UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

SOCIAL DESIRABILITY AND SELF-REPORTED LEVELS OF STIGMA AMONG MENTAL HEALTH PROVIDERS AS IT RELATES TO PEOPLE WITH SCHIZOPHRENIA

A THESIS

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

Degree of

MASTERS OF HUMAN RELATIONS

By

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Norman, Oklahoma

2023

SOCIAL DESIRABILITY AND SELF-REPORTED LEVELS OF STIGMA AMONG MENTAL HEALTH PROVIDERS AS IT RELATES TO PEOPLE WITH SCHIZOPHRENIA

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Acknowledgements

I would like to thank several people who have influenced, supported, and encouraged me throughout my academic career thus far. First and foremost is my mother, Amoree Michalek. Thank you for being such a kind, supportive, and understanding mother, even in times when I was not necessarily deserving of those things you provided me. Thank you to my grandparents, Robert, and Diane Kusek. You both have always supported me in my choices and are willing to help in any way possible. Tayler, thank you for noticing my potential before I recognized it myself. It took a little longer than most would have liked, but I finally reached the conclusion you and mother saw so many years ago. Though, it is only the start of that realization as I have much, much more to develop and accomplish. I hope you will continue to watch my progress. Cole Seffense, you have been a cherished friend that has allowed me to passionately discuss my academic interests and pursuits even when you had absolutely no idea what I was talking about. I believe any person in their academic career needs a friend like you. Azad Almosov, you have helped change my understanding of certain scientific principles into an organized and comprehensible way in which I can apply to my academic career. Not to mention our long talks over tea. Rashad, your logical thought process really does help in deciding what is and is not important in life. Your ability to decide what is best for yourself and not others is something I am trying to incorporate into my life. Dr. Jody Worley, thank you so much for being a great committee chair and mentor throughout my masters and thesis. Without your help and guidance, I would have found myself very confused at times. You have allowed me to make my own path with minimal intervention which is appreciated more than you will know. And a final thanks to the rest of the committee, Dr. Linda Barnum, Dr. Chad V. Johnson, Dr. Brenda Lloyd-Jones, and Professor Rodger Randall.

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Abstract

This study explores the relationship between levels of mental health stigma in mental health providers, and how they compare to the general population. In this literature mental health stigma is explored through the lens of neuroscience, cognitive psychology, and the Mental Illness Stigma Framework (MISF). The participants in this study were divided into two dichotomous groups: general population and mental health providers. Two driving variables, levels of stigma and social desirability, were explored and compared between populations. The results of analysis demonstrated the difference in level of mental health stigma between both populations were not statistically significant. While level of social desirability was positively correlated, and elevated, in the mental health provider population with statistical significance as compared to the general population.

Chapter 1: Introduction

Social desirability and self-reported levels of stigma among mental health providers as it relates to people with schizophrenia

Purpose of Study

This study aims to explore the level of stigma and social desirability between mental health professionals and the general population. The construct of stigma within the general population has been researched extensively due to the large pool of potential participants and convenience (such as college students). Mental health professionals' level of stigma, though, has not been extensively researched *and* compared to the general population. By comparing these two distinct populations, an insight of how these professionals may be equally swayed by societal indoctrination in relation to those diagnosed with schizophrenia can be uncovered. It is equally important to understand the cognitions of mental health professionals as they are actively treating the clients, as they may unknowingly harbor stigmatizing beliefs about them and cause undue harm.

Background

Stigmatization is not a new concept within human society. In the time of ancient Greece, a "stigma" was a physical brand mark for slaves and criminals (Rössler, 2016). Now, it is conceptualized as an abstract phenomenon that consists of negative behaviors, thoughts, and beliefs individuals have about a specific group. These negative beliefs often lead to stereotypes that do not fully consider these individuals are in pain and suffering- instead, it perpetuates the cycle within society and disadvantages them. Stigmatization of individuals with mental health disorders is a widespread and damaging phenomenon, and if not corrected or combated, society will see the further consequences of this "silent battle of stigma."

The rise in notice of mental health stigma in academia began in the 20th century in 1963 by Erving Goffman, an American sociologist (Goffman, 2009). Those that are versed in the subfield of stigma will notice Dr. Goffman's research in the book titled, "*Stigma: Notes on the Management of Spoiled Identity*" (2009). At the heart of his piece of literature, he states that the incorrect labeling of patients with mental health disorders and the way they are treated create the very issues that society points to as what is "wrong" with the mentally ill. This was not particularly well received within the current academic era as psychiatrists and psychologists disputed that labeling was a necessary evil- it is needed for the psychological fields to categorize disorders. While this is not technically incorrect, Dr. Goffman was not criticizing the diagnosis and classification of mental health disorders. If this were the case, the title would most likely read in a way that said the whole field of psychology was a farce and whimsical land of diagnosis to cure the mentally ill. The finer point Dr. Goffman was trying to make is this: labeling and diagnosing mental health disorders is needed, just like in medicine they label and diagnose physical ailments, but how society *interacts* with these individuals, based on their stigmatizing beliefs, on an interpersonal level is the issue that needs to be understood and remedied.

Before serious inquiry on provider stigma began, Day and colleagues created a questionnaire Self-Assessment Stigma Scales to understand the severity of stigma in the general population (2007). Guided by earlier literature from the likes of Dr. Goffman, Dr. Day set out to understand society's negative beliefs and attitudes towards those diagnosed with depression, bi-polar disorder, and, more specifically to this literature, schizophrenia. This measurement has been instrumental in understanding the impact on the spread of the negative messages the media and individuals have disseminated due to the misunderstanding of schizophrenia. Their addition to the stigma literature has been invaluable to the field and this study in question.

While the study of stigma in the general population has been thoroughly considered, providers stigma had barely begun to gain notoriety within the stigma research community. To further the understanding and development of measuring provider stigma, Dr. Jennifer Charles developed the Mental Health Provider Self-Assessment of Stigma measure (2013). The purpose of the measure is not to condemn providers who scored with elevated levels of stigma. Instead, the purpose is to help bring attention to the potentially unhelpful or harmful behaviors providers may model towards their patients (similar to Dr. Goffman's proposition). Considering the date of publication, 2013, this is a recent but much-needed inquiry to help providers recognize the issues they may have with those diagnosed with schizophrenia.

Due to this misunderstanding of individuals with schizophrenia, the United States is experiencing the devastating effects of mental health stigma. Here are a few disturbing statistics that may urge those reading this literature to read onward. For example, individuals who are diagnosed, experiencing symptoms, and labeled with schizophrenia are *12 times* more likely to commit suicide (Saha, et al, 2007). This means that an estimated 24 out of 100,000 people who are diagnosed with schizophrenia or another psychotic disorder will end their life in the US (Fu, et al, 2021). These statistics are a minuscule representation of the difficulties that individuals affected by schizophrenia experience compared to the general population. This leads to the questions this study sets out to understand: to capture the level of stigma mental providers may have in their practice as compared to the general population, and how does social desirability potentially affect the outcome of scores.

Setting

The current study was conducted in Oklahoma, United States of America. The study participants for the general population were gathered from personal affiliations, mental health facilities in Oklahoma, social media platforms (such as Facebook, Instagram, Reddit, and LinkedIn), convenience and random sampling. For mental health providers, a list of LPC, LMFT, LCSW, and MSW (including candidates) were provided by the Oklahoma State Board of Behavioral Health Licensure. Emails were distributed to the mental health providers asking for participation in the study. The surveys were distributed via a link to Qualtrics, a third-party survey platform used by the University of Oklahoma. The minimum requirement for participation in both surveys were to be 18 years or older. Mental health professionals needed to be licensed in the state they practice in or are currently a student under supervision.

Significance of the Study

The aim of this study is to bring awareness to mental health stigma experienced by people diagnosed with schizophrenia, inflicted (unknowingly) by mental health providers. More specifically, the levels of stigma observed in the mental health provider population. A term, "associated stigma", will be mentioned later in this literature. Societies assume because mental health providers receive training to treat individuals with mental health disorders, they must also dislike or not harbor negative beliefs about their patients (Stanley, et al, 2023). Mental health providers can develop stigmatizing beliefs and stigmatize their cohort due to the associated stigma (Wallace, 2013). This study aims to add to the current literature of mental health provider stigma and how though society views providers as less susceptible to stigma, they are no more immune to societies indoctrination than the general population.

Research Questions

1. Will mental health providers exhibit similar levels of stigma as compared to the general population?
2. Will there be a statically significant difference in levels of social desirability between the general and mental health provider populations?

Chapter 2: Literature Review

Application To Human Relations

Human relations is the study of individuals resolving and preventing issues occurring in groups and society, the application of theory, and the study of societal changes to better educate and inform those that need their services (Reece & Brandt, 2016). While this study is grounded in psychology, there is also a place for this research within human relations. Due to the issue presented, mental health stigma, as it occurs between two distinct populations (mental health providers and the general population) it is vitally important for both fields to notice. Individuals practicing under the umbrella of human relations can enact change on a larger scale than in the psychological field. Where psychology is the study of human cognitive, social, and individual behavior; human relations professionals monitor these issues uncovered by research and enact broader change and awareness to the general population.

Societal Stigma of Mental Illness Through the Lens of Neuroscience

Mental health stigma, and all stigma, does have genetic foundations to help with the heuristic functions of day-to-day life (Griffith & Cohrt, 2016; Almeda & Sousa, 2022). In more simplified terms the human brain has mental shortcuts (heuristics) that humans act upon without thinking due to the thousands of stimuli and choices that could be available at any given second. Without mental heuristics it would be impossible for humans to function productively- period. This does cause mistakes, such as stigma. It is important to note the individual processes of stigma as it occurs neurologically, cognitively, and socially within the individual peoples in a societal context. As more is discovered about the process of mental health stigma and the root of human behavior it is easier to identify, observe, and implement strategies to reduce stigma and the harmful effects of this phenomenon.

Cognitive Psychology and Neuroscience

Through the lens of cognitive psychology and cognitive neuroscience research, stigma is an efficient way to protect most of the group or society from potential dangers (Griffith, 2010). Social cognition is split between two systems. The first system is categorical, group member-to-group member relation which is amazingly fast to enact and process. The second and slower system, individualized, person-to-person in relation to self. These systems rely on sociobiological systems such as social hierarchy, peer affiliation, social exchange, and kin recognition (Griffith & Cohrt, 2016). Once an individual observes the difference between themselves, their peer group or society, a neurological cascade begins to develop.

There is a set of neurological systems that account for the formation, encoding, activation, and deactivation in areas of the brain that allows for mental health stigma to occur (Griffith & Cohrt, 2016; Botvick, et al, 2001; Almeda & Sousa, 2022; Loughman & Haslam, 2018). First, categorical social cognition forms from social stimuli, and the categorization is routed to the rostral anterior cingulate gyrus which is then compared to a model of expectable reality when communicated to the prefrontal cortex during memory retrieval. Once the brain recognizes the difference of the individual as compared to others within their group as not normal (i.e., someone with a mental health disorder), this creates conflict and an unexpected reality. The anterior cingulate gyrus detects this conflict and signals to the prefrontal cortex to control this dilemma.

In the secondary process, the dorsolateral and ventrolateral prefrontal cortices are signaled from the prefrontal cortex to help mitigate and resolve the conflict via top-down modulation in the subcortical systems. These systems culminate as the pain matrix which includes the amygdala, insula, and ventral anterior cingulate gyrus (Griffith & Cohrt, 2016; Chiao, 2010; Green, et al, 2004). Once the pain matrix is activated it manufactures the motivation to avoid the

person or group who they view as different, creating stigmatizing behaviors. The communication between the mirror neurons and the aforementioned areas of the brain are then suppressed and the person-to-person social cognition is lessened, or discontinues, to activate. Individuals now start to have a lesser feeling of guilt when they ignore or oppress the individuals of the stigmatized group (Griffith & Cohrt, 2016; Griffith, 2010).

There are 5 forms of stigma which Griffith and Cohrt mention in their classification as they found most relevant for individuals affected by mental health disorders: peril stigma, moral stigma, disruption stigma, courtesy stigma, and empathy fatigue (2016). These are more specific to cognitive and evolutionary neuroscience as opposed to social psychology and sociology. This explanation attempts to standardize the understanding of where and how stigma is produced within the individual. This is different from the MISF (Mental Illness Stigma Framework) as seen later in figure 1, due to the purpose of that framework is to take into consideration the 400 different frameworks of how stigma is viewed *socially in society* as opposed to using FMRI, MRI, CAT scans, etc. It is the difference between observation of behaviors with and without the need for technology. Fox and colleagues provide a more detailed explanation of the types of stigma in the following descriptions (2018).

Peril stigma. This is triggered as an immediate threat response to those who show odd, impulsive, or unpredictable behaviors. Much like the symptoms of schizophrenia. When individuals diagnosed with schizophrenia start interacting with auditory and visual hallucinations, and no one else sees them, it makes others uncomfortable. And due to this unfamiliarity with the symptoms of schizophrenia a feeling of "peril" forms to keep themselves safe.

Moral Stigma. Occurs when the stigmatized individual challenges the group's belief or values. When the symptoms of a mental health disorder cause the stigmatized individual to not conform to the norms of social engagement, others may feel the individual in question does not care for the group standards. Such stigmatizing thoughts may be that the individual does not care for their own life and laziness.

Disruption Stigma. These negative thoughts start when the individuals exhibiting mental health symptoms interfere with the family or work group functioning. For example, a family member may decide to separate themselves socially and physically as to not become responsible for taking their family member diagnosed with schizophrenia to appointments. This may become a problem and cause other family members to view the helping family member as coddling or enabling the family member. Or it may affect the helping family members ability to keep a stable occupation as they would need to conform their schedule around their mentally ill family member. This also occurs within the mental health field. A psychiatrist or other programs "dump" clients onto other programs in hopes to "get rid" of the problem.

Empathy fatigue. Like disruption stigma, is the sense of distancing oneself from the stigmatized individual, in this case they avoid them due to emotional fatigue. Whether it is too much for them to emotionally handle or they have too little emotional availability they will feel tired after socially interacting with the person. This causes them to spend less time with the person or creates excuses as to why they do not socially interact with them.

Courtesy stigma. The last of the stigmas for this specific framework, also termed "stigma by association", is the result in the loss of social status due to interacting with the stigmatized individual. This includes family, friends, and even mental health providers such as psychiatrists, psychologists, licensed practicing counselors, etc. for simply interacting with individuals diagnosed with mental illness.

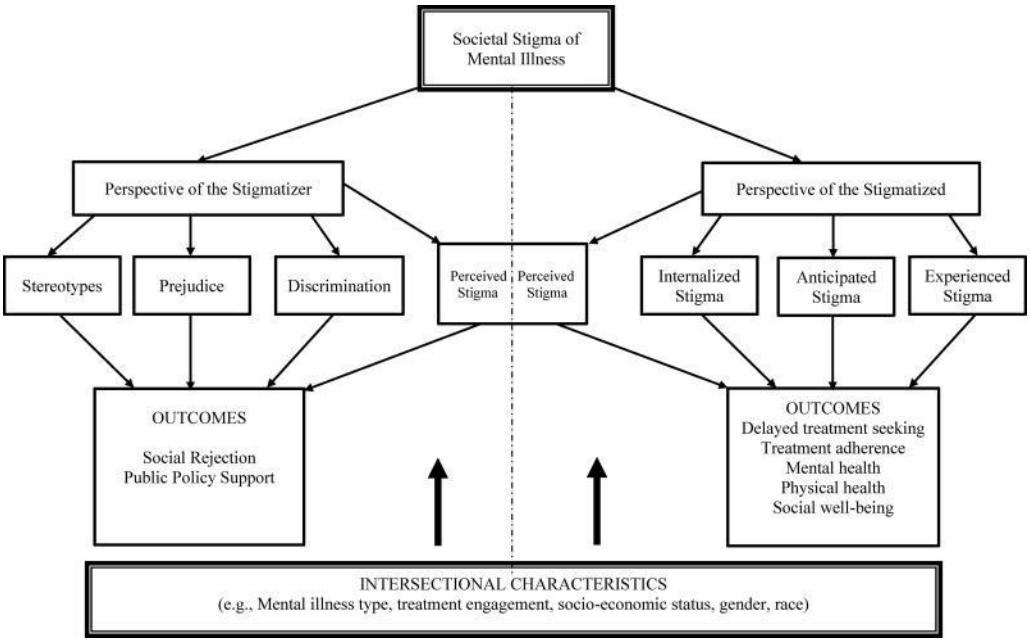
Societal Stigma Through the Lens of Social Psychology and Psychiatry

Continuing to the societal observations that explain why and how stigma is enacted via the lens of social psychology. First is the beginning of social psychological research on stigma, where Andro and colleagues postulated that the parent roots of stigma stem from innate, core characteristics of a human's individual personality (1950). Later research in taxonomic studies suggest that prejudicial behavior, a specific behavior seen in mental health stigma, cannot be simply categorized into "racists and nonracists" (Denson, Lyer, & Lickel, 2010). Or in the case of this study, "stigmatizers and nonstigmatizers". The reason simple categorization has been found to be ineffective in explaining stigma is due to the need to base the phenomenon on a continuum. This is akin to how many mental health disorders are now measured in severity by continuum in the most recent (and controversial) DSM 5 (American Psychological Association, 2013).

Mental Illness Stigma Framework (MISF)

The *Mental Illness Stigma Framework (MISF)* was created to help centralize the understanding of how individuals experience mental health stigma (Fox, et al, 2018). This framework will serve as a primary focus of how stigma is experienced and perpetrated by society. In Figure 1, the framework is laid out in 6 distinct categories and 6 subcategories: Societal Stigma of Mental Illness, Perspective of the Stigmatizer (subcategories of stereotypes, prejudice, and discrimination), Perspective of the Stigmatized (subcategories of internalized stigma, anticipated stigma, and experienced stigma), Perceived stigma, Outcomes, and Intersectional characteristics (Fox, et al, 2018). Other simplified frameworks, such as one created by Bos and colleagues, help to support the validation of the MISF (2013).

Figure 1: Mental Illness Stigma Framework



Fox, et al, 2018

Perspective of the Stigmatizer

There are three processes that occur within the stigmatizer; which is the individual who has negative thoughts, beliefs, and behaviors against those with mental illness. The three mechanisms are stereotypes, prejudice, and discrimination (Fox, et al, 2018). Stereotypes help build a cognitive schema or "framework" (whether it is an abstract, universal, or social construction concept) of thinking of how an individual should understand, relate, and act based on their perceived reality (Dividio, et al, 2010). They then think about these stereotypes, in this case negatively, and create negative thoughts in the form of cognition. Examples of prejudice are believing people diagnosed with schizophrenia are lazy, can't work in a long-term or permanent occupation, or have poor hygiene. Then these cognitions are acted upon in physical form, or are manifested via observable behavior, which is discrimination. Examples of active discrimination are not hiring individuals because they are diagnosed with schizophrenia, labeling them as "schizo" or "schizophrenic", or openly verbalizing how much someone hates people diagnosed with schizophrenia.

Stereotypes. This mechanism serves as a learned set of behaviors an individual should express within their current societal context. Such learned behaviors are social roles, qualities of those behaviors in other people, and how to react to individuals who do not fit their cognitive schemas (Dividio, et al, 2010; Oaks & Turner, 1990). This helps as a comparison between individuals that do follow the typical societal norms in their context as opposed to those who do not. For instance, there are two people walking past each other in a city and the first person starts yelling at someone who is not physically there, and the second person observes this erratic behavior. The second person will then unconsciously compare the first person's actions to the stereotypes and the behaviors that they *believe* others should demonstrate in their society.

Prejudice. Negative thoughts and attitudes about another group or individual is what is called prejudice (Dividio, et al, 2010). Typically, prejudice is caused by people generalizing a set of negative stereotypes and behaviors to others. It serves as a mechanism to share an individual's thoughts about the victims they are inflicting their prejudicial thoughts upon. Groups will often use prejudice to find others with the same ideology and expose others that do not hold the same mindset about the stigmatized group.

Discrimination. An action which is put into motion when stereotypes and prejudice are confirmed through the interaction with others who agree with them is called discrimination (Dividio, et al, 2010). People who engage in discriminatory practices are making it known that people who do not fit the "correct" stereotypes should not be treated as equals in their society. They have found an "in-group", a group of like-minded individuals that agree these discriminatory behaviors are acceptable, to communicate and act on these negative behaviors in that confederacy (Allport, 1954).

Perspective of the Stigmatized

When people experience the previously mentioned mechanisms of stigmatization from the stigmatizers, they will then start to manifest signs of these repeated negative actions. The three key concepts are: internalized, anticipated, and experienced stigma. While all these concepts have the label "stigma", it does not mean an individual will need to have experienced the negative behaviors personally, in the past or present, to feel the effects (Cechnicki, et al, 2011).

Internalized Stigma. This is the process in which the stigmatized person chooses to believe the negative thoughts about them are true and may inadvertently believe they are the cause of their inequitable treatment (Bos, et al, 2013). A person who is called "schizophrenic" will start to believe their diagnosis as a defining characteristic of their personality. Individuals then demonstrate the "inappropriate" behaviors and accept being punished because it is *their* fault. By labeling a person as schizophrenic instead of by their birth name, this further ingrains the thought that the person is the embodiment of a mental health disorder. They do not see themselves as a family member, friend, work-colleague, but instead are constantly reminded they are an object of repugnance.

Anticipated Stigma. When the stigmatized individuals start to fear or expect that they will be the target of the perpetrators of stigmatizing behavior this is called anticipated stigma (fox, et al, 2018). People diagnosed with schizophrenia, with an exceedingly high probability, have experienced or seen others fall victim to stigmatizing behavior. In turn they may decide to not apply for work, not communicate with friends, family, or try to make new relationships, or stop participating in hobbies that they once enjoyed in fear of rejection. As mentioned before, they do not need to personally experience the negative behaviors of stigmatization. They only need to watch as others are persecuted for being diagnosed with the same mental illness.

Experienced Stigma. As the last proponent from the perspective of the stigmatized, experienced stigma is exactly as it sounds: a person is the direct recipient of the stigmatizing behaviors (fox, et al, 2018). The individual may be denied job opportunities due to their diagnosis; others may choose not to speak to them in fear of being associated with them or be ousted from their friend group. The experience can also come in verbal confrontation or physical. And, sadly, this is often repeated throughout their lifetime.

Perceived Stigma

Fox and others report perceived stigma as, "perceptions of societal beliefs (stereotypes), feelings (prejudice), and behaviors (discrimination) toward PWMI (persons with mental illness)" (2018). In this case the concept is not independent to one group, it can be shared between those not experiencing or experiencing mental illness. As an example, there are two individuals, one diagnosed with schizophrenia and the other, not. Both are afraid to interact socially with each other due to the fear that 1. The person diagnosed thinks the other person will act negatively towards them without provocation and 2. The person who is not diagnosed with mental illness fears society will reject them for interacting with a "tainted" person. It is the *perception* of how people will view or interact with them (diagnosed or not) that causes psychological stress.

Intersectionality

In the final portion of the MISF, fox and colleagues assert that experiences of stigma are not the same for every person (2018). Different individual characteristics, socioeconomic and social status, or societal differences can change the way people affected by schizophrenia experience stigma. By incorporating intersectionality into this framework, it creates a more holistic understanding of how one person may experience stigma as opposed to another. While it would be preferable to treat every person or situation as if they are in a proverbial "vacuum" there are too many variables that influence a person's understanding of stigmatizing behavior.

The earlier literature proves research interest in mental health stigma, and more specifically for people diagnosed with schizophrenia.

Therefore, the study hypotheses that will be examined in this study are:

1. Null (H_0): Mental health providers will show similar levels of stigma as compared to the general population.

2. Alternative (H_1): Mental health providers will exhibit lower levels of stigmatization towards schizophrenia compared to the general population.

3. Null (H_0): Mental health providers will show similar levels of social desirability as compared to the general population.

4. Alternative (H_1): Mental health providers will exhibit lower levels of social desirability compared to the general population

Methods

Participants

The volunteers for this study were categorized into two groups: mental health providers and the general population. Mental health providers are classified for this study as individuals who have achieved a master's level degree or above, such as a Doctor of Philosophy or Medicine in a mental health related degree, are currently licensed in their respective state, are currently or have given treatment to those diagnosed with schizophrenia and are at or above 18 years of age. The general population is classified as persons at or above 18 years of age and have no prior treatment experience with people diagnosed with schizophrenia. The responses were collected to measure the level of stigma between both groups and compare. There was a total of $N = 138$ respondents in this study. There were only 2 options for sex: male ($n = 35$), female ($n = 100$), and no response ($n = 3$). The options for race with their distributions are as follows: American Indian or Alaska Native ($n = 5$), Asian ($n = 4$), Black or African American ($n = 8$), Caucasian ($n = 117$), and no response ($n = 4$).

Measures

There were three measurements used in this study: the Mental Health Provider Self-Assessment Stigma Scale (MHPSASS) created by Charles and Bentley for mental health providers, Self-Assessment Stigma Scales (SASS) created by Day and colleagues for the general population, and the reduced Marlow-Crowne social desirability questionnaire MC-(10) 1 created by Strahan and Gerbasi for both populations (2018, 2007, 1972). Both the MHPSASS and SASS questions were rated on a 7-point Likert scale.

Mental Health Provider Self-Assessment Stigma Scales (MHPSASS). The MHPSASS is a 20-item self-report scale designed to assess the level of mental health stigma mental health providers may exhibit. Sample items from the MHPSAS include, “It’s hard not to sometimes be irritated with clients who have schizophrenia”, “When my client’s family calls too many times, I can become irritated”, and "Even though I try not to, I can sometimes be impatient with my client with schizophrenia”. Response options range from 1 = strongly agree to 7 = strongly disagree. Available psychometric information on scores from the MHPSAS across studies from previous samples indicates an acceptable range of internal consistency reliability and construct validity of the measure; Cronbach’s Alpha = .82 (Charles & Bentley, 2018). Higher scores on the MHPSASS reflect higher levels of stigmatization.

Self-Assessment Stigma Scales (SASS). The SASS is a 28-item self-report scale designed to assess the level of mental health stigma in the general population. Sample items from the SASS include, “There are effective medications for schizophrenia that allow people to return to normal and productive lives”, “I don’t think that it is possible to have a normal relationship with someone with schizophrenia” and “I would find it difficult to trust someone with schizophrenia”. Response options range from 1 = completely disagree to 7 = completely agree. Available psychometric information on scores from the SASS across studies from previous samples indicates an acceptable range of internal consistency reliability and construct validity of the measure. The subscales with Cronbach’s Alpha are as follows: Relationship Disruption α = .84, Anxiety α = .90, Hygiene α = .83, Visibility α = .78, Treatability α = .71, Professional Efficacy α = .86, and Recovery α = .75 (Day, 2007). Higher scores on the SASS reflect higher levels of stigmatization.

Marlow-Crowne social desirability questionnaire (MC-10)1. The MC-(10) 1 is a 10 question self-reporting scale adapted from the original 33 item instrument (Crowne & Marlow, 1960). Response options to the 10 questions are 0 = False, or 1 = True. When the responses across the 10 questions are average higher scores, closer to 1.0, reflect higher levels of social desirability, while scores closer to zero reflect lower social desirability in responding. Sample items from the MC-(10) 1 include, I like to gossip at times", "There have been occasions when I took advantage of someone", and "I'm always willing to admit it when I make a mistake". Available psychometric information on scores from the MC-(10) 1 across studies from previous samples indicates an acceptable range of internal consistency reliability and construct validity of the measure. Available psychometric information on scores from the MC-(10) 1 across studies from previous samples indicates an acceptable range of internal consistency reliability and construct validity of the measure; Cronbach's Alpha = .64 (Barger, 2002).

Request for authorization to collect data for this study was approved by the Institutional Review Board at the University of Oklahoma, IRB approval #16263. Participants were not compensated for participation in the study and were assured that their responses will be kept confidential and only be used for research purposes.

Procedures

The participants who were asked to participate in this study were recruited through various social media platforms (such as Facebook, reddit, Instagram, etc.), email, personal contact, and via recruitment form/material. An online survey was submitted to the Qualtrics Survey Software and a link distributed to participants via the recruitment documents/material. There were 4 sections for both surveys. The first section for both measurements included the consent to participate which noted what they are taking the survey for, potential risks involved, any benefits, and

that they were allowed to discontinue participation at any time. The second section for both surveys included demographic data collection which included age, sex, race, years of education, degree level achieved, specialty, and years of practice in occupation. The third section included the MHPSASS for mental health providers and SASS for the general population that measures self-reported level of stigma. And the fourth and last section for both surveys included the MC-(10) 1 to measure social desirability.

Chapter 3: Results

Sample Characteristics

There was a total of $N = 138$ respondents in this study. Mean age of participants was 43.35, with a minimum age of 20 and maximum of 85 years old as seen in Table A1. The predominate sex of the participants was female (72.5%) and male (25.4%), the remaining sample did not have a response (2.2%). The options race with distributions in the sample was: American Indian or Alaska Native (3.6%), Asian (2.9%), Black or African American (5.8%), Caucasian (84.8%), and no response (2.9%). Of the participants that responded to degree achieved, 1.4% their degree did not fit the categories, 5.1% were current doctorate students, 4.3% achieved their doctorate, 67.4% achieved their masters, 5.8% with current licensing as a masters or doctorate degree, 10.9% achieved an undergraduate degree, and 3.6% achieved a high school degree. For mental health providers years of practice, the mean was 12.78 years of practice, with a minimum of 0 years and maximum of 43. Lastly in Table A1, of the population frequencies 68.8% were mental health providers and 31.2% belonged to the general population.

Analytic Protocol

Due to the disparity of participants between the mental health provider and general population, non-parametric tests were required at the onset of analysis. This allowed the researcher to understand if further analysis was warranted between groups. The data was analyzed using IBM SPSS Statistics (Version 28) by using the Mann-Whitney U Test, a non-parametric test to observe if there was a difference in populations for stigma and social desirability. Initial findings of stigma between groups from the Mann-Whitney U Test indicated that distribution of mean stigma score scales is same across populations. For social desirability, Mann-Whitney U Test found distribution of mean social desirability scales as higher for the general population compared to mental health providers. After initial analysis One-way ANOVA

test was conducted comparing both populations, showing the descriptives of populations and Sum of Squares, F statistic, and level of significance (*p*).

Stigma

Scores on the measure for stigma were higher among the general population as seen in Table B1 (M = 2.66, SD = 0.58; 95% CI = 2.45 to 2.88) than the stigma scores reported by the mental health professionals (M = 2.47, SD = 0.60, 95% CI = 2.35 to 2.60). Although the average score on stigma was higher for the general population compared with mental health professionals, the observed difference was not statistically significant as seen in Table B3 ($F_{(1,119)} = 2.34$, $p = 0.129$). Therefore, the alternative hypothesis that scores on stigma would be lower among mental health providers was not supported. Mental health providers in this sample reported similar levels of stigma, on average, as respondents from the general population. It is worth noting that the average scores on the measure of stigma toward people with schizophrenia were low for both groups, with little variability among scores within the groups.

Social Desirability

The scores on the measure of social desirability were higher among the general population as seen in Table B2 (M = 0.61, SD = 0.13, 95% CI = 0.56 to 0.66) compared with the average response on social desirability from mental health professionals (M = 0.48, SD = 0.15, 95% CI = 0.45 to 0.51). The average score on the social desirability of responding among the general population was significantly higher than the average social desirability score among mental health providers in Table B4 ($F_{(1, 118)} = 10.34$, $p = 0.001$). Therefore, the alternative hypothesis that mental health providers will exhibit lower levels of social desirability was supported.

Chapter 4: Limitations and Discussion

Implications of Results

Results of the study for stigma were found to be inconclusive. The level of stigma was higher for the general population, but the low level of significance ($p = 0.129$) showed the likelihood of results was due to chance. Therefore, this study cannot conclude that mental health providers do not have lower levels of stigma against those diagnosed with schizophrenia. For social desirability the results were conclusive, with a higher level of social desirability ($p = 0.001$) for the general population. Mental health providers did exhibit less social desirability, though previous literature does not align with the findings of this particular study. Further consideration of participant demographics and group size will need to be examined for future study.

Connection to Previous Literature

Previous literature does show there were significant findings of stigma in the mental health provider profession (Charles, 2015; Dell, et al, 2021; Giralt, et al, 2022). While the results of this study were inconclusive, this does not mean mental health provider stigma is lower than the general population. This study by itself cannot successfully conclude mental health providers have lower levels of stigma. As for social desirability, while this study did show there were higher levels of social desirability in the general population, other studies have found this to be the opposite (Giralt, et al, 2022). Also, previous research of female mental health providers was found to be less likely to answer truthfully (Dalky, et al, 2020).

Previous studies did in fact show a larger proportion of female participants in the research conducted (Chares, 2015; Giralt, et al, 2022). This was consistent in participant collection for this study as 67.4% of participants identified as female. As mentioned previously, female participants have been observed to be less truthful, resulting in higher scores of social

desirability. Due to the largest demographic being female, there is a possibility elevated scores of social desirability is due to this gender bias. Further research is needed to understand the potential impact of the findings in this study and a future consideration for future research.

Because social desirability was significantly higher among the general population, a reasonable conclusion could be that reported levels of stigmatization toward people with schizophrenia might be influenced in a negative direction, that is lower reported scores on stigma from respondents in the general population. To test possible interaction between levels of social desirability and group membership on reported levels of stigma, further research and data is needed.

Insufficient number of respondents impacted the ability to "drill down" into the data and understand the differences between professional degrees/licensure. Preferably the number of respondents would be similar- instead of having a 60-participant disparity between populations. Also, allowing more than just mental health providers in Oklahoma to participate in the survey would allow for a more generalizable result. The results can only be responsibly generalized to Oklahoma mental health providers, and more specifically LPC, LMFT, LCSW, and MSW degree/licensure. While medical mental health providers (such as psychiatry, APRN (advanced practitioner nursing), D.O., and M.D.) were included in the population, no participants from this subfield decided to take the survey. Those who responded with a Ph.D. were minimal, another sub-population of mental health providers which actional data would be useful.

As with this literature's topic, stigma became a limiting factor in collecting participants for the mental health provider population. When the researcher contacted the mental health facilities in Oklahoma, the individuals were hesitant to help. The researcher first introduced themselves as a master's student seeking participant responses which did garner report. But once the

researcher explained the topic of the study, stigma, most facilities declined or requested they contact the researcher later out of courtesy.

Interpretation of Demographics

Sample selection developed into a constraint for the study. Most of the respondents for the mental health providers were collected from an excel spreadsheet provided by the Oklahoma board of state licensure. While this was helpful in collecting data from participants the mental health provider pool became a convenience sample as opposed to random sampling. Convenience sampling decreases the generalizability of results and introduces other sampling biases unique to that participant pool.

A more diverse race and gender sample of both populations would be beneficial for further research. Increasing the number of participants that identify as other than Caucasian presents an opportunity to observe the differences in stigma across racial categories. Understanding whether the traditional gender dichotomy of male and female participants could affect outcomes could be a future consideration for studies as well. Also, comparing levels of stigma within non-traditional genders would bring a unique understanding not only of mental health stigma but also the stigma of non-conforming gender identities. Increasing and including this data in a future study will help bring understanding not just to the level of stigma these populations may hold but also if traditional gender roles and indoctrination influence increasing or decreasing stigma.

Clinical Recommendations

Based on the findings of this study and previous literature, there are 3 recommendations that would be suggested. First is lived experience, and second are supplemental educational programs, and the third being experiential learning (immersive programs) (Alipanopoulos, 2020). Lived experience, for example, mental health professionals and the general population would

benefit from volunteering at homeless shelters. This allows the individual to interact with those diagnosed with schizophrenia and understand the hardships they face, along with humanizing them. They can interact with individuals diagnosed with schizophrenia and learn how their experience has been and the stigmatization they have encountered. Supplemental educational programs would be college-level courses or seminars that help individuals understand what the diagnosis of schizophrenia means, correct interpretation of symptoms, and explanation of behaviors of those living with schizophrenia. Experiential learning includes internships, hands-on learning, and simulations. This is similar to supplemental education programs, but instead of passive learning the individual is immersed in a facility (such as a crisis center) and interacts with those who live with schizophrenia. For example, and hopeful LPC candidate, nurse, psychologist, or medical doctor, would gather clinical hours for licensing at a crisis center. This way they can gather their own experience in interacting with those diagnosed with schizophrenia. Preferably an individual would attempt all three recommendations to fully view the spectrum of the experience that those diagnosed with schizophrenia experience.

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Appendix A

Participant Demographics

Table A1
Demographic Characteristics of the Participant Sample (n = 138)

Demographic Variable List		N	Min.	Max.
Sample Size		138		
Populations	Mental Health Providers	95 (68.8%)		
	General Population	43 (31.2%)		
Mean Age *(SD)*		43.35 (SD)	20	85
Sex	Male	35 (25.4%)		
	Female	100 (72.5%)		
	Other	3 (2.2%)		
Race	American Indian or Alaska Native	5 (3.6%)		
	Asian	4 (2.9%)		
	Black or African American	8 (5.8%)		
	Caucasian	117 (84.8%)		
	Native Hawaiian or Other Pacific Islander	0 (0%)		
	Total	134		
	Missing	4 (2.9%)		
Degree Level Achieved	My degree does not fit the other categories	2 (1.4%)		
	Current Doctorate Student	7 (5.1%)		
	Current Medical Student	0 (0%)		
	Doctorate	6 (4.3%)		
	Masters	93 (67.4%)		
	Current Licensed Therapist/other mental health provider with masters or doctorate	8 (5.8%)		
	Undergraduate	15 (10.9%)		
	High School	5 (3.6%)		
	Total	136		
	Missing	2		
Years Of Education		120		
Years of Practice *(SD)*		12.78 (SD)	0	43

Appendix B

Analysis of Stigma and social desirability

Table B1

Mean Stigma Scales

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	
					Lower Bound	Upper Bound
Mental Health Providers	90	2.47	.599	.063	2.35	2.60
General Population	31	2.66	.582	.104	2.45	2.88
Total	121	2.52	.598	.054	2.42	2.63

Table B2

Mean Social Desirability Scales

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	
					Lower Bound	Upper Bound
Mental Health Providers	90	.48	.138	.015	.45	.51
General Population	30	.61	.131	.024	.56	.66
Total	120	.51	.147	.013	.48	.54

Tables B3

ANOVA Mean Stigma Scales

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.826	1	.826	2.335	.129
Within Groups	42.081	119	.354		
Total	42.906	120			

Table B4

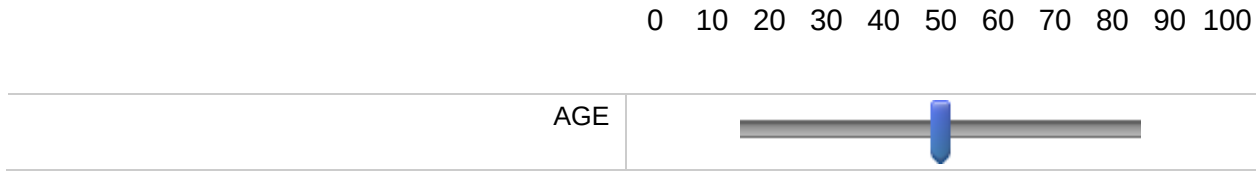
ANOVA Mean Social Desirability Scales

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.381	1	.381	20.434	<.001
Within Groups	2.200	118	.019		
Total	2.581	119			

Appendix C

Survey Demographic Data Collection- General Population

Age



Sex

- Male
- Female

Race

- American Indian or Alaska Native
- Asian
- Black or African American
- Caucasian
- Native Hawaiian or Other Pacific Islander

Years Of Education

Degree Level Achieved

- ○ High school
- ○ Undergraduate
- ○ Masters (non-licensed)
- ○ Doctorate
- ○ Current Medical Student
- ○ Current Doctorate Student
- ○ Current Medical Doctor
- ○ Current Licensed Therapist/other mental health provider with masters or doctorate

Specialty.

Please be specific. Examples: Accountant, Financial Advisor, etc. PLEASE DO NOT MENTION THE COMPANY YOU WORK FOR

_____

Years of Practice In Current Occupation

0 10 20 30 40 50 60 70 80 90 100

Years 

Appendix D

Stigma and Self-Stigma Scales General Population Measurement

PLEASE READ

Schizophrenia is an illness with symptoms that include delusional thinking (ideas that are believed to be true but have no basis in reality). For example, people with schizophrenia might believe that they are being persecuted by others (e.g., someone is poisoning their food) or that ordinary events have special meaning for them (e.g., the television is speaking directly to them). People with schizophrenia might believe that they are important or powerful people (e.g., the President of the United States or Jesus Christ), or that others are controlling their thoughts, feelings, and behavior. Hallucinations are a predominant feature of schizophrenia that might occur in a number of forms. For example, people might hear sounds or voices that don't really exist or see events that aren't really occurring. Other common symptoms of schizophrenia include a lack of emotional expression, feelings of apathy, lack of energy, lack of interest in usual activities, and social withdrawal. We are interested in your opinions about schizophrenia and people with schizophrenia in general.

- ○ I have read the paragraph

1. There are effective medications for schizophrenia that allow people to return to normal and productive lives.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

2. I don’t think that it is possible to have a normal relationship with someone with schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

3. I would find it difficult to trust someone with schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

4. People with schizophrenia tend to neglect their appearance.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion

- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

5. It would be difficult to have a close meaningful relationship with someone with schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

6. I feel anxious and uncomfortable when I'm around someone with schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

7. It is easy for me to recognize the symptoms of schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

8. There are no effective treatments for schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

9. I probably wouldn't know that someone has schizophrenia unless I was told

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion

- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

10. A close relationship with someone with schizophrenia would be like living on an emotional roller coaster.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

11. There is little that can be done to control the symptoms of schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

12. I think that a personal relationship with someone with schizophrenia would be too demanding.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

13. Once someone develops schizophrenia, he or she will never be able to fully recover from it.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

14. People with schizophrenia ignore their hygiene, such as bathing and using deodorant.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion

- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

15. schizophrenia prevents people from having normal relationships with others.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

16. I tend to feel anxious and nervous when I am around someone with schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

17. When talking with someone with schizophrenia, I worry that I might say something that will upset him or her.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

18. I can tell that someone has schizophrenia by the way he or she acts.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

19. People with schizophrenia do not groom themselves properly.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree

- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

20. People with schizophrenia will remain ill for the rest of their lives.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

21. I don’t think that I can really relax and be myself when I’m around someone with schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

22. When I am around someone with schizophrenia I worry that he or she might harm me physically.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

23. Psychiatrists and psychologists have the knowledge and skills needed to effectively treat schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree

- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

24. I would feel unsure about what to say or do if I were around someone with schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

25. I feel nervous and uneasy when I'm near someone with schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

26. I can tell that someone has schizophrenia by the way he or she talks.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

27. People with schizophrenia need to take better care of their grooming (bathe, clean teeth, use deodorant).

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

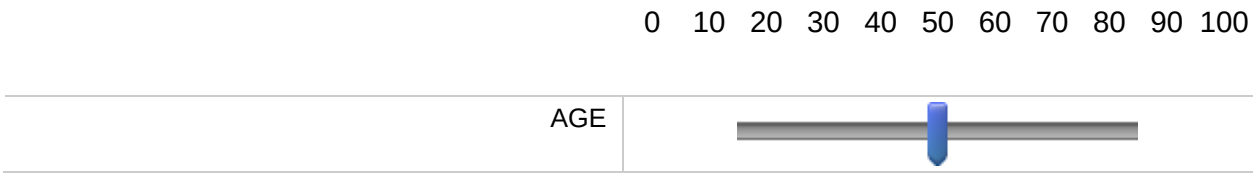
28 Mental health professionals, such as psychiatrists and psychologists, can provide effective treatments for schizophrenia.

- ○ Completely Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Completely Agree

Appendix E

Survey Demographic Data Collection- Mental Health Providers

1. Age



2. Sex

- ○ Male
- ○ Female

3. Race

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Caucasian
- ○ Native Hawaiian or Other Pacific Islander

4. Years Of Education

5. Degree Level Achieved

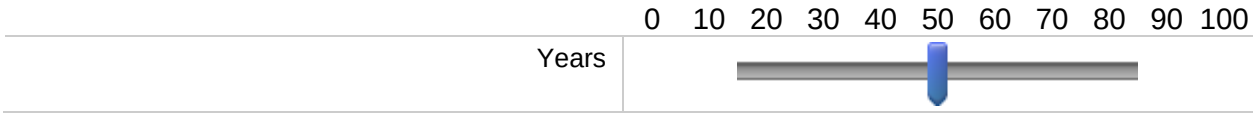
- ○ Masters
- ○ Doctorate
- ○ Current Medical Student
- ○ Current Doctorate Student
- ○ My degree does not fit the other categories

6. Specialty.

Please be specific. Examples: Doctorate of Osteopathy, Psychiatrist, LPC, Clinical Psychologist, LCSW, LCSW in Training, etc. PLEASE DO NOT MENTION THE COMPANY YOU WORK FOR

_____

7. Years of Practice. If you are a student, answer 0



Appendix F

Mental Health Providers Self-Assessment of Stigma Measurement

1. It's hard not to sometimes be irritated with clients who have schizophrenia

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

3. Even though I try not to, I can sometimes be impatient with my client with schizophrenia

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

4. If a client with schizophrenia is behaving in an annoying manner, I find that I am less likely to return their calls Item

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

5. Sometimes, I wish my client with schizophrenia would hurry up when speaking with me

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree

- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

8. When a client with schizophrenia calls me too often, I get irritated with their neediness

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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

- ○ Strongly Disagree
- ○ Disagree

- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

11. When a family member of a client diagnosed with schizophrenia asks if their loved one will ever get better, I try to minimize their expectations, so they aren't disappointed

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

12. My client's with schizophrenia treatment plan may not reflect their goals, but rather goals that I think are realistic, to make sure they are successful in achieving these goals

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree

- ○ Strongly Agree

13. If I think my client with schizophrenia would benefit from a particular service, I find myself continuing to suggest this to them, even if they've declined

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

14. When a client with schizophrenia is not taking prescribed medication, they are probably resistant to being treated

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

15. Clients with schizophrenia have a hard time making good choices for themselves, so service providers need to help them

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

17. My client, diagnosed with schizophrenia, will probably always need to take medication to function

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree

- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

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

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

20. In the past, I have occasionally made reference to a client using a diagnostic label they have, instead of their name

- ○ Strongly Disagree
- ○ Disagree
- ○ Somewhat Disagree
- ○ No Opinion
- ○ Somewhat Agree
- ○ Agree
- ○ Strongly Agree

Appendix G

MC-10 Marlow-Crowne Social Desirability Measurement Used for Both Populations

1. I like to gossip at times

- ○ False
- ○ True

2. There have been occasions when I took advantage of someone

- ○ False
- ○ True

3. I'm always willing to admit it when I make a mistake

- ○ False
- ○ True

4. I always try to practice what I preach

- ○ False
- ○ True

5. I sometimes try to get even rather than forgive and forget

- ○ False
- ○ True

6. At times I have really insisted on having things my own way

- ○ False
- ○ True

7. There have been occasions when I felt like smashing things

- False
- True

8. I never resent being asked to return a favor

- False
- True

9. I have never been irked when people expressed ideas very different from my own

- False
- True

10. I have never deliberately said something that hurt someone's feelings

- False
- True

Appendix H

IRB Approval Letter

The UNIVERSITY of OKLAHOMA

Institutional Review Board for the Protection of Human Subjects

Approval of Initial Submission - Exempt from IRB Review - AP01

Date: August18,2023 **IRB#:** 16263

Principal Investigator: Brady W Michalek

Approval Date: 08/17/2023

Exempt Category: 2

Study Title: Social desirability and self-reported levels of stigma among mental health providers as it relates to people with schizophrenia

On behalf of the Institutional Review Board (IRB), I have reviewed the above-referenced research study and determined that it meets the criteria for exemption from IRB review. To view the documents approved for this submission, open this study from the *My Studies* option, go to *Submission History,* go to *Completed Submissions* tab and then click the *Details* icon.

As principal investigator of this research study, you are responsible to:

- Conduct the research study in a manner consistent with the requirements of the IRB and federal regulations 45 CFR 46.
- Request approval from the IRB prior to implementing any/all modifications as changes could affect the exempt status determination.
- Maintain accurate and complete study records for evaluation by the HRPP Quality Improvement Program and, if applicable, inspection by regulatory agencies and/or the study sponsor.
- Notify the IRB at the completion of the project.

If you have questions about this notification or using iRIS, contact the IRB @405-325-8110 or irb@ou.edu.

Cordially,

Ioana Cionea, Ph.D.
Vice Chair, Institutional Review Board