S.

Psychology Department

Loyola University Maryland

4501 North Charles Street

Baltimore, Maryland 21210

THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY THE LOYOLA UNIVERSITY
MARYLAND INSTITUTIONAL REVIEW BOARD (PHONE: 410-617-2561).

Updated 7/2012

APPENDIX G

Debriefing Statement

DEBRIEFING STATEMENT

This study is concerned with challenging psychiatric stigma within mental health professionals. Previous studies have shown that mental illness stigma not only exists within providers, but also results in detrimental consequences for patients. Because components of stigma exist at implicit levels and operate outside of awareness, individuals often underestimate the degree to which their prejudices still function, and therefore do not think to employ cognitive strategies that can be used to combat stigma.

In this study, you were asked to read a clinical vignette. For some participants, the individual depicted in this vignette was said to have received a previous diagnosis of personality disorder. For other participants, no previous diagnostic information was given. If results are consistent with prior research, we expect more stigmatizing attitudes and behavioral intentions to surface for the case given a previous personality disorder diagnosis, demonstrating differential attitudes and treatment towards certain clientele.

We are also interested in the influence of anti-stigma training. We suspect that if individuals are educated about the negative consequences of stigma and given cognitive strategies that can be used to override implicit attitudes with explicit ones, stigmatization will decrease. Therefore, some participants were asked to read a brief anti-stigma training intervention before approaching the clinical vignette. Other participants were given no such reading. We expect less stigmatizing attitudes and behavioral intentions to appear when clinicians are given anti-stigma training.

If you would like to receive a report of this research when it is completed (or a summary of the findings), please contact Douglas Girard (dmgirard@loyola.edu). If you

have concerns about your rights as a participant in this experiment, please contact the Loyola University Maryland Institutional Review Board (410-617-2561).

If you are interested in learning more about psychiatric stigma within mental health professionals, you may want to consult: Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry*, 19, 137-155.

Thank you for your participation.

VITA AUCTORIS

Mr. Douglas M. Girard earned a Bachelor's in Computer Science Engineering from the University of Michigan. Subsequently, he worked as a Program Manager at Microsoft Corporation on the company's distributed composite application platform. He then worked on neuroscience research at the University of Washington and New York University, studying the neural basis of attention-deficit/hyperactivity disorder, autism, and fear learning. During his time at Loyola University Maryland, Mr. Girard received his Master of Science degree in Clinical Psychology in 2011, and worked in various externship positions including The Loyola Clinical Centers, Notre Dame of Maryland University, and Towson University. He plans to graduate with his Doctor of Psychology in Clinical Psychology from Loyola University Maryland in September 2014 after completing his internship at Stony Brook University. In the future, he hopes to practice individual psychotherapy and psychoanalysis, and is also interested in supervision and teaching.