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The Stigmatization of Mental Illness and Drug Addiction Among the Criminally Involved

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LOYOLA UNIVERSITY CHICAGO

THE STIGMATIZATION OF MENTAL ILLNESS AND DRUG ADDICTION
AMONG THE CRIMINALLY INVOLVED

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
MASTER OF ARTS

PROGRAM IN APPLIED SOCIAL PSYCHOLOGY

BY

BRENDA MARIE ARSENAULT

CHICAGO, IL

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ABSTRACT

This study examined the perceived stigma of mental illness compared to drug addiction among a sample of criminally involved persons who receive probation services through the Cook County Adult Probation Department. The first section of the study surveyed current probation clients using a modification of the PSAS scale by Luoma, Rye, Kohlenberg, Hayes, Fletcher & Pratte (2010), and assessed levels of stigma consciousness with a modified version of the SCQ (Pinel, 1999). Three groups of participants were surveyed for their perceptions of stigma and stigma consciousness. The first group consisted of drug probation case management clients with no known mental health problems, the second group was drawn from the general probation population and served as a non-equivalent comparison group, and the third group comprised of Mental Health Court clients, who have both mental illness and drug addiction issues. In the second section of the study, case managers were interviewed to collect information on clients' reactions to mental illness service referrals and how stigma can be a barrier to treatment. It was found that there was not a significant difference in perceived stigma of mental illness and drug addiction between the three client groups, however there was higher stigma consciousness for mental illness among female participants in the drug probation program. Additionally, there was an unanticipated inverse relationship between stigma consciousness and perceived stigma. Anecdotal evidence collected from the caseworkers helped to illuminate how treatment is hindered by stigma.

CHAPTER ONE

INTRODUCTION

Substance abuse disorders have been formally labeled and treated as a psychiatric illness by the psychological and medical community since 1980 with the publication of the DSM-III (American Psychiatric Association, 1980). Not only is addiction itself a disorder but, many people who abuse substances do so in order to self-medicate the symptoms of other mental disorders, indicating the presence of co-occurring disorders and increasing the need for mental health services (i.e.,; Khantzian, 1997; Yalisove, 1997). The World Health Organization (2004) reported high rates of co-morbid substance dependence in individuals who have mental illness and noted that substance use can be a means to alleviate the symptoms of mental illness.

The stigmatization of mental illness plays a role in treatment adherence, and the Surgeon General's report on mental health described stigma as "the most formidable obstacle to future progress in the arena of mental illness and health" (U.S. Department of Health and Human Services, 1999). Psychological barriers, including clients' perceptions of mental illness stigma, have been linked to compliance with treatment, including compliance with medications (Sirey, Bruce, Alexopoulos, Perlick, Raue, Friedman & Meyers, 2001). Mental health treatment is often rejected in an attempt to avoid the label of 'mentally ill' and the subsequent loss to self-esteem and social

opportunities that the label can bring (Corrigan, 2004). This study will explore how people currently receiving drug treatment perceive the stigma of mental illness and how this might affect treatment. By gauging the perceived stigma of both mental health and addiction, this study will allow the two to be compared while analyzing the correlations among perceived stigma and stigma consciousness, race, gender, and probation type of correctional programming.

Paucity of Research on Dual-Stigmatization

Previous studies of dual-stigmatization have mostly focused on ascribed traits, such as racial status, which are beyond a person's control or responsibility. Recent studies have examined topics such as race and mental health (Gary, 2005); gender and HIV status (Turman, 2003); and age and HIV status (Emler, 2006). In contrast, the current study proposes to examine the dual stigmatization of two psychological or behaviorally-based stigmas, specifically mental illness and drug addiction. Moreover, focusing on two devalued traits associated with morality, self-control, and perceived dangerousness not only enriches the body of research on stigmatization but also serves to provide practical information to the participating agency, Treatment Alternatives for Safe Communities (TASC), regarding the presence of mental health stigma within its client population.

CHAPTER TWO

LITERATURE REVIEW

The literature on stigma is greatly informed by research and theories in the field of social psychology, which has contributed much to the understanding of stigma since the latter half of the twentieth century. As evidence of the burgeoning interest and research on this topic, a chapter was devoted to social stigma in *The Handbook of Social Psychology* (Crocker, Major, & Steele, 1998). The tools and approaches that social psychology offers can help explain the importance of social context, describing the cognitive, affective and behavioral elements of stigma, and differentiating stigma from related constructs such as prejudice and discrimination.

Since the influential work of sociologist Erving Goffman (1963) in *Stigma: Notes on the Management of Spoiled Identity*, scores of researchers were inspired to examine the process and effects of stigmatization. However, much of the research regarding stigma has focused on the outcomes of being stigmatized. In the field of social psychology, the effects of stigma have been studied in relation to self-esteem (Crocker and Major 1989; Major & O'Brien 2005), academic performance (Steele & Aronson 1995, Brown & Pinel 2002), cognitive functioning (Schmader and Johns, 2003), approach–avoidance reaction (Walton and Cohen, 2007), and psychological distress (Quinn and Chaudoir, 2009; Hatzenbuehler, Nolen-Hoeksema & Dovidio, 2009). The current study hopes to fill a gap in the research on stigma related to substance abuse

treatment barriers—a need recognized by Luoma, Rye, Kohlenberg, Hayes, Fletcher, & Pratte (2010).

Defining Stigma

Some people consistently experience rejection and lose social power because they possess a certain attribute or characteristic that is devalued in a particular culture or community (Crocker, Major, & Steele, 1998). A standard dictionary definition refers to stigma as ‘a mark of disgrace, shame, or discredit,’ which is related to definitions of social stigma as a specific type of negative labeling. The Latin roots of the word “stigma” translate into ‘mark’ or ‘brand’. Although originally used in reference to a physical mark, such as a tattoo or iron branding, the concept of stigma has been extended to the social domain since Goffman’s (1963) notable work, which spurred much social research on the topic.

Exclusion based on a negatively viewed trait, or “an attribute that is deeply discrediting,” (Goffman, 1963, p.3), and that puts an individual into an out-group is the defining characteristic of stigma (Leary & Schreindorfer, 1998). Other researchers have emphasized that this labeling and subsequent discrimination is only truly stigmatization when power is exercised over the negatively categorized group (Link and Phelan, 2001). As Link and Phelan stated, “stigmatization is entirely contingent on access to social, economic and political power that allows those who would stigmatize to put real teeth into their treatment of the stigmatized” (2001, p. 367). Typically, stigmatizing traits are thought to be visible characteristics that violate the norm. However, many attributes that

are stigmatized are not easily seen, such as HIV status or addiction, and these stigmas can be more easily concealed than ascribed traits such as racial group membership.

Many concealed stigmas are acquired over time (such as AIDS, mental illness, or a criminal history). Prior to attaining this identity, the person affected could have had knowledge of or personally endorsed the societal beliefs regarding the stereotypes of the stigmatized group (Levin & Van Laar, 2006). According to Levin and Van Laar (2006), having the experience of being an in-group member and knowing how those with the devalued trait are treated leads to a greater belief that the newly afflicted person will now be ostracized. Furthermore, a series of studies by Santuzzi and Ruscher (2002) revealed that having a hidden or concealable stigma in an inter-group context resulted in negative perceptions and negatively biased inferences about others' dispositions. Specifically, they found that people with hidden stigmas expected that others would negatively assess them (Santuzzi & Ruscher, 2002). If persons with a concealable stigma never reveal the stigmatized characteristic, they should react similarly to stigma-free persons; however, their own knowledge of their stigma and their increased sensitivity based on prior experiences of stigma-based rejection could result in a type of paranoia regarding discrimination based on the devalued trait. Therefore, this study also measured stigma consciousness, which is defined as the degree to which people expect to be stereotyped and thus susceptible to stigmatizing (Pinel, 1999).

Theoretical Considerations: Theories of Attribution as Applied to Stigma

Essentially a theory of human motivation and emotion, theories of attribution are

based on the assumption that people search for a causal understanding of events (Weiner, 1980; 1985). In terms of observing a person with addiction, the attribution theorist would propose that the observer seeks out the causes for that person's addiction (moral weakness, thrill-seeking, etc.). The attribution theory applied to stigma suggests that the constructs of stability and controllability of the stigmatized trait affect these causal attributions (Weiner, 1993; 1995). Regarding mental illness, this trait is seen as relatively stable (i.e. will not go away) and unable to be completely 'cured'. Furthermore, mental illness is also viewed as behaviorally-based and therefore somewhat personally controllable, and those with mental illness are often blamed for their symptoms. These attributions regarding responsibility for the stigma can result in emotional responses, such as blame or anger, when the person is perceived to have control over the onset of mental illness, or pity or assistance, when a person is perceived to lack control or be a victim of circumstance (Corrigan, 2000). As such, the affective reactions to the presence of a socially devalued trait will be mediated by the perception of controllability and permanence of the feature.

The sight of others' social failure can prompt a cognitive need to determine the cause for the flawed trait. Weiner (1985) explored this tendency of the need to determine causality in terms of motivation and emotion. His research found that negative events (i.e. seeing a disfigured person) signal a need to ascertain the reason for the presence of the stigmatized trait. The perception of the cause for the stigma (for example, either self-inflicted or congenital) determines the type of affective reaction that would be elicited,

regardless of the correctness of the perception. The affective reaction would then influence one's behavioral response, for example an affect of anger would likely yield a harsh reaction, and pity would likely yield helping behavior.

Attribution theory is useful in explaining why some stigmatized groups are seen more negatively and demeaned more harshly than others. Weiner, Perry and Magnusson (1988) investigated ratings of perceived responsibility and stability of various stigma types. The concept of the fundamental attribution error suggests that we explain our own behavior in terms of the situation and the behavior of others in terms of their personality or character. Traits that we perceive as being under a person's control, such as drug addiction, result in assigning greater blame to the individual's character and a greater likelihood of blaming the person's character for moral weakness as opposed to acknowledging the situational or societal factors that might be at work.

Other studies have also found that the nature of a disease can determine the type of stigmatization and that physical diseases are often seen as less controllable than psychological disorders (Bishop, 1987; Crandall & Moriarty, 1995; Corrigan, River, Ludin, Wasowski, Champion, Mathisen, Goldstein, Bergman, Gagnon, & Kubiak 2000). This difference is based on the belief that psychological disorders are more controllable than physical illnesses (Crandall & Moriarty, 1995). Traits that are perceived as being under a person's control, such as drug addiction or HIV status, result in the assignment of greater blame to the individual's character (i.e. weak morals or lack of self restraint). However, stigmas that are deemed as 'situational' (i.e. someone is handicapped because

of a car accident) would not likely result in a judgment of the person's character.

Social Psychological Components of Stigma

Social Cognition

As with many social psychological constructs, there are cognitive, affective, and behavioral elements that interact in the process of stigmatization. As Ottati, Bodenhausen, and Newman (2005) suggested, these components are critical in the understanding of the stigma of mental illness. Stigmatization can be understood as a product of knowledge structures (Crocker & Lutsky, 1986). Social cognition can be useful in conceptualizing how stigmatization occurs through mediating thought processes. Corrigan (2000) presents a useful social cognition model of mental health stigma: descriptive stimuli → cognitive mediators → behavioral response. This social cognitive perspective illuminates how social cues that signal the presence of a devalued trait, such as talking to one's self or lack of eye contact, are given particular meaning by knowledge structures (stereotypes of the mentally ill), which can result in behaviors (avoidance, discrimination).

As social cues are interpreted and given meaning by mediating knowledge structures, stereotypes influence the meaning of social signals (e.g. physical appearance or group membership). Stereotyping involves a cognitive representation of a group (often a generic, narrow view) to be stored, activated, and then retrieved from memory when stimulated by a cue. At the root of this cognitive approach to stigma is the natural tendency to categorize stimuli. This routine process of categorization results in the

formation of general principles and expectancies about the vast amount of information encountered in everyday life (see Allport 1954; Campbell 1956; Tajfel, 1969). The process of categorization conserves mental resources and maximizes the ability to respond appropriately to social situations and to predict others' responses. However, this process can lead to stigmatization, as in the case of those with a mental disorder being categorized uniformly as incompetent or unpredictable.

Although stereotypes often consist of inaccurate or exaggerated generalizations about members of a group, they can be based on a kernel of truth. Our sensitivity to information varies, and particularly distinctive information can greatly influence the formation of stereotypes. Furthermore, negative information has been shown to be particularly distinct and even more available than positive information, which makes negative associations of minority groups easier to recall (Fiske, 1980). Using this concept of the availability of unusual and negative information combined with the rate with which we encounter the mentally ill, our perceptions can be strongly influenced by the novelty of such encounters with a member of this minority group (Ottati, et al 2005). To compound this issue of a negative trait associated broadly with a minority group, research on stereotypes has found that members of a stigmatized group are judged overall to be less competent and less friendly (Fiske, 1998).

Other studies suggest that pre-existing perceptions can cause even further bias by influencing the attention, interpretation, and recollection of new information (Bodenhausen, 1988). When new information or evidence about a minority member is

encountered, it is likely that we will succumb to an expectancy bias to confirm our original perception. Our biased perceptions influence which information is attended to and stored and determine our expectations toward a member of that group. An experiment by Langer and Abelson (1974) showed that altering a label or social category can greatly influence how people view the same actions by the same person.

Another factor to consider is how the stigmatized think about themselves. Being the victim of stigmatization and knowing the cultural stereotypes associated with a particular group can shape the cognitions of negatively labeled people. According to Pachankis (2007), the stigmatized are often preoccupied with the label or trait, vigilant about hiding the trait, and suspicious of others. Additionally, knowing the cultural values placed on certain traits leads people with stigmas to consider the consequences of revealing themselves as a member of that group; such exposure is likely when seeking services or help relating to the devalued trait. In summary, research in social cognition has been critical in understanding the processes at work in stigmatization. A cognitive approach illuminates how negative stigmatizations are developed and explains their consequences and resistance to change.

Affective Components

Social cognition models can explain affective changes in the stigmatization process. As individuals compare themselves to, or compete with, an out-group (the stigmatized), their negative feelings toward the stigmatized result in a prejudicial attitude towards members of the out-group. Affective reactions and subsequent discriminatory

actions can be examined using Systems Justification Theory, which explain the rejection of other people based on a singular characteristic. This theory posits that injustices and inequalities are rationalized and people will accept stereotypes that support the status quo by blaming individuals for their stigmatized characteristics, instead of attributing differences to situational or environmental factors. According to this theory, guilt, frustration, and anxiety can be decreased if the group is perceived to deserve the treatment or that the negative treatment is inevitable; meanwhile, one's own satisfaction increases with comparisons to the disadvantaged (Tyler & Jost, 2007). Excluding those with the devalued trait can also lessen the anxiety or discomfort of those in non-stigmatized groups.

Attribution theory is also useful in elucidating the affective reactions at play in the stigmatization process. A study of attribution theory suggested that variation in the treatment of the stigmatized is based on the characteristics of the specific stigmatized trait. In this study, Weiner et al. (1988) compared physically based stigmas with mentally and behaviorally based stigmas. The study found that among the ten stigmas in the experiment, the attribution of blame for the possession of the stigmatized traits was not equal and varied based on the level of personal responsibility that was associated with each trait. The study also found that when stigmatized persons are perceived as 'needy,' or if they are not perceived to be extending the proper amount of effort to remedy their situation, then people may react with anger toward them and be unlikely help to them. However, if such persons are deemed unable to help themselves (such as a disabled child)

then people react differently and more positive social responses are likely when a low level of personal responsibility is attributed to the trait.

How people choose to make attributions based on the type of trait is similar to the fundamental attribution error. Using the attribution theory to explain stigmatization is useful as it takes into account how perceptions of the reasons for the presence of the stigmatized trait can alter expectancies, motivation, aggression, helping-behavior, withdrawal, and social motivation (Weiner, Perry & Magnusson, 1988). Analyzing these perceived reasons can shed light on why some stigmatized groups are seen more negatively and demeaned more than others. The main affective reaction to a stigmatized trait is prejudice, which involves negative feelings towards someone deemed to be in an out-group. The affective implications among those stigmatized, which can include shame, guilt, hostility, anxiety, and demoralization, are also important considerations in the stigmatization process (Pachankis, 2007).

Behavioral Components

Stereotypes and prejudicial attitudes often result in discriminatory behavior. Discrimination manifests itself in negative treatment and low social status. As described by Sidanius & Pratto, those associated with a stigmatized group experience discriminatory treatment and actions against them in the areas of education, employment, law, housing, and health care (1999). The behavioral manifestations of stigmatization can include social avoidance, isolation, and poor relationship skills (Pachankis, 2007). However, the effects of stigmatization do not end there. Not only do those who are

stigmatized take the brunt of others' stereotypes, prejudice, and discrimination but they may also internalize this stigma, come to believe it, or personally endorse societal views of the trait, which could have other adverse cognitive consequences. As discussed previously, many studies regarding stigma have focused specifically on the outcomes of those who are stigmatized (i.e., Steele & Aronson 1995; Brown & Pinel 2002; Schmader and Johns, 2003; Walton & Cohen, 2007; Quinn & Chaudoir, 2009; Hatzenbuehler, Nolen-Hoeksema & Dovidio, 2009).

In examining stigma and social exclusion, Major and Eccleston (2005) identified four types of responses: enhancing relational desirability, seeking alternative bases of inclusion, avoiding situations where exclusion is anticipated and deflecting exclusion from the personal self. Attributing negative feedback to one's group membership instead of one's own self is a coping mechanism used to protect self-esteem; this function can even be employed when it is not rational to attribute the failure to prejudice (Crocker & Major, 1989). As Major and Eccleston (2005) point out, blaming the rejection on a group stereotype makes it about the stigmatized group—not about the individual who harbors the prejudice but about the characteristics shared by all members of the stigmatized group. They further propose that the more a person identifies with the stigmatized group, the more their self-esteem will be protected (Major & Eccleston, 2005). In the same way, when the exclusion based on others' prejudice is rationalized as unjust and undeserved, it is therefore not an expression of anything that the target has done. This attribution of unfair prejudice serves to protect self-esteem. Again, the more that one believes the

rejection is unfair or unjust, the more self-esteem will be protected.

Not all people with a stigmatized trait necessarily have the same level of awareness regarding the stigmatization. People vary in terms of whether they characterize stigma-based reactions, such as discrimination, as being directed towards their group as a whole or towards themselves personally. Prior research on this topic found that those high in stigma consciousness (as measured by the SCQ – Stigma Consciousness Questionnaire) were found not to make this differentiation (Pinel, 1999).

Components of Stigma

Link (2001) offers a clear explanation of the mechanisms involved in stigmatization and identifies four necessary components in stigmatization. First, a distinguishing characteristic or trait must be labeled. However, as Pachankis (2007) and Crocker, Major & Steele (1998) have pointed out, stigma goes beyond merely being different or being in the minority and can be even observed in populous groups such as women (who make up approximately half the population). So, stigma is not wholly dependent on being unique, odd, or in the minority of a population.

The second component Link identified involves dominant cultural beliefs linking those labeled to negative stereotypes, such as the stereotype that members of a certain race are naturally aggressive or cannot be trusted. The third component entails those being labeled as viewed as a separate, distinct category from those doing the labeling (i.e. *they* were in a mental hospital and are therefore unstable, whereas *we* are sane). The fourth component in Link's description of the elements of stigma states that in order for

stigmatization to occur, those being labeled must “experience status loss and discrimination that lead to unequal outcomes with regard a broad arrays of life chances, including jobs, housing, health care, quality of life, self-esteem, and longevity” (Link, 2001, p.8). A situation of unequal power, in which those who are prejudiced and discriminate against those with the negatively viewed trait, is therefore a key aspect. Furthermore, not only does stigma take place in settings of unequal power, but it also serves to maintain and expand this inequality by “reproducing relations of social inequality that are advantageous to the dominant class...and maintaining....the socio-political status quo” (Deacon, Stepheny, & Prosalendis, 2005, p.18).

Race and Mental Health Stigmatization

As a racial minority group with a history of discrimination, African Americans are at an increased risk for mental illness because of experiencing the effects of racism and discrimination. According to Schneider, Hitlan, & Radhakrishnan (2000), these negative experiences and lack of social power results in African Americans having a higher likelihood for low-income jobs, multiple role strain, and increased health problems, which can precipitate the onset of mental health problems. However, despite the need for mental health services in the African American community, there appears to be a high level of stigmatization and rejection surrounding mental illness. In a study on acceptability of treatment for depression Cooper, Gonzales, Gallo, Rost, Meredith, & Rubenstein (2003) found that African Americans were less likely than Whites to view antidepressant medication and counseling as socially acceptable. Similarly, the U.S.

Department of Health and Human Services (2001) verifies that the use of mental health services among African Americans is low compared to Whites. However, other studies, such as Ojeda & Bergstresser (2008) found the opposite; white men were the most likely to avoid mental health care because of perceived mental illness stigmatization.

Summary

Social science research on stigmatization has grown prolifically since the 1960s due, in part, to Goffman's influential work, which explored how a devalued trait could result in social rejection and a loss of power. Definitions of stigma have varied among researchers (i.e. Leary & Schreindorfer, 1998; Crocker, Major & Steele 1998; Link & Phelan, 2001; Pachankis 2007); however throughout various works, the devaluing of a characteristic has been linked to the social context. As people search for a causal understanding, including the cause of an undesired trait, many of Weiner's studies (1980; 1985; 1993; 1995) are useful in applying theories of attribution towards understanding stigmatization. In particular, Weiner's more recent research (1993; 1995) identified how the perception of stability and controllability of the stigmatized characteristic affect the attribution of blame for the trait. Subsequently, the nature of a disease can determine the type of stigmatization. As many people believe that psychological disorders are more controllable than physical illnesses, those with psychological disorders are stigmatized more than those with a physical ailment (i.e. Bishop, 1987; Crandall & Moriarty, 1995; Corrigan, River, Ludin, Wasowski, Campion, Mathisen, Goldstein, Bergman, Gagnon, & Kubiak 2000).

In discussing the stigmatization of mental health Ottati, Bodenhausen, and Newman (2005) stress the importance of examining cognitive, affective, and behavioral constructs. Research in social cognition is useful in analyzing how social categorization occurs (i.e. Allport 1954; Campbell 1956; Tajfel, 1969) and analyzing the role of recall, particularly within minority groups (Fiske 1980; Bodenhausen, 1988; and Ottati, et al 2005). These concepts then can be applied specifically to members of stigmatized groups (Crocker & Lutsky, 1986; Corrigan 2000). People with a concealable stigma might try to hide a trait in an attempt to avoid negative categorization; however there are still affective sequelae that can include shame, guilt, hostility, anxiety, and demoralization (Pachankis, 2007). If the trait or symptoms of the trait become revealed, the people who are associated with a stigmatized group can experience discrimination and low social status (Sidanius & Pratto 1999). Further outcomes of discrimination of the stigmatized can include social avoidance, isolation, and poor relationship skills among those who have this devalued trait (Pachankis, 2007). Other research has explored why some stigmatized groups are seen more negatively and demeaned more harshly than others (Weiner, Perry & Magnusson, 1988). Similarly, research on social exclusion has analyzed how those with various stigmatized traits are perceived and how exclusion or inclusion may vary (Major & Eccleston. 2005).

This present study seeks to investigate the stigmatization of two concealable traits, mental illness and drug addiction. By exploring these specific stigmas, more can be learned about treatment adherence and making referrals for these common disorders. By

gauging the perceived stigma of both mental health and drug addiction, this study will compare the two while analyzing the correlations among perceived stigma and stigma consciousness, race, gender, and probation program of the participants.

CHAPTER THREE

METHODOLOGY

The main purpose of this study was to examine the perceived stigma of mental illness compared to the perceived stigma of drug addiction among criminally involved persons who may be eligible for mental health or addiction referrals. Treatment Alternatives for Safe Communities (TASC) agreed to cooperate in this research, which employed a mixed- methods design in order to explore, describe, and compare the stigmatization of mental health illness to the stigmatization of drug addiction among drug users. Two studies were conducted. The first included probation clients as participants and the second involved case managers as participants.

In Study 1, three groups of participants were surveyed on their perceptions of stigma and stigma consciousness. The first group consisted of drug probation case management clients with no known mental health problems, the second group was drawn from the general probation population and served as a non-equivalent comparison group of criminally involved persons, and the third group comprised of Mental Health Court (MHC) clients, who have both mental illness and drug addiction. In Study 2, case managers were interviewed for evidence of the effects stigma in relation to their clients and barriers to treatment.

Study 1: Client Perceptions of Stigma and Level of Stigma Consciousness

A survey was administered to measure the participants' 1) perceived stigma towards someone who has been treated for substance abuse, 2) perceived stigma towards someone who has been treated for a mental disorder, 3) level of stigma consciousness regarding drug abuse, and 4) level of stigma consciousness regarding mental illness, while controlling for basic demographic characteristics. Six hypotheses were tested to investigate whether mental illness has a higher perceived stigma than drug addiction in this population, if this varies among the three client groups, and whether stigma consciousness correlates with any of the scales.

Hypotheses

H1: Group 1 (drug program clients) and Group 2 (standard probation clients) will report higher scores on their perceived stigma for drug addiction than for mental illness. Group 3 (Mental Health Court clients) will show the opposite and report higher scores on perceived stigma for mental illness than for drug addiction. This prediction is based on a recent study by Corrigan, Kuwabara and O'Shaughnessy (2009) who found that in the general public, people with drug addiction were seen to be more blameworthy than people with mental illness. It is predicted that Group 1 and Group 2 participants will echo the public's attitude of viewing addiction as more stigmatizing than mental illness. However, it is predicted that Group 3 (Mental Health Court clients) will rate addiction as having a lower perceived stigma than mental illness because they have experienced the stigma of mental illness.

H2: Among all client groups, those participants who are high in stigma consciousness for mental illness will report higher perceived stigma for mental illness.

H3: Among all client groups, those participants who are high in stigma consciousness for addiction will report higher perceived stigma for addiction.

H4: African American clients will score higher on the perceived stigma of mental illness scale than other racial group participants. Previous studies have indicated that among African Americans, a high level of stigma is associated with seeking mental health services (Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2000). As the majority of the TASC client population (80%) is either African American (67%) or White (13%), this study will focus on these two racial groups, as it would be difficult to generate a large enough sample to properly represent clients in other racial groups.

H5: Gender is predicted to play a role in the perceived stigma of mental illness. Men are predicted to have higher scores of perceived stigma of mental illness compared to women, based on previous findings about gender and attitudes regarding mental health care (Oliver, Pearson, Coe, Gunnell, 2005; Ojeda and Bergstresse, 2008).

H6: No effect of age is predicted based on the findings of Ward and Heidrich (2009), showing that perceptions of the stigma of mental illness did not correlate with age differences.

Recruitment and Procedure

Group 1

For clients in the Adult Criminal Justice Services (ACJS) program, the opportunity to volunteer to participate in the study was offered by case managers during the months of August and September while clients were at the office for their regular appointment for drug-related case management. After completion of their case management sessions or while waiting for their appointments, clients (as identified by case managers as having no history of mental illness, and no current/pending psychiatric evaluations), were offered the opportunity to participate in the study. Participants were advised to read the informed consent form and instructions about participating in the study (Appendix A). The case manager briefly introduced and distributed the survey for Group 1 participants (Appendix B). It was stated that their choice to participate would not affect their relationship with their caseworker, TASC, or their treatment in any way. Participants took the survey while alone in the case manager's office, when the space was available, or in the TASC waiting area. They were instructed to deposit the completed survey in a designated envelope and then office staff distributed the incentive. Group 1 consisted of a total of 71 ACJS clients who participated in the survey.

Group 2

The researcher was stationed in an office just outside of the probation waiting room in the basement of the Cook County Courthouse at 26th and California Avenue. The researcher announced the opportunity to participant to clients in the waiting room

approximately every half hour. Those electing to participate were brought to the researcher's office either while they waited for their appointment with their probation officer, or after their session had ended. The front-desk reception staff was made aware of which clients were currently in the survey office for reasons of safety and security and to permit probation officers to locate their client when it was time for their appointment and the clients' services were not interrupted. In the researcher's office, the study was explained and participants were advised to read the informed consent form and instructions about participating in the study (Appendix A). After completing the questionnaire (Appendix C), participants placed their survey in an envelope in the researcher's office and received the incentive for participation. The researcher assisted two participants who reported forgetting their reading glasses by reading the survey aloud and recording their responses on their behalf. Group 2 had a total of 30 clients from the standard probation program who participated in the survey.

Group 3

The researcher was present for nine days when the Mental Health Court was in session in order to recruit participants. While waiting for court to begin, or after the court session, the researcher was introduced to clients by TASC staff and the researcher introduced the participation opportunity. The researcher verbally stated that taking the survey was their choice and that their individual survey responses would be kept confidential and anonymous to TASC staff. Participants were advised to read the informed consent form and instructions about participating in the study (Appendix A). Participants

filled out the survey (Appendix D) in a quiet hallway outside of the courtroom; when available, some participants sat in an unused courtroom while filling out the survey. The researcher stayed in the area to answer any questions and to administer the survey to participants that needed assistance. A few participants requested help reading due to vision problems or low literacy levels. The researcher assisted three participants in reading the survey and provided examples and definitions of key words, such as “stereotype”. After completing the questionnaire, participants placed their survey in an envelope, and received their incentive for participation from the researcher. Group 3 had a total of 30 participants who participated in the survey.

Incentive

In addition to appealing to the participants’ sense of altruism by helping to enhance services for future clients, the researcher offered a \$5 gift card to Dunkin Donuts as an incentive for participation.

Materials

The first section of the survey measured the dependent variable: perceived stigma. The Perceived Stigma of Addiction Scale (PSAS) was used as well as the PSAS modified by the researcher for mental illness (Luoma et al., 2010). Independent measures included Stigma Consciousness Questionnaire (SCQ), modified by the researcher for addiction and mental illness (Pinel, 1999). General demographic questions on race, age, and gender were also presented. The survey was customized for each participant group so that it reflected personalized questions related to the stigma associated with receiving drug addiction or

mental illness treatment (Appendices B, C, and D). Group 1, who were clients in TASC's Adult Criminal Justice Service program, received the survey that had questions regarding drug addiction treatment but was neutral regarding mental illness treatment (Appendix B). Group 2, standard probation clients, received the survey that was neutral toward both mental illness and drug addiction services (Appendix C). Group 3, client in TASC's Mental Health Court program, received a survey that was geared toward mental illness but was neutral regarding drug addiction (Appendix D).

Perceived Stigma

The Perceived Stigma of Addiction Scale (PSAS) is a self-report measure of perceived stigma towards substance users that has previously been developed and tested for construct and internal consistency (Luoma, Rye, Kohlenberg, Hayes, Fletcher, & Pratte, 2010). This measure is based on the discrimination and devaluation items created by Link (1997), which were originally designed for mental illness stigma. In order to provide a comparable measure for the perceived stigma of mental illness, the PSAS was modified by substituting "mental illness" in place of "substance abuse". The measure used a 7-point Likert scale, ranging from (1) strongly disagrees to (7) strongly agree. Six of the eight PSAS items were reverse-scored.

Stigma Consciousness

A modified version of the Stigma Consciousness Questionnaire (SCQ) was used to measure levels of both drug addiction- and mental illness-related stigma in survey items 17-36 in all three versions of the survey. Items from the SCQ measure the expectation that

one will be stereotyped based on the stigmatized trait, regardless of their behavior (Pinel, 1999). The SCQ has been used to determine stigma consciousness for both ascribed physical traits, such as gender, and concealed stigmatized traits, such as sexual orientation, but has not yet been used for the specific domains of drug addiction or mental illness. The constructs of addiction and mental illness were inserted into the measurement items. Although the original scale used a 7-point scale, ranging from (0) strongly disagree to (6) strongly agree, the researcher changed the scale format to 1 being 'strongly disagree' to 7 being 'strongly agree' in order to match the PSAS, to maintain consistency between the scales, and to avoid confusion among participants since all items were presented in one survey. Seven of the ten SCQ items for both constructs were reverse-scored.

Study 2: Case Manager Interviews

TASC case managers were offered the opportunity to meet with the researcher to participate in an interview about their perceptions of clients' mental health stigma and their experiences with stigma as a barrier to treatment. Prior to conducting case manager interviews, three TASC staff members were interviewed to allow the researcher to practice the questions while testing the organization and flow of the interview schedule. The researcher attended a staff meeting at which all case managers (N = 14) were present to introduce the study, recruit participants, and all case managers were provided the researcher's contact information in order to contact the researcher privately to participate. None of the case managers used the provided information to schedule an interview. Due to the lack of response, while on-site at TASC offices and the courthouses, the researcher

individually approached case managers to inquire if they might be available and willing to participate; this method more proved effective in recruiting participants. A total of 6 case managers participated in interviews which lasted from 10 to 25 minutes. All participants (N = 6) were currently employed as case managers at TASC. All participants were women and their experience as a case manager ranged from 1 month to 11 years.

Procedure

The researcher offered case managers the opportunity to volunteer as a participant, explaining the study and their rights as subjects. Participants received a copy of the consent form (Appendix G) and the researcher utilized an interview script (Appendix E) to ask questions regarding the staff's experiences with the stigmatization of drug addiction and mental health services. All in-person interviews took place in an isolated area of the TASC office or courthouse. Due to courthouse regulations, tape recorders were not permitted on the premises. Instead of recording interviews as planned, the researcher took detailed notes during and after the participants' interviews.

Hypotheses

This portion of the study is primarily exploratory; no specific hypotheses were formulated regarding the possible interview findings. In a qualitative study by Waite and Killian (2008) of African American's beliefs about depression, participants cited stigma as a significant barrier to seeking mental health services and blamed personal weakness, spiritual issues, or low self-esteem as reasons for mental health problems. Similar findings were expected in the case manager interviews for this study. However, the main purpose of the

interview was to obtain examples from case managers of clients' stigmatization of mental illness and drug addiction treatment in order to further illuminate the findings in the client surveys and to provide anecdotal evidence of how stigma acts as a barrier to treatment.

CHAPTER FOUR

RESULTS

Study 1

Participant Sample

A total of 131 participants were recruited from three Cook County Court locations (Skokie, Bridgeview and 26th Street) where TASC case management services are provided. TASC is a non-profit agency that serves as the bridge between the criminal justice and drug treatment systems. TASC professionals engage in assessment, case management, and advocacy for criminally involved people with substance use problems. Three participants were removed from the sample because of missing data (more than 10 of the 36 questions were blank) or because they gave repetitive responses to every item in the survey. The final sample size therefore included 128 respondents. Participants in Group 1 ($n = 70$) were recruited from TASC courthouse locations in Skokie, on Chicago's north side ($n = 14$), Bridgeview, on the south side ($n = 22$), and at 26th Street on the west side ($n = 34$). Participants in Group 2 ($n = 29$) and in Group 3 ($n = 29$) were recruited from the 26th Street location. Of the total sample, roughly two-thirds (68%) were men and one-third were women (32%). Ages ranged from 18 to 75 ($M = 34.63$, $SD = 12.9$). The composition of the sample was 62% African American, 20% White, 15% Hispanic, 1% Asian and less than 2% multi-racial or other.

The participant sample's demographic characteristics were compared with the characteristics of the TASC population. The sample was somewhat similar to the TASC client population in terms of race (62% African American in the sample and 67% in the TASC population) and gender (68% men in the sample and 80% in the TASC population). The sample's average age ($M = 34.63$, $SD = 12.9$) was lower than the average age of the TASC client population, whose average age is slightly greater than 40.

Results and Discussion

Perceived Stigma by Group

As seen in Table 1, the perceived stigma of mental illness is highest among Group 3 (Mental Health Court Clients). Participants in the MHC program reported a lower level of perceived stigma of drug addiction ($M = 3.39$) than of mental illness ($M = 3.70$). They also perceived more mental illness stigmatization than participants in the other two groups did. MHC participants live with the label of "a mental health disorder," and they have likely experienced stigmatization and developed a heightened consciousness regarding mental illness stereotypes and discrimination. It should be noted that many of the MHC clients also struggle with substance use problems and were initially brought into the court system because of drug charges or drug-related felonies; hence, they potentially face stigmatization for both drug use and mental health conditions. Group 3 could experience the social stigma of both of the labels examined in this study, but interestingly; the perception of mental illness stigma was found to be greater than that of drug addiction among people with mental illness.

With regard to the perceived stigma of drug addiction, Group 2 (Standard Probation Clients) had the highest mean score ($M = 3.70$), whereas Group 1 (Drug Program Clients) scored similarly ($M = 3.68$); however, Group 3 (Mental Health Court Clients) scored much lower on perceived stigma for drug addiction ($M = 3.39$). These findings were expected; the two groups that are not labeled with mental illness perceived less stigmatization regarding those afflictions. Previous studies suggest that low personal responsibility is associated with mental illness and higher personal responsibility is associated with drug addiction (e.g., Weiner, Perry, & Magnusson 1988, and Corrigan 2000). Likewise, the drug program and standard probation clients viewed those with mental illness as bearing less fault or blame for their illness than people with a drug addiction. Drug addiction is viewed by these participants as a condition that people could have prevented and, therefore, they are viewed as more blameworthy.

	<u>Mental Illness</u>		<u>Addiction</u>	
	Mean Score	Standard Deviation	Mean Score	Standard Deviation
Group 1 (n=70)	3.51	0.897	3.68	0.916
Group 2 (n=29)	3.40	0.944	3.70	0.932
Group 3 (n=29)	3.70	0.973	3.39	1.051
All Participants (N=128)	3.53	0.923	3.61	0.952

Table 1. Perceived Stigma of Addiction and Perceived Stigma of Mental Illness by Group

H1. *Group 1 (Drug Program Clients) and Group 2 (Standard Probation Clients) will report higher perceived stigma for drug addiction than for mental illness. Group 3*

(Mental Health Court Clients) will report the opposite, higher in perceived stigma for mental illness compared to drug addiction. With respect to the perceived stigma of drug addiction, Group 1 ($M = 3.68$) and Group 2 ($M = 3.70$) scored similarly, and both rated mental illness stigma lower (Group 1 $M = 3.51$, and Group 2 $M = 3.40$) lower than the perceived stigma of drug addiction. Group 3 (Mental Health Court Clients) reported higher perceived stigma ($M = 3.70$) for mental illness, compared with drug addiction ($M = 3.39$), supporting Hypothesis 1. However, in further analyzing the effect of group on perceived stigma, two one-way ANOVAs were run for both the perceived stigma for mental illness (PSAS-MI) and the perceived stigma for drug addiction (PSAS-ADD). There was no significant main effect of group for either PSAS-MI, $F(2, 125) = .841, p = .442$, or for PSAS-ADD, $F(2, 125) = 1.106, p = .334$. Therefore, H1 was not supported.

H2: Among all client groups, those participants who are high in stigma consciousness for mental illness will report higher perceived stigma for mental illness. Results showed that the stigma consciousness of mental illness was negatively correlated with the perceived stigma of mental illness, $r(128) = -.354, p < .01$. The inverse relationship suggests that as the perception of mental illness stigma increases, stigma consciousness decreases. Perhaps participants recognize the social stigma of mental illness while not acknowledging or expecting to be stigmatized personally. H2 was not supported; among all three client groups, participants who scored high in stigma consciousness for mental illness (SCQ-MI) did not report higher perceived stigma for mental illness (PSAS-MI). However, stigma consciousness for mental illness explained a

significant proportion of the variance (12.5%) in perceived stigma of mental illness, $R^2 = .125$, $F(1, 126) = 18.063$, $p = .001$.

A regression analyses (coefficients shown in Table 2) was run to explore the perceived stigma of mental illness among the 3 groups and revealed that stigma consciousness for mental illness was significant for both Group 1 (Drug Program Clients) ($p = .025$) and Group 3 (Mental Health Court Clients) ($p = .001$), but not Group 2 (Standard Probation Clients) ($p = .953$). In this model, gender was also a significant predictor of perceived stigma of mental illness for Group 1 (Drug Program Clients) ($p = .015$), but not the other groups, suggesting an interaction between group type and gender for the perceived stigma of mental illness, which will be further explored in the testing of Hypothesis 4.

		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
Group 1: Addiction – ACJS	(Constant)	4.634	0.676		6.857	0.001
	African American	0.376	0.197	0.209	1.903	0.061
	Male	0.581	0.231	0.28	2.51	0.015
	SCQmi	-0.375	0.163	-0.256	-2.302	0.025
Group 2: Neutral - General Probation	(Constant)	3.561	1.562		2.28	0.031
	African American	-0.473	0.368	-0.254	-1.287	0.210
	Male	0.032	0.537	0.015	0.059	0.953
	SCQmi	0.021	0.386	0.014	0.055	0.956
Group 3: Mental Illness – MHC	(Constant)	6.554	0.809		8.1	0.001
	African American	0.414	0.342	0.175	1.209	0.238
	Male	-0.129	0.287	-0.067	-0.45	0.656
	SCQmi	-0.797	0.175	-0.674	-4.563	0.001

Table 2. Perceived Stigma of Mental Illness by Group

H3: *Among all client groups, those participants who are high in stigma consciousness for addiction will report higher perceived stigma for addiction.* Overall, stigma consciousness for drug addiction (SCQ-ADD) was negatively correlated with the perceived stigma for drug addiction PSAS-ADD, $r(128) = -.301, p = .001$, demonstrating an inverse relationship between stigma consciousness for drug addiction and perceived stigma of drug addiction. Regression analysis also showed that stigma consciousness for drug addiction significantly predicted perceived stigma of addiction, $\beta = -.301, t(126) = -3.542, p < .01$, and explained a significant proportion of the variance (9.1%) in perceived

stigma of drug addiction, $R^2 = .091$, $F(1, 126) = 12.546$, $p = .001$. However, the third hypothesis was not supported. That is, participants with high stigma consciousness for drug addiction exhibited lower levels of perceived stigma compared to participants with low stigma consciousness.

In a regression analysis (Table 3) predicting the perceived stigma of drug addiction, with the data split by probation program type. Stigma consciousness for drug addiction was a significant predictor ($p=.005$) only for Group 1 (Drug Program Clients). This makes sense given that Group 1 is being treated for drug addiction and therefore these participants are more aware, or ‘conscious’, of the stigma of addiction. Interestingly, this effect decreased to $p = .066$ for the Group 2 (Standard Probation Clients) and to $p = .515$ for Group 3 (Mental Health Court Clients), suggesting that stigma consciousness was an important factor in determining Group 1 (Drug Program Clients) participants’ perception of addiction stigma, which makes sense given the role of addiction in their lives. However, this heightened consciousness (as measured by the SCQ-ADD) was negatively correlated ($B= -.333$) with the perceived stigma of addiction as measured by PSAS-ADD.

		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
Group 1: (Constant) Addiction - ACJS	(Constant)	5.162343	0.596821		8.649731	1.83E-12
	SCQadd	-0.39004	0.134524	-0.33266	-2.89943	0.005072
	Male	0.393943	0.241083	0.185656	1.634056	0.107009
	African American	0.027074	0.210843	0.014725	0.128407	0.898217
Group 2: (Constant) Neutral - General Probation	(Constant)	6.073391	1.083145		5.607183	7.82E-06
	SCQadd	-0.47421	0.246642	-0.36548	-1.92267	0.065985
	Male	-0.0719	0.412479	-0.03358	-0.17431	0.863028
	African American	-0.57709	0.334736	-0.31321	-1.72401	0.097053
Group 3: (Constant) Mental Illness - MHC	(Constant)	4.150416	1.641527		2.528388	0.018146
	SCQadd	-0.23944	0.362313	-0.13535	-0.66087	0.514738
	Male	0.277489	0.427289	0.132305	0.649418	0.521991
	African American	0.139323	0.507256	0.054636	0.27466	0.785835

Table 3: Perceived Stigma of Addiction by Group

Individual Predictors

H4: *African American clients will score higher on the perceived stigma of mental illness scale than other racial group participants.* Overall, there was no significant correlation between race and the perceived stigma of mental illness, $r(128) = -.048$, $p=.588$. African American participants were compared with other races in a regression analysis with race dummy-coded (African Americans were coded as 1 and all other races coded as 0). As shown in Table 2, race was not a significant predictor of the perceived stigma of mental illness in any of the client groups. However, for the Group 1 (Drug Program Clients), the results approached statistical significance $t(126) = 1.903$ $p=.061$.

However, hypothesis 4 was not supported as African American participants did not score significantly higher than participants of other races for the perceived stigma of mental illness.

Similarly, in predicting the perceived stigma of addiction, no significant correlation was found between race and the perceived stigma of mental illness, $r(128) = .108, p = .226$. When African American participants were compared to other races in a regression analysis predicting the perceived stigma of drug addiction with race dummy-coded (African Americans coded as 1 and all other races coded as 0), race was not a significant predictor of the perceived stigma of mental illness in any of the client groups (Table 3).

H5. Men are predicted to have higher scores of perceived stigma of mental illness than women. An analysis of variance for both PSAS-MI and PSAS-ADD by gender confirmed the significant effect of gender on the perceived stigma of mental illness $F(1,126) = 4.912, p = .028$, however women scored higher ($M = 3.79$) than the men ($M = 3.40$) in this sample, contrary to the hypothesis. A gender difference was not found for the perceived stigma of addiction $F(1,126) = .189, p = .644$, (Women $M = 3.67$ Men $M = 3.59$).

As gender was significantly correlated with the perceived stigma of mental illness, $r(128) = .194, p = .028$, an interaction between group membership and gender was tested for the perceived stigma of mental illness. In a regression analysis predicting the perceived stigma of mental illness, results showed that membership in the MHC

group was significant for men but not women (Table 4). Additionally, the effect of gender on stigma consciousness of mental illness (SCQ-MI) was significant for women, but not for men, as shown in Table 4. These two findings suggest a possible interaction of gender and stigma consciousness for the perceived stigma of mental illness (PSAS-MI). However, the interaction of Gender x SCQ-MI, was non-significant (Table 5).

		B	Std. Error	Beta	t	Sig.
Male	(Constant)	1.587	0.608		2.609	0.011
	African American	0.138	0.146	0.075	0.946	0.347
	MHC	0.489	0.21	0.187	2.332	0.022
	SCQ-MI	-0.161	0.12	-0.106	-1.341	0.184
	PSASadd	0.644	0.076	0.676	8.48	0.001
Female	(Constant)	3.564	1.053		3.385	0.002
	African American	0.348	0.224	0.182	1.551	0.13
	MHC	-0.101	0.231	-0.055	-0.439	0.663
	SCQ-MI	-0.415	0.164	-0.357	-2.526	0.016
	PSASadd	0.455	0.134	0.478	3.405	0.002

Table 4. Perceived Stigma of Mental Illness in Men and Women

<u>Main Effects and Interactions</u>	<u>B</u>	<u>b</u>	<u>t</u>	<u>p</u>
Gender	-0.341	-0.173	-2.108	0.037
SCQMICentered	0.004	0.003	0.011	0.991
Gender X SCQMICentered	-0.334	-0.368	-1.459	0.147

Table 5. Interaction of Gender and Social Conscious in Predicting Perceived Stigma of Mental Illness

Next, the effect of gender and group on stigma consciousness of mental illness was examined. There was a significant interaction between Gender X SCQMI in Group 3 ($p=.01$), as shown in Table 6. Simple slopes for high and low levels of SCQ were tested for both men and women within each program for predicting the perceived stigma of mental illness.

<u>Main Effects and Interactions</u>	<u>B</u>	<u>b</u>	<u>t</u>	<u>p</u>
Group 1: Drug Program				
Gender	-0.51	-0.245	-2.118	0.038
SCQmiCentered	-0.618	-0.423	-2.121	0.038
Gender X SCQmiCentered	0.351	0.195	0.992	0.325
Group 2: Standard Probation				
Gender	0.683	0.315	1.079	0.291
SCQmiCentered	0.805	0.509	1.343	0.191
Gender X SCQmiCentered	-1.271	-0.494	-1.643	0.113
Group 3: Mental Health				
Gender	0.234	0.12	0.904	0.375
SCQmiCentered	-1.293	-1.093	-5.514	0.001
Gender X SCQmiCentered	0.881	0.545	2.794	0.010

Table 6. Interaction of Gender and Social Conscious in Predicting Perceived Stigma of Mental Illness by Group

The simple slope for female participants was significant for participants in Group 1 (Drug Program Clients) ($b = -.681, p = .038$), not significant for Group 2 (Standard Probation Clients) ($b = .805, p = .191$) and significant for Group 3 (Mental Health Court Clients) ($b = -1.293, p < .01$). For female participants (shown in Figure 1), higher stigma consciousness for mental illness was related to lower perceived stigma for Group 1 (Drug Program Clients), unlike the other two groups. The simple slope for male participants was then run among the three groups; results revealed that the slope was not significant for participants in Group 1 (Drug Program Clients) ($b = -.266, p = .191$), not significant for Group 2 (Standard Probation Clients) ($b = -.466, p = .350$) and not significant for Group 3 (Mental Health Court Clients) ($b = -.412, p = .061$).

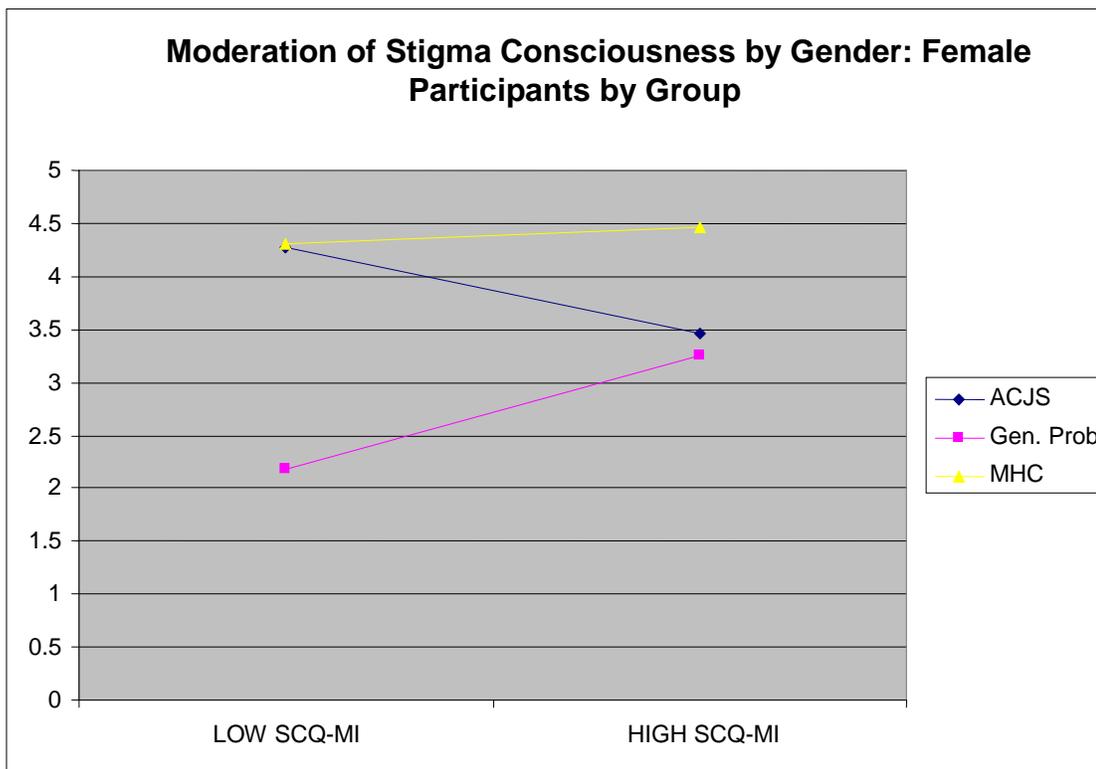


Figure 1. Moderation of Stigma Consciousness Perceived Stigma of Mental Illness: Female Participants by Group

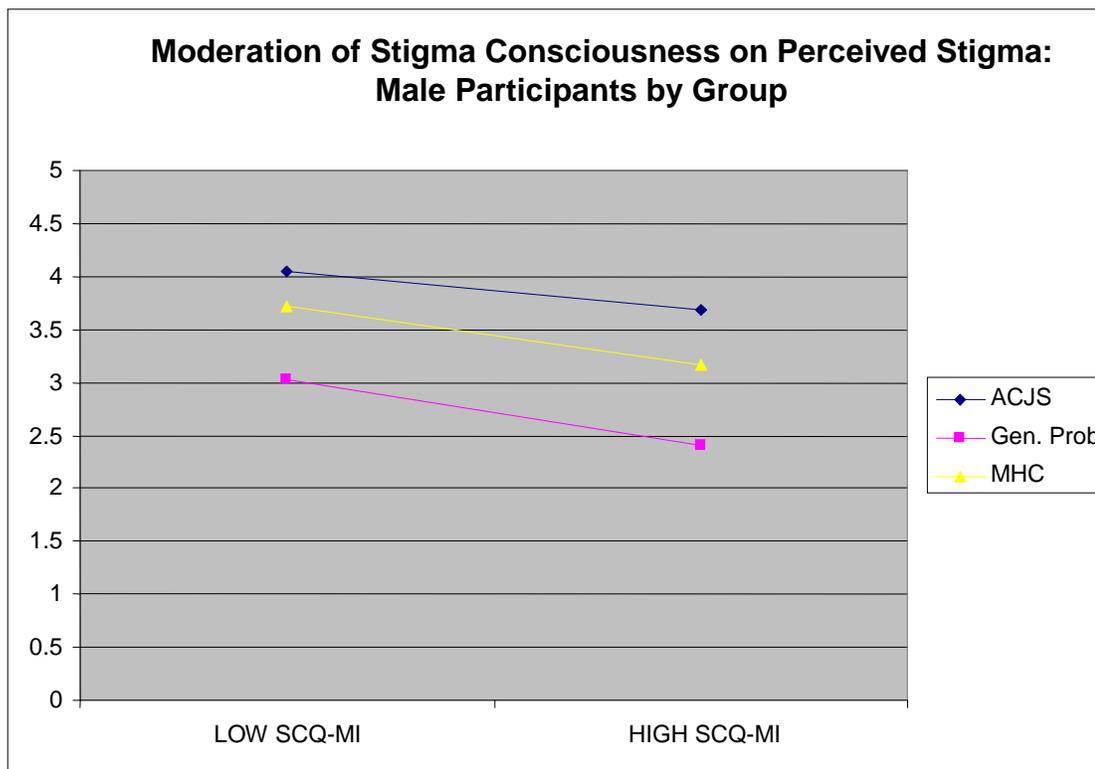


Figure 2. Moderation of Stigma Consciousness on Perceived Stigma of Mental Illness: Male Participants by Group

H6: *Age will have no effect on perceived stigma of mental illness.* Overall, there was no significant correlations between the perceived stigma of mental illness and age, $r(127) = -.039, p = .659$. H6 was supported and perceived stigma of mental illness did not correlate with age. Likewise, no significant correlation was found between the perceived stigma of drug addiction and age $r(127) = .199, p = .183$.

Discussion

Group Results. The results showed Group 1 (Drug Probation Clients) and Group 2 (Standard Probation Clients) perceived higher stigma associated with drug addiction than mental illness, while Group 3 perceived a higher level of stigma for mental illness than

for drug addiction. This result is particularly noteworthy, as these participants experience the social stigma of both mental illness and drug addiction yet rate these two differently and suggest that stigma reduction efforts should focus on mental illness for this particular client group.

Role of Stigma Consciousness. Perceived stigma and stigma consciousness were inversely related for both mental illness and drug addiction. To the best of the researcher's knowledge, no other studies have used these particular scales to measure these constructs so this is an area to be explored further. However, as the creator of the SCQ scale noted "... people high in stigma consciousness may actually reject stereotypes about their group more than people low in stigma consciousness" (Pinel, 1999, p.115). This could explain why those with high stigma consciousness did not perceived stigma as affecting them personally; and hence, the finding of lower PSAS scores among participants with higher consciousness scores.

Role of Race, Age, and Gender. Although participants' race and age did not predict perceived stigma, there were some interesting effects of gender. Gender was found to be a significant predictor for the perceived stigma of mental illness but not for the perceived stigma of drug addiction. Among women, there was an interaction of stigma consciousness of mental illness and group type. As seen in Figure 1, for women in Group 1 (Drug Program Clients), low stigma consciousness was associated with higher perceived stigma for mental illness than for women in Group 3 (Mental Health Court clients), there was not much change in perceived stigma despite a low or high stigma

consciousness. For men, across group membership (program type) low stigma conscious was correlated with a higher perceived stigma of mental illness.

Relationship between the Perceived Stigma of Mental Illness and Drug Addiction.

Overall, there was a high correlation between the perceived stigma for mental illness and the perceived stigma for addiction, $r(128) = .655, p < .01$, which suggests that persons who score high in perceived addiction stigma also score high on perceived mental illness stigma. People might have higher social awareness or be more sensitive to social cues that signify stigmatization. Similarly, stigma consciousness scores for both addiction and mental illness were significantly correlated, $r(128) = .283, p = .001$.

Study 2

Participants ($n = 6$) were current TASC case managers in either the Mental Health Court (MHC) or Adult Criminal Justice Service (ACJS) departments. All were women, and their experience as a case manager ranged from one year to more than 11 years. Case managers reported having between 26 and 100 clients on their caseloads. Case managers from both MHC and ACJS participated in the study.

Due to courthouse security protocol, voice recorders were not allowed in the courthouse building and the researcher had to make use of hand-written notes. The researcher's interview notes were elaborated with additional details immediately after the interview session. Upon completion of all six interviews, the case managers' responses were coded for common themes. The following topics were mentioned by the majority of

participants: reactions to stigma, family, examples, cultural and racial backgrounds, and tactics in confronting stigma.

Reactions to Mental Health Referrals

Within the MHC program, case managers reported that most clients have previously been in the mental health system, and the case managers serve to reconnect clients with services. Often this treatment had been interrupted by drug or alcohol addiction and the case managers help reestablish services while the client is in addiction recovery. With a history of previous mental health treatment combined with and judge's mandate to receive psychological therapy, medication, or other interventions as deemed appropriate, case managers reported that, overall, MHC clients display little resistance to treatment.

As participation in the MHC is voluntary and a means of avoiding jail time, MHC case managers report that clients are willing to accept mental illness treatment as part of the probation program and are compliant with services. For those clients who do not think they need medication or therapy, they mostly view the program as "just a hoop to jump through to avoid jail", a "means to an end", or another step towards getting clean. However, one case manager noted that the label "mentally ill" was problematic for clients who were actively employed or trying to become so, and "they see it (the label of mentally ill, and their criminal record due to their illness) as a hindrance."

ACJS case managers reported that clients had stronger objections to mental health treatment. Many reported that their clients do not want to be labeled as "crazy", and

therefore do not want mental health services, such as group therapy. This was reported to be especially true for clients who are in denial regarding their drug addiction. It is not uncommon for clients to state, “I don’t have a problem” after they were referred to therapy. For clients who are committed to ending drug use and confronting their addiction, they are more willing to try different methods of achieving sobriety, including psychological services. However, as one case manager advised, they are more accepting of mental health services if they are framed in the context of addiction, that “as long as it has that addiction element, there could be CBT (cognitive behavioral therapy), anger management, depression, other stuff in there....but if they can call it addiction counseling, then they feel better with it.”

Clients’ Families and Stigma

When case managers were asked for examples of clients who either rejected mental health referrals or expressed perceptions of stigmatization, a frequent topic they discussed was the clients’ family, family support, or family stigmatization of mental illness. One case manager noted that families might recognize symptoms of mental illness but not connect those behaviors with a mental disorder. “The family just noticed something was different, but didn’t attribute it to mental illness. Maybe he slept all day as teen, and his high school teacher mentioned that he was always sad. We need to educate the family about what mental illness is.”

Another example of the misunderstanding of what mental illness is and how it is treated was mentioned by another case manager. She discussed a client’s mother who,

after learning of her daughter's assignment to the Mental Health Court, responded, "My daughter ain't crazy. You can't put her in a crazy house." However, once the case manager explained that her daughter had depression, the mother's response was, "Oh, that doesn't make you crazy". This illustrates the how mental illness is often perceived as a very limited type of diagnosis and the assumption about how it is treated.

Another case manager commented that usually the family knows or has suspicions about the mental illness. When a case manager recalled an instance of telling a client's family about the need for mental health care the response was, "Yeah, he crazy." The case manager commented on this response, "I hate when they say that." However, many case managers interviewed also reported that some families support mental illness treatment and "recognize it as part of addiction treatment, or, are at least willing to accept mental health treatment as long as the main goal is to get them clean".

Another case manager mentioned that some families "don't buy into" mental illness and they see it as an excuse for behavior that they believe should be controlled. The same case manager also noted that some families use the client "as a check," in the form of disability payment, or social security collection, and that neither the mental health nor drug addiction is much of a concern of the family. Similarly, another interviewee expressed that sometimes family is just "fed up with their using" and might not be supportive of any type of treatment at all.

Conversely, another case manager commented that some family members of clients "blow the label (of mental illness) out of proportion". She shared that she explains

to the family that the client's "brain cells are not quite healthy, but with meds they can stabilize and be able to function." This case manager said she often compares mental illness to epilepsy in order to provide an example to show clients and their families who are struggling with the concept of mental illness that "it is a disease that can be treated with medicine, and although you need to be aware of the symptoms and try to prevent the onset of episodes, they still can be a functioning person." She continued to say that "much like with epilepsy, you shouldn't blame the client for health issues – including mental illness." She reported that equating a mental health diagnosis with epilepsy made it easier for some families to understand and accept the client's situation. This case manager stressed that everyone should be treated equally, regardless of mental health history or type of illness.

Two case managers mentioned that the family members of clients sometime blame the drug use or the drugs themselves for the onset of the mental illness. One case manager explained that a client's mother blamed her son for "bringing on" this problem of mental illness through the use of drugs and that "it (the onset of mental symptoms) wouldn't have happen if they stayed off drugs." Likewise, another family thought that "someone slipped them a 'mickey' when they were using" and that this caused the mental health concerns in their family member. This speaks to the misunderstanding of mental illness among the clients' family and support network.

Rejection of Mental Illness

Case managers in the MHC program reported that mental illness stigma was rarely discussed by clients and that the clients' "level of stigma depends on where they are at in the process of mental health services." However, an ACJS case manager mentioned that that following her suggestion of individual counseling, it is common for clients to respond, "No, no, I don't have a problem" and they do not initially accept the referral for services. Another MHC case manager pointed out that her clients understand that psychological services are part of probation plan, and even if they do not personally accept the need for these services, they see mental health treatment as a "means to an end" and will therefore comply. However, case managers in both MHC and ACJS reported that many clients felt that that they did not need medication. One case manager noted that mental illness stigma was a big concern for those who are employed and that they see their history and label as hindrance, especially as it is linked to criminal behavior.

Stigma as Influenced by Social Demographics

One case manager noted that there is much more resistance to mental health services among Latino men compared with other clients. This was especially difficult for her, as she has observed much severe depression and suicide in this specific population. She thought this was related to the concept of "Machismo," which promotes the idea of men being strong and not asking for help. She found the best way to help these clients was to connect them with resources specifically within their own community. This case

manager noted that clients who experience stigma because of cultural reasons should be referred to culturally sensitive care within their own communities, whenever possible.

Another case manager expressed that among her clients, African American men were highly likely to be stigmatized for mental illness. She added that they do not want any mental health services that could potentially cause anyone to label them as “crazy”. The same case manager noted that African American women are more accepting of counseling and psychological services than African American men. In her experience, women, “seem to be more aware of their meds, what they do, their symptoms, and diagnosis.” A different interview participant also expressed the same concern about African American men dismissing mental health services. She found that, overall, they were very wary of counseling and any treatment labeled as therapy. She reported that sometimes she needed to present mental health treatment as a facet of drug counseling and explain it within context of addiction in order for it to be more acceptable among African American men.

Stigma of Mental Illness Compared to the Stigma of Drug Addiction

Many case managers commented that mental illness is more acceptable than drug addiction because of the element of morality and choice associated with drug use. This is consistent with the literature on stigma types and the role of personal responsibility, given that there is low personal responsibility associated with mental illness and high personal responsibility associated with drug addiction. As one case manager stated, “people can’t help (having) mental illness, while the public thinks that people choose to use drugs.”

On the other hand, two case managers commented that clients would prefer receiving drug addiction services rather than mental health services. One case manager mentioned that if her client was referred to both and that if there was any barrier to getting to services, such as limited bus fare, she thinks they would choose attending drug addiction treatment over mental health treatment. This underscores the fact that drug addiction is the key concern of clients, not mental illness, and that clients might not necessarily understand the role of mental health problems in contributing to their substance abuse. However, as various case managers noted, mental illness and drug use are often connected. As two case managers pointed out, some clients use drugs to manage mental illness symptoms, to escape a background of trauma, or to self-medicate. One case manager noted that drug use can also begin when clients are seeking relief from the side effects of psychotropic medications.

Strategies in Confronting Stigma as a Treatment Barrier

To confront barriers that result from the stigma of mental illness, case managers relied broadly on education to change the perceptions of the client and the client's family. A key strategy was raising the client's awareness of their diagnosed illness, psychiatric medications, and the general benefits of treatment. Additionally, educating family members or significant others who can serve as a social support network also was recommended as a way to increase the acceptance of treatment and ensure follow-through with treatment plans. However, for many case managers educating proved to be difficult in a client base in which low literacy and poor education are common. This can cause

case managers difficulty in explaining mental illness services to their clients and the client's support system.

Another theme that was revealed is that mental illness stigma is not limited to clients and their families. Case managers detected stigma among other professionals and at the agency level in organizations that the clients are referred to or already involved with for other needs. Similarly, education was also a frequent strategy in dealing with other agencies and organizations that TASC works with in providing clients services. One case manager expressed frustration that drug treatment agencies do not want to treat a client with a mental health disorder; frequently, mental health providers do not want to treat the client until the addiction is under control. As one case manager clarified, "Both need treatment. But, both types (of providers) say the other should go first." This paradox appears to be a critical issue among providers who encounter clients with comorbid diagnoses and it is an on-going issue with case managers.

An example of this situation was reported by one case manager. Her client was not accepted into a drug treatment program because the intake worker noticed the client talking to himself, and when questioned by the intake worker, the client acknowledged that he hears voices. She recalled, "They sent him home! Where he would drink!" He was denied entry to the program due to his mental health despite the fact that he was not dangerous, or suicidal. The case manager further stated that this client was very coherent and lucid and would have greatly benefited from the intensive detoxification program had they allowed him to be admitted. After the TASC case manager advocated with this

particular institution regarding her client, over the course of six months of wrangling, he was finally allowed into the program. She found that the solution was to talk with people in upper management at the other agency to educate them about treating comorbidity, which was a mechanism to advocate for her client's addiction treatment. Another case manager agreed that "advocacy with the higher-ups at the partner agencies" was a good way to create change and make sure clients can receive the services that they need. If other agencies do not take the TASC case manager's word, she found that "psychiatrists seem to be successful in convincing them co-occurring treatment for comorbidity is okay".

Discussion

The interviews with case managers revealed several specific examples of how stigma can affect treatment or treatment planning as well as some additional complexities involving stigmatization that were unanticipated. ACJS case managers noted that many of their clients (in drug probation program) objected to mental health services and made statements that expressed stigmatization regarding mental illness. Several instances of misunderstandings about what mental illness is, its' symptoms, and how it can be treated were mentioned. Conversely, the MHC case managers reported that their clients typically complied with mental health treatment plans and accepted mental health services as just another part of their probation requirements.

Consistent with the literature, case managers confirmed that there was less personal responsibility associated with mental illness than drug addiction. Several case

managers explained that their clients view drug use and addiction as a moral issue, not a medical or psychological issue, and because of this view, they attribute more personal blame to drug users. It would be logical to think that mental illness treatment would be therefore more accepted. However, ACJS case managers reported that clients were concerned with not wanting to be called “crazy”, denied the need for help, and were mainly concerned with drug addiction. According to ACJS case managers, clients often do not truly understand how mental health services could help them in their path to sobriety.

An unexpected topic that was brought up in several of the interviews was the role of the clients’ families. After the interviews, it became clear that the clients’ family could be a substantial source of the clients’ perceptions of stigmatization. Families often serve as the primary support system, and their acceptance or denial of a problem (either related to drug use or mental illness) and their attitude toward treatment can influence the clients’ own stigmatization and views on treatment. Two case managers reported that clients’ families blamed their family member’s drug use for the onset of mental illness symptoms, which points to the need for education and the misperceptions about mental health. Case managers from both programs reported varying levels of family support. Some families demonstrated high levels of support in the treatment process whereas others were uninvolved or completely estranged.

In speaking with case managers, a range of strategies for confronting stigmatization were revealed. Several case managers mentioned that when they refer a

client to services or discuss treatment plans they are very conscious of the language and words they use with the client. Nearly every case manager interviewed cited education as the key to dealing with stigma as well as clients' misperceptions about mental illness and addiction. However, educating clients and their families was reported to be challenging with those who have low literacy levels or less than a high school education. In addition to educating the client and their family, educating other service providers was also a strategy used by case managers. Stigma within agencies was also revealed as a barrier to treatment, as service providers can misunderstand the complexities of co-occurring drug addiction and mental illness, and as a result, reject or delay needed services. In dealing with stigmatization among other service providers, case managers reported a combination of advocacy at the institutional level with education.

CHAPTER FIVE

CONCLUSIONS

Summary of Findings

Overall, the findings from staff interviews were useful in interpreting and illuminating the results from the client surveys. A strong correlation was found between clients' perceived stigma of mental illness and drug addiction, $r(128) = .665$ $p < .001$, and an unexpected inverse relationship was found between stigma consciousness and perceived stigma for both mental illness and drug addiction. While there was not any significant main effect of program type on perceived stigma as predicted, within program type there was an interaction between gender and social consciousness for the perceived stigma of mental illness. The examples and anecdotes provided by the interviewees provided rich information into how clients react to referrals for mental health services, the role of family, the link between race and gender and stigmatization of mental illness, and case managers offered a variety of strategies for facing stigma as a barrier to services. This information should be valuable to TASC staff in terms of both policy efforts and case management.

There were some discrepancies between the survey results and interview findings, however, much of this could be due to the studies limitations, such as statistical power given the relatively small sample size and any bias in the case managers interviews (especially given the interviewees were aware of the project's title and hypotheses). One

instance of an incongruity between the two studies was the role of race in client's perceived stigma. Race had no main effect on perceiving stigma for either mental illness or drug addiction; however, many case managers mentioned specific racial groups having a negative view of mental health services. However, the case managers also specified that it was the men within these racial groups (particularly African American men and Latino men) who maintained these views. Similarly, while case managers agreed that clients were more likely to stigmatize mental illness treatment, the client survey found that only those in the Mental Health Court program perceived more stigmatization against mental illness whereas the drug program clients and standard probation clients perceived more stigmatization against drug addiction.

Suggestions for Future Research

The negative correlation between stigma consciousness (SCQ scale) and perceived stigma (PSAS scale) is a finding that clearly calls for further study and exploration. It is possible that the SCQ is tapping into a cognitive understanding of the effects of stigmatization whereas the PSAS is assessing the perception of stigma expressed socially. To my knowledge, these scales have never been used together in the same study, which warrants further examination of these constructs and their relationship to each other. It would be worthwhile to investigate if women generally score higher than men on Stigma Consciousness, regardless of the stigma type.

Overall, as results of this study are very specific to a certain group of participants in the Cook County Criminal Court, this is only a starting point in examining the

relationship between the perceived stigma of mental illness and drug addiction. While the data provide specific information relevant to TASC and its' programs, the client survey data could be replicated in other settings and other jurisdictions for comparison and validation. Further research is needed to fully explore the dynamics that might be occurring in the relationships among gender, race, and perceived stigma of mental illness. Finally, the implication of perceived stigma on treatment adherence warrants further exploration.

APPENDIX A
CONSENT FOR SURVEY PARTICIPANTS

CONSENT TO PARTICIPATE IN RESEARCH

Survey Participants

Project Title: *Perceived stigma of mental illness among those with drug addiction*

Researcher(s): *Brenda Arsenault*

Faculty Sponsor: *Dr. Art Lurigio*

Introduction:

You are being asked to take part in a research study being conducted by Brenda Arsenault for a thesis project under the supervision of Dr. Lurigio in the Department of Psychology at Loyola University of Chicago. You are being asked to participate because you are either a TASC client in the Adult Criminal Justice Services program, a TASC client in the Mental Health Court, or are currently involved with Cook County Probation Court.

Please read this form carefully and ask any questions you may have before deciding whether to participate in the study.

Purpose:

The purpose of this study is to examine beliefs and attitudes regarding substance use, mental health, and people who may be treated for either addiction or mental illness.

Procedures:

If you agree to participate in the study, you will be asked to complete a written survey that will take approximately 20 minutes to complete.

Risks/Benefits:

There are no foreseeable risks in this study. You could potentially experience minimal stress or anger in recalling your own experiences of social stigmatization. You may choose to withdraw at any time if the study makes you uncomfortable. Please contact your caseworker or the researcher regarding any concerns or feelings that the study brought about. If a question on this survey makes you feel uncomfortable, please feel free to skip that question.

There are no direct benefits to participants from participating in this study. The opinions and information you provide in this survey may help to shape aspects of treatment and referral services for future clients in probation programs.

Compensation:

Participants who fill out the survey will receive a \$5 Dunkin Donuts gift card for their time.

Confidentiality:

No names or identifying information will be asked on the survey. Your responses to the survey will be kept confidential.

Voluntary Participation:

Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

Your choice on whether to participate will not affect your relationship with your case manager, probation officer, The Cook County Court system, TASC, or your treatment in any way.

Contacts and Questions:

If you have questions about this research project, you can contact the primary researcher, Brenda Arsenault, at barsenault@luc.edu or the faculty sponsor, Dr. Art Lurigio, at 773-508-3503 or alurigi@luc.edu

If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

Your completion of the survey indicates that you have read the information provided above, have had an opportunity to ask questions, and agree to participate in this research study. You will be given a copy of this form to keep for your records.

APPENDIX B
CLIENT SURVEY VERSION A

Version A

Demographic Information

Gender: ____ Male ____ Female

Age: _____

Race/Ethnicity (select all that apply):

____ Black, African American

____ White, European American

____ Hispanic, Latino

____ Asian, Pacific Islander

____ Native American, Alaska Native

____ Other (please specify)

Instructions: Please rate the following statements as 1 being you strongly disagree with through with number 7 being a statement you strongly agree with. Circle the corresponding number that best describes your level of agreement with each statement.

Strongly		Somewhat		Somewhat		Strongly
Disagree	Disagree	Disagree	Neutral	Agree	Agree	Agree
1	2	3	4	5	6	7

1. Most people would willingly accept someone who has been treated for substance use as a close friend.

1 2 3 4 5 6 7

2. Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen.

1 2 3 4 5 6 7

3. Most people would accept someone who has been treated for substance use as a teacher of young children in public school.

1 2 3 4 5 6 7

4. Most people would hire someone who has been treated for substance use to take care of their children.

1 2 3 4 5 6 7

5. Most people think less of a person who has been in treatment for substance use.

1 2 3 4 5 6 7

6. Most employers will hire some who has been treated for substance use if he or she is qualified for the job.

1 2 3 4 5 6 7

7. Most employers will pass over the application of someone who has been treated for substance use in favor of another applicant.

1 2 3 4 5 6 7

8. Most people would be willing to date someone who has been treated for mental illness as a close friend.

1 2 3 4 5 6 7

9. Most people would willingly accept someone who has been treated for mental illness as a close friend.

1 2 3 4 5 6 7

Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

10. Most people believe that someone who has been treated for mental illness is just as trustworthy as the average citizen.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

11. Most people would accept someone who has been treated for mental illness as a teacher of young children in public school.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

12. Most people would hire someone who has been treated for mental illness to take care of their children.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

13. Most people think less of a person who has been in treatment for mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

14. Most employers will hire someone who has been treated for mental illness if he or she is qualified for the job.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

15. Most employers will pass over the application of someone who has been treated for mental illness in favor of another applicant.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

16. Most people would be willing to date someone who has been treated for mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

17. Stereotypes about those who have a drug addiction have not affected me personally.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

18. I never worry that my behavior will be viewed as stereotypical of someone with a drug addiction.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

19. When interacting with the public, I feel like they interpret all my behaviors in terms of the fact that I have a drug addiction.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

- | | Strongly
Disagree | Disagree | Somewhat
Disagree | Neutral | Somewhat
Agree | Agree | Strongly
Agree |
|--|------------------------------|-----------------|------------------------------|----------------|---------------------------|--------------|---------------------------|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
20. Most people do not judge those who use drugs on the basis of their drug usage.
- 1 2 3 4 5 6 7
21. My drug addiction does not influence how other people with a drug addiction act with me.
- 1 2 3 4 5 6 7
22. I almost never think about the fact that I have a drug addiction when I interact with the public.
- 1 2 3 4 5 6 7
23. My drug addiction does not influence how people act with me.
- 1 2 3 4 5 6 7
24. Most people have a lot more prejudice thoughts about people who are addicted to drugs than they actually express.
- 1 2 3 4 5 6 7
25. I often think that the general public is unfairly accused of being prejudice towards those with a drug addiction.
- 1 2 3 4 5 6 7
26. Most non-drug users have a problem viewing drug addicts as equals.
- 1 2 3 4 5 6 7
27. Stereotypes about people with a mental illness do not personally affect those with a mental health problem.
- 1 2 3 4 5 6 7
28. People with mental illness don't worry that their behavior will be viewed as stereotypical of someone with a mental illness.
- 1 2 3 4 5 6 7
29. When interacting with the public, all the behaviors of people who have a mental illness are interpreted in terms of their mental health.
- 1 2 3 4 5 6 7

Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

30. The public does not judge the mentally ill on the basis of their mental health.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

31. People with mental illness treat other people with mental illness different from the way treat the general public.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

32. People with a mental illness are very conscious of their illness when interacting with the public.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

33. People act differently toward someone when they know the person has a mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

34. Most people have a lot more prejudice thoughts about mentally ill people than they actually express.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

35. People are unfairly accused of being prejudiced towards those with a mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

36. Most people have a problem viewing people with a mental illness as equals.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

APPENDIX C
CLIENT SURVEY VERSION B

Version B

Demographic Information

Gender: _____ Male _____ Female

Age: _____

Race/Ethnicity (select all that apply):

- _____ Black, African American
- _____ White, European American
- _____ Hispanic, Latino
- _____ Asian, Pacific Islander
- _____ Native American, Alaska Native
- _____ Other (please specify)

Instructions: Please rate the following statements as 1 being you strongly disagree with through with number 7 being a statement you strongly agree with. Circle the corresponding number that best describes your level of agreement with each statement.

Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

1. Most people would willingly accept someone who has been treated for substance use as a close friend.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

2. Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

3. Most people would accept someone who has been treated for substance use as a teacher of young children in public school.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

4. Most people would hire someone who has been treated for substance use to take care of their children.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

5. Most people think less of a person who has been in treatment for substance use.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

6. Most employers will hire some who has been treated for substance use if he or she is qualified for the job.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

7. Most employers will pass over the application of someone who has been treated for substance use in favor of another applicant.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

8. Most people would be willing to date someone who has been treated for mental illness as a close friend.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

9. Most people would willingly accept someone who has been treated for mental illness as a close friend.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

10. Most people believe that someone who has been treated for mental illness is just as trustworthy as the average citizen.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

11. Most people would accept someone who has been treated for mental illness as a teacher of young children in public school.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

12. Most people would hire someone who has been treated for mental illness to take care of their children.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

13. Most people think less of a person who has been in treatment for mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

14. Most employers will hire someone who has been treated for mental illness if he or she is qualified for the job.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

15. Most employers will pass over the application of someone who has been treated for mental illness in favor of another applicant.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

16. Most people would be willing to date someone who has been treated for mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

17. Stereotypes about those who have a drug addiction do not personally affect those with an addiction.

18. People with a drug addiction don't worry that their behavior will be viewed as stereotypical of someone with a drug addiction.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

19. When interacting with the public, all the behaviors of people who have a drug addiction are interpreted in terms of their addiction.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

- | | Strongly
Disagree | Disagree | Somewhat
Disagree | Neutral | Somewhat
Agree | Agree | Strongly
Agree |
|--|------------------------------|-----------------|------------------------------|----------------|---------------------------|--------------|---------------------------|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
20. Most people do not judge those who use drugs on the basis of their drug usage.
- 1 2 3 4 5 6 7
21. People with a drug addiction treat other people with a drug addiction different from the way that they treat the public.
- 1 2 3 4 5 6 7
22. People with a drug addiction are very conscious of their condition when interacting with the public.
- 1 2 3 4 5 6 7
23. People act differently toward someone when they know that the person has a drug addiction.
- 1 2 3 4 5 6 7
24. Most people have a lot more prejudice thoughts about people who are addicted to drugs than they actually express.
- 1 2 3 4 5 6 7
25. People are unfairly accused of being prejudice towards those with a drug addiction.
- 1 2 3 4 5 6 7
26. Most non-drug users have a problem viewing drug addicts as equals.
- 1 2 3 4 5 6 7
27. Stereotypes about people with a mental illness do not personally affect those with a mental health problem.
- 1 2 3 4 5 6 7
28. People with mental illness don't worry that their behavior will be viewed as stereotypical of someone with a mental illness.
- 1 2 3 4 5 6 7
29. When interacting with the public, all the behaviors of people who have a mental illness are interpreted in terms of their mental health.
- 1 2 3 4 5 6 7

Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

30. The public does not judge the mentally ill on the basis of their mental health.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

31. People with mental illness treat other people with mental illness different from the way treat the general public.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

32. People with a mental illness are very conscious of their illness when interacting with the public.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

33. People act differently toward someone when they know the person has a mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

34. Most people have a lot more prejudice thoughts about mentally ill people than they actually express.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

35. People are unfairly accused of being prejudiced towards those with a mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

36. Most people have a problem viewing people with a mental illness as equals.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

APPENDIX D
CLIENT VERSION VERSION C

Version C

Demographic Information

Gender: ____ Male ____ Female

Age: _____

Race/Ethnicity (select all that apply):

____ Black, African American

____ White, European American

____ Hispanic, Latino

____ Asian, Pacific Islander

____ Native American, Alaska Native

____ Other (please specify)

Instructions: Please rate the following statements as 1 being you strongly disagree with through with number 7 being a statement you strongly agree with. Circle the corresponding number that best describes your level of agreement with each statement.

Strongly							
Disagree	Disagree	Disagree	Neutral	Agree	Agree	Agree	Agree
1	2	3	4	5	6	7	

1. Most people would willingly accept someone who has been treated for substance use as a close friend.

1 2 3 4 5 6 7

2. Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen.

1 2 3 4 5 6 7

3. Most people would accept someone who has been treated for substance use as a teacher of young children in public school.

1 2 3 4 5 6 7

4. Most people would hire someone who has been treated for substance use to take care of their children.

1 2 3 4 5 6 7

5. Most people think less of a person who has been in treatment for substance use.

1 2 3 4 5 6 7

6. Most employers will hire some who has been treated for substance use if he or she is qualified for the job.

1 2 3 4 5 6 7

7. Most employers will pass over the application of someone who has been treated for substance use in favor of another applicant.

1 2 3 4 5 6 7

8. Most people would be willing to date someone who has been treated for mental illness as a close friend.

1 2 3 4 5 6 7

9. Most people would willingly accept someone who has been treated for mental illness as a close friend.

1 2 3 4 5 6 7

Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

10. Most people believe that someone who has been treated for mental illness is just as trustworthy as the average citizen.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

11. Most people would accept someone who has been treated for mental illness as a teacher of young children in public school.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

12. Most people would hire someone who has been treated for mental illness to take care of their children.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

13. Most people think less of a person who has been in treatment for mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

14. Most employers will hire someone who has been treated for mental illness if he or she is qualified for the job.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

15. Most employers will pass over the application of someone who has been treated for mental illness in favor of another applicant.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

16. Most people would be willing to date someone who has been treated for mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

17. Stereotypes about those who have a drug addiction do not personally affect those with an addiction.

18. People with a drug addiction don't worry that their behavior will be viewed as stereotypical of someone with a drug addiction.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

19. When interacting with the public, all the behaviors of people who have a drug addiction are interpreted in terms of their addiction.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

20. Most people do not judge those who use drugs on the basis of their drug usage.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

21. People with a drug addiction treat other people with a drug addiction different from the way that they treat the public.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

22. People with a drug addiction are very conscious of their condition when interacting with the public.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

23. People act differently toward someone when they know that the person has a drug addiction.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

24. Most people have a lot more prejudice thoughts about people who are addicted to drugs than they actually express.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

25. People are unfairly accused of being prejudice towards those with a drug addiction.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

26. Most non-drug users have a problem viewing drug addicts as equals.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

27. Stereotypes about people who have mental illness have not affected me personally.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

28. I don't worry that my behavior will be viewed as stereotypical of someone with a mental illness.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

29/. When interacting with the public, I feel like they interpret all my behaviors in terms of the fact that I am mentally ill.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

- | | Strongly
Disagree | Disagree | Somewhat
Disagree | Neutral | Somewhat
Agree | Agree | Strongly
Agree |
|--|------------------------------|-----------------|------------------------------|----------------|---------------------------|--------------|---------------------------|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
30. The public does not judge the mentally ill on the basis of their mental health.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
31. My mental health does not influence how others who are mentally ill interact with me.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
32. I almost never think about the fact that I have a mental illness when I interact with the public.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
33. My having a mental illness does not influence how people act with me.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
34. Most people have a lot more prejudice thoughts about mentally ill people than they actually express.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
35. I often think that people are unfairly accused of being prejudiced towards people with a mental illness.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
36. Most people have a problem viewing people with a mental illness as equals.
- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|

APPENDIX E
INTERVIEW SCRIPT

This interview is part of a research study on how those with drug addictions view mental health. Your participation is voluntarily and your choice whether to participate or not will not be shared with your supervisor or any of the staff at TASC.

Your comments will be anonymous in my report, and though I will be asking you to refer to specific instances or situations, please refrain from mentioning any client names as to protect their identity as well.

If you agree, I would like to tape this conversation. I will only use the audio tape help me recall what was said here when I write my report, then it will be destroyed. Depending on the length of your response, it is estimated that the interview will take approximately 10 to 20 minutes.

Do have any questions about this study or your participation? Are you willing to participate?

- 1) Approximate number of clients on caseload? Number seen per week?
- 2) Could you share with me the some of the range of reactions you have witnessed from clients if/when you recommend mental health services?
(Probes: Do caseworker feel/notice resistance to mental health services? Issues with a negative label attach to mental illness? Do you notice a lack of follow through with referrals for mental health treatment? Is this stigma causing a barrier, or is this resistance due to other reasons?)
- 3) Can you think of any specific instance(s) when your clients were either against receiving mental health services or denied addiction as a mental health issue/disorder? (please share. How common is this among your clients?)
- 4) How common is this (rejection of mental health services) among your clients?
- 5) Do you think this might be influenced by social background , such as religion or other cultural attitudes? (probe for examples)
- 6) How do you see the stigma of mental health disorders compare to the stigma of addiction?
- 7) In working with your clients, does the stigma around mental illness create any barriers in servicing or following through with treatment plans

8) (If mental health stigma among clients was expressed by caseworker...) How do they combat or counter this? , what might be options for decreasing and changing the clients' negative perception of mental health labels/ services?

APPENDIX F
DIRECTIONS FOR SURVEY DISTRIBUTION FOR TASC CASE MANAGERS TO
ACJS CLIENTS

Directions for Survey Distribution for TASC Case Managers

Step 1)

Please review your current caseload and identify potential participants – those who do not have a history of mental illness, a mental disorder, or have a pending psych evaluation.

Step 2)

After your case management session, please read the following script to the clients who you have identified in Step 1.

“You are being asked to participate in a research study conducted through Loyola University Chicago. Your participation is voluntary and your responses will be kept confidential. The study involves a paper survey that will take about 20 minutes. The purpose of the study is to examine beliefs and attitudes regarding substance use, mental health, and people who may be treated for either addiction or mental illness. No names or identifying information will be asked. Your choice on whether to participate will not affect your relationship with your me, TASC, or your treatment in any way.

A \$5 gift certificate to Dunkin Donuts will be given to you as a thank you for your time and participation.

Do you have any questions regarding the study or your rights if you choose to participate? Do you agree to participate?”

(If yes, please hand survey packet and pencil to client and direct them where to turn in the completed survey and how to receive the gift certificate).

Thank you again for your time and help with this project. I look forward to sharing the results with you and hope the study will provide information that can help shape treatment or referral services for future clients.

APPENDIX G
CONSENT FOR INTERVIEW

CONSENT TO PARTICIPATE IN RESEARCH
Interview Participants

Project Title: *Perceived stigma of mental illness among those with drug addiction*

Researcher(s): *Brenda Arsenault*

Faculty Sponsor: *Dr. Art Lurigio*

Introduction:

You are being asked to take part in a research study being conducted by Brenda Arsenault for a thesis project under the supervision of Dr. Lurigio in the Department of Psychology at Loyola University of Chicago.

You are being asked to participate because you are currently an employee of TASC who works with clients in the Adult Criminal Justice Services or Mental Health Court programs.

Please read this form carefully and ask any questions you may have before deciding whether to participate in the study.

Purpose:

The purpose of this study is to examine beliefs and attitudes regarding substance use, mental health, and people who may be treated for either addiction or mental illness.

Procedures:

If you agree to participate in the study, you will be asked to complete an interview with the researcher on your experiences with clients and your opinion of how your clients view mental health and mental health services. The interview is projected to last approximately 15 minutes, depending on the length of your response.

Risks/Benefits:

There are no foreseeable risks in this study.

The opinions and information you provide may help shape the researcher's recommendations to TASC regarding mental health stigmatization and add to the body of knowledge regarding stigmatization.

Confidentiality:

- Your statements made during the interviews will be confidential. All names and any identifying information will be removed when the research transcribes the interview. TASC management will not be informed of content of your responses or your decision not to participate.

- If you agree to an audio recording of the interview, the tape will be stored with the Primary Investigator (Brenda Arsenault) and at the conclusion of the research the tape will be erased and destroyed. If the interview occurs over the phone or over email, all notes and records will be stored with the Primary Investigator and destroyed at the conclusion of the study.

Voluntary Participation:

Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

Contacts and Questions:

If you have questions about this research project or interview, feel free to contact Brenda Arsenault at barsenault@luc.edu or the faculty sponsor Dr. Art Lurigio at 773-508-3503 or alurigi@luc.edu

If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

Your agreement to participate in the interview indicates that you have read the information provided above, have had an opportunity to ask questions, and agree to participate in this research study. You will be given a copy of this form to keep for your records.

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VITA

Brenda Marie Arsenault attended Judson College (1997-1998) and North Park University (1999-2001) where she majored in Sociology. While attending North Park, she explored her interests in social deviance and the criminal justice system. As an undergraduate she completed an original research project entitled, "Social Nudism: student views on the morality, deviance, and laws surrounding the clothing-optional lifestyle." She graduated with her Bachelor of Arts in 2001. After working in the non-profit sector, she began her studies in Applied Social Psychology at Loyola University Chicago in August 2008. In September 2009, she was awarded a research assistantship and began assisting on a program evaluation for the Center for Math and Science Education at Loyola. She conducted her master's thesis on the stigmatization of mental illness among the criminally involved under the direction of Dr. Arthur Lurigio and Dr. Linda Heath. Her research interests include sexual violence, school-based interventions, criminal justice, and program evaluation.