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Quantitative Research: Social Workers' Perceptions of Mental Illness

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Quantitative Research: Social Workers' Perceptions of Mental Illness

by

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MSW Clinical Research Paper

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

Committee Members

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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

This study examines Minnesota Licensed Social Workers' perceptions of mental illness. The researcher developed a quantitative survey consisting of 39 questions from four pre-existing surveys, as well as the researcher's own questions, to measure different types of stigma associated with mental illness. Three major themes were analyzed: level of education, personal experience, and professional experience, and how they related to possible stigma towards mental illness. A combination of frequency distributions, Chi Square, Pearson Correlation, and Independent T-test were utilized to answer the question: "What are social workers' perceptions on mental illness related to stigma; and how does this vary based on level of education, personal experience, and professional experience?" One hundred and seven Minnesota licensed social workers took part in this survey. Findings indicate that level of education, personal experience, and professional experience were not significantly related to level of self-reported stigma around mental illness. The study did find, however, that for the social workers who have diagnosed individuals with mental illness, the longer they had been working in the field, the less likely they were to perceive individuals with mental illness as dangerous (harm to themselves or others). One of the possible explanations is the extensive knowledge it takes to diagnose individuals with mental illness. Future research should continue to explore mental illness stigma among social workers, mental health professionals, providers, and recipient with mental illness.

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Introduction

In the United States, mental illness is a significant problem (National Association of Social Workers [NASW], 2012). Mental illness affects people of all races, ages, and sex. The prevalence of mental illness in the United States is approximately 26% of the adult population (NASW, 2012). Around 60% of all mental health professionals are clinical social workers (NASW, 2012). Social workers ought to be aware of their perceptions around mental illness. They are vital to the role of promoting social justice in the field of mental health (NASW, 2012). A large majority of social worker clients will either have a mental illness or will have been affected by one. We, as social workers, are required to follow a code of ethics that guides our practice. According to the National Association of Social Workers Code of Ethics, Section 4.02 under discrimination, “social workers should not practice, condone, facilitate, or collaborate with any form of discrimination...” (NASW code of ethics [NASW], 2008, p. 22).

Embracing key policy statements from the NASW is imperative to improving mental health issues across the United States. The policy states, “NASW is committed to improving mental health services and advocates for legislation action to improve the quality of care, access, reimbursement, research, and education in mental health” (NASW, 2012, p. 233). This is a vital philosophical belief social workers must follow, and they should promote prevention, education, access to services, interventions, and treatment in regards to mental health (NASW, 2012).

The lens through which society views mental illness will be examined throughout this research paper, and is a crucial part of social workers' perceptions. Our perceptions, as social workers, can impact the overall needs of clients and the people around us

(Lodato & Theriot, 2012). Negative attitudes can affect the way clients with mental illness receive services (Lodato & Theriot, 2012).

Although social workers receive special training in accordance with the NASW code of ethics, they also face some of the same social influences and messaging that exist in society. Education and training that social workers receive may add to a greater understanding of mental illness and therefore reduce stigma associated with mental illness. It is unclear, however, whether the most influential experiences contributing to social workers' perceptions have to do with personal experiences (such as knowing a family member or friend with a mental illness), educational experiences (such as obtaining a Master's degree or not), or professional experiences (working with people with mental illness, including a number of hours of training received).

On one hand, there has been an abundant amount of research done in regards to stigma around mental illness. Previous research has focused mainly on the public's perceptions, non-social work professionals, discrimination, stereotypes, recipients, and students' perceptions in regards to mental illness. On the other hand, there has been little done for the investigation of professional social workers' perceptions of mental illness (Lodato & Theriot, 2012).

Therefore, this quantitative research paper analyzes Minnesota's licensed social workers' perceptions of mental illness. The overall research question is: *What are social workers' perceptions on mental illness related to stigma; and how does this vary based on level of education, personal experience, and professional experience.* This research will help analyze social worker perceptions and whether or not they are upholding the core standards of the NASW and the Code of Ethics. This research can help identify data

related to social workers' perceptions of mental illness. The overall research encompasses the values of social workers, our perceptions of mental illness and how stigma impacts individuals.

Literature Review

This literature review synthesizes research related to mental illness, effects of mental illness on individuals, causes of mental illness stigma, stigma and self-stigma, attitudes, beliefs, misconceptions, value of empathy, and National Alliance of Social Workers (NASW) policy statements. Literature will be discussed on study findings, education, personal experiences, and professional experiences with mental illness. This literature review uses a wide lens approach on perceptions of mental illness from the point of view of the recipient, students, professionals, and the general public. The themes represented in this literature review encompasses social work practice.

Mental Illness

For the purpose of this research, mental illness will be defined by the National Alliance of Mental Illness (NAMI, 2015):

A mental illness is a condition that impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis.

Each person will have different experiences, even people with the same diagnosis.

(p. 1)

People from all around the world have different types and levels of mental illness.

According to Feldman and Crandall (2007) mental illness can be divided into two different kinds of harm. The first is from the disorder itself, for example, "cognitive, affective, and behavioral difficulties that limits one's ability to function effectively"

(Feldman & Crandell, 2007, p. 138). Social rejection is the second form of harm, “the social rejection, interpersonal disruption, and fractured identity that comes from the stigma of mental illness” (Feldman & Crandell, 2007, p. 138).

Mental Illness Stigma

According to the NASW, having negative attitudes, stereotyping, and discrimination towards individuals can be harming (NASW, 2012). Various literature stresses the importance of stigmas attached to mental health. Stigma can have negative impacts on clients. “The stigma of mental illness can be as harmful as the symptoms, leading to family discord, job discrimination, and social rejections (Feldman, 2007, p. 137). Corrigan (2004) breaks stigma into two categories; public stigma and self-stigma; and, how they can be obstacles to individuals seeking treatment. He suggests that public stigma and self-stigma stems from stereotypes, prejudice, and discrimination. Corrigan suggests these are all barriers to treatment for individuals suffering from mental illness (Corrigan, 2004). The NASW states, in terms of prevention and education, “destigmatize and maximize early identification and treatment of mental illness” (NASW, 2012, p. 233). Education, access to services, interventions, and treatment services are important variables in the fight towards de-stigmatizing mental illness (NASW, 2012). Sartorius (2007) talks about obstacles people with stigma face:

The stigma attached to mental illness is the main obstacle to the provision of care for people with [mental illness]. Stigma does not stop at illness: it marks those who are ill, their families across generations, institutions that provide treatment, psychotropic drugs, and mental health workers. Stigma makes community and health decision-makers see people with mental illness with low regard, resulting

in reluctance to invest resources into mental health care. Furthermore, stigma leads to discrimination in the provision of services for physical illness in those who are mentally ill, and to low use of diagnostic procedures when they have physical illness. (p.810)

Sartorius goes on to suggest that even mental health professionals, such as psychiatrists and social workers, are not aware of how their behavior can contribute to stigma in recipients (Sartorius, 2007).

Causes of Mental illness stigma

Mental illness research has been done around social rejection, social distance and labeling around mental illness as potential causes of mental illness stigma. An important aspect of stigma as it is related to mental illness, is the concept of dangerousness. For the purpose of this research, dangerousness is defined by the Psychology Dictionary as, "The condition wherein people come to be more plausible to cause damage to themselves or other people, presenting a hazard to the wellbeing of themselves or others" (p.1).

Social rejection. One of the major dimensions of mental illness stigma is social rejection (Feldman & Crandell, 2007). Feldman and Crandell (2007) wanted to explain social rejection and social distance related to mental illness. The study's sample size was n=270 undergraduate students who were in an Intro to Psychology class. The study used vignettes and 40 different diagnoses of mental illness. The researchers wanted to get a ranking of which mental illness had more social rejection. They found that, "Mental illnesses that lead to greater social distance usually are perceived to be higher in personal responsibility, dangerousness, rarity, or some combination of the three" (Feldman &

Crandell, 2007, p. 148). Larking and Brown (2012) examined professional perceptions of causes of mental illness stigma. They found, "Greater quantity of contact and higher levels of environmental causal beliefs were associated with lower levels of stigma, while psychological causal explanations were associated with higher levels of stigma" (Larking & Brown, 2012, p. 819).

Social Distance. For this study, social distance is defined as, "the willingness to interact with the mentally ill..." (Kasow & Weisskirch, 2010, p. 547). There have been different studies done on social distance as a factor in mental illness stigma. Kasow and Weisskirch (2010) studied undergraduate students (n=180) and they found that there were, "significant differences in social distance among schizophrenia, panic disorder, and skin cancer vignettes" (p. 549). Lauber, Nordt, Falcató, and Rössler (2004) looked at different factors that influence social distance in regards to mental illness. Their results suggest, "Social distance is a multifaceted concept influenced by, e.g., social-economic and cultural factors, but also by the respondent's general attitude towards (mental) health issues. These results suggest that more knowledge about mental illnesses, especially schizophrenia, may increase social distance" (Lauber et al, 2004, p. 265).

Labeling. The power of labeling was demonstrated in the Kroska and Harkness (2008) study. They suggest, "Diagnostic labeling is predicted to have a negative effect on self-feeling, and it is expected to trigger defensive reactions that create a type of 'secondary deviance,' further damaging patients' social interactions, occupational success, and self-image" (p. 193). Angermeyer and Matschinger (2003) examined the role that labeling has on individuals diagnosed with either schizophrenia or major depression. They found that, "Labeling of mental illness has an impact on public

attitudes towards people with schizophrenia, with negative effects clearly outweighing positive effects” (Angermeyer & Matschinger, 2003, p. 304). They also found that, “Labeling has practically no effect on the public’s attitude towards people with major depression” (Angermeyer & Matschinger, 2003, p. 304).

Attitudes, Beliefs, and Misconceptions of Mental Illness

Student’s perceptions of mental illness. According to Theriot and Lodato (2012), “...stigma also may encompass beliefs that people with serious mental illness are dangerous, should be feared, and must be kept away from the larger community” (Lodato & Theriot, 2012, p. 404). Theriot and Lodato use qualitative data to analyze new social work students’ attitudes in regards to mental illness. Their sample size was n=111. According to their research, they found that new social work students had generally more positive attitudes towards individuals with mental illness. They typically showed less fear, and were less avoidant, than other students (Lodato & Theriot, 2012). They also suggest that, “negative types of attitudes towards serious mental illness can have a negative effect on social work services...” (Lodato & Theriot, 2012, p. 406). In addition, they indicated that social work students were more willing to help individuals with mental illness (Lodato & Theriot, 2012).

Abundant amounts of research has indicated there are stigmas, discrimination, and stereotypes associated with mental illness (Corrigan et al., 2005; Covarrubias & Hans, 2011; Lee et al., 2014; NASW, 2012; Stromwall, Holley, & Bashor 2011; Theriot & Lodato, 2012; Thoits, 2011). Covarrubias and Hans (2011) researched a cross-sectional quantitative study on mental health stigmas among Masters of Social Work students. Their study involved n=71 graduate students from the northwestern section of the United

States, and looked at their attitudes towards serious mental illness (SMI). The researchers examined the amount of contact students had with SMI, stereotypes, the belief that people could recover from SMI, and whether or not SMI defines a person's identity. The study found there were no significant findings between stigmas of serious mental illness and Masters of Social Work students. Though this was not statistically significant, the study also found that having more contact with a family that had family members with SMI actually resulted in fewer stigmas towards individuals with SMI. The researchers indicated that stereotypes of dangerousness might have an undesired stigma towards people living with a serious mental illness (Covarrubias, 2011).

Aguinia, Madden, and Zellman (2014) conducted quantitative research of $n=198$ Bachelor of Social Work students at a Midwestern public university. They specifically looked at attitudes related to mental health stigma, while at the same time trying to understand those attitudes. They found that, "The majority of students do not hold stigmatizing attitudes toward mental illness. Students who believed mental health work is rewarding were less likely to be afraid or uncomfortable around people with mental illness" (Aguinia et al., 2014, p.660). 48.5% of the BSW students agreed and 35.4% strongly agreed, "Working with people with mental illness would be rewarding" (Aguinia et al., 2014, p. 667). The research also indicated that only 3.5% of students agreed or strongly agreed with "I am afraid of people with mental illness" (Aguinia et al., 2014, p. 667). Data indicated a statistically significant link between, "comfort seeking treatment for mental illness and attitudes about people with mental illness not being smart enough to do most jobs ($T_b = -.199; p \leq .001$) and being capable of achieving meaningful goals ($T_b = -.178; p \leq .01$)" (Aguinia et al., 2014, p.669). In regards to a correlation between

student attitudes and course level, there were two statistically significant findings. They were, “An increased belief that individuals with mental illness are not smart enough to do most jobs ($T_c = .133; p \leq .05$)” (Aquineia et al., 2014, p.669) and “As class level increased, students indicated a decreased belief that meaningful goals could be achieved by individuals with mental illness ($T_c = -.181; p \leq .01$)” (Aquineia et al., 2014, p.669).

In social work practice, social workers should, according to an NASW policy statement, “Foster resilience in people experiencing mental illness and in those who care for them” (NASW, 2012, p. 233). The perceptions of the client are an important part of the mental health professional’s responsibilities (Mitchell, 1998). In other words, it is important to show empathy and compassion to clients.

Mental health professionals’ perceptions of mental illness. Smith and Cashwell (2010) examined the attitudes towards mental illness of mental health professionals and found that they were less stigmatizing than other professionals in non-mental health professions. One of the misconceptions they investigated was that individuals with mental illness are more dangerous and should be avoided. Also, individuals with mental illness should be blamed for their illness. According to Smith and Cashwell (2010), these issues can create barriers to services, and can take individuals much longer to recover. This was a quantitative study, using $n=188$ participants; 118 were women, and 70 were men. They used 4 subgroups. One group was a non-mental health student group, and included a sample of 20 students who were in a Master’s program for Business Administration. The second group had social work and psychology students in mid-level Master’s programs, for a total of 41. The third group was comprised of 76 mental health professionals, including 24 counselors, 20 social workers, and 32

psychologists, who all worked in the mental health field. The last group had 34 non-mental health professionals employed in business. Smith and Cashwell (2010) used the *Community Attitudes Toward the Mentally Ill* instrument to gather the data. This is a 40 item self-report survey that uses a 5-point Likert scale for each item. The results indicated that, "A main effect was found for mental health status, suggesting that mental health training, education, and experience resulted in more positive attitudes toward mental illness" (Smith & Cashwell, p. 197, 2010). The largest significant difference the study found was between non-mental-health students and non-mental-health professionals in terms of benevolence (Smith & Cashwell, 2010). The "results from this study suggested that participants who were not associated with the mental health field still held stigmatizing attitudes towards adults with mental illness" (Smith & Cashwell, p. 197, 2010). According to Smith and Cashwell (2010) this study found there was no difference between the mental health students and professionals.

Singer and Slovak (2011) conducted a study of school social workers (SSWs) and their experiences working with clients who have suicidal ideations. Their sample size was n=399 School Social Workers from all across the United States. The professional School Social Workers reported, "Almost 90% percent of SSWs worked with suicidal youths in the past two years, and rates for SSWs at the HS level approached 100 percent." (Singer & Slovak, 2011, p.222). This same study asked if, 'My graduate training prepared me to work with suicidal youth' (Singer & Slovak, 2011, p. 223) which only 58% of the social workers reported that it had. The study found that, "SSWs' experience, beliefs, attitudes, and roles with student suicide affects their attitude and suggest that SSWs across all levels of schools feel confident in identifying suicide risk factors and

conducting an assessment and are highly knowledgeable on school suicide policy”(Singer & Slovak, 2011, p. 226).

Stromwall, Holley, and Bashor (2011) studied stigma and discrimination in professional workplaces with peer employees and clinicians, the research was a quantitative survey with a sample size of 52 licensed clinical professionals who work in the behavioral health field. This researcher asked the questions, “Do peer employees’ perceptions of discrimination against service recipients in the work place differ from mental health clinicians’ perceptions? Do peer employees’ perceptions, that they themselves experience discrimination in the workplace, differ from clinicians perceptions about whether discrimination occurs?” (Stromwall et al., 2011, p. 475). They found that “...white employees are more likely than employees of color to perceive discrimination against service recipients, but not against peer employees” (Stromwall et al., 2011, p. 478).

Kopera and colleagues (2015) researched stigma of 29 psychiatrists and psychotherapists and compared their implicit and explicit stigma related to mental illness to 28 first-year medical students. Their research indicated that, “both groups reported negative implicit attitudes towards the mentally ill” (Kopera et al., 2015, p.628). The research examined the “attitudes towards people with mental illness are ambivalent, both among students and professionals” (Kopera et al., 2015, p.632), as a result the study suggested that professionals had higher emotions towards individuals with mental illness than did the non-professionals (Kopera et al., 2015). The non-professional held a “...less restrictive attitude” (Kopera et al., 2015, p.628).

General public's perceptions on mental illness. Kobau et al. (2010) examined the general public attitudes about mental illness. They had a sample size of n=5,251 and this quantitative research used the U.S. adult population. The research found that "Those who knew someone with a mental illness and those who had ever had a mental illness had lower scores" (Kobau et al., 2010, p. 171) in terms of negative attitudes. This suggests that experience is a major factor in reducing stigma. Also, while not a statistically significant finding, younger adults held higher stigma toward individuals with mental illness than others in the study (Kobau et al., 2010, p.174).

Barezyk (2015) looked at the public's stigma towards mental illness by conducting a quantitative study with a sample size of n=1,437 adults from the 2006 General Social Survey. Two key aspects were examined. First, the level of stigma and negative attitudes towards mental illness and the belief that the individual suffering from mental illness could recover. Second, Barezyk wanted to examine, "...whether previous contact with an individual who received treatment was a mediator" (Barezyk, 2015, p.38). Data concluded from the survey indicated that "the belief in recovery led to lower levels of social distance. Prejudicial attitudes were found to be a predictor of one's level of social distance" (Barezyk, 2015, p.38). Also, "Previous contact was not a mediator; however, males, minorities and those with less education were less likely to have had previous contact" (Barezyk, 2015, p.38).

Corrigan et al. (2007) researched whether education from watching a movie changed perceptions of mental illness in regards to stigma. The study used a pre-test and post-test given 1 week apart. Research consisted of a sample size of 244 people divided into two groups. One group viewed contact videotape and the other saw education

videotape. During the contact videotape, a real person with schizophrenia gave his story, while explaining his recovery and experiences with mental illness. In the education videotape, the same individual gave the same information, but didn't disclose he was the person with those experiences. The results were interesting, "Contact led to positive change in pity, power, avoidance, and segregation. Pity showed a significant reduction from pre-test to post-test in the contact group ($p < .05$), and the effect was also evident at follow-up" (Corrigan et al., 2007, p. 178). Results also indicated from the study, "...education group manifested a significant reduction in responsibility from pre-test and follow-up" (Corrigan et al., 2007, p. 178). According to Corrigan and colleges (2007), the findings from their research indicate that both tapes had an impact on stigma related to mental illness.

Recipient's Perceptions of Mental Illness

Individuals who have been diagnosed with a mental illness believe if the professional is cold and distant, it's hard for their recovery process (Mitchell, 1998). Different research has indicated different viewpoints in research. Mitchell (1998) examines the recipient's perspective. Mitchell suggests that warmth, empathy and concern for clients is an important part of recovery, and that clients place high value on a social worker's use of empathy. Mitchell's (1998) research was a quantitative study that looks at the overall perceptions of empathy and satisfaction within a behavioral health unit, while individuals were either in an unstructured individual therapy or a time-limited standardization group therapy. The individuals who took part in this study either had anxiety or a mood disorder. The sample size was $n=230$ individuals, who were members of the Washington, DC, and Mid-Atlantic region. The staff consisted of psychiatrists,

social workers and child psychologists. The respondents were from ages 18-70 years old. They used a non-experimental survey design. The survey consisted of 27 items of self-reporting, consisting of two scales; an empathy scale and a client satisfaction questionnaire. This study found that there was "...no statistical difference between a client's perception of empathy or of their overall satisfaction with mental health based on the types of treatments they received" (Mitchell, 1998, p. 409).

In the article, *Resisting The Stigma of Mental Illness* by Thoits (2011), Thoits examines the idea of whether individuals who have mental illness can resist stigma attached to labeling. This article examines the co-existing relationship between stigma and self-esteem. According to Thoits (2011), "An abundance of evidence shows that a stigmatized label and expectations and/or experiences of social rejection significantly diminish the life quality and life chances of consumers, countering earlier assertions that stigma has only minor or short-lived negative consequences for patients' lives compared to the influence of their symptoms" (p. 8). Thoits' article also discusses the evidence for resistance to stigma saying,

When patients with major depression and schizophrenic disorders were asked what they would do in the face of other discomforts, from 65 to 85 percent endorsed educating others about mental illness/psychiatric treatment, and 81 percent of Clubhouse respondents with serious disorders agreed that it was better to confront stigmatizing behavior than to ignore it. (Thoits, 2011, p. 10)

Thoits has identified many different ways to resist stigma that are often not discussed in the literature.

Freidl, Spitzl, and Aigner (2008) researched the correlation between depressive symptoms and stigma of perceptions of mental illness. The study consisted of 115 clients who had been diagnosed with somatoform pain disorder. Friedl, Spitzl, and Aigner (2008) stigma questionnaire and then analyzed the results with the Beck Depression Inventory. The research found that, "Fear of stigma increases with depressive symptoms and both are a risk for treatment delay" (p. 510). Another interesting finding was that, "...nearly 70% think that 'most people' would not allow a mental patient to take care of their children, and 'most employers' would pass over the application of a psychiatric patient in favour of another applicant" (Freidl et al., 2008, p. 510).

Kahng and Mowbray (2004) researched the factors that influence people who suffer from serious and persistent mental illness. They used cross-sectional quantitative research that had a sample size of n=290, and comprised of individuals with mental health issues. They looked at two aspects; self-worth and self-deprecation. The research found that, "Participants, on average, presented relatively higher positive affect and self-worth than negative affect and self-deprecation, respectively. On average, participants indicated that they had experienced rejection by others in education, employment or housing opportunities" (Kahng & Mowbray, 2004, p. 229).

Social justice is a major concern for individuals with mental illness. Corrigan, et al (2005) suggests, "Traditional focuses on education-based interventions may not be sufficient" (p. 367). Education is important in removing stigma of mental health (NASW, 2012). Corrigan, Watson, Byrne, and Davis. (2005) suggest that when individuals who suffer from mental illness start having fewer obstacles and begin to have, "...more life

opportunities and more willingness to seek help” (p. 367), the result is less obstacles to life. As social workers, we need to follow a code of ethics and values. According to the NASW value of social justice, “Social justice is the view that everyone deserves equal economic, political and social rights and opportunities. Social workers aim to open the doors of access and opportunity for everyone, particularly those in greatest need” (NASW, 2015, p.1).

Conceptual framework

Social Labeling Theory

According to Link, Yang, Phelan and Collins (2004), labeling individuals with mental illness is a major part in measuring stigma. The paradigm of Social Labeling looks at social forces and the importance of those factors in abnormal behaviors. Labeling people with a mental illness can be detrimental to a client’s recovery process through services (Lodato & Theriot, 2012). Catalano (1979) suggests that residual rule breaking is breaking implicit rules in society. He also suggests that labeling can occur if you break explicit rules, such as breaking laws. You are now labeled “criminal”. This is similar to when an individual is given a diagnosis of a severe mental illness, they are often labeled upon receiving a diagnosis. Social rejection and social distance plays a major role with stigma for individuals given the diagnosis of mental illness (Feldman & Crandall, 2007). Feldman and Crandall (2007) suggest, “Rejection of mentally ill persons is certainly based in part on their deviant (i.e., non-normative) behavior” (p.138).

Catalano (1979) discussed four basic assumptions with social labeling. One, “Abnormal behavior is breaking of residual rules detected by those with low tolerance and power to label” (p. 176). Two, “Residual rule breaking is usually part of a strategy to

relieve anxiety over problems in living” (p. 176). Three, “The system of professional treatment for those who break residual rules actually conditions them to act abnormally” (p. 176). Four, “Decreasing abnormal behavior means societal reform and increased tolerance” (p. 176). For example, think about the LGBT community. Fifty years ago there was little or no tolerance for homosexuality, but now it is more widely accepted. This “abnormal behavior” is no longer considered abnormal to society’s rules. In some areas, there is still some stigma attached to the LGBT community, but we are moving in the right direction.

One of the major limitations, when looking at individuals being labeled, is that each individual can perceive that labeling differently. The paradigm is unable to explain this. One of the strengths is that this paradigm looks at the abnormal behavior in a social context and examines those parts of social labeling. Another strength is it looks at society, and the people labeling these abnormal behaviors, not just the individual (Catalano, 1979).

As social workers, we believe in social justice for all individuals and that labeling can be harmful to people. People have the right and responsibility to participate in society. Social labeling can be harmful to these rights. Social workers should advocate for the poor and vulnerable, in that we pursue change by addressing oppression, discrimination, and other forms of social injustice (NASW, 2012).

In conclusion, research has indicated that stigma around mental illness is still prevalent, even among professionals. The research also indicated that society still labels many mental illnesses as abnormal behaviors. As social workers, we follow a code of ethics and values to help combat mental illness stigma and labeling. The NASW policy

states, in regards to mental illness, “NASW is committed to improving mental health services and advocates for legislative action to improve the quality of care, access, reimbursement, research, and education in mental health” (NASW, 2012, p. 233). This is an important philosophical belief social workers must follow. It is important for social workers to promote prevention, education, access to services, interventions, research, and treatment in regards to mental health” (NASW, 2012). It’s important to be involved in such organizations as the National Alliance for Mental Illness (NAMI) that educate, advocate, support, and help bring communities together (NAMI, 2015). Thus, this research will examine Minnesota licensed social workers’ perceptions of mental illness stigma through the use of a survey.

Methods

Research Design

This study is quantitative and uses a cross-sectional design. The Perceptions of Mental Illness Survey (Appendix A) was developed to help assess social workers’ perceptions in regards to mental illness. There are two purposes of this research: First was to assess social workers’ perceptions of mental illness as related to stigma overall. Second, was to examine the level of education, personal experience, and professional experience to how they might relate to a social worker’s perceptions of mental illness.

Sample

A total of 111 participants took part in this study; 4 of the surveys were removed due to being under 50% completed, leaving a sample size of N=107 social workers. Table 1 shows descriptive statistics for the sample; Age, Gender, Race, and Political Philosophy of Participants. The gender characteristics of the respondents were as

follows: 12 identified as male, 93 as female, and 1 respondent didn't answer. The race of the respondents: 4 identified as American Indian or Alaska Native, 2 as Asian, 98 as White, 1 as American Indian or Alaska Native and White, 1 participant in the other category identified themselves as Bi-racial, but didn't specify, and 1 respondent left the question blank. For the political philosophy, 63 identified themselves as liberal, 31 as moderate, 8 as conservative, and 5 chose not to answer. In addition, Table 1 shows a mean age of 42.76 years, with the youngest licensed social worker being 21 and the oldest being 74. It also shows a standard deviation of 12.48.

Table 1.

Descriptive Statistic: Age, Gender, Race, and Political Philosophy of Participants

Variable	Frequency	Percent	Min	Max	Mean	Std. Deviation
Age	106		21	74	42.76	12.48
Gender						
Male	13	12%				
Female	93	87%				
Didn't Answer	1	1%				
Race						
American Indian or Alaska Native	4	4%				
American Indian or Alaska Native and White	1	1%				
Asian	2	2%				
White	98	91%				
Other	1	1%				
Didn't Answer	1	1%				
Political Philosophy						
Liberal	63	62%				
Moderate	31	30%				
Conservative	8	8%				

Level of Education. Questions (#5, 6, Appendix A) were used to assess level of education. See Table 2. Results indicate 20 respondents identified as having a Bachelor's, 81 identified having their Master's, and 6 with a Doctorate. In regards to

licensure of the respondents, 23 identified as having LSW, 25 LGSW, 30 LISW, and 29 LICSW.

Table 2.

Descriptive Statistic: Level of Education

Variable	Frequency	Percent
Level of Education:		
Bachelors:	20	19%
Masters:	81	76%
Doctorate:	6	5%
Level of Licensure:		
LSW	23	22%
LGSW	25	23%
LISW	30	28%
LICSW	29	27%

Personal Experience. Question (#37, 38, 39, Appendix A) from the survey were used to assess personal experience. See Table 3. The respondents who are currently diagnosed with a mental illness or have ever been: 48 respondents answered yes, 54 answered no and 5 didn't answer the question. In regards to anyone in your family ever been diagnosed with a mental illness; 83 answered yes, 19 answered no, and, again, 5 didn't answer this question. Of the participants who knew someone personal outside of work and outside of their family with a mental illness, respondents answered with 94 yes, 8 no, and 5 left this question blank.

Table 3.

Descriptive Statistic: Personal Experience

Variable	Frequency	Percent
Participants diagnosed with a mental illness:		
Yes:	48	45%
No:	54	51%
Didn't Answer:	5	4%
Family Diagnosed With a mental illness:		
Yes:	83	78%
No:	19	18%
Didn't Answer:	5	4%

Friends with someone with a mental illness outside of family and work:		
Yes:	94	88%
No:	8	8%
Didn't Answer:	5	4%

Professional experience. Questions (#7, 8, 9, Appendix A) from the survey was used to assess professional experience and mental illness. See Table 4. When looking at the participants and how many years' social workers have worked, responses ranged from 1-46 years, with a mean of 14.93 years, a standard deviation of 10.589, skewness of .667, and standard error of 2.34. Data shows that when participants were asked whether or not they work with clients with mental illness, 97 answered yes, 8 sometimes, and 2 no. Participants were asked whether or not they have diagnosed someone with mental illness, and 32 participants answered yes, 75 answered no.

Table 4.

Descriptive Statistic: Professional Experience

Variable	Frequency	Percent	Min	Max	Mean	Std. Deviation
Years worked as a social worker:	107		1	46	14.93	10.59
Working directly with clients with mental illness:						
Yes:	97	91%				
Sometimes:	8	7%				
No:	2	2%				
Diagnosing individuals with mental illness:						
Yes:	32	30%				
No:	75	70%				

Protection of Human Subjects

Recruitment process. Once approval was given by the St. Catherine's IRB, the author of this research contacted the Board of Social Workers and obtained a random

sample of Minnesota licensed social workers' e-mail addresses at various licensure levels. A mass email consisted of a brief explanation of the survey and a link to take the online survey using an online survey tool called Qualtrics.

Assurance of confidentiality. The e-mail addresses acquired by the BOSW were on a password protected thumb drive. The email list was never used in conjunction with the data collected. The survey was anonymous and there was no information in the survey to identify individuals. The Qualtrics survey link was located in the email, and personal email addresses weren't stored as part of the data gathering process. The account for Qualtrics was password protected and data collected by Qualtrics didn't have identifying indicators in the survey. Once the data was converted to SPSS, the IP addresses stored by Qualtrics were removed. These IP addresses were not examined at any time by the researcher. Once this research is complete, by May 31th, 2016, the e-mail list and Qualtrics account will be deleted.

Protocol to ensure informed consent. Before the survey could be started, each social worker was given a chance to read the informed consent form. The consent form was given to the social worker taking the survey with background information, procedures, risks and benefits of being in the study, confidentiality, voluntary nature of study, and the researcher's contact information. It also asked if there are any questions or concerns. Prior to taking the survey on Qualtrics, the social worker taking the survey was prompted with the statement, "I have read and understand the consent form and I consent to participate in the study by clicking on the arrow below". The individual must have answered yes to continue on to take the survey.

Procedure

The survey was open for 2 weeks, from Jan. 28th to Feb. 11th, 2016. A sample of 996 licensed social workers' e-mail addresses was obtained from the MN BOSW. The social workers who participated in the survey were given a consent form to read prior to taking the survey, in both the email and at the start of the survey. At this time, any individual not wishing to take the survey could have chosen to opt out. Qualtrics, which is an online survey platform done through a web browser, was used to gather the data from the individuals who decided to take the survey. Those taking the survey were told this survey will take 20-25 minutes. The data from Qualtrics was converted to SPSS and statistical analysis performed.

Measures and Instruments

This research used primary data collection and used the Perceptions of Mental Illness Survey (POMIS) (Appendix A) developed for this research. The survey consists of 39 questions related to perceptions of mental illness in regards to stigma. The survey is a compilation of different scales developed in the past, in addition to questions developed by this researcher. A total of 4 previous scales were used as follows: Questions (#14-23) uses parts of a Tucker et al. (2013) survey related to self-stigma from the Self-Stigma of Mental Illness Scale (SSOMI). It has 10 questions using a 5-point scale to rate how you might feel if you were to have a mental illness. The purpose of the survey questions is to, "measure the reduction in self-esteem and self-efficacy that resulted in receiving the label of mental illness" (Tucker et al., 2013, p. 522). Reliability for this measure, from the SSOMI original scale was used in two independent studies, "Cronbach's alpha for the

SSOMI, was .91 and .92” (Tucker et al., 2013, p. 522). In addition, “Convergent validity of the SSOMI was demonstrated through its strong, positive correlation with the modified Self-Stigma of Depression (SSD) Scale ($r = .73, p < .001$)” (Tucker et al, 2013, p. 522). For the purpose of this research, the SSOMI puts the survey taker in the shoes of someone diagnosed with mental illness and measures how they would react if this happened to them. The relationship between what the social worker believes and what they perceive may be an indicator of what their own perceptions of mental illness might be towards others with mental illness.

Questions (#24-35) are from the Attribution Questionnaire AQ-27, developed by Corrigan et al. (2012). It had the respondent read a vignette related to Harry, an individual diagnosed with schizophrenia. 12 of the 27 original questions were used to measure perceptions related to dangerousness, segregation, avoidance, and coercion of mental illness (Corrigan et al., 2012). The rationale behind only using 12 of the 27 was due to length of the survey. The researchers didn't provide validity or reliability for this measure. This section allows the researcher to measure mental illness perceptions to SMI through the story of Harry. The response scale for the questions range from 1-9, with 1 being not at all to 9 being very much.

For questions (#36-39), the Attitudes to Mental Illness Scale, developed by Madianos, et al (2012), was used. For this survey, the original survey questions were changed from a scale to percentage responses. This allows for a larger range of statistical analysis. The original survey had strong validity and reliability. The researcher selected 4 questions, one from each different factor, including stereotyping, optimism, coping and understanding.

For questions (#5-13), the researcher developed 9 questions relating to level of education, personal experience, and professional experience. Scaling for these questions ranged from nominal and ordinal, to interval. Demographic questions (#1-4) were used from the Student Attitudes, Attributions, and Responses Regarding Poverty survey (Cozzarelli, C., Wilkinson, A. V., & Tagler, M.J., 2001). These 4 questions measured age, gender, race, and political philosophy.

Reliability of measure. SPSS was used to calculate Cronbach's Alpha for components of the POMIS survey (Appendix A) as a test for reliability of the scales. Questions #11-20 "SSOMI Scale" (Tucker et al., 2013) and questions #21-32 "Attribution Questionnaire AQ-27" (Corrigan et al, 2002) were used. Both were found to be highly reliable (10 items; $\alpha = .86$) and (12 items; $\alpha = .82$), respectively.

Data Analysis

To answer the research questions of: *What are social workers' perceptions on mental illness related to stigma; and How does this differ based on level of education, personal experience, and professional experience?*, a combination of descriptive and inferential statistics from the survey were completed using the program Statistical Package for the Social Science (SPSS). A combination of frequency distributions, Chi Square, Pearson Correlation, and Independent T-tests were completed using the data from the survey. Cronbach's Alpha was run to see how the items of each scale are holding together (reported above).

In order to gather more information, two descriptive statistics questions were analyzed (see above), "What are the race, age, gender, and political philosophy of social

workers participating in the survey?” and “What is the level of education, personal experience, and professional experience of the social workers taking the survey.”

In order to answer the overall research questions, four specific inferential questions were asked. The first one is, “Does personal experience change the way social workers perceive self-stigma related to mental illness?” Second, “Does a social worker’s level of education change the way the social worker perceives dangerousness, avoidance, segregation, and coercion of individuals with mental illness?” Thirdly, “What is the correlation between a social worker’s professional experience and his or her perceptions of mental illness in regards to dangerousness, coping difficulties, seeking help, and being treated differently?” And finally, “Does the amount of training per year that a social worker receives change the way he or she perceives dangerousness?”

Question 1: Does personal experience change the way social workers perceive self-stigma related to mental illness?

1a) Social workers who have been diagnosed with a mental illness will have less self-stigma.

1b) Social workers who personally know someone outside of their own family with a mental illness will have less self-stigma.

1c) Social workers who have someone in their family diagnosed with a mental illness will have less self-stigma.

Personal experience and self-stigma Chi-square. To answer question 1, statements (1a, 1b, 1c) were analyzed using SPSS. A Chi-square test was completed for each. Data from the SSOMI questions (#11-20) scale were used to analyze the responses and can be compared to three questions (#37, 38, 39). “Are you now, or have you ever

been diagnosed with a mental illness?" "Has anyone in your family ever been diagnosed with a mental illness?" And, "Have you ever personally known someone outside of your family with mental illness (outside of work)?" Each question was separated into two groups, "yes" or "no". For a Chi square test to be run, both the independent and dependent variable of measure need to be nominal for the set of questions (#11-20). A sum of scores was calculated. Questions (#11-20) used a Likert scale response with (1) strongly disagree, (2) disagree, (3) neither agree nor disagree, (4) agree, and (5) strongly agree. So, for the purpose of running a Chi-Square, the sum of responses were re-coded, with a total score of (1-30) = 0 meaning less self-stigma and (31-50)=1 for greater self-stigma. Note questions (#12,14,15,17,19) are reverse scored.

Question 2: Does a social worker's level of education change the way the social worker perceives dangerousness, avoidance, segregation and coercion of individuals with mental illness?

2a) Social workers who have a Master's degree or higher will have a lower perception of dangerousness.

2b) Social workers who have a Master's degree or higher will have less avoidance of mental illness.

2c) Social workers who have a Master's degree or higher will have less segregation of mental illness.

2d) Social workers who have a Master's degree or higher will have less coercion of mental illness.

Level of education Chi-Square. Using SPSS, a Chi-square test was run for each statement (2a, 2b, 2c, 2d). Level of education in the survey is measured by the question

(#5) “What is your Highest Level of Education completed?” Recoding was done for question (#5), breaking the 5 possible responses into two categories; non-Masters (1,2,3)=0 and Masters or higher (4,5)=1. A total of 4 Chi-Square tests was completed for each set of statements. Dangerousness was measured by questions (#21, 25, 30) “I would feel unsafe around Harry”, “How dangerous would you feel Harry is?” and “I would feel threatened by Harry”. Avoidance was measured in (#24, 28, 32). “If I were an employer, I would interview Harry for a job”, “I would share a car pool with Harry”, and “If I were a landlord, I probably would rent an apartment to Harry”. Reverse scoring for these questions was used in the survey. Segregation was measured by questions (#23, 27, 29). “I think Harry poses a risk to his neighbors unless he is hospitalized.” “I think it would be best for Harry’s community if he were put away in a psychiatric hospital.” And, “How much do you think an asylum, where Harry can be kept away from his neighbors, is the best place for him?” Coercion was measured by questions (#22, 26, 31). “If I were in charge of Harry’s treatment, I would require him to take his medications.”, “How much do you agree that Harry should be forced into treatment with his doctor even if he does not want to?”, and “If I were in charge of Harry’s treatment, I would force him to live in a group home.” These questions used a scale from 1 to 9. For each category, the sum of the data in the three questions were combined. For example, the sum of questions (#24, 28, 33) was recoded into 1-12 =0 indicating less endorsement and 13-27= 1 has greater endorsement.

Question 3: What is the correlation between a social worker’s professional experience and his or her perceptions of mental illness in regards to dangerousness, coping difficulties, seeking help, and treated differently.

3a) Social workers will have a positive correlation between number of years worked and what percent perceive that people with mental illness are dangerous.

3b) Social workers will have a positive correlation between number of years worked and what percent perceive that people with mental illness can cope with life's difficulties.

3c) Social workers will have a positive correlation between number of years worked and what percent perceive that people with mental illness must seek help from a specialist.

3d) Social workers will have a positive correlation between number of years worked and what percent of people with mental illness must seek help from a specialist.

Professional experience correlations. A Pearson Correlation test was completed using SPSS for each of the statements (3a, 3b, 3c, 3d). Questions (# 36, 7, 8, 9) “What % of people with mental illness are dangerous?” “What % of people with mental illness can cope with life difficulties?” “What % of people with mental illness must seek help form a specialist?” And, “What % of people with mental illness are usually treated differently by others?” will be compared to question (#7) “How many years have you worked as a social worker” No recoding was done for this question, as they are both interval/ratio. Also, a scatterplot chart was made for each to give visualization of the correlation, if one exists.

To gather more information from the category of professional experience, a second calculation was completed. Using the original sample from the survey for question (#17) “How many years have you worked as a social worker” and using

question (#8), "Do you have clients diagnosed with mental illness", new parameters were made from question (#7), with only the individuals who answered "yes" to question (#8) being used. A new correlation was run for each statement (3a, 3b, 3c, 3d). Using the same process for question (#9) "Have you ever diagnosed someone with a mental illness?" Only the individuals who answered yes were used in the sample for question (#7), to complete the 4 correlations. A table was completed using SPSS to display the correlations.

Question 4: "Does the amount of training per year that social workers receive change the way they perceive dangerousness of mental illness?"

4a) Social workers with more training hours believe that a smaller percentage of people with mental illness are dangerous than social workers with less hours of training.

Professional experience Independent T-test. To answer question 4, an independent samples T-Test was completed for statement 4a using questions (#33) and (#10) from the survey. An independent samples T-test looks for significance between the means of the two groups. For a T-test to be completed using SPSS, the dependent variable must be interval/ratio. The dependent variable was question (#33) "What % of people with mental illness are dangerous?" The independent variable was question (#10). "Approximately how many hours of mental health training have you received per year since your licensure?" The independent variable must be nominal or ordinal in order to complete an Independent T-test. Therefore, question (#10) was recoded to (1,2,3,4)= 0 less training and (5,6,7,8)= 1 greater training.

Findings

This research sought to answer four main questions: 1) Does personal experience change the way social workers perceive self-stigma related to mental illness?; 2) Does a social worker's level of education change the way he or she perceives dangerousness, avoidance, segregation and coercion of individuals with mental illness?; 3) What is the relationship between a social worker's professional experience and his or her perceptions of mental illness in regards to dangerousness, coping difficulties, seeking help, and treated differently; 4) Does the amount of training per year that social workers receive change the way they perceive dangerousness of mental illness? Data revealed that the hypotheses that correspond with these questions couldn't be supported statistically. Below, each question will be explored in turn.

Question 1: Does personal experience change the way social workers perceive self-stigma related to mental illness? In exploring this question, it was hypothesized that: 1a) Social workers who have been diagnosed with a mental illness will have less self-stigma; 1b) Social workers who personally know someone outside of their own family with a mental illness will have less self-stigma; 1c) Social workers who have someone in their family diagnosed with a mental illness will have less self-stigma.

To answer question 1, exploring the association between personal experience and perceived self-stigma, data from the survey questions (#11-20, Appendix A) were added, resulting in a range of scores from 1 to 50. The resulting scores were then recoded into two categories where 0 = less self-stigma (score of 1-30) and 1 = greater self-stigma (score of 31-50). They were then run in a series of 3 Chi-Square tests, corresponding with each of the hypothesis stated above. Results indicated that there was no significant

relationship between having had a personal experience with mental illness and the perception of self-stigma. For Hypothesis 1a: The percentage of participants endorsing low or high levels of self-stigma did not differ by whether they had ever been diagnosed with a mental illness, $\chi^2(1, N=102) = .65, p = .42$ (see Table 5). For Hypothesis 1b: The percentage of participants endorsing low or high levels of self-stigma did not differ by whether or not they personally know someone outside of their family with a mental illness. Fisher's Exact Test was used, $p = .45$ (2-sided) (see Table 6). For Hypothesis 1c) The percentage of participants endorsing low or high levels of self-stigma did not differ by whether anyone in their family has ever been diagnosed with a mental illness, $\chi^2(1, N=102) = .02, p = .88$ (see Table 7).

Table 5.

Cross Tabulation: Self-Stigma and Diagnosed With A Mental Illness

Ever been diagnosed with a mental illness	Less stigma	Greater stigma
Yes	33 (50%)	15 (42%)
No	33 (50%)	21 (58%)

Table 6.

Cross Tabulation: Self-Stigma and Have You Personally Been Friends With Someone Outside of Your Family with Mental Illness

Outside of your family with a mental illness	Less stigma	Greater stigma
Yes	62 (94%)	32 (89%)
No	4 (6%)	4 (11%)

Table 7.

Cross Tabulation: Self-Stigma and Has Anyone in Your Family Ever Been Diagnosed With a Mental Illness

Inside of your family	Less stigma	Greater stigma
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with a mental illness	54 (82%)	29 (81%)
Yes		
No	12 (18%)	7 (19%)

Question 2: Does a social worker's level of education change the way he or she perceives dangerousness, avoidance, segregation and coercion of individuals with mental illness? In exploring this question, it was hypothesized that: 2a) Social workers who have a Master's degree or higher will have a lower perception of dangerousness; 2b) Social workers who have a Master's degree or higher will have less avoidance of persons with mental illness; 2c) Social workers who have a Master's degree or higher will have less segregation of persons with mental illness; 2d) Social workers who have a Master's degree or higher will have less coercion towards persons with a mental illness.

To answer Question 2, exploring the association between level of education and perceived dangerousness, avoidance, segregation, and coercion of individuals with mental illness, data from the survey questions (#5, #21-32 and Appendix A) were used. Level of education was separated by breaking the 5 possible responses into two categories of non-Master's (1,2,3)=0 and Master's or higher (4,5)=1. Additional coding was done for the measures of dangerousness, avoidance, segregation, and coercion, and three questions were used for each. Results were added and recoded to 1-12 =0 less endorsement and 13-27= 1 greater endorsement. A series of 3 Chi-Square tests were run corresponding with each of the hypotheses stated above. Results indicated that there was no significant relationship between level of education and perceived dangerousness, avoidance, segregation, and coercion of individuals with mental illness.

For Hypothesis 2a: The perception of dangerousness of individuals with mental illness did not differ between those with non-Master's degree and those with a Master's degree or higher. Fisher's Exact Test was used $p = .50$ (2-sided) (see Table 8). For Hypothesis 2b: The perceptions of avoidance of individuals with mental illness did not differ between those with non-Master's degree and those with a Master's degree or higher, $\chi^2 (1, N=105) = .83, p = .440$ (2-sided) (see Table 9). For Hypothesis 2c: The perception of segregation of individuals with mental illness did not differ between those with non-Master's degree and those with a Master's degree or higher. The Chi-Square could not be completed, since no participants endorsed greater segregation (see Table 10). For Hypothesis 2d: The perceptions of coercion of individuals with mental illness did not differ between those with non-Master's degree and those with a Master's degree or higher. $\chi^2 (1, N=105) = .37, p = .54$ (see Table 11).

Table 8.

Cross Tabulation: Dangerousness and Level of Education

Masters or higher or no Master's	Less Endorsement	Greater Endorsement
Masters +	73 (82%)	12 (75%)
No Masters	16 (18%)	4 (25%)

Table 9.

Cross Tabulation: Avoidance and Level of Education

Masters or higher or no Master's	Less Endorsement	Greater Endorsement
Masters +	9 (45%)	29(34%)
No Masters	11 (55%)	56 (66%)

Table 10.

Cross Tabulation: Segregation and Level of Education

Masters or higher or no Master's	Less Endorsement	Greater Endorsement
	Masters +	85 (81%)
No Masters	20 (19%)	0

Table 11.

Cross Tabulation: Coercion and Level of Education

Masters or higher or no Master's	Less Endorsement	Greater Endorsement
	Masters +	53 (83%)
No Masters	11 (17%)	9 (22%)

Question 3: What is the relationship between a social worker's professional experience and his or her perceptions of mental illness in regards to dangerousness, coping difficulties, seeking help, and treated differently. In exploring this question, it was hypothesized that 3a) Social workers will have a positive correlation between number of years worked and what percent perceive that people with mental illness are dangerous; 3b) Social workers will have a positive correlation between number of years worked and what percent perceive that people with mental illness can cope with life's difficulties; 3c) Social workers will have a positive correlation between number of years worked and what percent perceive that people with mental illness must seek help from a specialist; 3d) Social workers will have a positive correlation between number of years worked and what percent perceive people with mental illness are usually treated differently by others.

To answer Question 3, exploring the relationship between professional experience and perceptions of dangerousness, coping difficulties, seeking help, and differential treatment of individuals with mental illness, data from the survey questions (7#, #33-36, Appendix A) were used. A series of 4 Pearson Correlations were run, corresponding with

each of the hypotheses stated above. Results indicated that there was no significant relationship between participants' professional experience and their perceptions of mental illness in regards to dangerousness, coping difficulties, seeking help, and differential treatment of individuals with mental illness.

For hypothesis 3a), A Pearson correlation coefficient was computed to assess the relationship between numbers of years worked and the percent who perceived that people with mental illness are dangerous. Results indicate there was a weak, positive correlation between years worked and perceptions of dangerousness, $r = .034$, $n=99$, $p = \leq .716$. For Hypothesis 3b), results indicated there was a weak, negative correlation between years worked as a social worker and the perception that people with mental illness can cope with life's difficulties, $r = -.115$, $n=96$, $p = \leq .265$. For hypothesis 3c), results indicated there was a weak, negative correlation between years worked as a social worker and perception of people with mental illness must seek help form a specialist, $r = -.170$, $n=97$, $p = \leq .096$. For Hypothesis 3d), results indicate there was a weak, negative correlation between years worked as a social worker and people with mental illness are usually treated differently by others, $r = -.098$, $n=98$, $p = \leq .335$.

To gather additional data on Question 3, people who answered no to question (#8, Appendix A) were removed from the data set. In essence, only participants who have diagnosed individuals were used for Question 3. The correlation was recalculated, corresponding with each of the hypothesis stated above. Results indicated there was no significant relationship between participant's who have diagnosed someone with mental illness and their perceptions of mental illness in regards to dangerousness, coping difficulties, seeking help, and treated differently of individuals with mental illness.

For Hypothesis 3a) A Pearson Correlation Coefficient was computed to assess the relationship between numbers of years worked and the percent who perceived that people with mental illness are dangerous. Results indicate there was a moderate, negative correlation between years worked and perceptions of dangerousness, $r = -.315$, $n=31$, $p = \leq .085$. For Hypothesis 3b), results indicated there was a weak, negative correlation between years worked as a social worker and people with mental illness can cope with life's difficulties, $r = -.065$, $n=30$, $p = \leq .732$. For Hypothesis 3c), results indicated there was a weak, positive correlation between years worked as a social worker and perception that people with mental illness must seek help from a specialist, $r = -.017$, $n=31$, $p = \leq .927$. For Hypothesis 3d), results indicate there was a weak, negative correlation between years worked as a social worker and people with mental illness are usually treated differently by others, $r = -.274$, $n=31$, $p = \leq .136$.

Question 4: Does the amount of training per year that social workers receive change the way they perceive dangerousness of mental illness? In exploring this question, it was hypothesized that 4a) social workers with more training hours believe that a smaller percentage of people with mental illness are dangerous than social workers with less hours of training.

To answer Question 4, exploring the means between hours of training and perception of dangerousness, data from the SSOMI questions (#33, 10, Appendix A) were used. Results from Question #10 were recoded into two categories; (1,2,3,4) =0 less training and (5,6,7,8,9)=1 greater training, and were run in an Independent Samples T-test for 4a). Results indicated that there was no significant correlation between the two

variables of social workers professional experience and people with mental illness are dangerous.

For Hypothesis 4a: An Independent-Samples T-test was run to compare social workers hours of training and the perception that people with mental illness are dangerous. There was no significant difference between the scores for less training (M=12.35, SD=10.15, n=86) and greater training (M=10.15, SD=6.73, n=13) conditions; $t(97) = .753, p = .45$ (see Table 12). These results suggest that training doesn't affect perceptions of dangerousness.

Table 12.

Results of T-test: Training and What % of People with Mental Illness Are Dangerous (Harm to Themselves or Others)

	Less Training			Training Greater Training			95% CI for Mean Differen ce	t	df
	M	SD	n	M	SD	n			
Perception of Dangerousnes s	12.35	10.15	86	10.15	6.73	13	-3.59, 7.98	.753	97

Discussion

We, as social workers, must be aware that having negative attitudes, stereotyping and discrimination towards anyone can be harming (NASW, 2012). An extensive amount of research has stressed the importance of stigma related to mental illness. Research has indicated that stigma can have negative impacts on clients. Feldman and Crandall (2007) indicates, "The stigma of mental illness can be as harmful as the symptoms leading to family discord, job discrimination, and social rejections" (Feldman & Crandall, 2007, p. 137). Corrigan (2004) identified that it can be an obstacle to individuals seeking treatment. He suggests that public stigma and self-stigma stems from

stereotypes, prejudice, and discrimination. This quantitative research paper analyzed these stigmas within Minnesota's Licensed Social Workers. The researcher asked the question: *What are social workers' perceptions on mental illness related to stigma; and how does this vary based on level of education, personal experience, and professional experience.* The findings found that, when looking at levels of education, personal experience, and professional experience around the research questions that were asked, there were no statistical significance findings. Though not statistically significant, this study found, of the participants who have diagnosed someone with a mental illness, there was a moderate, negative correlation between years worked and perceptions of dangerousness (harm to self or others) towards people with mental illness. In other words, from this study, the perception of dangerousness in those with a mental illness went down the more years a social worker (who has diagnosed others) worked. One of the possible explanations is the extensive knowledge it takes to diagnose individuals with mental illness. A part of this knowledge base is that it takes years to gain the skill of diagnosing people with mental illness; unlike other medical diagnosis, where a physical test can be used.

Past research has found that mental illness impacts clients on many levels, and as social workers we play a vital role in services to people who have been diagnosed with mental illness (NASW, 2012). When comparing results from this study with a study done by Kobau et al. (2010), they found that people who had known someone with a mental illness or had been diagnosed with a mental illness, had lower negative attitudes towards people with mental illness. Unlike the Kobau et al. study, this research found there was no statistical difference between social workers personal experience, such as

knowing a friend or family member with a mental illness. It's important to note that this study doesn't tell us that social workers have more or less stigma than others, but there was no difference in level of education, personal experience, and professional experience among participants.

In the study done by Smith and Cashwell (2010), they found that the results of mental health training, education, and experience resulted in having more positive attitudes towards individuals with mental illness. This differs from this research findings that level of education, amount of training and personal experience resulted in no statistical significances in stigma around mental illness. Covarrubias and Hans (2011) examined stigma among Master's level social work students. Similar to this research, they found no significant findings between stigma of mental illness and social work students. In their study they found that having a family member with SMI actually resulted in less stigma towards individuals with mental illness, but it was not statistically significant. Also not statistically significant, this study found that people that had family members or they themselves had been diagnosed with a mental illness, had less endorsement of self-stigma.

Implications for Future Social Work Research, Practice and Policy

Research. There has been little done on the perceptions of mental illness in terms of licensed social workers. Most research has focused on students and other professional's perceptions of mental illness. Future research around stigma of mental illness can help identify specific areas where social workers need improvement. This present research looked at levels of education, personal experience, and professional experience; though the findings found that these things were not significant. Research

should continue to examine these themes. We, as social workers, follow a code of ethics and core values that consist of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (National Association of Social Workers, 2008). This research gives us insight to whether we, as social workers, are upholding these key values. Future research should go more in-depth, looking at specific values that might impact stigma. Research has been limited to examining social worker's perceptions of mental illness stigma. It is important that we, as social workers, must uphold the NASW ethics and core values. The National Association of Social Workers (2008) mission identifies "The primary mission of the social work profession is to enhance human well-being 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" (p.1).

Practice and policy. Education, access to services, interventions, and treatment services are important variables in the fight towards de-stigmatizing mental illness (NASW, 2012). The author is in agreement with the National Association of Social Workers (2012) that politicians should be "committed to improving mental health services and advocates for legislation action to improve the quality of care, access, reimbursement, research, and education in mental health" (NASW, 2012 p. 233). Stigma and discrimination can be a barrier to this care (NASW, 2012). Future policies should include easy access to services, insurance, housing, and mental health workers. Policy makers should be aware of different cultures. "Cultural competency is critical to reducing health disparities and improving access to high-quality health care, health care that is

respectful of and responsive to the needs of diverse patients” (National Institutes of Health, n.d, p.1).

Education is important regarding stigma of mental health. Education can increase awareness and decrease the overall stigma that is attached to mental illness. Education can have prevention measures attached to the understanding of the effects of mental health, and being aware of symptoms (NASW, 2012). An increase in funding would help provide research in the mental health fields. We have a moral responsibility, as Americans, to provide insurance, services and funding to those that cannot provide for themselves.

Strengths and Limitations

In examination of the research question, we found that stigma did not differ by level of licensure, personal experience and professional experience. One of the major limitations is measuring the construct of stigma, unlike the construct of discrimination which can be measured more directly. The researcher believes that stigmas towards people with mental illness can also change from moment to moment. This research only examines one moment of time, when measuring something like the impact of education, it might be best to do a pretest then a posttest. Corrigan et al. (2007) researched whether education from watching a movie changed perceptions of mental illness in regards to stigma. They found that “Contact led to positive change in pity, power, avoidance, and segregation. Pity showed a significant reduction from pre-test to post-test in the contact group ($p < .05$), and the effect that was also evident at follow-up” (Corrigan et al., 2007, p. 178). In essence, to have a better understanding of the impact of education on social workers, a longitudinal study should be completed.

One of the major strengths of this research is that it is quantitative in nature. A lot of information can be gathered from a larger sample size. Since the data gathered is numerical, the researcher can do statistical evaluations on the data. This method of gathering information, in regards to social workers' perceptions, is another strength.

Another limitation is the location of the sample. The sample consists only of Minnesota licensed social workers, and, only those willing to respond to the email. Minnesota doesn't represent the total population of social workers in the United States. Also a limitation is that social workers have been trained to be aware of their biases. Just because an individual has negative perceptions towards a group doesn't necessarily mean they are representing that in the data. In other words, they may have negative feelings towards individuals diagnosed with mental illness, but they stay professional and don't let that feeling be expressed externally in any nature.

Conclusion

Mental illness impacts the lives of many individuals and the people around them. Of the individuals diagnosed with a mental illness, stigma can often be incapacitating for them (Overton & Medina, 2008). "It has an impact on their options of life, their beliefs about themselves, and even the course of their illness" (Overton & Medina, 2008, p. 149). Social workers play a vital role in many individuals who suffer from stigma. This research has indicated that Minnesota licensed social workers who responded to this survey do not differ statistically in their responses based on level of education, personal experience, and professional experience. We, as social workers, have a responsibility to continue to fight against social injustice experienced by individuals who have been diagnosed with mental illness. The researcher recognizes that more research is necessary

to develop a better understanding of mental illness stigma and the impact it has on individuals.

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Appendix A

Perceptions of Mental Illness Survey (POMIS)

Please note: 1. All of the questions below will contain a “skip” feature in Qualtrics. 2. The scales used in each section of the survey are noted. 3. The information in red will not be visible to the participants.

Demographic

Directions: First, I'd like to ask you to describe a bit about how you identify yourself.

Please fill in the box or select the answer that best describes you.

1. Age: _____(1)
2. Gender: _____ Male (1) _____Female (2) _____Other, (Please specify_____) (3)
3. Race:
 - _____ African American (1)
 - _____ American Indian or Alaska Native (2)
 - _____ Asian (3)
 - _____ Hispanic or Latino (4)
 - _____ Native Hawaiian or other Pacific Islander (5)
 - _____ White (6)
 - _____ African American AND White (7)
 - _____ American Indian or Alaska Native AND White (8)
 - _____ Hispanic or Latino AND White (9)
 - _____ Asian AND White (10)
 - _____ Other (please specify) _____ (11)
4. Political philosophy:

- _____ Liberal (1)
- _____ Moderate (2)
- _____ Conservative (3)

Directions: The following questions are related to your level of education, personal experience and professional experience.

5. What is your highest level of education completed?

- _____ High School (1)
- _____ Associates (2)
- _____ Bachelors (3)
- _____ Masters (4)
- _____ Doctorate (5)

6. What is your highest level of social worker licensure acquired in Minnesota?

- _____ LSW (1)
- _____ LGSW (2)
- _____ LISW (3)
- _____ LICSW (4)

7. How many years have you worked as a social worker? _____ (1)

8. Do you currently, or have ever, worked directly with clients diagnosed with mental illness?

____ Yes (1) ____ Sometimes (2) ____ No (3)

9. Have you ever diagnosed someone with a mental illness?

____ Yes (1) ____ No (3)

10. Approximately how many hours of training specific to mental health have you participated in each year since your licensure? (E.g. training obtained through work, conference or workshop participation, etc.).

_____ 0-10 (1)

_____ 11-21 (2)

_____ 22-32 (3)

_____ 33-43 (4)

_____ 44-54 (5)

_____ 65-75 (6)

_____ 86-86 (7)

_____ 97+ (8)

SSOMI Scale (Tucker et al., 2013)

Directions: People, at times, find that they face mental health problems. This can bring up reactions about what mental illness would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react if you were to have a mental illness (Tucker et al., 2013).

	Strongly Disagree(1)	Disagree(2)	Agree/Disagree Equally(3)	Agree (4)	Strongly Agree (5)
11. I would feel inadequate if I had a mental illness.	1	2	3	4	5
12. My self-confidence would not be threatened if I had a mental illness.	1	2	3	4	5
13. Having a mental illness would make me feel less intelligent.	1	2	3	4	5
14. My self-esteem would increase if I had a mental illness.	1	2	3	4	5
15. My view of myself would not change just because I had a mental illness.	1	2	3	4	5

16. It would make me feel inferior

to have a mental illness. 1 2 3 4 5

17. I would feel okay about myself

if I had a mental illness. 1 2 3 4 5

18. If I had a mental illness, I

would be less satisfied with myself. 1 2 3 4 5

19. My self-confidence would

remain the same if I had a 1 2 3 4 5
mental illness.

20. I would feel worse about

myself if I had a mental illness. 1 2 3 4 5

Note questions (#12,14,15,17,19) are reverse scored.

(Corrigan et al, 2002) Attribution Questionnaire AQ-27

Please read the following statement about Harry:

Harry is a 30 year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He has been hospitalized six times because of his illness.

Please answer the following questions about Harry, and select the best answer for each question:

21. I would feel unsafe around Harry.

1 2 3 4 5 6 7 8 9

No, not at all

Yes, very much

22. If I were in charge of Harry's treatment, I would require him to take his medication.

1 2 3 4 5 6 7 8 9

Not at all

Very much

23. I think Harry poses a risk to his neighbors unless he is hospitalized.

1 2 3 4 5 6 7 8 9

None at all

Very much

24. If I were an employer, I would interview Harry for a job.

1 2 3 4 5 6 7 8 9

Not likely

Very likely

25. How dangerous (harm to himself or others) would you feel Harry is?

1	2	3	4	5	6	7	8	9	
Not at all								Very much	

26. How much do you agree that Harry should be forced into treatment with his doctor, even if he does not want to?

1	2	3	4	5	6	7	8	9	
Not at all								Very much	

27. I think it would be best for Harry's community if he were put away in a psychiatric hospital.

1	2	3	4	5	6	7	8	9	
Not at all								Very much	

28. I would share a car pool with Harry every day.

1	2	3	4	5	6	7	8	9	
Not likely								Very likely	

29. How much do you think an asylum, where Harry can be kept away from his neighbors, is the best place for him?

1	2	3	4	5	6	7	8	9	
Not at all								Very much	

30. I would feel threatened by Harry.

1 2 3 4 5 6 7 8 9

No, not at all

Yes, very much

31. If I were in charge of Harry's treatment, I would force him to live in a group home.

1 2 3 4 5 6 7 8 9

Not at all

Very much

32. If I were a landlord, I probably would rent an apartment to Harry.

1 2 3 4 5 6 7 8 9

Not likely

Very much

(Madianos et al, 2012). Attitudes to mental illness Scale.

Directions: Please fill in the number below that corresponds with your own beliefs about people with mental illness.

33. What ___ % of people with mental illness are dangerous (harm to themselves or others)?

34. What ___ % of people with mental illness can cope with life difficulties?

35. What ___ % of people with mental illness must seek help from a specialist?

36. What ___ % of people with mental illness are usually treated differently by others?

Demographic continued:

Directions: Often personal experience contributes greatly to our understanding of our clients. Below, please select the answer that best fits your experience.

37. Are you now, or have you ever been diagnosed with a mental illness?

___ Yes (1) ___ No (2)

38. Has anyone in your family ever been diagnosed with a mental illness?

___ Yes (1) ___ No (2)

39. Have you ever personally been friends with someone outside of your family with mental illness (outside of work)?

___ Yes (1) ___ No (2)