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The Experience of MSW Students: Self-Stigma and Mental Illness

by

Ashley Trudell, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this research study was to investigate the ways in which current MSW students experience different forms of the stigma of mental illness. The broader research question for this study is: Do current MSW students experience self-stigma of mental illness? Self-stigma is the internalization of negative attitudes and stereotypes created by general stigma (Corrigan et al., 2008). This study will examine the relationship between levels of general stigma and self-stigma in order to answer an additional question: If social work students are non-judgmental towards others in the general population with mental illness, are they similarly less judgmental towards themselves or each other? The sample population of this study included 48 current MSW students enrolled at two separate MSW programs in Minnesota. These students consented to participate in a quantitative study by completing an online questionnaire distributed by faculty members representing each MSW program. Findings highlight the prevalence of self-stigma of mental illness within the two MSW programs, demonstrating some discrepancies in the literature about the relationship between levels of general stigma and self-stigma. The goal of this research will be to enhance general knowledge about how MSW students experience mental illness in order to identify gaps in current research related to levels of general and self-stigma experienced within current MSW programs. Generalized knowledge about MSW students will benefit the professional field of social work by focusing on important subject areas in need of more social work research.

Keywords: MSW, mental illness, general stigma, self-stigma, social work

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The National Alliance on Mental Illness found that in a given year, over 61 million people in America experience mental illness. Research has demonstrated that, “one in four adults are affected by mental illness and one in 17 live with a serious and persistent mental illness (SPMI) such as major depression, bipolar disorder and schizophrenia” (National Alliance on Mental Illness, 2013; National Institute of Mental Health, 2013). Despite the prevalence of mental illness in American society, stigma of mental illness persists at many levels and in many domains.

The stigmatization process begins with the general population reacting to unfamiliar behaviors, characteristics, and symptoms. The public then creates stereotypes and prejudicial attitudes towards people labeled ‘mentally ill’ in order to control the undesirable sense of fear in misunderstood behaviors viewed as violent or dangerous (Corrigan, Mueser, Bond, Drake, & Solomon, 2008). Undesirable labels and negative stereotypes can lead to discrimination in different occupational, educational and social settings resulting in the significant loss of opportunities (Alexander & Link, 2003; Corrigan, 2007; Corrigan, 2004; Link & Phelan, 2001; Ross & Goldner, 2009). Furthermore, stigma can create barriers for individuals seeking treatment if they encounter prejudicial attitudes or unwanted labels resulting in avoiding help altogether (Corrigan, 2007; Corrigan et al., 2008; Scheyett, 2005; Ting, 2011). The harm caused by public stigma and self-stigma of mental illness warrants a strong response from the field of social work.

The *NASW Code of Ethics* includes values such as ‘promoting social justice’ and ‘pursuing social change’ concerning vulnerable and oppressed groups of people (National Association of Social Workers, 1999). The negative impact of public stigma itself,

threatens the social justice of those experiencing mental illness. Due to the prevalence of mental illness in American society, it is important to reduce public stigma affecting individuals suffering from disempowerment and unequal treatment. Research has shown that the reduction of public stigma is not only possible but should be the focus of social work education and professional practice (Carpenter, 2002; Covarrubias & Han, 2011; Drummond, 2012; Johnson, Seipel & Walton, 2011; Kram-Fernandez, 2012; Pittman, Noh & Coleman, 2010; Scheyett, 2005; Ting, 2011). Several studies also argue that social workers and mental health professionals generally hold less public stigma of individuals with mental illness (Alexander & Link, 2003; Carpenter, 2002; Corrigan et al., 2008; Kondrat & Teater, 2009; Pittman et al., 2010; Ross & Goldner, 2009; Scheyett, 2005). Research suggests that social workers are among the least stigmatizing mental health professionals and that stigma reduction is possible (Carpenter, 2002; Pittman et al., 2010). Social workers are expected to exhibit positive attitudes towards others experiencing the negative affects of stigmatization. However, there is a need for studies exploring how social workers experience self-stigma and how social workers stigmatize the mental illness of other social workers.

Self-stigma is the internalization of negative attitudes and stereotypes created by public stigma, frequently resulting in the loss of self-esteem or self-worth (Corrigan et al., 2008). Self-stigma may ultimately influence an individual's decision to disclose a mental health issue and may also create barriers towards seeking professional help (Corrigan, 2007; Corrigan, 2004; Corrigan et al., 2008; Drummond, 2012; Masuda, Suzumura, Beauchamp, Howells & Clay, 2005; Scheyett, 2005; Ting, 2011). Social work students are not required to disclose any evidence of personal experiences with mental illness, as

evidenced by MSW program admission standards. Furthermore, without knowledge of the mental health status of current MSW students it is difficult to examine the scope of stigma that may exist in MSW programs currently influencing the professional field of social work.

The purpose of this study will be to measure amounts of stigma that may currently exist amongst MSW students in two separate MSW programs in Minnesota. MSW students are an important population, as they are the future of the social work profession. Another reason for studying MSW students is the lack of research about social workers in general and the levels of stigma of mental illness social workers hold of others and themselves (Scheyett, 2005). MSW students are understudied, especially in regards to stigma. Furthermore, MSW students, compared to undergraduate college students, will typically have more life experiences that shape the levels of self-awareness needed to reflect upon the impact of stigma. MSW students have larger amounts of personal and occupational experiences based on the average age of students in current programs. MSW program websites range the average age of students between 26-60 years, allowing this study to assume that MSW students will have a higher level of self-awareness and self-reflective ability compared to undergraduate students representing a younger age range.

The gaps in current research have developed a unique opportunity for this researcher to examine MSW students in a new way that could potentially influence the future of social work education and professional practice. The main research question for this study is: Do MSW students experience the stigma of mental illness? This study will try to answer related questions including: How do MSW students experience the

stigma of mental illness based on student attitudes and beliefs? Do MSW students experience different levels of stigma based upon variables used in the literature to measure factors that impact levels of stigma? Finally, do MSW students feel comfortable disclosing information about personal experiences with mental health?

Literature Review

Many sources of literature and available research studies were reviewed in order to examine if stigma exists in MSW programs or if MSW students experience self-stigma. The following literature review will demonstrate that studies focusing on MSW students and self-stigma of mental illness are absent from current literature. There is also a lack of research into stigma among social work professionals and mental illnesses of social workers. The following literature review will demonstrate findings pertaining to mental illness and stigma leading to a discussion about gaps of knowledge in current research.

The definition of the general stigma of mental illness, the impact of stigma, and stigma reduction strategies are among the most common topics present in current literature (Alexander & Link, 2003; Carpenter, 2002; Corrigan, 2007; Corrigan, 2004; Corrigan et al., 2008; Covarrubias & Han, 2011; Kondrat & Teater, 2009; Kram-Fernandez, 2012; Link & Phelan, 2001; Pittman et al., 2010; Ross & Goldner, 2009; Scheyett, 2005; Ting, 2011). Research studies have examined stigma within professional realms such as nursing and social work focusing on the professionals' attitudes of patients (Carpenter, 2002; Eack & Newhill, 2008; Kondrat & Teater, 2009; Kram-Fernandez, 2012; Ross & Goldner, 2009; Scheyett, 2005), how mental health professionals perceive mental illness (Alexander & Link, 2003; Corrigan, 2004;

Drummond, 2012; Johnson, Seipel, & Walton, 2011; Rompf & Royse, 1994), and the impact of stigma on mental health patients (Alexander & Link, 2003; Carpenter, 2002; Corrigan, 2007; Corrigan, 2004; Corrigan et al, 2008; Link & Phelan, 2001; Link, Yang, Phelan & Collins, 2004; Ross & Goldner, 2009; Scheyett, 2005). Research focused within the professional realms of nursing and social work target areas for improvement within mental health systems, highlight stigma reduction strategies, and provide implications for mental health professionals.

Other studies have examined attitudes and personal attributes of undergraduate and graduate social work students regarding stigma focusing on implications for social work education (Covarrubias & Han, 2011; Drummond, 2012; Han et al., 2012; Johnson et al., 2011; Link & Phelan, 2001; Link, Yang, Phelan & Collins, 2004; Masuda et al., 2005; Pittman et al., 2010; Rompf & Royse, 1994; Ting, 2011). The following sections of this literature review will focus on three main clusters found in current research including: public stigma of mental illness, self-stigma of mental health patients, and implications for social work.

Public Stigma of Mental Illness

Mental illness in American society is discussed in many recent research studies, government data sets, books and journal articles. Research focusing on the stigma of mental illness addresses the particular problem pertaining to the large amount of public stigma that still exists today despite the prevalence of mental illness (Corrigan et al., 2008; National Alliance on Mental Illness, 2013; National Institute of Mental Health, 2013). Mental illness is considered to be the most stigmatized condition in our society (Alexander & Link, 2003, p. 271). Thus, understanding why the stigmatization of mental

illness continues to exist is an important focus of current literature. Many studies have identified the ways in which individuals are impacted by the stigma of mental illness including studies examining the creation of stigma, the consequences of stigma and the strategies for reducing stigma.

Creation of Stigma

In 1963, Erving Goffman defined stigma as the result of the majority group stealing rights and privileges from a discredited group, such as individuals with mental illness (as cited in Corrigan et al., 2008, p. 35). Goffman identified 'signals' that reinforced stigma, as the general population reacted to certain indicators of mental illness perpetuating stigma through negative stereotypes and prejudicial attitudes (Corrigan et al., 2008). Thus, individuals that display psychiatric symptoms, deficits in social communication, poor hygiene or bizarre physical characteristics are stigmatized due to the inferred signals of mental illness (Corrigan et al., 2008). Misunderstood signals often lead to undesirable labels associated with unwanted characteristics and disabilities (Alexander & Link, 2003; Kram-Fernandez, 2012; Link & Phelan, 2001; Scheyett, 2005). Thus, the label of 'mentally ill' is socially constructed based upon negative attributes and broad misunderstandings.

Some research highlights the role media plays in perpetuating stigma and reinforcing negative attitudes about mental illness. Entertainment, news and advertising mediums display individuals with mental illness as violent, out-of-control, and dangerous (Corrigan et al., 2008). Unfortunately, these images reinforce negative stereotypes that reduce life opportunities for individuals labeled 'mentally ill' (Alexander & Link, 2003; Corrigan, 2007; Corrigan, 2004; Corrigan et al., 2008; Link & Phelan, 2001; Scheyett,

2005). The consequences of public stigma will be addressed in the following section highlighting: discriminatory practices of people in power, prejudicial attitudes impacting individual rights, internalized negative feelings of self or others, and treatment barriers.

Consequences of Public Stigma

One of the most significant consequences of public stigma is the loss of life opportunities (Corrigan et al., 2008). Stigma impacts social status and self-esteem by influencing outcomes in recovery, levels of unemployment, increased isolation, and delayed treatment seeking (Link et al., 1991, 2001; Perlick et al., 2001; Sirey et al., 2001; Struening et al., 2001 as cited in Ritsher, Otilingam & Grajales, 2003). People in positions of power stigmatize individuals labeled 'mentally ill' impacting the decision to extend certain opportunities. For example, a landlord may choose not to offer housing to an individual with a severe mental illness based upon negative stereotypes including the perceived threat of danger and harm (Corrigan, 2007; Corrigan, 2004; Corrigan et al., 2008; Link & Phelan, 2001; Link et al., 2004; Scheyett, 2005). Other research has demonstrated individuals facing discrimination in occupational settings as individuals with severe and persistent mental illness have difficulty obtaining competitive employment (Corrigan et al., 2008). In one such instance, psychiatric hospital patients report being turned down for jobs despite being qualified (Alexander & Link, 2003). Serious mental illnesses such as schizophrenia, bipolar disorder and major depression can impact occupational functioning for some individuals making it more difficult to regain entry into competitive work environments (Alexander & Link, 2003; Corrigan, 2004; Corrigan et al., 2008; Kram-Fernandez, 2012; Link & Phelan, 2001; Link et al., 2004; National Alliance on Mental Illness, 2013; Ross & Goldner, 2009). However, labels and

stigma frequently make it more difficult for these individuals to experience normal and successful lifestyles, regardless of the severity of their mental illness.

People labeled 'mentally ill' earn less income and are more underemployed, compared to individuals with similar psychiatric characteristics and difficulties who do not hold the same stigmatized label (Alexander & Link, 2003). Labels are also considered a significant treatment barrier as individuals may avoid necessary treatment in order to avoid being labeled 'mentally ill' (Corrigan et al., 2008). Patients who would benefit from receiving treatment may choose not to seek help, which may ultimately worsen symptoms or lead to significant impairments in social functioning (Corrigan, 2004; Corrigan et al., 2008; Covarrubias & Han, 2011; Drummond, 2012; Scheyett, 2005). Furthermore, with considerable data suggesting that current treatment models such as the medical model focuses on deficits instead of strengths, patients may feel dehumanized during treatment and may choose to avoid this stigmatization by avoiding future treatment (Carpenter, 2002; Kram-Fernandez, 2012; Link & Phelan, 2001; Masuda et al., 2005; Ross & Goldner, 2009; Ting, 2011). Thus, it is apparent that the stigma process can directly impact treatment, an example of the harmful consequences of mental health stigma.

Strategies for Reducing the Stigma of Mental Illness

In efforts to examine the prevalence of negative attitudes towards individuals with mental illness, several studies compared operational definitions of stigma and variables of mental illness. One study used the operational definition of stigma to evaluate participant perceptions of desired social distance from and perceived dangerousness of individuals labeled mentally ill (Alexander & Link, 2003). This study found that increased contact

with individuals with a mental illness would reduce stigma and improve overall attitudes towards individuals with mental health issues. The theme of increased contact was present in several other studies that found similar results in the importance of reducing stigma by more exposure to mental illness leading to greater understandings and empathy for individuals experiencing affects of mental illness (Corrigan, 2007; Corrigan et al., 2008; Covarrubias & Han, 2011; Drummond, 2012; Eack & Newhill, 2008; Kondrat & Teater, 2009; Rompf & Royse, 1994; Scheyett, 2005). The following research studies used similar definitions and variables but are focused on particular areas of mental health education for future helping professionals.

In a 2011 study, MSW student attitudes towards serious mental illness were examined using factors such as: level of contact, adherence to stereotypes, belief in recovery and the relationship between SMI and identity. In order to measure the level of stigma of mental illness amongst MSW student participants, desired social distance and belief in restrictions were variables examined (Covarrubias & Han, 2011). The study was able to associate social contact and belief systems to participants' levels of mental health stigma reflecting other research findings that more exposure to mental illness leads to a reduction in stigma (Corrigan, 2007; Corrigan et al., 2008; Covarrubias & Han, 2011; Drummond, 2012; Eack & Newhill, 2008; Kondrat & Teater, 2009; Rompf & Royse, 1994; Scheyett, 2005). Reduction in mental health stigma is also examined using anti-stigma campaigns present in mental health education. One study relevant to education and reduction in stigma was an evaluation of the *In Our Own Voice* anti-stigma presentation given to 30 MSW students. The study concluded that anti-stigma programs would benefit graduate level students. The study also found that graduate level students

in helping professions held less stigmatizing attitudes toward people with mental illness compared to the general population (Pittman, Noh & Coleman, 2010). Additional studies pertaining to mental health stigma and students focus on attitudes toward seeking professional psychological help (Masuda et al., 2005), reasons preventing students from using mental health services (Ting, 2011) and barriers to students receiving mental health care (Drummond, 2012). Despite the relevance to students and mental health, the studies mentioned thus far are not specific to MSW students nor do they include the study of MSW experiences with self-stigma.

Current research about stigma reduction is limited to anti-stigma campaigns or general findings about reducing public stigma. One study in particular is exclusive to the nursing profession (Ross & Goldner, 2009) while another study provides implications for social work practice using a specific recovery paradigm (Carpenter, 2002). Therefore, research focusing on the stigma of social work professionals would be valuable in evaluating current strategies for public stigma reduction in the occupational realm. Furthermore, examining self-stigma amongst social work professionals and social work students would provide a solid foundation for future knowledge pertaining to social work practice and the implications for stigma reduction strategies on the profession as a whole.

Self-Stigma and Empowerment

As stated above in the previous sections of this literature review, understanding why mental illness continues to be one of the most stigmatized conditions in our society is of great importance. An examination of current research pertaining to the public stigma of mental illness identified ways in which individuals are impacted by stigma due to the negative consequences that result from stigmatization. Such consequences include

loss of life opportunities and labels as barriers to treatment (Alexander & Link, 2003; Carpenter, 2002; Corrigan, 2007; Corrigan, 2004; Corrigan et al, 2008; Covarrubias & Han, 2011; Drummond, 2012; Kram-Fernandez, 2012; Link & Phelan, 2001; Link et al., 2004; National Alliance on Mental Illness, 2013; Masuda et al., 2005; Ross & Goldner, 2009; Scheyett, 2005; Ting, 2011). The definition of public stigma and the consequences of labels is just one side of the stigma process. On the other side is the personal self, affected by negative labels influencing self-worth and self-esteem. The following section will include a discussion about the definition of self-stigma, the impact of self-stigma and strategies for the reduction of self-stigma.

Self-Stigma Defined

Public stigma of mental illness originates from signals of symptoms, dysfunctions and disabilities that are negatively perceived by the general population (Corrigan et al., 2008). The negative attitudes that lead to stereotypes, prejudice and discrimination ultimately impact an individual's self image. Thus, self-stigma refers to the way individuals internalize stigma, which leads to a decreased sense of self-worth (Corrigan et al., 2008). The process of self-stigma leads an individual to expect to be discriminated against and ultimately foster a negative belief about him or herself based on the perceived prejudice (Kondrat & Teater, 2009). The internalization of negative stereotypes, prejudicial attitudes and anticipated discrimination results in significant and persistent damage to an individual's self-esteem and self-efficacy (Scheyett, 2005). Thus, self-stigma can also have serious consequences for individuals experiencing mental health issues.

Self-Stigma Consequences

The unfortunate loss of opportunities for individuals with mental illness can influence how one accepts and lives with negative images of self. The social-cognitive model helps explain the relationship between signals and labels as the public mediates the constructs of discriminative stimuli and consequent behavior (Corrigan et al., 2008). In other words, the social-cognitive model provides a framework for understanding the existence of public stigma and the consequences that result from the stigma of mental illness. The social-cognitive model can similarly be used to understand how the process of self-stigma leads an individual to believe that mental illness is bad and therefore he or she is bad (Corrigan et al., 2008). The perception of being devalued by others because of a mental health diagnosis, is what most directly influences a person's level of self-esteem and increases an individual's distress (Ritsher et al., 2003). Self-stigma impacts feelings of self worth that ultimately result in a variety of consequences.

Similar to the results of public stigma, self-stigma can lead individuals to avoid seeking services (Carpenter, 2002; Corrigan, 2004; Corrigan et al., 2008; Covarrubias & Han, 2011; Drummond, 2012; Kram-Fernandez, 2012; Link & Phelan, 2001; Masuda et al., 2005; Ross & Goldner, 2009; Scheyett, 2005; Ting, 2011). The "modified labeling theory" may be useful in understanding this phenomenon of treatment avoidance. The theory posits that individuals labeled with a mental illness disorder, understand their label to be negative based upon their understanding of existing negative stereotypes. Thus, persons with mental illness anticipate being discriminated against or negatively viewed by the public based upon their knowledge of their culture's negative and prejudicial attitudes of mental illness (Corrigan, 2004; Corrigan et al., 2008; Scheyett, 2005). Therefore, if an individual fears being labeled or identified as mentally ill, that individual

will avoid seeking treatment despite evidence that seeking treatment can improve symptoms and reduce barriers to functionality (Corrigan et al., 2008). As such, self-stigma has a significant impact on accessing services and is yet another example of the consequence of mental health stigma.

Self-Stigma Reduction

Fortunately, self-stigma does not exist for every individual experiencing issues with mental illness. Unfortunately, little research exists pertaining to reducing self-stigma. Patrick Corrigan offers a thoughtful discussion concerning self-stigma and mental illness. For example, studies found that persons with mental illness will not necessarily agree with negative stereotypes of which they are aware (Bowden, Schoenfield, & Adams, 1980; Hayward & Bright, 1997; Kahn, Obstfeld, & Heiman, 1979; Shurka, 1983; Wright, Grofein, & Owens, 2000; as cited in Corrigan et al., 2008). Therefore, not every person with a mental illness will react to stigma with a loss of self-esteem (Corrigan et al., 2008). This finding is not only a source of hope for patients but also for practitioners especially in the social work field. Personal empowerment is a term found in Corrigan's research that is relevant to social work and also relevant to research concerning self-stigma reduction.

Empowerment is defined as an individual having personal control over life decisions in many different domains (Corrigan et al., 2008). Despite the dangers of public stigma, empowered individuals have positive attitudes regarding their mental illness and hold optimistic beliefs about their future. Empowered individuals can potentially impact community attitudes by promoting change through action (Corrigan et al., 2008). Thus, personal empowerment is a strong yet understudied variable in

combating self-stigma. However, the connection to social work is obvious as empowerment, advocacy and self-determination are highly valued principles that impact social work practice and education (National Association of Social Workers, 1999). The final cluster in this literature review will focus on the implications for social work practice found in existing research as demonstrated throughout the findings leading to a discussion about the gaps in current knowledge.

Implications For Social Work Practice

The Preamble of the NASW Code of Ethics identifies the fundamental connection between social work practice and reducing the stigma of mental illness. For example, the Preamble states, “The primary mission of the social work profession is to enhance human wellbeing and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (National Association of Social Workers, 1999). As addressed in the previous sections of this study’s literature review, individuals that carry the “mentally ill” label are largely oppressed and discriminated against in American society (Alexander & Link, 2003; Carpenter, 2002; Corrigan, 2007; Corrigan, 2004; Corrigan et al., 2008; Ross & Goldner, 2009; Scheyett, 2005). Thus, the mission of social workers should be to address this issue by enhancing the life and wellbeing of those individuals suffering from the consequences of public stigma and self-stigma. The importance of social work practice impacting the reduction of stigma of mental illness is addressed in few studies found in current research. The following sections will examine current studies that focus on social work student attitudes towards mental illness, what personal attributes enable social workers to succeed in the field and the role of the social work profession in mental health

recovery. The discussion of key themes in current research will allow for a direct discussion of what is missing from current literature and what gaps in knowledge concerning social work practice will be examined in this study.

Social Work Student Attitudes and Attributes

Mental health stigma is examined in one study that addresses the social contact and attitudes of MSW studies in the northwestern United States (Covarrubias & Han, 2011). The level of stigma held by students was examined in relation to the amount of social contact an individual has had with severe mental illness (SMI) populations, belief in stereotypes about SMI populations, attitudes towards recovery and identity as defined by a mental illness (Covarrubias & Han, 2011, p. 317). The methodology of this study included a survey format and cross-sectional design with identified demographic features of each participant. The study found that students who experienced greater amounts of social contact with SMI populations held less stigma of mental illness (Covarrubias & Han, 2011). Furthermore, the study highlighted some consequences of stigma such as the refusal to seek treatment, decreased quality of life and fewer life opportunities that were similarly found in other studies mentioned in this literature review. Despite findings that concur with other studies, this particular study lacks any indication that the MSW students themselves experience stigma for their own mental illnesses or that MSW students are asked to identify personal experiences with mental health issues.

Another study, focusing on MSW students, details burnout in relation to personal attributes (Han, Lee & Lee, 2012). This study highlights how little is known about the relationship between personal attributes and burnout in social work research. Furthermore, the personal attributes of emotional contagion, over identification and trait

anxiety are only associated to levels of burnout. The methods and data analysis used in this study would be helpful comparison models for creating a study that focuses on the relationship between personal attributes and participation in stigma. The personal attributes include: intellectual; leadership; problem solving; social awareness; creativity; emotional strength; and maturity. Each is examined in another study of desired characteristics of MSW students and future social work employees (Johnson et al., 2010). The personal attributes examined in this study are identified as factors that allow social workers to succeed as demonstrated in the findings. What is not found in this study is any mention of student experience with mental illness.

One study that does draw attention to the mental illness of students focuses on BSW students that experience depressive symptoms (Ting, 2011). Reasons that prevent students from seeking mental health services include the common theme of stigma and embarrassment of the label. Again, this study replicates findings from other studies that focus on the impact and consequences of labeling in creating barriers to treatment (Carpenter, 2002; Corrigan, 2007; Corrigan, 2004; Corrigan et al., 2008; Drummond, 2012; Scheyett, 2005). Ting's study is valuable in its findings that social work students also experience personal concerns with feelings of shame, stigma and embarrassment towards seeking help for mental health problems (Ting, 2011, p. 263). Furthermore, self-stigma is explored in relation to social work students experiencing feelings of shame for seeking help for mental health problems. However, this dissertation is one of a kind in that the variables studied do not occur in any other current research. That is not to say it is not valuable research but that the methodology and variables used can be utilized in future studies specifically pertaining to MSW students as opposed to this study's focus on

BSW students. Furthermore, a more specific examination of a student's personal experiences with mental illness that is not limited to depression would be valuable for future research.

The Professional Domain

The following section is given the title of 'The Professional Domain' for several reasons. First of all, current literature demonstrates implications for social work practice using recovery models to evaluate best practice (Carpenter, 2002; Kram-Fernandez, 2012). Secondly, current literature evaluates the possible influences leading individuals to choose a career in social work (Rompf & Royse, 1994). Lastly, one particular study focused on the stigma, negative attitudes and discrimination towards mental illness within the nursing profession, which does not directly include a discussion of social work but provides a framework of methodology for evaluating stigma in a mental health profession (Ross & Goldner, 2009). Thus, a discussion of each study will highlight the trends in current research related to the professional domain of social work.

The guiding principles of social work practice are used to explain why social workers in the mental health profession should criticize the medical model of treatment and recovery. For example, the medical model views the client as a diagnosis as opposed to a unique individual (Carpenter, 2002). Thus, treatment that focuses on symptoms and diagnoses fails to engage the whole person. This particular study highlights major implications for social work practice including the need to focus on empowerment, self-determination and individual worth as guidelines for the recovery paradigm (Carpenter, 2002). The study concludes by asking social workers to embrace the recovery model and vision in order to redefine the mental health system. Another study that focuses on

recovery examined how social workers practice the recovery perspective in psychiatric rehabilitation (Kram-Fernandez, 2012). This study concludes that social work principles align with the recovery model but mostly compares the use of the recovery perspective within the nursing profession. Thus, little is actually known as far as the stigma social workers experience themselves and instead research continues to focus on recovery models as the future of mental health professional practice (Carpenter, 2002; Kram-Fernandez, 2012). One study did take a random national survey of 2,000 NASW members in order to investigate their professional experiences and attitudes about working with individuals with mental illness (Eack & Newhill, 2008). Respondents reported frustrations about working with severe and persistent mentally ill patients related to client behaviors. Results suggest that social worker attitudes are not related to system issues and implications for social work practice include concerns with burnout (Eack & Newhill, 2008). This study does focus on social work attitudes but lacks any inclusion of social work attitudes about self-stigma. Thus, the studies used to describe professional social work practice and attitudes do not find any relevant research pertaining to the existence of self-stigma or general attitudes amongst social work professionals regarding personal experiences with issues in mental health.

The reasons why individuals choose a career in social work is another focus relevant to the professional domain. The main focus of one study was family dysfunction operationalized as a variable in studying current MSW students (Rompf & Goldner, 1994). Although the methodology and focus are important, this study is the oldest of available resources. Thus, current research would benefit from evaluating reasons for choosing a career in social work other than family dysfunction. A study conducted by

Ross and Goldner, 2009, addresses current attitudes of mental illness. However, the study primarily focuses on the nursing profession. The reason it is included in this discussion are the sub-themes that examine nurses as ‘the stigmatizers’ and ‘the stigmatized’ (Ross & Goldner, 2009). Findings demonstrate the importance of understanding the attitudes of mental health workers in order to evaluate the quality of practice. Furthermore, this study is valuable as a comparable source for the variables that should be highlighted in current social work professional domains including: social workers as ‘the stigmatizers’, social workers’ attitudes towards patients with mental illness, social workers as ‘the stigmatized’, social workers who have a mental illness and finally stigma within the social work profession in general (Ross & Goldner, 2009). Unfortunately, studies of social workers using a similar approach as demonstrated in the Ross and Goldner evaluation of nursing professionals, are not available in current literature highlighting a major implication for future research studies. The studies discussed above will also provide a solid foundation in a critical evaluation of the current gaps in knowledge present in research today. A common theme found in current research that focused on social work and stigma of mental illness was the absence of any discussion regarding social work students in a master’s level graduate program that specifically addressed self-stigma. Thus, gaps in current research have been examined in order to formulate a new study that could evaluate variables in a way that has never been done before. The gaps in knowledge are actually essential in creating a research study that could provide relevant information potentially impacting the future of social work research, education and practice.

Gaps in Knowledge

Much time was spent gathering information about the stigma of mental illness by locating reliable sources of data and reading through large amounts of literature in order to be certain that all available research was considered before determining what gaps existed. The literature review of this study included definitions of public stigma and self-stigma highlighting evidence of the harmful consequences stigma creates for individuals experiencing mental illness especially when they are labeled and consequentially discriminated against. The literature review also called attention to the scope of social work principles and values that directly relate the reduction of stigma as a main concern for social work practice. The gaps in current literature were found in the narrow focus of each study included in the literature review and also with studies that were not relevant enough to even be mentioned but that surfaced when searching for mental health stigma and social work. Themes in current research provide an outline that will highlight what is missing and what will be closely examined in the future of this study.

Mental Illness of Social Work Students

Little is known regarding the reasons behind an individual's choice to be a social worker. For example, one study goes so far as to state that findings should not be misconstrued as evidence that social work students are drawn to the profession because of their own mental health problems (Rompf & Royse, 1994, p. 169). This same study identifies family dysfunction as an important influence towards choosing a career in social work. This study is not only the most outdated resource used in the previous literature review but is also the only study that attempts to examine why individuals choose social work especially in relation to personal experiences. Thus, one major gap in

current research is that individuals who choose to pursue an education in social work at the master's level are understudied.

Current research fails to determine what personal and shared experiences social work students have upon entry into a master's level program. There is no available evidence-based study that determined if social work students have a mental illness and how this illness has impacted their current attitudes about the mental illness of others. It is almost as if social workers are not expected to have any mental illness of their own yet they must be able to treat patients using best practice and client centered techniques solely based on work and education experiences, not personal experiences with the actual illness. At this moment in time, only assumptions can be made about social workers and social work students regarding the influence of personal experience due to the gaps in current knowledge. Gathering basic knowledge about personal experiences with mental illness could influence data and findings regarding the existence of stigma amongst social work students. In other words, more knowledge collected about the personal experiences of social work students especially regarding mental illness would be beneficial as a foundation for future studies about why individuals pursue a master's level degree in social work education. However, this particular gap in knowledge is important because it can and will be addressed in this study in order to understand the population being studied and the reasons why stigma could exist in a social work program.

Stigma and Social Work Students

Gaps in knowledge related to social work students and stigma include variables that are important factors in the process of stigmatization. Key elements of the process of stigma are not studied in relation to social work students thus providing another area in

need of future research. Such variables include: concealability; label avoidance; self-esteem; level of disclosure; and anti-stigma. Other key factors in the stigma process such as signals, stereotypes, prejudice and discrimination are also absent from current research. Thus, it is nearly impossible to make any conclusions about the level of self-stigma that currently exists due to the lack of knowledge about the general stigmatization process that potentially exists in social work programs. Furthermore, self-stigma is an extension of public stigma and conceptual frameworks that are used to study stigma are not used in any current studies of social work students. The lack of applicable theory and available data make it extremely difficult to draw connections and conclusions about the relationship between stigma and social work students. This relationship will be closely examined in this study in order to fill the gaps of knowledge present in current research.

Stigma and Social Work Education

What is most commonly absent from current research is a discussion about the existence of stigma within social work education programs. The initial process of admission to a social work education program is an area that lacks much evidence in relationship to the creation of stigma. For example, the admission process could be examined using the modified labeling theory in order to demonstrate that any inclusion of mental illness on an application would be grounds for rejection due to the nature of stigma, stereotypes, prejudice and discrimination. The lack of evidence in current research of social work programs makes it difficult to make any conclusions about disclosure during the admission process but would be a valuable addition to any study. The social-cognitive model would also be a theoretical framework worth considering for future research since it is currently only viewed as a general framework for understanding

the existence of public stigma based on the findings that signals lead to stereotypes and discrimination (Corrigan et al., 2008). Furthermore, the social-cognitive model is not related to self-stigma or social work education in any current research studies.

There are many questions that arise from reviewing current research pertaining to social work education. The first question is: Do MSW students experience general and/or self-stigma of mental illness? If the literature demonstrates that social workers do in fact hold less stigma of mental illness compared to the general population (Carpenter, 2002; Johnson et al., 2011; Kram-Fernandez, 2012; Pittman et al., 2010) the next question asks: Do social work students experience self-stigma if they have lower amounts of general stigma of mental illness? A continuation of this question refers to the lack of research pertaining to social work student attitudes regarding the mental illness of other social work students. If social work students indicate having a mental health diagnosis, do these students feel stigmatized within their own MSW programs? In addition to an identified mental health diagnosis, are MSW students impacted by factors such as previous work experience in the mental health field, social contact with individuals with mental illness or SPMI, and being related to someone with MI or SPMI? These variables are used in the literature to measure amounts of general stigma and this study will examine if these factors similarly impact MSW student levels of general and self-stigma. Furthermore, is there a significant relationship between students who identify as having a mental health diagnosis and amounts of general, self and MSW self-stigma? Based on the available research, it is unknown what levels of stigma social work students hold about mental illness. In order to determine the MSW student experience, levels of general stigma, levels of self-stigma and levels of MSW student self-stigma within the MSW program

will be measured in order to address gaps in the literature and address the research questions.

Conceptual Framework

Generalist social work principles and practice theories will provide a conceptual guide for this study. Social work values of service, social justice, human dignity, integrity and competence (National Association of Social Work, 1999) are core values that summarize professional codes and guidelines for ethical practice. Social work research examines ethical practice by evaluating the existence of core values such as: acceptance, individualization, non-judgment, objectivity, self-determination, accountability and empowerment (Miley, O'Melia, & Dubois, 2011). This study is rooted in social work perspectives, theories and values, providing a theoretical framework for understanding the implications of the findings. Recognizing the importance of social work theories and perspectives used in this study will make the research findings relevant and influential for future practice. The target population of current MSW students in this study will benefit the social work profession by better understanding future social work practitioners. Furthermore, using social work theory in this study is essential to understanding the population being studied. This study will maintain a social work identity while simultaneously incorporating other theoretical frameworks in order to understand the data.

Behavioral and cognitive theories provide the most useful frameworks for conceptualizing the existence of stigma and mental illness while maintaining a social work lens. The core features of cognitive and behavioral models highlight the structure of the stigma of mental illness. For example, stereotypes are *cognitive* structures and

prejudices are the *cognitive* consequences of stereotypes, ultimately resulting in the *behavioral* consequences of prejudice, known as discrimination (Rüsch, Angermeyer & Corrigan, 2005). Social Cognitive Theory is used for understanding stigma at the individual level and as a way to outline the process of stigmatization. This model also demonstrates the interaction between cognitive, behavioral and environmental determinants that relate to social work frameworks for understanding the person-in-environment perspective.

Essentially, everything is intertwined and important in evaluating social systems and social functioning of individuals with mental illness. The interaction between social work and stigma can be conceptualized using behavioral and cognitive theories because human beings are complex. Student participants in this study will each be unique, despite attending the same MSW programs, sharing similar characteristics and experiences but also holding very different traits and histories. Students may have a variety of experiences and different levels of insight regarding the presence of stigma of mental illness within their MSW program. Based on the histories and characteristics of each student that will be evaluated in this study, stigma may hold a different meaning especially if the student has a mental illness. Therefore, this study will be using a social work lens to understand cognitive, social and behavioral theories as a way to empower, educate, and effectively evaluate the existence of stigma of mental illness amongst MSW students.

Methods

Research Design

Combining a social work perspective with cognitive and behavioral theories allowed for a strengths-based perspective to assist in developing the most objective frameworks to evaluate current MSW student experiences. This study used a client-centered and insight-oriented approach to encourage students to feel comfortable in sharing personal experiences with mental health. The two MSW programs were evaluated using a strengths-based perspective in order to recognize what was happening amongst MSW students regarding mental illness and self-stigma without blaming the program or students. In order to ensure the protection and privacy of the two programs, student participants were not asked to disclose the name of the MSW program where they were currently enrolled. This may become a limitation in the findings section, as this study will not be able to indicate levels of stigma based upon specific institutional influences. However, for the purposes of this study to protect the student participants, disclosing the MSW program was unimportant and unrelated to the overall implications of this study.

The research design created for this study relies heavily upon social work theory and practice in order to gather data in an empowering way. Quantitative methods of research were combined with research methods of relevant studies and findings in the literature review using cognitive, behavioral and environmental theories. The following methods section will incorporate theory, frameworks and current knowledge, combined with the use of a multi-level theoretical orientation rooted in social work values, to appropriately assess the development of a research design tailored to the social work student participants in this study.

Sample

This study sampled from two separate MSW programs to examine the potential existence of self-stigma amongst current social work students. Due to the workload and minimal availability of graduate students, this study used a convenience sample of MSW students. Sample-size was based upon available participants, as the research focused on flexibility and depth of data (Padgett, 2008). If every MSW student from both programs participated in the study, the sample size would include at least 300 people. However, limitations of recruitment and data collection will demonstrate the use of a much smaller sample size compared to what was originally hypothesized.

Students were recruited by contacting the directors of each program who then connected their faculty members about survey distribution. Individual faculty members were responsible for distributing the survey link and information to students in their classes. Faculty members were sent reminder emails from program directors. The questionnaire was available as an online survey and faculty members were asked to help distribute the survey link to students. I contacted two specific faculty members from each program, with permission from program directors, and provided them with more specific details about the study including information sheets about the project. Students who chose to participate were given a link to the online survey where they were asked to consent before beginning the questionnaire. Consent forms were electronically filed as separate documents and students were not able to begin the questionnaire without consenting. Students did not provide any identifying information unless they chose to enter into a drawing for a \$100 visa gift card to be distributed in May of 2014, after the

study is complete. The contact information for the random drawing will remain separate from questionnaire data guaranteeing confidentiality and privacy for participants.

Participation for this study was completely voluntary and students were able to end participation at any time. Participants were provided a brief summary of the importance of this research study found on the first page of the questionnaire. This written summary was included in this study as Appendix C. Students were given an online link to the questionnaire that consisted of a brief summary of the project followed by the request for consent, a list of definitions of terms used in the questionnaire, questions of yes/no and likert-scale design to measure general stigma, with an additional set of questions for specific individuals that identified as having a mental illness. All students were given the opportunity to opt-out of answering questions at any time and were given this information in the questionnaire. The total time commitment varied for each participant based upon given responses but the goal was a maximum time commitment of 20 minutes. Findings demonstrate that the average time used to complete this survey was 12 minutes.

Protection of Human Subjects

The conceptual framework used to understand the theoretical orientation of this research study builds upon a foundation rooted in social work values ensuring the safety, protection and promotion of human dignity. Thus, participants were recruited and sampled as ethically and responsibly as humanly possible. The researcher was able to utilize the help of a committee member with their connection to a chosen MSW community being studied. Thus, the protection of student rights was always considered before the researcher was able to collect data from participants. Participants were invited

to complete surveys and questionnaires based upon availability and convenience. The participants were informed that their participation was completely voluntary and that they had the ability to be removed from the data at any time.

Current University of St. Thomas and St. Catherine University MSW students were excluded from this study, as they are peers to this researcher, in order to avoid the danger of coercion or feelings of obligation. Participant information collected through quantitative research methods was anonymous and confidential. Submitted responses used for data analysis were stored in a private database with no identifying information about the participant. The database is password protected and only the researcher has access to the collected information. Although demographics and personal experiences were examined, the data collected did not include any identifying information of the participant. Also, participants could choose not to answer any question that was deemed too personal or identifying.

Data Collection

The instrument used in this study was a carefully constructed questionnaire available as an online survey through Qualtrics.com. The instrument included questions reflecting quantitative forms of measurement, as responses were either yes/no nominal variables or a specific set of choices later coded as nominal variables. On the other hand, 6 open-ended questions were used and reflect a qualitative form of measurement. The purpose of including some forms of qualitative measurement within a quantitative research design was to paint a more complete picture of the MSW student represented in this study, especially as MSW students will carry with them a wide variety of personal experiences. The descriptive statistics in this study demonstrated the different ways in

which the target population was represented based upon responses to questions 3 - 18 in the survey. Descriptive statistics were prevalent measures of data used in almost every research study examined in this study's literature review section. Thus, validity and reliability can be ensured by following the data collection techniques used in studies measuring the stigma of mental illness of other target populations.

Attitudes and beliefs of MSW students were examined in the survey using dependent variables of restrictions and desired social distance to measure negative stigma toward individuals with SPMI. The variable of belief in stereotypes was measured by similarly coding responses to questions about perceived dangerousness and violence of individuals with SPMI found in questions 21 - 58. Adherence to stereotypes of perceived dangerousness is associated with higher levels of general stigma (Alexander & Link, 2003; Covarrubias & Han, 2011; Ross & Goldner, 2009; Scheyett, 2005). Therefore, if MSW students strongly agreed with items associated with adherence to stereotypes, those MSW students would predictably hold a higher level of general stigma of mental illness. Thus, student responses to survey items 21 – 58 demonstrated levels of general stigma of mental illness held by MSW students based on the self-generated theoretically based questionnaire used in this study.

Survey questions related to general stigma used yes/no responses and likert-scale formations with response categories of Strongly Agree, Agree, Disagree and Strongly Disagree. The dependent variable general stigma was specifically measured by items 21 - 30 using nominal response codes of yes or no and by items 31 - 57 using likert-scale response categories of strongly agree, agree, disagree or strongly disagree. The variable social contact was used to predict the amount of desired social distance from individuals

with mental illness preferred by MSW students. Social contact is a variable that is commonly used in studies measuring general stigma of mental illness, as people with more social contact will perceive mental illness as less dangerous (Alexander & Link, 2003; Covarrubias & Han, 2011; Ross & Goldner, 2009; Scheyett, 2005). Furthermore, research studies have found that individuals who indicate higher amounts of social contact will also prefer less social distance from individuals with mental illness (Corrigan, 2007; Corrigan et al., 2008; Covarrubias & Han, 2011; Drummond, 2012; Eack & Newhill, 2008; Kondrat & Teater, 2009; Rompf & Royse, 1994; Scheyett, 2005). Thus, responses to questions about social contact examined what factors influence the amount of general stigma of mental illness amongst MSW students.

Examining the general stigma of MSW students concluded with question #58, which allowed the participant to indicate if he or she had a mental health diagnosis, with six follow up questions specific to the designated mental health diagnosis. If participants responded with 'no' to question #58, they were automatically redirected to the end of the survey. If the participant responded with 'yes' to questions #58, they were asked to complete the rest of the survey by answering 28 questions that measured self-stigma using the Internalized Stigma of Mental Illness (ISMI) scale (Ritsher, Otilingam, & Grajales, 2003). The student could choose to complete the survey without sharing any personal information about mental health while still providing valuable data regarding MSW student attitudes about general stigma absent from current research. Furthermore, if participants only provided demographic information and only answered questions 21 – 58, findings will still be able to determine levels of general stigma in comparison to self-stigma and self-stigma within an MSW program. Significant associations and correlations

will be addressed in the data analysis regardless of response rates or survey completion rates. Each participant was given a sum score of responses for questions 21 – 57 measuring general stigma, a sum score of responses for questions 65 – 94, measuring self-stigma and finally a sum score of responses to questions 95 – 104 measuring self-stigma within the MSW program. These sum scores were used in the statistical analysis of the data.

Questions 58 – 64 used yes/no responses to describe the mental health status of participants and allowed for participants to disclose personal mental health details. If a participant answered ‘yes’ to question 58, he or she identified as having a mental health diagnosis and were asked to complete the rest of the survey. If a participant answered ‘no’ they were redirected to the end of the survey without needing to answer questions 65 – 93 to measure levels of self-stigma, followed by an additional set of questions measuring self-stigma within the MSW program.

The Internalized Stigma of Mental Illness (ISMI) scale, used for items 65 - 93, will measure the subjective experience of stigma, with subscales measuring Alienation, Stereotype Endorsement, Perceived Discrimination, Social Withdrawal and Stigma Resistance (Ritsher, Otilingam & Grajales, 2003). The items contain 28 likert-scale items which will be coded as 1 = strongly agree, 2 = agree, 3 = disagree and 4 = strongly disagree for response to questions 65 – 88 and reverse coded for questions 89 - 93. Based upon relevant studies and evaluations, the ISMI scale will hold high internal consistency and test–retest reliability (Ritsher et al., 2003). Construct validity is also supported by comparing scales of related constructs with the same methodology, similarly used in comparison with scales measuring general stigma. Following the ISMI scale in the

questionnaire is an 11-item likert-scale, which will be used to measure personal experiences with mental health stigma within the individual's MSW program. The 11-item likert-scale will be coded as 1 = strongly agree, 2 = agree, 3 = disagree and 4 = strongly disagree to maintain construct validity. It will be the last section of the questionnaire concluding the participation of MSW students.

Data Analysis

SPSS (IBM Corp., 2010) was the database used for the statistical procedures conducted in this study, beginning with measurements of frequency distributions and central tendencies based upon descriptive statistics collected. Statistical procedures to measure descriptive statistics were followed by procedures to measure inferential statistics in order to evaluate significant statistical relationships between variables in the data and test hypotheses proposed in this study.

Five t-tests were conducted in order to test the hypothesis that MSW students would hold less stigma of mental illness in comparison to the general public. The first t-test used the independent variable 'mental health diagnosis' and was divided into two groups. These two groups were formed based upon participants' identification of having a mental health diagnosis or not having a mental health diagnosis, as determined by the response to question 58 in the survey. If a participant answered yes, their response was coded as 1 and if the participant answered no, their response was coded as 2. Thus, these coded inferential statistics were operationalized using the independent variable of mental health diagnosis and the dependent variable, general stigma to identify the statistical significance between these variables. In other words, the t-test was used in order to

understand the significance of having a mental health diagnosis in regards to levels of general stigma held by the participant as indicated in questions 21 – 58.

The second t-test used the independent variable ‘know someone with mental illness’. Participants could answer yes or no and these answers were similarly coded as 1 or 2 in order to run the t-test with the dependent variable, general stigma. As findings in the literature indicate degree of social contact as a determining factor in levels of general stigma, MSW students who knew someone with a mental illness were operationalized into two categories of knowing or not knowing someone with a mental illness in order to measure any statistical significance with levels of general stigma. The third t-test measured the independent variable ‘know someone with SPMI’ and was similarly coded and measured for statistical significance in levels of general stigma. Knowing someone with SPMI or MI were measured based upon responses to questions 19, 20, 21, 23, 24, 25, 26 and 30 in order to encompass the variety of ways someone could know an individual with MI or SPMI ultimately determining different levels of social contact.

The fourth t-test used the variable ‘previous experience working in the mental health field’ and was coded as yes = 1, no = 2. Previous experience working in the mental health field was determined by question 10 and participants could select from 20 different options or select ‘other’ if something was not listed. Determining previous work experiences with individuals with MI or SPMI relates to the findings in the literature including level of social contact or desired social contact based upon work experience. Various forms of previous experience working in the mental health field were determined by responses to questions 10, 13, 23, 27, 28 and 29. An individual who has worked in the mental health field was hypothesized to hold less amounts of general stigma based upon

findings in the literature. In other words, degree of social contact was hypothesized as being a statistically significant factor in determining levels of general stigma amongst participants. The fifth t-test used the variable 'related to someone with SPMI' determined by question 22 and was the final t-test measuring degree of social contact. Responses were coded as yes = 1, no =2 and were used in a t-test to measure the significance of being related to someone and amount of general stigma. This study hypothesized that being related to someone with SPMI would be a statistically significant factor impacting the level of general stigma.

After running five t-tests to determine the statistical significance of responses indicating level of social contact and levels of general stigma, the relationship between general stigma and self-stigma of mental illness was tested using a correlation to determine if there is an association between the two variables. The hypothesis is: There is an association between self-stigma and general stigma of mental illness. An additional hypothesis is: There is an association between self-stigma and self-stigma of mental illness within the MSW program.

Findings

Descriptive Statistics

There were 60 individuals who consented to take the survey but only 48 students completed the survey in its entirety. Qualtrics.com provided additional statistics that were specific to the online questionnaire. Since students were not asked to evaluate the questionnaire, the survey statistics highlight some unintended reflections of their experience taking the survey. For example, the average duration for completion was

approximately nine minutes, which was less than the anticipated time originally proposed in the consent form at 15 – 20 minutes.

As the initial sample size of 60 consenting students decreased to 48 total respondents, the sample size dropout rate can be interpreted based on the data regarding the last answered question before dropout. *Table 1* is included below to defend the overall validity of the survey. Data from *Table 1* can be interpreted to mean that the drop out rate per question is based on alternative reasons unrelated to any limitations of survey questions. For example, the drop out rate is based on the last question answered and in *Table 1*, it appears that MSW students did not drop out of the survey because of feeling stigmatized while taking it or by being uncomfortable disclosing personal information related to mental health. *Table 1* highlights that MSW students who consented to take the survey either completed the survey in its entirety or decided not to take the survey after reading the consent form. Thus, survey statistics ultimately reflect the careful construction of the survey, as it was intended to be clear, concise and considerate of MSW students taking the time to participate.

<i>Table 1.</i> Drop out rate based on last question answered		
Question #	Question	# Of MSW Students Who Dropped Out After Question
Q2	I have read the above consent form and desire of my own free will to participate in this study.	10
Q29	Have you volunteered at a mental health clinic or psychiatric hospital?	1
Q31	Have you ever talked to someone with SPMI?	5
Q51	Labels have many consequences for individuals with SPMI.	1
Q59	I have a mental health diagnosis.	1
Q94	Living with mental illness has made me a tough survivor.	1

The following outline of descriptive statistics will specifically highlight the ways in which the MSW sample population was represented in the study. The age range of the 48 MSW participants was 22 – 59 years old with no significant average. However, 36 students were under 30 years old and the most common age, at nine participants, was age 26. The findings in the data suggest that the descriptive statistics accurately paint a picture of the sample population. The basic demographics collected in this study did not have any statistical significance on the outcomes but will be outlined in the following tables. MSW student demographics are represented below in *Table 2*. The nominal variables related to work status are represented in *Table 3*. With 21 available choices, mental health settings with less than 10 respondents were excluded from the table. In addition, respondents were able to select more than one setting at a time. The education track and history of MSW student participants is represented in *Table 4*. As demonstrated in *Table 4* below, MSW students without an undergraduate degree in social work indicated a total of 15 different degrees received in addition to the most common non-BSW degrees of Psychology and Sociology.

Gender	#	Race/Ethnicity	#	Marital Status	#	Religion/Spirituality	#
Female	41	Caucasian	36	Single	33	Christian	11
Male	7	Asian	5	Married	11	N/A	6
		African American	3	Divorced	2	Catholic	6
		Latina	2	Partnered	2	Atheist	4
		Other	2			Buddhist	3
						Lutheran	3
						Judaism	2
						Other	7

Table 3. Previous Work Experience

Currently Working	#	Experience Working in Mental Health Field	#	Mental Health Field Settings (could select multiple)	#	Work Status	#	Years Worked in Mental Health Setting	#
Yes	42	Yes	38	County	15	Part-time	29	No Response	10
No	3	No	9	Outpatient	14	Full-time	16	0 years	4
				Group home	13	On Leave	3	1 year	3
				School	13			2 years	5
				Clinic	12			3 years	7
				Residential	12			4 years	9
				Hospital	9			5+ years	12

Table 4. Education Experiences

Undergrad Degree in Social Work (BSW)	#	Other Undergrad Degree	#	Current Field Placement in MH Setting	#	Years Completed in MSW Program	#	Years Left to Complete in MSW Program	#
Yes	19	Other Degree	18	Yes	25	0	12	0	14
No	29	Psychology	8	No	23	1	21	1	26
		Sociology	3			2	13	2	7
						3+	2	3+	1

Survey questions 3 – 19 were carefully constructed in order to represent the biological, social, occupational and educational experiences of the 48 MSW participants. The demographic data collected from these 16 questions were not part of the statistical analysis because the responses are simply intended to describe the sample population being studied. The basic demographic data is useful for identifying common factors and

characteristics amongst MSW respondents. Furthermore, the responses gathered are clues about the sample population but could not be tested for levels of impact on the total sum scores of participant general stigma, self-stigma or MSW self-stigma. The personal histories of each participant would require further statistical analysis in order to measure the amount of direct impact demographic factors have on an MSW student's experience with the stigma of mental illness.

Inferential Statistics

Five variables were selected in order to determine what grouping variables potentially create differences in amounts of general stigma amongst MSW students. Five t-tests were conducted in order to determine if there were relationships between variables that would provide a more generalized view of the MSW sample population in regards to general stigma. The first t-test used the independent variable 'mental health diagnosis' and was divided into two groups. These two groups were formed based upon participants' identification of having a mental health diagnosis or not having a mental health diagnosis, as determined by the response to question 58 in the survey. The results from the first t-test can be viewed below as *T-test 1: Figure 1*, the group statistics, and *T-test 1: Figure 2*, the independent samples test.

T-test 1: Figure 1

	MH Diagnosis	N	Mean	Std. Deviation	Std. Error Mean
Total General	1	22	58.05	6.313	1.346
Stigma	2	20	60.70	4.889	1.093

T-test 1: Figure 2

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Total General Stigma	Equal variances assumed	.621	.435	-1.512	40	.138	-2.655	1.755	-6.202	.893
	Equal variances not assumed			-1.531	39.060	.134	-2.655	1.734	-6.162	.853

In *T-test 1*, the independent variable ‘mental health diagnosis’ is the variable by which the groups are divided. The dependent variable ‘general stigma’ is used to analyze the difference between the groups of MSW students who do or do not identify having a mental health diagnosis. The P-value is .138, which is greater than .05 indicating no statistically significant difference between respondents who have or do not have a mental health diagnosis. For this t-test, the hypothesis is rejected meaning that levels of general stigma are not impacted by the identification of a mental health diagnosis. The second t-test findings are represented below as *T-test 2: Figure 1*, the grouping statistics, and *T-test 2: Figure 2*, the independent samples test.

T-test 2: Figure 1

Know someone with MI	N	Mean	Std. Deviation	Std. Error Mean
Total General Stigma 1	44	53.59	18.328	2.763
2	4	42.25	28.570	14.285

T-test 2: Figure 2

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Total General Stigma	Equal variances assumed	1.724	.196	1.133	46	.263	11.341	10.008	-8.804	31.486
	Equal variances not assumed			.779	3.228	.489	11.341	14.550	-33.164	55.846

The p-value is .263, which is greater than .05, indicating that there is no statistically significant difference in scale score for general stigma, between two groups of respondents who know or do not know someone with a mental illness. The third t-test measured the independent variable 'know someone with SPMI' and is an additional grouping variable for the general variable 'know someone' which represents social contact and quantity of relationships. The dependent variable 'general stigma' is used to analyze the difference between the groups of MSW students who know or do not know someone with SPMI. The results of the third t-test are represented by *T-test 3: Figure 1*, grouping statistics, and *T-test 3: Figure 2*, the independent samples test.

T-test 3: Figure 1

	Know someone SPMI	N	Mean	Std. Deviation	Std. Error Mean
Total General Stigma	1	36	52.28	19.916	3.319
	2	12	53.75	17.741	5.121

T-test 3: Figure 2

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2- tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Total	Equal variances assumed	.557	.459	-.227	46	.821	-1.472	6.473	-14.501	11.557
General Stigma	Equal variances not assumed			-.241	21.017	.812	-1.472	6.103	-14.164	11.219

Similar to the findings from *T-test 2*, there is no statistically significant difference in scale score for general stigma, between the groups of respondents who know or do not know someone with SPMI. This is demonstrated by the p-value being greater than .05. The fourth t-test includes the independent variable 'experience working in the mental health field' and is the variable by which the groups are divided. The dependent variable 'general stigma' is used to analyze the difference between the groups of MSW students who have or do not have previous work experience in the mental health field. The results of the fourth t-test are represented by *T-test 4: Figure 1*, grouping statistics, and *T-test 4: Figure 2*, the independent samples test.

T-test 4: Figure 1

	Experience working	N	Mean	Std. Deviation	Std. Error Mean
Total General Stigma	1	38	56.00	14.478	2.349
	2	9	44.33	26.898	8.966

T-test 4: Figure 2

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Total General Stigma	Equal variances assumed	8.794	.005	1.814	45	.076	11.667	6.431	-1.287	24.620
	Equal variances not assumed			1.259	9.126	.239	11.667	9.269	-9.256	32.589

T-test 4 resulted in different findings compared to the other four t-tests conducted. However, the difference from other t-tests is due to the violation of assumptions in the Levene's Test for Equality of Variances. This means that equal variance cannot be assumed and that the data in this t-test was unreliable, most likely because of the small sample size from which it was collected. Thus, findings from this test are not valid ultimately following the trend of being statistically insignificant. Therefore, there is no statistically significant difference in scale score for general stigma, between the groups of respondents with previous or no previous work experience in the mental health field. The

fifth and final t-test used the dependent variable 'general stigma' to analyze the difference between the groups of MSW students who are related or are not related to someone with SPMI. The results of the fifth t-test are represented by *T-test 5: Figure 1*, grouping statistics, and *T-test 5: Figure 2*, the independent samples test.

T-test 5: Figure 1

Related SPMI	N	Mean	Std. Deviation	Std. Error Mean	
Total General	1	20	50.00	22.840	5.107
Stigma	2	28	54.54	16.345	3.089

T-test 5: Figure 2

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Total General Stigma	Equal variances assumed	3.014	.089	-.803	46	.426	-4.536	5.649	-15.906	6.835
	Equal variances not assumed			-.760	32.392	.453	-4.536	5.969	-16.688	7.616

Findings from *T-test 5* indicate a p-value greater than .05. Thus, there is no statistically significant difference between being related to someone with SPMI and not being related to someone with SPMI in response to general stigma scale scores. The overarching theme after conducting 5 t-tests is that the five independent variables used to

measure social contact, desired social distance and previous work experience had no impact on the amount of general stigma amongst MSW students. Thus, all five hypotheses were rejected because there are no differences between groups that are statistically significant.

Three correlations were conducted in order to measure the strength and direction of the relationships between variables. The correlations in this study will determine if there are statistically significant relationships between the dependent variables general stigma, self-stigma and MSW self-stigma. The following table demonstrates the relationships that were analyzed and can be seen below as *Correlation Table 1*.

Correlation Table 1

		Total General Stigma	Total MSW Self-Stigma	Total Self-Stigma
Total General Stigma	Pearson Correlation	1	.279	.253
	Sig. (2-tailed)		.054	.083
	N	48	48	48
Total MSW Self-Stigma	Pearson Correlation	.279	1	.914**
	Sig. (2-tailed)	.054		.000
	N	48	48	48
Total Self-Stigma	Pearson Correlation	.253	.914**	1
	Sig. (2-tailed)	.083	.000	
	N	48	48	48

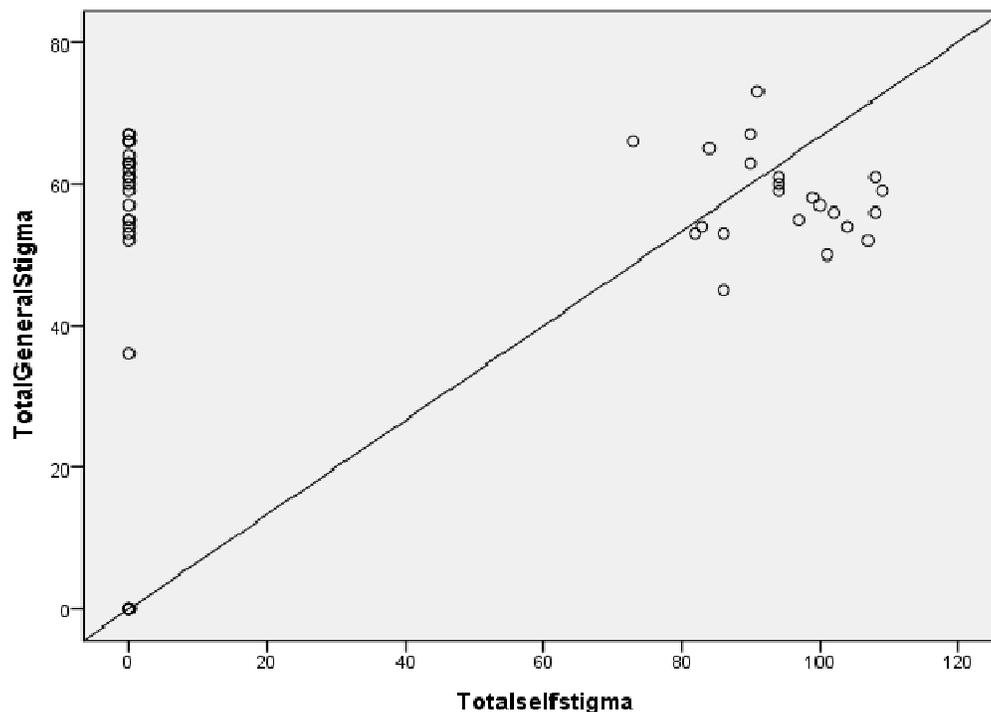
** . Correlation is significant at the 0.01 level (2-tailed).

Correlation Table 1 includes the three different dependent variables general stigma, MSW self-stigma and self-stigma, grouped into one output table called a correlation matrix. The statistic **.914**** in *Correlation Table 1*, represents a statistically significant correlation between self-stigma and MSW self-stigma. The significance of

this correlation will be described in greater detail with a scatterplot visual represented below as *Correlation Table 3: Test 2*.

Three separate correlations were conducted in order to analyze the statistical significance of these findings. The first correlation measured the relationship between general stigma and self-stigma. The relationship between general stigma and self-stigma can be interpreted based upon the Pearson Correlation score or R-value of .253. In this case, there is no statistically significant relationship between variables. However, there is a positive correlation, which means that as one variable increases, the value of the other variable will also increase. Thus, if someone indicates a high general stigma score, they will also have a high self-stigma score. Furthermore, .25 indicates a moderately strong positive relationship. *Correlation Table 2: Test 1* was graphed using a scatterplot after the correlation was conducted and can be seen below.

Correlation Table 2: Test 1



Correlation Table 2: Test 1 is a visual representation of the moderately strong positive relationship between general stigma and self-stigma. The second correlation conducted reveals a significant correlation between variables self-stigma and MSW self-stigma. The strong relationship between variables is indicated by the Pearson Correlation or R-value score of .914, which represents a statistically significant correlation between the two dependent variables: self-stigma and MSW self-stigma. Thus, the hypothesis that there is a relationship between these two variables was proven true. Another scatterplot will similarly represent the strong relationship and positive correlation between self-stigma and MSW self-stigma and can be viewed below as *Correlation Table 3: Test 2*.

Correlation Table 3: Test 2

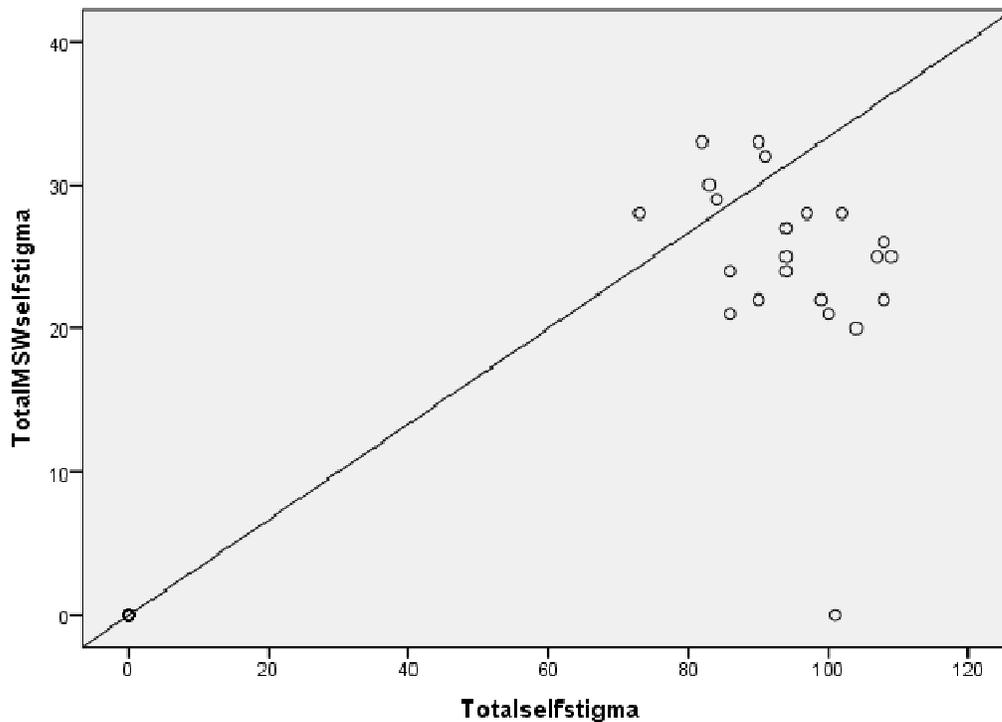


Figure 2. The relationship between Self-Stigma and MSW Self- Stigma

P-value <.001 R-value = .914

A third correlation was conducted to test the relationship between dependent variables general stigma and MSW self-stigma. The R-value was .279 demonstrating a weak relationship between variables. The p-value was .054, which is very close to being statistically significant and represents a positive direction of relation. However, the findings demonstrate that there is no statistically significant relationship between general stigma and MSW self-stigma.

Discussion

Descriptive Statistics

The survey statistics provided by Qualtrics.com allows for some interpretations to be made regarding the quality of the survey based upon participant experiences. For example, the IRB board was originally concerned that the proposed questionnaire would take longer than 20 minutes to complete. Thus, the consent form was modified to address this concern and propose an estimated completion time of 15 – 20 minutes despite personal efforts to develop a short survey in order to respect the personal time of MSW students. The average completion time of nine minutes suggests that the carefully constructed survey was successful in addressing a wide range of questions while simultaneously respecting the personal time of MSW students. The short duration time may have also allowed for higher survey completion rates.

The descriptive statistics used in this study were intended to cover a wide range of variables other research studies have used in order to understand what demographic information impacts levels of stigma. The findings demonstrate that the descriptive statistics had no statistical significance in this study despite what was found in the literature. For instance, one may assume that MSW students would feel less stigmatized

by others if they had an undergraduate degree in social work. In future studies, it would be worth exploring why such factors made no difference on levels of stigma for the MSW student participants in this study. However, the descriptive statistics in the study highlight what factors deserve future reflection. *Table 3* reflects different settings where participants have had some previous work experience in the mental health field. An interesting finding was that no participant selected VA, military or Federal settings. This finding indicates that, at least in this sample, MSW students had no military experience and therefore reflects a subgroup of the entire social worker population with an even greater risk of being understudied. It is worth exploring why MSW students had no connection to the military and what this might be suggesting about military social work misrepresentation.

Inferential Statistics

T-test 2 demonstrated that there is no statistically significant difference in scale scores for general stigma, between two groups of respondents who know or do not know someone with mental illness. *T-test 3* demonstrated a similar trend of no statistically significant difference in scale score for general stigma, between respondents who know or do not know someone with SPMI. Thus, *T-test 2* and *T-test 3* represent the general grouping variable 'know someone' because social contact was suggested in the literature as a way to predict the amount of general stigma of mental illness for an individual. The findings from *T-test 2* and *T-test 3* demonstrate that amongst MSW students, knowing someone with mental illness or SPMI lacks any statistical significance in determining differences in levels of general stigma. Furthermore, the hypothesis that knowing someone with mental illness or SPMI would cause MSW students to have different levels

of general stigma is rejected. This finding is significant because results in current literature do not translate when studying MSW students, providing evidence for identified gaps in the literature and future implications for mental health professionals.

An individual who has worked in the mental health field was hypothesized to hold less amounts of general stigma based upon findings in the literature. As the literature suggests, mental health professionals hold less general stigma of mental illness compared to the American public. *T-test 4* demonstrates that experience working in the mental health field actually makes no difference in levels of general stigma. This could potentially mean several things. Initially, these findings might cause one to reject the idea that all mental health professionals hold lower amounts of general stigma because experience working in the mental health field was insignificant in this study. On the other hand, these findings suggest that within the sample population of MSW students, many do not yet have experience working in the mental health field despite entering into that professional domain.

Furthermore, levels of general stigma amongst MSW students may just be another way to generalize the field of mental health and assumes that any individual within this profession will most likely hold lower amounts of general stigma regardless of previous work experience. The fact that MSW students are joining the mental health profession by enrolling in an MSW graduate program could mean that the degree of social contact or previous work experience may or may not have an impact in developing a lower sense of stigma of individuals with mental illness. The findings in this study demonstrate an absence of knowledge in the literature regarding reasons why MSW students choose to be social workers and reasons why MSW students wish to join the mental health profession.

Gaps in the literature reflect that backgrounds and demographics may not actually explain reasons for joining a profession with lower amounts of general stigma. Furthermore, if individuals join the mental health profession, trends in the literature related to the findings in this study reflects the need for future research studies to include a thorough investigation of the impact of demographic data on levels of general stigma, self and MSW self-stigma.

Three correlations were conducted in order to determine if there were any statistically significant relationships between the three dependent variables general stigma, self-stigma and MSW self-stigma. The first correlation, between dependent variables general stigma and self-stigma, demonstrated a moderately strong positive relationship. This is congruent with findings in the literature about levels of stigma. For example, it was hypothesized that as social workers experience higher levels of general stigma, they would similarly experience high levels of self-stigma meaning that perception of others is related to the perception of self. In this study, MSW students with a higher general stigma score will also have a higher self-stigma score and vice versa.

The second correlation conducted, between dependent variables self-stigma and MSW self-stigma, found an R-value of .914 and was represented in a scatterplot labeled as *Correlation Table 3: Test 2*. The R-value of .914 means that there is a very strong and positive statistically significant relationship between self-stigma and MSW self-stigma. The hypothesis that there is a relationship between these two variables is correct but findings demonstrate that the relationship is much stronger than hypothesized. Furthermore, the relationship between self-stigma and MSW self-stigma is more strongly and positive correlated compared to the relationship between general stigma and self-

stigma. Thus, as levels of self-stigma increase, levels of general stigma will also increase while levels of MSW self-stigma will increase at a stronger and more positively correlated rate representing a much more significant correlation between the variables self-stigma and MSW self-stigma. The interpretation of the findings can be understood using a scatterplot to visualize the statistical significance of the three correlations. *Figure 1: Correlation Scatterplot 4* can be seen below and is a pictorial representation of the three correlations conducted.

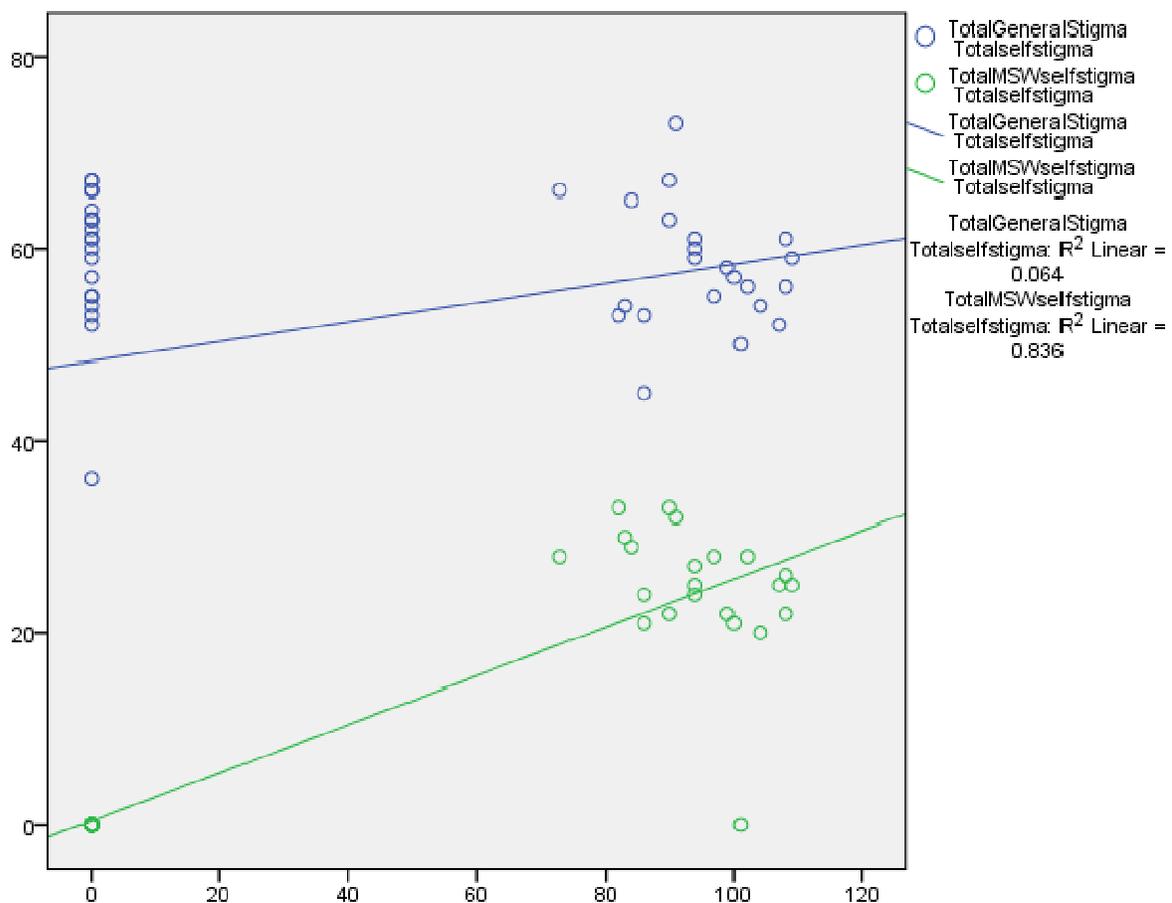


Figure 1. Relationship between General Stigma, Self-Stigma and MSW Self-Stigma

The interpretation of this scatterplot suggests that MSW students with higher levels of general stigma will similarly experience high levels of self-stigma. However, low levels of general stigma will not predict similarly low levels of self-stigma. In other

words, how we feel about ‘others’ may not make any difference about how we felt about ‘self’ in regards to mental health. Furthermore, the scatterplot demonstrates some interesting implications for the future of social workers, stigma and mental illness.

Implications

Descriptive Statistics

One major implication of this study is that personal experiences represented by basic demographic information may have no direct impact on levels of self-stigma or general stigma. This could be a result of the narrow sample population, which only includes individuals with an interest in becoming a social worker and accordingly joining the mental health field. Thus, basic demographics of individuals with an interest in becoming a mental health professional may reflect that demographic data is inconsequential when examining levels of stigma for an individual that is already interested in working with mental health issues. This study cannot conclude how and why social work students decided to become mental health professionals and the demographic data is a simple reflection of common experiences that may or may not have influenced levels of stigma of mental illness.

On the other hand, the narrow sample population was intentional because this study was only going to examine current MSW students. Thus, there is some indication that regardless of personal history that influenced levels of interest in working in the mental health field, social workers will generally be more accepting of others who experience mental illness simply because they chose a career working in the mental health profession. This is not a surprising finding because the literature predicted that mental health professionals would hold lower amounts of general stigma. However, if

mental health professionals will generally hold less stigmatizing views of others with mental illness, what accounts for the high levels of self-stigma regardless of demographic information? What is still missing from current research is a thorough investigation about why MSW students chose a career in the mental health profession and if this career choice has any statistically significant relationship with personal experiences represented by demographic data. This study intended to focus on the levels of stigma of mental illness amongst MSW students and did not include a statistical form of measurement for demographic differences between MSW students that could accurately predict levels of demographic influence.

Another interesting finding from an analysis of descriptive statistics, was the variety of ways social contact was achieved by MSW students and the lack of significance this had on levels of stigma. Due to the small sample size, results remain speculative but are worth discussing in reflecting upon the implications of this study. As previously highlighted, 44 MSW students know someone with mental illness. What has not been highlighted yet is the variation of social contact found amongst MSW students who know someone with a mental illness. On the following page, *Table 5: Q20 (Who do you know with mental illness)* will demonstrate the significance of responses given in regards to the variety of social contacts.

*Table 5: Q20
(Who do you know with mental illness?)*

<i>Column 1</i>	<i>#</i>	<i>Column 2</i>	<i>#</i>
<u>Bio-Mother</u>	<u>22</u>	Niece	2
Bio-Father	14	Daughter	2
Bio-Sister	5	Son	0
Bio-Brother	10	Grandma	11
Step-Mother	0	Grandpa	8
Step-Father	1	Relative	7
Step-Sister	1	Partner	9
Step-Brother	0	Spouse	1
Half-Sister	1	Family Friend	15
Half-Brother	2	<u>Personal Friend</u>	<u>32</u>
Sister In-Law	1	Neighbor	7
Brother In-Law	2	Colleague	15
Cousin	13	Teacher	7
Uncle	14	Classmate	17
Aunt	11	Acquaintance	13
Nephew	2	Not Listed	7

Table 5: Q20 (Who do you know with mental illness) reflects the varieties of ways MSW students know someone with mental illness. The table also presents an unintended but meaningful finding. 31 different options were given in the survey in order to include a wide variety of ways MSW students could know someone with mental illness. It was surprising to find that 22 MSW students identified having a biological mother with mental illness in comparison with rates for knowing other biological relatives. This study will not be able to conclude the significance of this finding. However, it is an unintentional finding that provokes the desire to explore why almost 50% of participants

have a biological mother with mental illness and if this has any significance, especially in regards to the stigma of mental illness. It would also be an interesting area to explore in gender studies, as females are over-represented in the social work profession.

It is also worth noting that 44 MSW students know someone with mental illness and the total sum of responses for being related to someone with mental illness was 126. Without enough data to formulate statistical significance, basic math would suggest that of the 44 individuals who identified knowing someone with mental illness, if evenly distributed amongst all 44 individuals, each individual could potentially be related to at least two individuals with mental illness. Unfortunately, a limitation of this is obviously its lack of statistical significance and inconclusive mathematical formula. However, it would be worth understanding more about the relationships MSW students have with individuals with mental illness and if this has any impact on general stigma or if this influences an individual's decision to become a social worker. In addition to this finding, it must be documented that only 37 MSW students identified as knowing someone with SPMI and 21 MSW students identified being related to someone with SPMI. Thus, another implication of this observation is that there is little information regarding the significance of knowing someone with MI and/or SPMI.

Inferential Statistics

The first t-test demonstrated that there is no difference in amounts of general stigma between MSW students who do or do not have a mental health diagnosis. This is perhaps one of the most important findings of this study for several reasons. First of all, this finding rejects the hypothesis that mental health diagnosis impacts the amount of general stigma. On the other hand, this finding is congruent with findings in the literature

in that mental health professionals will typically hold less general stigma compared to the public. However, the fact that MSW students will hold less general stigma regardless of an identified mental health diagnosis is curious. The implications of these findings support further implications represented by conducting correlations.

The interpretation of the data represented by conducting correlations highlights some important implications for the field of social work and the future of social work education. In continuation of aforementioned implications, it is no surprise that the MSW students would hold lower levels of general stigma if they also held lower levels of self-stigma because the literature has already indicated that mental health professionals will hold less general stigma compared to the public. The first major implication of this particular finding is that when measuring general stigma, MSW students will typically be more accepting of others with mental illness, as demonstrated by low levels of general stigma.

The second major implication is that regardless of demonstrated low levels of general stigma, MSW students in this study were more stigmatizing of themselves than they were of others. This is reflected in the scatterplots and correlation tables demonstrating the levels of self-stigma in association with general stigma. The implications of this are even more astounding in the evidence that MSW students feel more stigmatized within their MSW programs than they feel by the general public. The concerning implication of this interpretation of the data suggests that despite being amongst peers who hold low levels of general stigma, MSW students will still internalize negative perceptions about having a mental health diagnosis. This is an alarming finding because if we know that MSW students are not judgmental of others, why would MSW

students be so judgmental of themselves? Furthermore, self-stigma within the MSW program relates to how MSW students think others perceive them based upon mental health status and how this is negatively internalized as self-stigma. Thus, the major implication of this interpretation is that MSW students do in fact experience self-stigma and they experience even more self-stigma within their MSW programs. Although these findings are inconclusive due to some limitations of the study, this study can accurately generalize the culture of MSW programs to be unsafe and stigmatizing environments for students with mental illness. This is quite interesting that MSW students who are learning to work with mentally ill and severely mentally ill populations would feel so stigmatized for having their own mental illness. The exciting news is that the entire purpose of this study was supported in the findings, discussion and interpretations of the data analysis. This means that the personal experiences within my own MSW program may not be so different from other MSW students enrolled in different MSW programs.

Ultimately, the interpretation that MSW students experience self-stigma allows for an appropriate speculation of the social work education process. This study can support the argument that MSW students with mental illness can and most likely do experience high levels of self-stigma within their MSW programs regardless of generally low levels of public stigma. The findings in this study demonstrated that an MSW student's experience with self-stigma of mental illness is a topic worth pursuing in future research studies because we still do not understand why self-stigma is occurring amongst individuals that do not generally stigmatize others. This study was not designed to answer questions about why self-stigma occurs but this study did uncover the crucial and often missed first step excluded from current studies in the literature. The crucial topic that has

yet to be addressed is the reason *why* MSW students judge themselves or feel more judged by others for having a mental health diagnosis, despite personally holding less negative attitudes towards others with similar mental health diagnoses.

In order to reduce stigma and help MSW students to engage in less self-stigmatizing practices, an examination of the factors that produce self-stigma must be addressed in future studies. If we cannot understand why this is happening, there is little hope in preventing self-stigma from occurring within MSW programs. Furthermore, if MSW students are experiencing self-stigma amongst peers with less stigmatizing attitudes about mental illness, what is happening when these students graduate and enter into the mental health profession? Are these same self-stigmatizing and negative attitudes of oneself carrying over to the professional domain so that mental health professionals with mental health diagnoses feel similarly stigmatized in the field? Where are these negative attitudes of self truly coming from? If the root of self-stigma is not addressed, efforts to reduce general stigma may be insignificant in changing societal attitudes about mental illness. There is enough evidence to suggest that gaps in the literature that led to the creation of this study are in fact major gaps that continue to impact how individuals with mental illness experience life. This study is a small sliver of hope intended to empower the social work profession to take a deeper look into our feelings of self-worth and how self-stigma may be impacting our abilities to feel confident in who we are as individuals. We need to practice what we preach and this should begin with greater efforts to explore the factors that are really causing such alarming experiences of self-stigma to persist.

Limitations

A major limitation in this study was the sample size of 48 participants. Although the data can provide some areas for suspected implications, the study cannot conclude that all MSW students experience self-stigma of mental illness. However, the findings do call attention to the need for future studies to include larger sample sizes in order to gather a more comprehensive assessment of the stigma of mental illness. The findings in this study clearly demonstrates that self-stigma does exist but this was only the first step in a long process needed to uncover the reasons behind the prevalence of self-stigma amongst social work students and future mental health professionals.

Another limitation of this study is that specific MSW programs were not identified. Thus, it is nearly impossible to determine if one program had more respondents and if this skewed the data. For example, if the 48 respondents were all current MSW students at one program, the findings may be a better reflection of the stigma of mental illness within that particular program as opposed to a reflection of the general MSW experience in regards to the stigma of mental illness. On the other hand, the findings were statistically significant enough to suggest that there were no major differences amongst participants based on specific MSW program. For example, if the findings reflected significant differences in scale scores for general stigma, self-stigma and MSW self-stigma amongst respondents, then the influence of specific MSW program environments would have been a more significant limitation of this study.

A final limitation of this study was that the survey responses could not produce scale scores for general stigma and self-stigma to be compared to public levels of general stigma and self-stigma. For example, the scale scores for general stigma were theory

based and did not include a standardized scale, which limits validity and generalizability. Future standardized scales of general stigma should be created so that different sample populations can be compared using statistical analysis. With regards to this study, a standardized scale of general stigma would have allowed for MSW student general stigma scores to be compared with the general public scale scores, which would then have provided more evidence about the different influential factors affecting amounts of general stigma. Scale scores for self-stigma were adapted from the Internalized Stigma of Mental Illness scale (Ritsher, Otilingam & Grajales, 2003) but this scale did not have norms. Self-stigma scale scores similarly lacked ways to compare MSW student levels of self-stigma with broader populations. Therefore, levels of self-stigma may be higher in MSW programs compared to other educational programs but this hypothesis must be tested in future research.

The purpose of this study was to understand more about the experiences of MSW students who have a mental health diagnosis in order to interpret how these students experience themselves in the eyes of the general public and how they view themselves in the eyes of others each other within their MSW program. A positive outcome of this study is that the limitations discussed do not take away from the overall significance of various implications related to the findings. The findings suggest that MSW students with an identified mental health diagnosis feel that others perceive them differently based upon their mental illness. MSW students may already understand that social workers will generally be more accepting of individuals with mental illness or SPMI, but somehow this knowledge does not seem to contribute to any reduction in the occurrence of self-stigma, especially within the MSW programs. MSW students with or without a mental

health diagnosis had similar levels of general and self-stigma. This means that MSW students, regardless of personal diagnosis, will generally hold less stigmatizing attitudes of others with mental illness. However, levels of self-stigma do not follow the same logic because self-stigma exists despite assumed knowledge that social workers are generally less judgmental and more accepting of mental illness or SPMI. Thus, low levels of general stigma reflecting positive feelings about the 'other' did not automatically result in less stigmatizing attitudes of the 'self' experienced by MSW students. It is a very curious discovery that MSW students still internalize negative perceptions of self while having a mental health diagnosis within a mental health education program. It's hard to imagine why MSW students do not experience less-stigma within the MSW community, where amounts of general stigma are presumably lower because mental health diagnoses are more accepted, understood and treated. Thus, further exploration about the acceptance of others in relation to acceptance of self would benefit a more thorough investigation about the origins of such prevalent self-stigma within a social work environment.

The potential for this study to be a platform for future discoveries is an exciting outcome and reflection of the hard work needed to conceptualize such a far-reaching issue. If this study provides a starting point for future research, then this study was successful in portraying an important topic that has major implications for the mental health field including future social work professionals. This study hopes to motivate future researchers to address the missing link in available research that could eventually provide a much deeper understanding of why social workers do what they do and why social workers are who they are.

Appendix B

INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating the ways in which current MSW students experience the stigma of mental illness. The goal of this research will be to enhance general knowledge about MSW students and self-stigma and benefit the professional field of social work by focusing on important subject areas in need of more social work research. This study is being conducted by Ashley Trudell, a graduate student at St. Catherine University under the supervision of Lisa Kiesel, a faculty member in the Department of Social Work. You were selected as a possible participant in this research because you are a current MSW student from a program that is not affiliated with this researcher's MSW program. Please read this form and ask your faculty member questions before you agree to be in the study.

Background Information:

As a current MSW student, I believe that my past experiences led me to the field of social work. However, I was advised to omit any personal mental health experiences from my program application. This was how I began my MSW experience; curious about why I had to hide my past mental health experiences. I began to wonder if other students in my program felt uncomfortable sharing past mental health experiences. My curiosity grew stronger as I observed classmates withhold personal details from class discussions pertaining to mental illness and was eventually told by peers that they were similarly advised not to include any mental health experiences on applications. Students in my program are learning how to work with individuals with mental illness yet they feel as though they are not allowed to have a mental illness of their own. After learning a great deal about the stigma process, I knew I wanted to explore this issue further. The idea for this study came from a simple question: Do MSW students experience the stigma of mental illness within their MSW program? If MSW students experience stigma, then stigma could also exist within the larger social work profession.

The purpose of this research will be to address gaps found in current studies, as MSW programs are not considered when evaluating the influence of the stigma of mental illness on attitudes and beliefs. Little is known regarding social work students and how they feel about individuals who have a mental health diagnosis or how MSW students perceive the mental illness of others. Even less is known about the experience of MSW students in dealing with personal issues in mental health. The purpose of this study will be to examine how prominent the stigma of mental illness is within two MSW programs and how MSW students experience stigma within his or her MSW program. I am hoping that as future social work colleagues and licensed professionals of the same field, you will participate in my study.

Procedures:

If you choose to participate in the study, you will be asked to consent by checking a box in the space provided, before beginning the survey. After giving informed consent by

checking the appropriate box below, you will be asked to complete an online questionnaire that will take approximately 20-30 minutes to complete. The questionnaire will include questions with yes/no answers, 4-item response options, as well as several fill-in-the-blank questions. The data will be collected and saved using a secure network. Student participants will have the opportunity to enter into a random drawing for a \$100 Visa gift-card by providing an email address at the end of the survey. The drawing will take place in May of 2014, after the study is complete and will be anonymous. This researcher will not collect any identifying information of participants other than the separate entry for the anonymous drawing. Privacy will be protected, as students can choose to enter into the drawing and choose to provide contact information only to be viewed by this researcher after the study is complete. Please follow the specific instructions for this drawing provided in the questionnaire to protect your privacy.

Risks and Benefits of being in the study:

The study has minimal risks. The minimal risk is due to the sensitive nature of some questions and the potential for discomfort or emotional upset in response to those questions. There are not direct benefits of participation in this study. The anticipated benefit of this study for the professions would be an improved understanding of student experiences with mental illness while receiving an MSW education.

Confidentiality:

The faculty members who assist in recruitment by distributing the online survey link to their students will not be allowed to access survey information or data, which will allow student information to remain anonymous.

Consent forms will be electronically filed as separate documents from survey responses and consent forms will not include any identifying information of participants in order to protect participant privacy. Only this researcher will have access to consent forms and these documents will not be connected to questionnaire responses.

Any information shared will remain completely confidential. At no point in time will your personal information be known to anyone in your program, anyone who reviews the study, or ever known by this researcher. If you choose to participate, please know that you can withdraw at any time and that you can choose to skip questions. However, for validity and data collection purposes, it is strongly recommended that you complete the survey in its entirety to the best of your ability.

Voluntary nature of the study:

Participation in this research study is voluntary and students will be able to end participation at any time. Your decision whether or not to participate will not affect your future relations with St. Catherine University or your MSW program in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:

If you have any questions, please feel free to contact me, Ashley Trudell, at [cell phone number] or [email address]. If you have other questions or concerns regarding the study

and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board. You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Clicking 'Yes' below indicates that you have read this information and your questions have been answered.

Q2. I have read the above consent form and desire of my own free will to participate in this study.

- Yes
- No

Appendix C

Q1. Consent Form: Available as Appendix B

Q2. I have read the above consent form and desire of my own free will to participate in this study.

- Yes
- No

Q3. Survey questions will be based on the following definitions & terms:

Severe and Persistent Mental Illness (SPMI):

An adult who has a mental illness and meets at least one of the following criteria (as defined in section 245.462, subdivision 20 of the Minnesota Statutes) is recognized as having a severe and persistent mental illness:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months; (2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months; (3) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided; (4) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; or (5) the adult (i) was eligible under clauses (1) to (4), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided.”^[1]

*Although mental health and mental illness are related and mental health is often used in reference to mental illness, the two terms represent different psychological states.^[2]

They are defined separately below:

Mental Health: is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”

(<http://www.cdc.gov/mentalhealth/basics.htm>).

Mental Illness: refers to “all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning”

(<http://www.cdc.gov/mentalhealth/basics.htm>).

Please refer back to this page while completing the survey, if necessary.

^[1] <https://www.revisor.mn.gov/statutes/?id=245.462>

^[2] <http://www.cdc.gov/mentalhealth/basics.htm>

Q4. Age:

Q5. Gender:

Q6. Race/Ethnicity:

Q7. Marital Status:

Q8. Religion/Spirituality:

Q9. Are you currently working?

- Yes
- No

Q10. Do you have experience working in the Mental Health Field?

- Yes
- No

Q11. Please select all settings that apply to your work experience in the mental health field:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Group Home | <input type="checkbox"/> Federal |
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Foster Care | <input type="checkbox"/> VA |
| <input type="checkbox"/> Inpatient | <input type="checkbox"/> School | <input type="checkbox"/> Military |
| <input type="checkbox"/> Outpatient | <input type="checkbox"/> PCA | <input type="checkbox"/> Corrections |
| <input type="checkbox"/> Residential | <input type="checkbox"/> Child Protection Services | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> County | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> State | <input type="checkbox"/> Other |

Q12. If you selected 'Other' because a mental health setting was not listed, please provide setting in the space below:

Q13. Work Status:

- Full-Time
- Part-Time
- Paid Internship
- On Leave

Q14. Total number of years working in mental health field setting:

Q15. Do you have your undergraduate degree in social work? (BSW)

- Yes
- No

Q16. If 'no', please indicate other undergraduate degree:

Q17. Do you currently have a field placement in a mental health setting?

- Yes
- No

Q18. #Number of years completed in your MSW program:

Drop down menu with options: 0 – 4

Q19. #Number of years left in MSW program:

Drop down menu with options: 0 – 5+

Q20. Do you know someone with a mental illness?

- Yes
- No

Q21. If 'yes', Please select all that apply:

- | | | | |
|---------------------------------------|---|-----------------------------------|--|
| <input type="checkbox"/> Bio-Mother | <input type="checkbox"/> Half-Sister | <input type="checkbox"/> Niece | <input type="checkbox"/> Family Friend |
| <input type="checkbox"/> Bio-Father | <input type="checkbox"/> Half-Brother | <input type="checkbox"/> Daughter | <input type="checkbox"/> Personal Friend |
| <input type="checkbox"/> Bio-Sister | <input type="checkbox"/> Sister In-Law | <input type="checkbox"/> Son | <input type="checkbox"/> Neighbor |
| <input type="checkbox"/> Bio-Brother | <input type="checkbox"/> Brother In-Law | <input type="checkbox"/> Grandma | <input type="checkbox"/> Colleague |
| <input type="checkbox"/> Step-Mother | <input type="checkbox"/> Cousin | <input type="checkbox"/> Grandpa | <input type="checkbox"/> Teacher |
| <input type="checkbox"/> Step-Father | <input type="checkbox"/> Uncle | <input type="checkbox"/> Relative | <input type="checkbox"/> Classmate |
| <input type="checkbox"/> Step-Sister | <input type="checkbox"/> Aunt | <input type="checkbox"/> Partner | <input type="checkbox"/> Acquaintance |
| <input type="checkbox"/> Step-Brother | <input type="checkbox"/> Nephew | <input type="checkbox"/> Spouse | <input type="checkbox"/> Not Listed |

Q22. Do you know someone with a severe and persistent mental illness (SPMI)?

- Yes
- No

Q23. Are you related to someone with SPMI?

- Yes
- No

Q24. Do you work with someone with SPMI?

- Yes
- No

Q25. Do you go to school with someone with SPMI?

- Yes
- No

Q26. Has anyone in your family been hospitalized for mental health reasons?

- Yes
- No

Q27. Have you visited someone in a psychiatric hospital?

- Yes
- No

Q28. Have you worked at a mental health clinic or psychiatric hospital?

- Yes
- No

Q29. Have you volunteered at a mental health clinic or psychiatric hospital?

- Yes
- No

Q30. Have you ever wondered if someone had an undiagnosed mental illness?

- Yes
- No

Q31. Have you ever talked to someone with SPMI?

- Yes
- No

Q32. A person with SPMI should have help making financial decisions.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q33. I think that individuals with SPMI should not be the primary caretakers of their children.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q34. Individuals with SPMI should be allowed to foster or adopt children.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q35. Individuals with SPMI should be allowed to work as mental health providers.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q36. I would live with someone being treated for symptoms of mental illness.

- Strongly Agree
- Agree

- Disagree
- Strongly Disagree

Q37. I would live with someone with SPMI, treated or untreated.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q38. I would feel comfortable renting property to an individual with SPMI.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q39. I would feel comfortable having colleagues with SPMI.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q40. I would allow an individual with SPMI to babysit my children.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q41. I would marry an individual with SPMI.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q42. I do not want my children to have SPMI.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q43. Individuals with SPMI are more dangerous than the general public.

- Strongly Agree
- Agree
- Disagree

- Strongly Disagree

Q44. People with mental illness are more dangerous than the general public.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q45. Individuals with Schizophrenia are more violent than the general public.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

Q46. Individuals with Major Depression are more dangerous than the general public.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q47. People with SPMI are dangerous if they are un-medicated.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q48. I can tell if a person has SPMI just by looking at them.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q49. People with SPMI are usually strange and more bizarre than the general public.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q50. Labeling someone as 'mentally ill' can reduce employment opportunities.

- Strongly Agree
- Agree

- Disagree
- Strongly Disagree

Q51. Labels have many consequences for individuals with SPMI.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q52. An individual should always tell other people about their mental illness so that others can be aware.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q53. Negative stereotypes about mental illness can damage an individual's self-esteem or self-worth.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q54. Americans are generally accepting of individuals with mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q55. Discrimination based on race, ethnicity, gender and sexuality is worse than discrimination based on mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q56. I have judged or formed assumptions about someone with a mental illness at some point in my life.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q57. I would not feel comfortable stating that I have a mental illness even if the information remains confidential and anonymous

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q58. I have struggled with mental health but do not have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q59. I have a mental health diagnosis.

- Yes
- No

If respondent answered 'no' survey was complete. If answered 'yes' participant was automatically directed to questions 60 – 104.

Q60. I have received treatment for my mental illness.

- Yes
- No

Q61. My mental health diagnosis qualifies as severe and persistent (SPMI).

- Yes
- No

Q62. I feel comfortable sharing about my mental health diagnosis for this study.

- Yes
- No

Q63. Some people in my MSW program know about my mental illness.

- Yes
- No

Q64. I have decided not to tell people in my MSW program about my mental health diagnosis.

- Yes
- No

Q65. My mental health diagnosis is: _____

Q66. I feel out of place in the world because I have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q67. Having a mental illness has spoiled my life.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q68. People without mental illness could not possibly understand me.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q69. I am embarrassed or ashamed that I have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q70. I am disappointed in myself for having a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q71. I feel inferior to others who don't have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q72. Stereotypes about the mentally ill apply to me.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q73. People can tell that I have a mental illness by the way I look.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q74. Mentally ill people tend to be violent.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q75. Because I have a mental illness, I need others to make most decisions for me.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q76. People with mental illness cannot live a good, rewarding life.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q77. Mentally ill people should not get married.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q78. I can't contribute anything to society because I have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q79. People discriminate against me because I have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q80. Others think that I can't achieve much in life because I have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q81. People ignore me or take me less seriously just because I have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q82. People often patronize me, or treat me like a child, just because I have a mental illness

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q83. Nobody would be interested in getting close to me because I have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q84. I don't talk about myself much because I don't want to burden others with my mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q85. I don't socialize as much as I used to because my mental illness might make me look or behave 'weird'

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q86. Negative stereotypes about mental illness keep me isolated from the 'normal' world.

- Strongly Agree

- Agree
- Disagree
- Strongly Disagree

Q87. I stay away from social situations in order to protect my family or friends from embarrassment.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q88. Being around people who don't have a mental illness makes me feel out of place or inadequate.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q89. I avoid getting close to people who don't have a mental illness to avoid rejection.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q90. I feel comfortable being seen in public with an obviously mentally ill person.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q91. In general, I am able to live life the way I want to.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q92. I can have a good, fulfilling life, despite my mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q93. People with mental illness make important contributions to society.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q94. Living with mental illness has made me a tough survivor.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q95. I have lied to peers about having a mental illness, especially to avoid being labeled or judged.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q96. No one in my MSW program knows about my mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q97. Everyone in my MSW program is open about sharing personal mental health experiences.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q98. My personal mental health experiences inspired me to work in the mental health field.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q99. I feel comfortable sharing my personal experiences with mental illness during class.

- Strongly Agree
- Agree

- Disagree
- Strongly Disagree

Q100. My teachers/professors in the MSW program know that I have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q101. I am aware of other students in the program who have a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q102. I believe that social workers are not supposed to have severe mental health issues.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q103. I think my MSW peers would judge me for having a mental illness.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q104. I would tell a future employer that I have a mental illness even if it does not impact my work.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q105. Please contact Ashley Trudell: [\[email\]](#) if you have any questions or concerns about participating in this study. This study will be completed in May of 2014 and the \$100 visa gift card drawing will take place at that time.

If you would like to enter into the drawing, please answer the questions below:

Q106. THANK YOU FOR YOUR PARTICIPATION IN THIS RESEARCH PROJECT!!!



Q107. Would you like to enter into the anonymous drawing for a \$100 Visa Gift card?

- Yes
- No

Q108. I understand that by entering into this drawing I am providing an email address that will remain separate from survey responses and will not be contacted until this research project is complete in May, 2014.

- Yes
- No

Q109. I would like to use the following email address for the drawing:

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