Examing Mental Health Stigma among Doctoral-Level Healthcare Providers: The Impact of Burnout, Therapeutic Optimism, Experience in the Field, and Gender on Attitudes toward Patients with Mental Illness

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Exchanging Mental Health Stigma among Doctoral-Level Healthcare Providers: 
The Impact of Burnout, Therapeutic Optimism, Experience in the Field, and Gender on 
Attitudes toward Patients with Mental Illness 

by 
Lindsay Blevins 

Submitted in partial fulfillment of the requirements for the degree of 
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APPROVAL FOR SUCCESSFUL DEFENSE

Lindsay Blevins, has successfully defended and made the required modifications to the text of the doctoral dissertation for the Ph.D. during this Spring Semester 2018.

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Abstract

This study sought to discover differences in mental health stigma among doctoral-level healthcare providers. Previous research has found high levels of stigma among healthcare professionals and has often reported differences between non-mental health professionals and mental health practitioners (Bjorkman, Angelman, & Jönsson, 2008; Hori, Richards, Kawamoto, & Kunugi, 2011; Peris, Teachman, & Nosek, 2008). Most of the current literature has grouped many different levels of providers together, which makes it difficult to distinguish between the specific specialties and training models to determine if these factors impact stigma. Additionally, few studies have examined the connections between stigma and burnout or therapeutic optimism. Clinicians are typically at a higher risk of burnout the longer they have been in the field and studies indicate that professionals who endorse more burnout have more negative attitudes towards patients (Bakker, Schaufeli, Sixma, & Boseveld, 2000; Gibb, Beautrais, & Surgenor, 2010). Results indicated partial support for study hypotheses. Attitudes towards patients with mental illness were found to be influence by professional specialty, burnout (specifically depersonalization and personal accomplishment), and therapeutic optimism, while gender and time spent in the field were not significantly correlated with stigma scores. Interaction results indicated that stigma remains low and stable over time for mental health providers, while non-mental health providers show high levels of stigma early in their careers, but that these levels decrease over time. Additional analyses suggest that higher levels of stigma among non-mental health providers may be impacted by gender (male) and burnout (depersonalization and personal accomplishment). Implications, limitations, and future directions for study are discussed.

Keywords: Mental health stigma, integrated healthcare, burnout, therapeutic optimism
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CHAPTER 1

Introduction

The impacts of discrimination due to mental illness, against both those who are diagnosed with mental illness and those who treat them, are both diverse and far-reaching. In the past, studies have shown that mental healthcare received less support for government funding than physical healthcare (Corrigan 2003a; McSween, 2002). Though opinions may be starting to change (National Opinion Research Center, 2006), mental health care spending, in comparison to physical health care spending, has still been declining over the last three decades despite recent attempts to expand care with the Affordable Care Act (Corrigan, 2003a; Substance Abuse and Mental Health Services Administration, 2014). Mental health care and substance abuse treatment made up 7.8% of the United States’ $1 trillion health care budget in the beginning of the 21st century (Corrigan, 2003a). This decreased to 7.4% by 2009 and is projected to shrink to 6.5% by 2020 (SAMHSA, 2014). Additionally, due to the worst recession since the Great Depression, many states cut their mental health care budgets from 2009-2011 which totaled more than $1.8 billion in reductions (National Alliance for Mental Illness, 2011). This likely impacts the availability and quality of services for those suffering from mental illness. Mental disorders have remained one of the most expensive medical conditions in the U.S. despite perceived improvements to healthcare quality and cost (Agency for Healthcare Research and Quality, 2015).

Even if services are readily available, many potential clients do not utilize them, as shame, embarrassment, stereotypes, and fear of discrimination may discourage those in need from seeking help (Corrigan & Watson, 2002; Sartorius, Stuart, & Arboleda-Florez, 2012). In a study of nearly 2,000 participants with serious mental illness, Corrigan and colleagues (2003b) reported that of the participants who endorsed being discriminated against in some way during their daily lives,
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73.3% stated that it was at least in part due to their mental disability (rather than due to other demographic factors). In a similar study, 31% of participants reported having experienced discrimination due to a mental illness diagnosis while attempting to utilize physical health services (Gabbidon et al., 2014), highlighting that those seeking healthcare services often experience discrimination across settings.

Studies show that people with mental illness also face many physical health challenges, resulting in high morbidity rates (Jones, Howard, & Thornicroft, 2008; Mai, Holman, Sanfilippo, & Emery, 2011). There are many contributing factors for this, including severity of the mental disorder, possible cognitive impairment or other psychological factors impacting adherence to treatment, and medication side effects. Additionally, past research suggests lack of appropriate collaboration among treatment teams accounts for 70 to 80% of medical errors (Schaefer, Helmreich, & Scheidegger, 1994).

Corrigan and colleagues (2014) further suggest that negative attitudes toward patients with mental health issues may lead to poor decisions by healthcare providers, which in turn may negatively influence health outcomes in this population. Healthcare providers have been shown to be less likely to refer patients with comorbid mental illness diagnoses to specialists for physical health evaluations (Druss, Bradford, Rosenheck, Radford, & Krumholz, 2000; Koroukian, Bakaki, Golchin, Tyler & Loue, 2012; Sullivan, Han, Moore, & Kotrla, 2006). Although it is true that some patients with mental illness may have difficulty adhering to treatment, studies have found that healthcare providers reporting higher levels of stigma may consistently question a patient’s ability to follow treatment plans (Corrigan et al., 2014), which may result in the patient not being offered appropriate treatment options.
Mental Health Stigma in Healthcare Providers

Existing research suggests that mental health stigma varies significantly by specialty. Studies examining differences in mental health stigma among physical health versus mental health personnel have found that physical health practitioners generally tend to have more negative attitudes towards people with mental illness compared to mental health professionals (Bjorkman, Angelman, & Jönsson, 2008; Hori et al., 2011; Smith & Cashwell, 2010). This can be significant in a system that privileges medical doctors over other practitioners. As Corrigan et al. (2014) pointed out, the decision makers may hold the most power in determining the quality and consistency of care a patient receives.

The effect of stigma has been shown in studies focused on specific disorders. For example, Mittal and colleagues (2014) found that primary care providers endorsed significantly more negative attitudes and attribution of mental illness toward a vignette used in the Attribution Questionnaire (AQ-9; Corrigan et al., 2003b) portraying a male patient with schizophrenia compared to a patient without (Mittal, Corrigan, Sherman, Chekuri, Han, et al., 2014). Another study found that family physicians tended to not consider serious physical illnesses as potential causes of physical health symptoms if the patient had a history of depression (Graber, Bergus, Dawson, Wood, Levy, & Levin, 2000). Jones, Howard, and Thornicroft (2008) referred to this as “diagnostic overshadowing,” bias that clouds clinician judgement, and they attribute negative attitudes toward mental illness as one possible contributing factor.

Research into specific doctoral specialties in health care suggested that reported stigma and diagnostic error may also be related to the unique characteristics of the training models in each specialty (i.e., Counseling Psychology, Clinical Psychology, Family Medicine, Internal Medicine, and Psychiatry). One study utilizing multiple provider specialties found, somewhat surprisingly,
that psychiatrists hold more negative attitudes towards people with mental illness, while psychologists were found to have the most positive attitudes (Lauber, Nordt, Braunschwieg, & Rossler, 2006). Specifically, these researchers found that compared to psychologists, counselors, and nurses, psychiatrists believed people with mental illness to be more dangerous, less skilled, and more socially disturbing. Another study found that diagnostic error in a sample of family medicine physicians may be caused by biased heuristics based on inappropriate use of the patient’s past medical history, specifically psychiatric conditions (Graber et al., 2000). Specifically, researchers found that the participating physicians were less likely to explore further testing for patient’s presenting with headache or abdominal pain if these patients also had a prior history of depression compared to those with no prior history.

One important thing to note is that although research is already limited in comparing different healthcare specialties such as psychology versus psychiatry, it is even more limited when looking at specific training models. Within the fields of both mental health and physical health, professionals are taught to perform similar duties; however, the framework from which these professionals are taught in their respective programs may be very different. For example, Clinical Psychology programs emphasize a medical model (i.e., disease based), while Counseling Psychology programs more strongly emphasize a strengths-based approach. Similarly, Family Medicine has tended to be more integrative than Internal Medicine. Different training models may put stronger emphasis on different aspects of the profession (i.e., interpersonal skills or a strengths-based approach as opposed to a focus on diagnosis and pathology). Thus, it becomes apparent that perhaps this too may be impacting the stigma experienced by patients seeking mental health care.

Unfortunately, although there is some research about these individual specialties, there appears to be a lack of research that compares these groups. One limitation of the study examining
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psychiatric history on diagnostic error conducted by Graber and colleagues (2000) was that the researchers did not explain why only family physicians were chosen, as well as why this group was not compared to another clinical group. Inclusion of other specialties may have revealed where family physicians fall on the spectrum in terms of diagnostic error compared to other providers, thereby suggesting whether a bias related to psychiatric history is related to specialization training, professional specialty (i.e., general medical training), or other factors.

Research has shown some differences in mental health training among physicians that may account for some of the differences in stigma shown toward patients seeking psychological/psychiatric services. Whereas many studies have criticized a deficit in all medical training programs related to mental health training (Huzij, Warner, Lacy, & Rachal, 2005; Smith, 2011; Williamson, Major, Ulzen, Rubin, & Fotopoulos, 2016), other research also highlights discrepancies between internal medicine and family medicine programs in the amount and type of training and experience offered to residents regarding mental health (Leigh, Stewart & Mallios, 2006a; Leigh, Stewart & Mallios, 2006b; Smith et al., 2014, Williamson et al., 2016). Family medicine programs have been found to offer more coursework and more hands-on experience working not only with different types of mental health issues, but also in a variety of settings (Leigh et al., 2006a; Leigh et al., 2006b). Family medicine has also been found to incorporate training by and with other types of healthcare providers such as psychologists, thereby increasing residents’ ability to work in interdisciplinary settings and incorporate other types of approaches to treatment.

Research suggests that medical professionals, including psychiatrists, may hold more negative attitudes towards mental illness compared to other healthcare providers; however, all practitioners may display some level of stigma. Flanagan, Miller, and Davidson (2009) suggested
that systematic pressures may cause many stigmatizing behaviors among all practitioners. Through a mixed-methods design, these researchers found themes across participants related to feeling pressure to “treat the chart” instead of the patient, meaning providers felt pressure to treat the patient as if they are their mental illness, rather than a person with a mental illness. This suggests that all patients with the same diagnosis have the same presentation, the same level of severity, and the same capacity to improve, or lack thereof. Researchers also heard both positive and negative statements among the various types of health providers interviewed when asking them to describe their patients, specifically the use of labels, which participants attributed to time constraints and other system pressures. This suggests that perhaps there are other factors impacting a provider’s level of mental health stigma in addition to differences in training model and degree.

Verhaeghe and Bracke (2012) further proposed that mental health professionals may also be the victims of “associative stigma,” or stigmatization among the public because of their association with mental illness. Due to perceived failures of the healthcare system and media spotlight, mental health professionals may be viewed in a negative light, which could in turn impact mental health professionals’ attitudes towards their profession and the people they treat.

There is also little research examining differences between clinical psychologists and counseling psychologists in relation to stigma shown toward patients. This is likely because these two training models have been found to be very similar in terms of coursework and practicum experiences despite differences in philosophy as noted earlier (Cobb et al., 2004; Morgan & Cohen, 2008). Among clinical psychologists, less stigma was shown toward case vignettes compared to physicians and psychiatrists (Caldwell & Jorm, 2000; Jorm, Korten, Jacomb, Christensen, & Henderson, 1999); however, this sample was not compared to other types of psychologists,
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specifically counseling psychologists, highlighting the need for more research in this area to determine the impact of psychological training models.

**Other Factors Impacting Stigma in Healthcare Providers**

As research has indicated, other potential sources of influence increase the likelihood of physical and mental health professionals engaging in stigmatizing behaviors beyond degree and training model. It is probable that many practitioners have in fact been exposed to comprehensive training and education (though the tone and emphasis on patient-centered care may very likely differ across training models) and started out with low levels of stigma as early career professionals (ECPs). However, the longer someone remains in an emotionally taxing field, the higher his or her risk of burnout which could impact the quality of the care she or he provides (Bakker et al., 2000; Gibb, Beautrais, & Surgenor, 2010). One study found that having more negative attitudes toward depressed patients who self-harm was significantly associated with higher levels of burnout (Gibb et al., 2010). A five-year longitudinal study among general physicians found that a lack of reciprocity (i.e., client effort) may also contribute toward burnout and negative attitudes (Bakker et al., 2000).

In Verhaeghe and Bracke’s (2012) study, associative stigma was also found to contribute to burnout, which increased the experiences of stigma among consumers. These findings support the notion that reducing job-related stressors and improving self-care may indirectly improve the experience of patients. This supports the idea that stigma may not always be an implicit bias, but rather an unfortunate consequence of the impact of external factors on a provider. Mental health professionals who display stigma may also be victims of stigmatization themselves, which may perpetuate a cycle of bias as providers have the potential to project their own experiences onto the patient.
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One possible explanation for the development of stigma is Equity Theory, which postulates that beliefs about outcome expectations are related to an individual’s own level of investment (Adams, 1965). This suggests that the more invested an individual is, the more positive her or his outcome expectations. Positive outcome expectations can be more specifically referred to as therapeutic optimism, meaning there is optimism about the outcome of the treatment. When looking at this concept through a mental healthcare lens, it would be logical to find a connection between burnout/stigma and outcome expectations. This connection has been explored in psychiatric nursing literature with negative correlations found, but studies have not examined this phenomenon in other types of clinical providers (Happell & Koehn, 2011; Happell et al., 2012).

Within the limited literature that does exist, therapeutic optimism may predict persistence in service delivery (Aspinwall, Richter, & Hoffman, 2001) and may reduce the risk of burnout (Bruckner, 1979). As one may assume, these beliefs about patients can be related to the amount of time a clinician has spent in the field. The higher the level of severity of patients whom a practitioner deals with, the higher the risk of burnout and potentially lower the level of optimism regarding patient outcomes. Peris, Teachman, and Nosek (2008) used measures of implicit and explicit stigma and case vignettes to determine that explicit biases predicted more negative therapeutic outcomes, while implicit biases produced more patient over-diagnosis. These results suggest that professionals who show more stigma related to patients with mental illness may also lack optimism about patient prognosis and recovery, which can in turn become a self-fulfilling prophecy.

Due to the impact of time spent in the field on burnout, the difference in stigma levels between veteran professionals and early career professionals has also been a research topic of interest. Most studies have utilized students as this population is more readily available in
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comparison to early career professionals, who have not been frequently included in stigma research. Results are mixed; for example, Fernando and colleagues (2010) reported a reduction in stigma levels with experience, while Peris, Teachman, and Nosek (2008) found students to have more positive attitudes towards people with mental illness compared to more veteran professionals. One study also found that continued supervision (often utilized more by early career professionals) has been linked to more positive attitudes toward people with mental illness as well as increased support in order to cope with burnout (Smith & Cashwell, 2010). Using an Implicit Association Test that utilized words related to the categories “Mentally Ill People” and “Welfare Recipients,” as well as words representing “good” and “bad,” Peris and colleagues (2008) determined that graduate students showed more positive associations with mental illness than did veteran mental health professionals. Trainees have also been found to report wanting less social distance from people suffering from mental illness compared to more experienced providers (Smith & Cashwell, 2011).

Differences between early career professionals and those more established in the field have also been found between and within groups of both physical and mental health providers. Although research on early career professionals is limited, research that utilizes students and residents has demonstrated differences related to amount of experience. For example, Chin and Balon (2006) found that psychiatry residents scored lower on a measure of stigma than did medical residents in other specializations. Research indicates that these newer professionals may hold more stigmatizing attitudes due to fear and lack of adequate experience with mental health patients (among newer physicians; Filipcic et al., 2003), and similar to the views of more established physicians, medical students and residents may have doubts about psychiatric patients’ abilities to adhere to treatment (Dixon, Roberts, Lawrie, Jones, & Humphreys, 2008).
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Some studies looking into stigma among different types of health providers determined that gender may play a role in stigma differences in addition to degree or training model. For example, Smith and Cashwell (2011) found that female non-mental health providers sought less social distance from adults with mental illness compared to male non-mental health providers. Although research on gender of health care providers is rare, one study found that female doctoral-level health care providers tended to view those with mental illness as more creative, healthy, and highly skilled compared to male providers (Lauber et al., 2006). Male providers tended to have higher mean scores when thinking about stereotypes of those with mental illness.

Statement of the Problem

Research suggests that many people who struggle with mental health issues are often discriminated against due to their diagnoses (Corrigan et al., 2003a). These incidents occur at the client’s school, work, with family/friends, and unfortunately at times also with the very people who are supposed to be caring for their health. Many individuals with mental illness have reported being discriminated against while utilizing physical health services (Gabbidon, Farrelly, Hatch, Henderson, Williams, Bhugra, ...Clement, 2014), which is concerning as morbidity rates tend to be higher in those with mental illness (Jones, Howard, & Thornicroft, 2008; Mai, Holman, Sanfilippo, & Emery, 2011). Studies indicate that stigma shown by health providers may negatively contribute to clinical care, as healthcare providers have been shown to be less likely to refer patients with comorbid mental illness diagnoses to specialists for physical health evaluations (Druss et al., 2000; Koroukian et al., 2012; Sullivan, Han, Moore, & Kotrla, 2006). These findings make it imperative to determine what may be contributing to the increased levels of mental health stigma.
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One possible factor suggested by existing research may be differences in approach to clinical training among healthcare providers, which varies by specialty. For example, physical health practitioners appear to have more negative attitudes towards people with mental illness compared to mental health professionals (Bjorkman, Angelman, & Jönsson, 2008; Hori, et al., 2011; Smith & Cashwell, 2010). As Unutzer and colleagues (2006) noted, a large proportion of mental health care is provided in primary care settings. The combination of these factors puts clients at an increased risk for receiving lower quality care due to increased stigma in among providers in these settings. Additionally, there appear to be differences in reported stigma levels as a provider’s number of years spent in the field increases. The longer someone remains in an emotionally taxing field, the higher his or her risk of burnout, which could impact the quality of the care she or he provides (Bakker, Schaufeli, Sixma, & Boseveld, 2000; Gibb, Beautrais, & Surgenor, 2010). While the recent emphasis on integrated healthcare may help to improve some of the problem, more research needs to be done to address disparities in clinical care for those with mental illness.

Limitations of Existing Studies

Existing studies have acknowledged that stigma among healthcare providers is an important area of research; however, the variety among occupations grouped into the category “mental health professionals” in previous studies may have potentially caused error within study results and may explain some of the variability seen in results from different studies claiming to be examining very similar phenomena. For example, whereas some studies included psychiatrists in the mental health professional group (Peris, Teachman, & Nosek, 2008; Verhaeghe & Bracke, 2012), others grouped them with the physical health providers and some did not include psychiatrists at all (Borowsky et al., 2000). Similarly, when psychiatrists have been distinguished
from physicians, psychologists have been grouped with other types of “psychiatric staff” with varying levels of training (Nordt, Rossler & Lauber, 2006; Hori et al., 2011; Smith & Cashwell, 2011). Further, some studies have grouped all health-care providers together and did not consistently describe the distribution (Gibb et al., 2010; Happell et al., 2012; Corrigan et al., 2014). This has made it increasingly difficult to compare these studies or utilize them in any sort of meta-analysis. Additionally, prior studies have not distinguished among other types of professionals with different levels and types of training, including social workers, professional counselors, nurses, thereby reducing external validity. Smith and Cashwell (2011) found that mental health professionals desired less social distance than non-mental health professionals; however, when breaking the mental health provider group down further, they found that counselors and psychologists preferred less social distance compared to social workers, suggesting that even among more similar specialties, type of degree and training model may important factors to examine.

Existing research has also failed to fully explore factors that may account for variance in stigma levels between professionals or to examine inter-correlations among the variables proposed by this study to help put together a more complete picture of what contributes to stigma among providers. More specifically, although studies have examined individual factors potentially related to stigma, they have not utilized the combination of burnout and therapeutic optimism together to explain significant differences, despite research which suggests that therapeutic optimism may reduce the risk of burnout (Bruckner, 1979). Despite utilizing psychologists within the normative study (Byrne, Sullivan, & Elsom, 2006), subsequent research on therapeutic optimism has focused primarily on psychiatric nurses and failed to include doctoral-level providers (Happell et al., 2012; Happell & Koehn, 2011). Although this literature on psychiatric nursing include both burnout and
therapeutic optimism as individual variables, these studies did not examine interaction effects between the two. The current study hopes to bring to light the impact of the combination of potentially influential variables to better inform training, supervision, continuing education, and healthcare system policies, as well as to account for more of the variance in the model and reduce the number of confounding variables excluded from the study.

Prior research has also depended primarily on students when looking at those with less experience as this is a more readily available population to survey. There is a gap in the literature where researchers have failed to examine many different levels of experience/time spent in the field and how this may impact stigma levels as well as clinical care.

Finally, previous research failed to explore some of the variables correlated with increased stigma levels in the general population within studies examining healthcare providers, specifically the role of gender on their view of mental health care and mental illness.

**Definition of Terms**

**Mental Health Stigma:** Mental health stigma is often operationally defined as labeling, discrimination, and rejection of people who are socially and behaviorally different (Phelan & Basow, 2007). Because the participants in the proposed study will be doctoral-level healthcare professionals, external mental health stigma may not be overtly apparent and may manifest more as dismissiveness, apathy, and a larger emphasis on pathology. A measure specific to clinicians will be used because of these potential presentation differences. This variable is operationally defined as the score on the Mental Illness: Clinicians’ Attitudes (MICA) scale (Gabbidon et al., 2013).

**Professional Specialty:** “Professional Specialty” will be the overarching term used to describe the five different groups addressed in the present study, which include internal medicine physicians,
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family medicine physicians, psychiatrists, clinical psychologists, and counseling psychologists as the five most common doctoral-level providers interacting with those with mental illness.

Experience in the Field: This term refers to the amount of time each professional has spent in the field, in year, since receiving his or her degree, thus this is a continuous variable.

Burnout: Burnout will be defined using the three-factor model proposed by Maslach and Jackson (1986): Emotional Exhaustion, Depersonalization, and Personal Accomplishment. More specifically, this variable is operationally defined by the total score on the Maslach Burnout Inventory- Human Services Survey (MBI-HSS), which then breaks down individual scores on each of the three subscales related to the three-factor model.

Therapeutic Optimism: Therapeutic optimism will refer to clinicians’ outcome expectations for patients or clients as defined by the score on the Therapeutic Optimism Scale (TOS; Byrne, Sullivan, & Elsom, 2006).

Research Questions

The current study addresses the following research questions:

1. Are there differences in levels of mental health stigma between internal medicine physicians, family medicine physicians, psychiatrists, clinical psychologists, and counseling psychologists?

2. Do differences in mental health stigma exist between providers with different amounts of experience?

3. Is burnout (separated into three factors: emotional exhaustion, depersonalization, and personal accomplishment) a predictor of mental health stigma among providers?

4. Is therapeutic optimism a predictor of mental health stigma among providers?

5. Are there differences in levels of mental health stigma among providers based on gender?
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6. Are there interaction effects among these different predictor variables between groups?

Statement of Hypotheses

The following hypotheses are proposed, based on the existing literature:

**Hypothesis 1** predicts that significant differences in stigma levels will be found between the groups, with psychologists showing the least amount of stigma compared to physicians and psychiatrists. This hypothesis also predicts that psychiatrists will show the most stigma and that a significant difference will be found between internal medicine physicians and family medicine physicians with internists showing more stigma than family medicine physicians. This is based on previous literature which shows primary healthcare providers have significantly more negative attitudes towards people with mental illness compared to people without mental illness (Corrigan et al., 2014). This difference was not observed in mental health providers. Internal medicine residency programs have also been found to provide less mental health training than family medicine programs (Leigh et al., 2006a; Leigh et al., 2006b; Smith et al., 2014; Williamson et al., 2016). Research also suggests that medical doctors including psychiatrists have been found to have more negative attitudes toward people with mental illness compared to non-physician mental health professionals (Bjorkman, Angelman, & Jönsson, 2008; Smith & Cashwell, 2010; Hori et al., 2011).

**Hypothesis 2** predicts that mental health stigma will increase as time in the field increases. Education and supervision have been linked to more positive attitudes toward people with mental illness (Smith & Cashwell, 2010). Spending more time in the field makes medical professionals more critical of mental health patients or influences them to not work exclusively with this population (Crowe & Averett, 2015). Structural, systematic pressures are put on practitioners with an emphasis on symptoms and deficits (Flanagan, et al., 2009).
Hypothesis 3 predicts that higher levels of burnout will predict higher stigma levels among all professionals. Research shows more negative attitudes toward people with mental illness are associated with higher levels of burnout (Gibb et al., 2010).

Hypothesis 4 predicts that regardless of profession, participants with higher levels of therapeutic optimism will show lower stigma. Optimism may reduce the incidence of burnout (Bruckner, 1979). Explicit biases have predicted more negative therapeutic outcomes (Peris et al., 2008), while an optimistic outlook is associated with positive health outcomes (Gillham, Shatte, Reivich, & Seligman, 2001).

Hypothesis 5 predicts that significant differences will be found related to gender, specifically that female health providers will tend to show less stigma toward those with mental illness compared to male health providers. Lauber and colleagues (2006) found that female health professionals view those with mental illness as more creative, healthier, and more skilled while male professionals tend to hold more stereotypes toward those with mental illness.

Hypothesis 6 predicts that interaction effects will be found among these variables by professional specialty. Based on related research on individual variables, it is predicted that male non-mental health providers will show the highest levels of stigma, while female mental health providers will show the least. This hypothesis also predicts that non-mental health providers who experience more burnout will show higher levels of stigma than mental health providers with burnout, likely due to increased training on burnout and self-care. It is also predicted that a significant interaction effect will be found between professional specialty and therapeutic optimism, with non-mental health providers with lower levels of therapeutic optimism having more negative attitudes towards patients with mental illness. Finally, Hypothesis 6 also predicts
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that non-mental health providers with more years spent working in the field will show the most stigma, while early career mental health professionals will show the least.
CHAPTER II

Review of the Literature

The following chapter provides a discussion of mental health stigma and its relevance to psychiatrists, physicians in internal medicine, family physicians, counseling psychologists, and clinical psychologists, as well as their patients. A discussion of differences in stigma shown among the different specialties is provided, as well as literature related to its impacts. An overview of the literature on burnout and therapeutic optimism is provided due to their implications as potential contributors to stigma among providers. Attribution theory, equity theory, and social exchange theory are reviewed in relation to their influence on provider burnout and outcome expectations. The role of gender and time spent in the field are also discussed as influential variables related to stigma among doctoral-level healthcare providers.

Historical Perspectives on Mental Health Stigma

Stigma surrounding mental health care has been around for years. Historical perspectives on stigma related its causes to personal flaws, demonic possession, as well as a view of personal responsibility for one’s mental struggles. Those struggling with mental illness often tried to hide it or would end up in institutions that did little to help or re-engage the person back into the community. Historically people were admitted to these institutions for all sorts of reasons. In 1887, reporter Elizabeth Cochrane (aka Nellie Bly) faked insanity to report on conditions inside an asylum. Elizabeth discovered first-hand how many people had been admitted for seemingly irrelevant issues (i.e., not speaking English). She also found that it was extremely difficult to be released. Elizabeth herself was only discharged when the newspaper interceded on her behalf and explained the hoax. Reporter Geraldo Rivera is most known for his exposé on Willowbrook, an institution for the mentally ill (Rivera, 1972), highlighting the poor treatment of patients there. His
efforts, combined with the work of other activists, eventually resulted in the deinstitutionalization of the mentally ill and a shift in focus toward community integration and outpatient mental health.

These perceptions of mental illness among the general public likely stemmed from ignorance, as humanity has shown a trend of fearing what it does not understand. The media, while it has done much to showcase the horrors of institutions, has also likely contributed to increases in mental health stigma through their portrayal of incidents of mass violence and implied attribution of mental illness possibly causing many of these events. The media has been found to distort situations and perpetuate stereotypes, especially when dealing with mental illness issues (Stuart, 2006).

The National Comorbidity Survey Replication (NCS-R, 2005; a nationally representative household survey) examined the behaviors of those experiencing psychological and emotional symptoms (as determined by the Composite International Diagnostic Interview) found that only one-third had received treatment (Wang et al., 2005). The study further broke this down and discovered that of those who had received treatment, 12% met with a psychiatrist, 16% from a non-psychiatric mental health specialist, 23% from a general medical practitioner, 8% from a social services professional, and 7% from an alternative medical provider, indicating that treatment is spread across specialties. These numbers also emphasize the disparity between the numbers of people struggling with mental illness and the proportion of people who actually receive help, as well as highlighting the variety in types of providers sought out by those who do decide to get treatment.

The Future of Health Care and the Integration of Professionals

Questions related to the development of stigma and sources of stigma are especially important as the American healthcare system undergoes a transformation. The Patient Protection
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and Affordable Care Act (PPACA) is changing health care by expanding many existing health programs and introducing new provisions that aim to improve the quality and accessibility of care (Association of American Medical Colleges [AAMC], 2010; APA, n.d; Beronio, Po, Skopec & Glied, 2013). In the past, insurance restrictions, lack of anti-discrimination legislation, and a confusing and inefficient system likely also contributed to stigmatizing beliefs about mental health care (Corrigan & Watson, 2002; Mechanic, 2012; Sartorius, Stuart, & Arboleda-Florez, 2012). Patients are not always sure where to go to access services or must try to navigate being referred multiple times before receiving any care. The disintegration of care could be a large barrier specifically for those seeking mental health services.

Traditionally, health care has been somewhat segregated. Federal, state, and local governments have struggled to find ways to successfully integrate healthcare services, specifically for those with mental illness (Grob & Goldman, 2006). In addition to regulatory, statutory, and political barriers, integrated healthcare faces challenges with the providers themselves. In the past, there has traditionally been a hierarchy among professionals. This hierarchy has been found to create barriers among interdisciplinary teams related to communication and exchange of knowledge (Edmondson, 2003). Different disciplines have been found to be less likely to collaborate, much less communicate at all beyond giving patients phone numbers for referrals, making treatment somewhat disorganized for the patient (Mechanic, 2012). One study also found a significant association between professional status and psychological safety (feeling able to share ideas and concerns and ask questions within the treatment team), as well as a correlation between the ability of the team leader to encourage inclusiveness and engagement of team members in quality improvement of care (Nembhardi & Edmondson, 2006).
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Provisions included in the PPACA attempt to break down barriers between specialties by requiring professionals to work as multi-disciplinary teams (American Psychological Association, 2015; U.S. Department of Health & Human Services, 2015). In order for these teams to treat patients effectively and efficiently, professionals are increasingly focused on integration of care in determining a course of treatment for each patient. This type of care has been encouraged by psychologists and physicians alike (AAMC, 2010; American Academy of Family Physicians [AAFP], 2014; APA, 2015); however, there are many challenges facing its implementation. It is unclear how different health professionals will collaborate and work together in a productive and appropriate manner due to these long-standing hierarchies. Additionally, mental health stigma among specific professionals could cause conflict regarding patient care and make collaboration difficult, ultimately impacting the quality of care received by the patient.

Recent statistics indicate that of the patients who utilize primary care, 25% have comorbid physical and mental diagnoses and 83.6% are never actually seen by psychological professionals (Sorel & Everett, 2015). Further, half of the treatment for common mental disorders is provided in primary care settings, and this number rises to two-thirds among racial and ethnic minorities (Unutzer, Schoenbaum, Druss, & Katon 2006). However, research also suggests that these disorders are not treated properly in primary care settings (Sorel & Everett, 2015; Young, Klap, & Sherbourne, 2001). Finding ways for healthcare professionals from multiple specialties and training models to work together may improve care for patients with co-morbid diagnoses and ensure that all patients are assessed holistically.

Unfortunately, another barrier to care lies in stigmatizing attitudes found among healthcare professionals that are similar to those often seen in the general public. Research indicates that many who took the first step of trying to seek help often faced stigma from those providing
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treatment in the process of accessing care in the form of not being given proper referrals, diagnostic overshadowing, and feeling judged while seeking care (Corrigan et al., 2014; Gabbidon, 2014; Jones, Howard & Thornicroft, 2008). Another study suggested a multitude of possible provider-related factors including poor education in school about depression, limited interpersonal skills training, mental health stigma, lack of adequate time to assess and treat mental health symptoms, failure to consider psychological options and treatments, improper medication management (Thornicroft, Rose & Kassam, 2007). These findings provide evidence for the necessity of more research related to stigma among health care providers.

Mental Health Stigma in Doctoral-Level Healthcare Professionals

With the growing emphasis on healthcare reform, more focus has been placed on examining the quality and efficacy of care provided in many different types of health care settings. Provider practices and treatment outcomes are under closer scrutiny as “fee-for-service” is transitioning to set global fees and salary-based payments that will help to control health care costs (Nordal, 2011). Before the push for health care reform, providers were under no obligation to demonstrate that care was effective and as a result, may have tried to squeeze more patients into smaller periods of time to increase revenue. This could be frustrating and discouraging to patients, specifically those dealing with strong psychological distress.

Patients also sometimes faced inappropriate and incorrect evaluations of their symptoms when trying to seek help. Those who are already feeling stigmatized by the general public may often report physical symptoms in relation to their psychological and/or emotional distress. Additionally, cultural factors may also motivate a patient to report somatic symptoms rather than psychological complaints, as mental health and mental illness are often still not recognized in other cultures. Sometimes somatic complaints of those with mental illness are attributed to their mental
disorders and proper medical referrals are not given, an occurrence also referred to as diagnostic overshadowing (Druss et al., 2000; Sullivan, Han, Moore, & Kotrla, 2006; Jones, Howard, & Thornicroft, 2008; Koroukian et al., 2012). Conversely, psychological symptoms may be attributed to physical disorders, also resulting in a lack of proper referrals. This disparity in care offered to those with mental health symptoms or diagnoses is concerning due to the high morbidity rates in those with mental illness (Jones, Howard, & Thornicroft, 2008; Mai, Holman, Sanfilippo, & Emery, 2011).

Due to the stigmatizing behaviors seen among professionals, it is important to examine possible factors contributing to these perceptions. Since some research has shown stigma-related differences among specialties, it is also important to consider possible reasons for those differences. Some researchers have proposed that those without extensive mental health training may doubt the ability to adhere to treatment among those with mental illness (Corrigan et al., 2014). Studies indicate that providers who do not have as much familiarity with treating mental illness may show greater stigma toward those with mental illness (Corrigan et al., 2001a; Corrigan et al., 2001b). Other research has suggested psychiatrists may show the highest levels of stigma (Jorm et al., 1999; Caldwell & Jorm, 2000; Lauber et al., 2006); however, one possible rationale for this could be related to length and quality of the interaction between patient and psychiatrist which can be considered one aspect of familiarity. These results become especially important when considering data that indicates that many people go to primary care settings first when experiencing psychological symptoms (Unutzer et al., 2006). This study reported that half of treatment for common mental disorders is provided in primary care settings, and this number rises to two-thirds among racial and ethnic minorities (Unutzer et al., 2006). Research also suggests that these disorders are not always treated properly in primary care settings (Sorel & Everett, 2015;
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Young, Klap, & Sherbourne, 2001), thereby emphasizing the importance of integrated healthcare as well as the reduction of stigma among all healthcare providers in these settings.

Theoretical Framework for Sources of Stigma in Providers

The stigma shown among healthcare providers likely has many root causes. In addition to their professional specialties, providers are also human beings with the same capacity for internal biases and influence from one’s external environment (i.e., community, family, etc.). Frameworks regarding stigma among the general population many be applicable to health care providers as well. The attribution model proposed by Weiner (1995) describes the stereotyping-prejudice-discrimination pathway, highlighting human beings’ innate need to make sense of things. This model suggests that healthcare providers’ beliefs and reaction to an event or situation are influenced by their larger beliefs about cause, personal responsibility, and internal locus of control. These perceptions about control and responsibility may be byproducts of the way the individual was raised, a negative personal experience, the media, or potentially other factors related to a healthcare provider’s professional status and experience specific to her or his individual specialty (Mittal et al. 2014; Watson, Corrigan & Angell, 2005:).

Mental Health Stigma among Physicians

Early research into the relationship between professional specialty and attitudes toward those with mental illness has shown a difference among different types of health care providers. Generally, primary care providers have been found to have more negative attitudes toward those dealing with mental health issues compared to mental health providers (Bjorkman et al., 2008; Hori et al., 2011; Mittal et al., 2014). In addition to individual differences, training may be a component as to what causes this differential in stigma levels among healthcare professionals. Primary care providers may not have had as much focus on rapport with patients, current research
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on patient outcomes, as well as mental health training in general. It is also likely that many primary care providers just simply have not had enough exposure and experience with patients struggling with mental health concerns as research has shown contact with an individual who has made great improvements in terms of mental illness helps to reduce stereotypes and stigma (Corrigan, 2011; Corrigan & Watson, 2002).

**Differences in training among internists and family physicians.** When examining potential causes for the differences seen between physical and mental health providers, differences in training is a strong possibility. Smith (2011) wrote a piece in the journal of *Academic Medicine* in which he criticized today’s medical training programs for a lack of proper focus on psychiatry and mental health care. Smith criticized the norm of giving residents only a maximum of 16 weeks of psychiatry training during their residency programs with the majority receiving even less. Smith called for training reform in which training programs ensured residents were being trained by faculty with strong experience in primary care mental health as well as utilizing team-based collaborative approaches. These calls for improved and expanded training seem to span across medical specialty training; however, more research appears to focus on the improvement of family medicine as opposed to internal medicine.

Leigh, Stewart, and Mallios (2006a) sought to examine the differences in training between these different programs by surveying 733 residency training program directors. In their study, researchers inquired about the amount of psychiatric training received by residents, satisfaction with training, training formats, desire for more training, and the directors’ general feelings toward physicians treating mental illness. Significant differences were found in the responses of family medicine programs versus internal medicine programs. Results showed that 71% of internal medicine programs felt that their psychiatric training was suboptimal compared to 41% of family
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medicine programs. The majority of family medicine programs (64%) were satisfied with the psychiatric training their residents were receiving compared to one-third of internal medicine programs. While all types of residency programs offered mental health didactics and case conferences, only family medicine programs offered special coursework and joint rounds. Family medicine was also found to offer more individual supervision. Another interesting finding was that internal medicine programs utilized more faculty from the psychiatry department; however, family medicine by far had the most diverse faculty with 82% reporting hiring non-M.D. mental health professionals. When examining setting, 42% of family medicine programs included a psychiatry rotation compared to a third of internal medicine programs, though internal medicine sported the highest psychiatry department contribution to teaching.

Perhaps the most pressing takeaway from the study was that 57% of internal medicine residency directors desired more psychiatry training than what each program currently offered, highlighting the desire, interest, and recognition of the benefits of expanded training. This suggests that perhaps it is the system and the slow progression of change that is preventing more appropriate and inclusive mental health training in these programs. It is possible that the process of reform could be expedited by research which emphasizes the negative consequences to these segregated and incomprehensive training models.

That being said, very little research has investigated any differences among specialties beyond residency training programs in both early career physicians and veteran physicians. It appears that much of the research focused on individual specialties did so per convenience or personal interest, and research examining multiple specialties and comparing them is especially rare. Much of what we know about differences between family medicine and internal medicine comes from the training and guidelines themselves. The American Academy of Family Physicians
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has curriculum guidelines related to mental health treatment and stresses the importance of a biopsychosocial framework as well as the emotional components of health (AAFP, 2008; Williamson et al., 2016). The Accreditation Council for Graduate Medical Education (ACGME, 2006) has tried to expand educational competencies to include many of the interpersonal factors associated with quality healthcare. Unfortunately, despite these efforts, there are no specific and clear mandates regarding what types of interpersonal skills and professional development trainees must acquire in the scope of psychiatry (Leigh, Stewart & Mallios, 2006b). Research examining the mental health training in primary care residencies discovered that family medicine programs tend to have more extensive training in terms of educators, formats, and settings (Leigh et al., 2006a; Leigh et al., 2006b).

In a review of 34 articles related to expanding psychiatric curriculum in primary care training programs, Huzij and colleagues (2005) determined there were three main categories of focus which included psychiatry, primary care, and integrated. The researchers then described what each type of curriculum would look like. One interesting aspect of this review is that none of the three categories included instruction or experience by or with psychologists or other types of mental health providers. The curriculum proposed detailed the involvement of psychiatrists, primary-care physicians, or a combination of both in the case of the integrated curriculum. Swing (2007) discussed a behavioral medicine track established within a family medicine residency that included involvement of a psychologist, family physician-psychiatrist, social worker, and nurse behavioral health interventionist which was deemed a success by the faculty due to four residents completing the program. However, no assessment into the quality of the program was done including residents’ patient outcomes, patient satisfaction, or assessment of knowledge/skills learned (Williamson et al., 2016). Even further, the program did not assess resident perceptions or
attitudes related to the program, therefore their personal satisfaction, opinion on working with various types of mental health professionals without medical degrees, as well as mental health stigma levels (before or after) were not considered.

It appears that family physician training programs have considered the importance of receiving training across settings, as each type of setting often presents different types of disorders or even different types of symptoms to the same disorders. Although many programs appear to also have started to recognize the changing health care system and the transition to more integrated care and interdisciplinary collaboration, few programs have built adequate education and training related to this into their residencies (Leigh et al., 2006a; Williamson et al., 2016). Incorporating the integration of health care specialties into the training process will assist early career professionals with having the appropriate skills to work in these settings and with these types of patients upon entering the working world. This also provides for the integration of theory among the different disciplines which could provide for a more cohesive and comprehension experience for the patient (Smith et al., 2014).

Extensive literature on these concepts has apparently not quite caught up; however, one study sought to go beyond examining what could or should be improved within residency programs in order to look further into the experience of the trainees. Williamson and colleagues (2016) examined the experience of residents trained at the Psychiatric Consultation Clinic (PCC) that trains family physician residents to work in rural areas. The PCC developed curriculum that incorporated videotaped interviews of new patients, case formulation seminars co-led by a psychiatrist and psychologist, and four meetings over the year with a psychiatrist or psychologist mentor to discuss patient issues, aspects that are not necessarily common to residency programs. The researchers sought to understand the experience of the residents by engaging five participants.
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in qualitative interviews, a variable few articles have examined and a methodology few studies related to physician training have utilized.

Two main results emerged from the study. The first was the appreciation the residents had for the additional time they were given to obtain additional information and get to know the patient, specifically in relation to the patient’s mental health. Further, during the interview one resident commented on the extensive list of questions they were given as guidelines and stated, “When I saw that list of questions…I thought is that relevant? But it actually turned out to be relevant.” (Williamson et al., 2016, p. 34). This observation may highlight one aspect of stigma shown by physicians, lack of time to comprehensively evaluate the patient. Without proper evaluations, physicians may initially misdiagnose patients and spend extra time targeting the wrong problem. This may cause both the physician and patient to become frustrated which increases the risk of professional burnout and puts strain on the doctor/patient relationship, thereby potentially increasing negative attitudes and stigma shown by the provider.

The other significant finding from the study was the impact of training strategies. Residents reported benefiting from increased modeling from different types of providers as well as increased supervision. Participants described how the increased interactions with patients under the supervision of faculty helped to improve attitudes toward this type of work as well as increased their willingness and preparedness to query and assist with a patient’s mental health concerns. This suggests that one hypothesis related to stigma shown by physicians could be a lack of proper training which causes anxiety and potentially overcompensation by the provider in order to appear competent. Both main findings from the study emphasize the impact that the training model has on a provider’s attitudes toward psychiatric patients as well as the thoroughness and accuracy of their work. Participants’ responses also highlighted how the training model allowed them to
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develop a more positive view of mental health care and interdisciplinary care, as well as to feel more open to seeking out supervision when needed, thereby improving their knowledge/preparedness/confidence, reducing stress, and improving the overall care for the patient.

Smith and colleagues (2014) recognized a similar need to adapt physician training to a more comprehensive model within the internal medicine training program at Michigan State University. These researchers propose that perhaps medical curriculum is lagging in updates that correspond to health care reform and a stronger focus on proper psychiatric care due to a lack of strong theoretical framework as well as evidence of effectiveness, something that psychology doctoral curriculum is built on and has woven through every aspect of training. Smith and colleagues (2014) highlight that in order to fully address the psychosocial issues faced by patients, the scientific and academic theories utilized need to be relevant to this population. The article also discussed a perceived deficiency in team-based care, development of the doctor-patient relationship, as well as resident self-awareness, concepts that also tend to be a strong focus in psychology programs. It appears Smith and colleagues have not yet published a follow-up article to discuss the evaluation and outcomes of their proposed new training model for internal medicine residents.

**Variance in patient care among post-resident physicians.** One of the few studies to focus on medical specialties not still in residency examined family physicians and obtained results suggesting physicians responded differently to patients struggling with some type of mental health issue (Graber et al., 2000). In this study, Graber and colleagues (2000) surveyed 300 family physicians to examine the impact of psychiatric history on medical decision making. This design was based on prior research that showcased physicians’ reliance on heuristics when estimating the
probability of disease/disorders (McDonald, 1996; Peay & Peay, 1998). Graber and colleagues (2000) were interested in the potential error in using this approach when physicians put too much emphasis on prior diagnoses and symptoms that are not necessarily related to the current issue. Using vignettes about patients with presenting problems of severe headache and acute abdominal pain, researchers randomized participants into three groups. The first was given no past medical history, the second received information regarding a history of depression, and the third obtain information about a history of somatic issues without any biological or physiological cause. Physicians were then asked to determine whether they believe the patient had a serious medical issue as well as whether they would recommend additional testing. Results indicated that family physicians may hold bias related to patient medical history. Family physicians were less likely to fully believe that a patient’s symptoms may be indicative of a serious illness if the patient had a prior history of depression and were also less likely to order additional testing. Because this study was limited to family physicians, it is not clear how these findings would generalize to other physician specialties.

Borowsky and colleagues (2000) sought to study how physician specialty, system of care, and other demographic variables impacted patient treatment and outcomes. Researchers examined family physicians, general internal medicine physicians, endocrinologists, cardiologists, and psychiatrists. The study looked at care provided to over 7,500 patients by close to 350 physicians. The study had many significant findings regarding care provided to patients struggling with one or more mental health concerns. Of the patients who screened positive for depression (N=661), 38.4% were counseled by the treating physician for their mental health problems, only 8.5% had their mental health concern listed as the main reason for the visit and a mere 4.2% were referred to a mental health specialist. Additionally, the study determined that physicians had a more
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difficult time detecting patients who did not meet full criteria for major depression, suggesting that patients with dysthymia, subthreshold depression, or alternative presentations of depression may be missed during a primary care evaluation. Another interesting finding was that the rate of depression detection was raised significantly if another common medical illness was also present. This could suggest that perhaps physicians are more thorough or feel more responsible when somatic symptoms are also present. The study also determined that physician specialty was not a significant factor. However, they failed to report specific results related to the groups, as well as the sample sizes of each group; thus, it could be that a necessary power was not reached and/or groups were not equal when conducting analyses to determine the significance of specialty.

Mental Health Stigma among Psychologists

Despite the obvious increased focused on mental health training within psychology doctoral programs, research shows that psychologists too have been prone to stigmatizing attitudes and behaviors (Lauber et al., 2006; Verhaeghe & Bracke, 2012). As with physical health professionals, mental health providers face the organizational and systemic difficulties and pressures that can create ethical dilemmas for providers due to the conflict between authority and professional opinion (Flanagan, Miller, & Davidson, 2009). They are also at a similar risk of burnout due to demanding patients and increased patient loads. Additionally, psychologists also have different training models within the general realm of psychology doctoral training. Perhaps the slight differences between clinically focused and counseling focused programs account for some of stigma found among mental health professionals.

To assess stigma levels in mental health professionals, Lauber and colleagues (2006) designed a study which utilized a questionnaire and vignettes distributed to a group of mental health providers as well as the general public. When comparing results, members of the general
public tended to characterize those with mental illness as more unpredictable, less self-controlled, and less reasonable compared to mental health professionals; however, the general public also tended to view those with mental health concerns as healthier, less unreliable, and less stupid in comparison to providers. When separating the professionals into their respective specialties, psychologists were found to view those with mental illness as less dangerous, more skilled, and less socially disturbing compared to psychiatrists. However, the study did not distinguish between specialties within the field of psychology.

**Differences in training within clinical and counseling psychology.** There is little research that investigates differences between different types of training programs similar to the research previously discussed related to family medicine versus internal medicine. Applied psychology doctoral programs are typically classified into two types: clinical psychology and counseling psychology. Research examining the two specialties has determined that there is significant overlap (Cobb et al., 2004; Morgan & Cohen, 2008). Psychology graduates from either type of program are often trained to work as researchers, professors, and/or clinicians, as well as to do so in a wide range of settings. Examination into program core coursework shows few differences (Cobb et al., 2004). Much of this is likely due to strict accreditation requirements set forth by the American Psychological Association. Where these programs appear to have differed historically is related to emphasis/focus and elective coursework. Counseling psychologists have traditionally been more focused on vocational guidance while clinical psychologists focused more on mental health; however, these differences are not observed in the present day (Society of Counseling Psychology, 2016). According to their training philosophies, counseling programs emphasis a focus on the lifespan with increased coursework on developmental and vocational issues (Society of Counseling Psychology, 2016). Although the Society of Clinical Psychology
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does not address specific differences compared to counseling psychology, it does include a Model for Graduate Curricula which emphasizes a focus on evidence-based treatment (Society for Clinical Psychology, 2016), though it is important to note that this is not a point of discrepancy between the two training models.

When examining these differences from a research perspective, Cobb and colleagues (2014) determined that clinical programs seemed to offer more neuropsychology, behavioral health, and psychopharmacology courses, whereas counseling programs tended to include more vocational, developmental, and social classes. Morgan and Cohen (2008) sought to discover if differences could be found within printed program recruitment materials from 227 programs. Results indicated several significant differences. Among faculty, clinical programs were more likely to have faculty researching treatment of mental illnesses as well as general mental illness research. Another significant difference discovered was related to student admissions. The researchers found that clinical programs admitted significantly more students annually ($M = 35$) than counseling programs ($M = 8$). Results also showed that counseling programs tended to admit more students from racial and ethnic minority groups. No significant differences were discovered related to classes required in research or statistics. Despite the various concentrations available within the different types of programs, the only significant difference found related to specialized course offerings was that counseling programs tended to have more vocational psychology course offerings and requirements. Clinical programs were found to require more semesters of practicum ($M = 5.77$) than counseling programs ($M = 4.0$). Significant differences were also found in work setting of graduates with counseling programs reporting more graduates in college counseling centers.
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The findings of the study suggest that in practice there are not many differences between clinical and counseling programs. One thing to note is that the study appeared to inquire about requirements but failed to account for those who perhaps went above and beyond requirements. This is likely because data was obtained from recruitment materials rather than program directors or students. Researchers have also suggested that perhaps more differences exist within each specialty rather than between them, potentially indicating more individual program or student differences. Another consideration is that with the rapid changes within health care policy in the internal and external pushes for more integrated care, all types of programs may be moving toward a more interdisciplinary focus. One notable finding within the study was the apparent increased focus on psychopathology and training in inpatient or hospital settings within clinical programs, while counseling programs emphasized more multicultural and holistic training. This has been a long standing assumed distinction between the programs and leads to a strong rationale for the inclusion of these groups within the current study. Just as subtle differences between internal and family medicine could potentially create differences in stigmatizing attitudes toward patients, so to may be subtle differences between clinical and counseling psychology. Do to the few other differences determined based on previous research, this study seeks to discover whether differences in training program emphasis/focus increases stigma levels among psychologists.

**Variance in stigma based on psychology training model.** Research related to stigma that distinguishes clinical and counseling psychologists is few and far between. Some studies have utilized the term “clinical psychologist;” however, it is unclear whether this certifies that these participants graduated from a clinical psychology program as opposed to a counseling psychology program. No research related to stigma could be found that specified the participation of counseling psychologists. Jorm and colleagues (1999) completed a study comparing psychiatrists,
clinical psychologists, and general physicians utilizing a questionnaire and two vignettes (one depicting depression and one depicting schizophrenia). Results indicated that with the depression vignette, clinical psychologists rated positive outcomes more likely than general physicians and negative outcomes less likely than both general physicians and psychiatrists. On the schizophrenia vignette, clinical psychologists rated positive outcomes more likely and negative outcomes less likely compared to psychiatrists.

In a similar study, Caldwell and Jorm (2001) utilized the same groups and a similar study design, this time asking about prognosis after treatment. Results suggested that clinical psychologists were significantly less negative than general physicians and psychiatrists regarding both the schizophrenia and depression vignettes. Clinical psychologists were also less likely to believe there would be negative long-term outcomes compared to physicians and psychiatrists.

**Associative stigma among psychologists.** Other research related to stigma among psychologists has examined the concept of “associative stigma” and its impact on stigma within mental health professionals (Halter, 2008; Verhaeghe & Bracke, 2012). Associative stigma is the stigma felt by these professionals themselves in relation to their career choice. Due to the stigma experience by mental health service users, mental health professionals have also been stereotyped and marginalized at times. Previously the idea of associative stigma has been used with family members of stigmatized people (Angermeyer, Schulze & Dietrich, 2003); however, media portrayals of mental health professionals has made the phenomenon even more applicable to these providers being presented as neurotic, unethical, substance dependent, narcissistic, lacking empathy, and/or foolish (Schulze, 2007).

Due to these factors, as well as the importance of the therapeutic relationship within treatment, Verhaeghe and Bracke (2012) sought to examine the effects of associative stigma on
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the well-being of mental health professionals, as well as on the well-being of their patients. The study also highlights the relationship of burnout and associative stigma due to the impact of burnout on work-related well-being, this also emphasizing the relationship between stigma and burnout to be discussed further in the next section. The researchers utilized the same three-dimensional model of burnout proposed by Maslach and colleagues (2001) which examines depersonalization, emotional exhaustion, and personal accomplishment. The researchers hypothesized that the higher a professional’s experience of associative stigma, the less a professional may participate in the treatment of a patient thereby straining the therapeutic relationship and increasing the level of stigma felt by the patient. Additionally, professionals who have experienced increased associative stigma may have difficulty controlling counter-transference and emotional reactions to patients which could also impact the overall experience of each patient.

Verhaeghe and Bracke (2012) obtained samples of 707 service users and 543 psychiatric professionals. Of focus in the current study are the inclusion of 64 psychologists and 14 psychiatrists (other professionals included in the original study were nurses, vocational trainers, social workers, physiotherapists, and other miscellaneous service providers). Due to the fact that at the time of the study there were no standardized measures assessing associative stigma, the researchers devised a questionnaire asking about feelings and experiences that could be related to the concept of associative stigma utilizing a Likert scale. This was administered along with the Maslach Burnout Inventory, the General Health Questionnaire to assess mental health status, as well as a measure of job-satisfaction. Patients were also given the Devaluation Discrimination scale to assess perceived stigma among the general public toward people seeking psychological help. The study also utilized a measure of self-stigma to assess feelings of shame and inferiority.
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related to participants’ treatment experiences. Results of the study indicated that psychologists were ranked fourth out of ten categories of health care providers in terms of experiences of associative stigma indicating that they feel highly stigmatized for working in the mental health field. Psychiatrists were ranked toward the bottom of the list. When adding in burnout, associative stigma was positively associated with two of the three factors of burnout, depersonalization and emotional exhaustion. Associative stigma was also negatively correlated with job satisfaction. Most importantly, associative stigma was found to be significantly correlated with patient stigma. Patients being treated by professionals who endorsed more associative stigma reported being less satisfied with services. These findings suggest a relationship between associative stigma and burnout in professionals, as well as a correlation between associative stigma and stigma experienced by the patient as well as patient satisfaction. These results highlight the need for more exploration into the impacts of provider stress and burnout on their attitudes and behaviors toward mental health service users.

Stigma among Psychiatrists

Most of the literature examining stigma in psychiatrists has already been discussed. This is because few studies examine psychiatrists individually. Additionally, much of the past literature has created confusion related to the classification of psychiatrists. In studies that examined general groups of health practitioners, psychiatrists have been included with mental health providers, with physicians, or left as a separate group (Borowsky et al., 2000; Peris, Teachman & Nosek, 2008; Verhaeghe & Bracke, 2012). Often the designated “mental health provider” group includes professionals with various levels and types of training, thereby making it difficult to generalize results. Sometimes psychiatrists were not included at all. Due to their completion of both general medical school and psychiatry rotations, psychiatrists have the privilege of receiving dual training
in physical and mental health. However, because psychiatry programs are housed in medical schools, and they are trained first as physicians, their training does not focus as much on some of the other interpersonal factors stressed in psychology programs.

**Psychiatry residency training.** Research examining psychiatry residency training programs found some inadequacies related to mental health and therapy training. Sudak, Beck, and Gracely (2002) examined the readiness of these programs to train their residents in cognitive-behavioral therapy (CBT). Results showed that half of the programs surveyed had no requirement to perform CBT. Other results suggested that the programs’ confidence in their residents’ abilities to perform CBT was correlated with the number of didactic hours, psychotherapy hours, and ACT-certified faculty in the program. Another study found that supportive psychotherapy received the least amount of didactic time and supervision in psychiatry residency programs (Sudak & Goldberg, 2012). A third study surveyed chief residents in psychiatry residency programs regarding psychotherapy competency (Khurshid, Bennett, Vicari, Lee & Broquet, 2005). Twenty-six percent of chief residents believed that some faculty were not qualified to teach classes related to psychotherapy or assess competencies. Further, only 31% of chief residents reported that they believed that psychotherapy competencies were well integrated into the psychiatry curriculum. These findings have implications related to stigma, as many of the foundational aspects of psychotherapy (i.e., building rapport, establishing trust, and engaging in a collaborative process) may help to improve the doctor-patient relationship and therefore reduce stigma within the provider.

**Attitudes toward mental health among psychiatry residents.** There is little research examining psychiatry residents’ attitudes towards those with mental illness and even less research looking at possible training variables related to negative attitudes. Much of the literature within
this realm is focused on the decline of medical students entering psychiatry based on negative attitudes toward psychiatry as a specialization (Compton, Frank, Elon & Carrera, 2008; Katschnig, 2010). One study determined that medical students felt as though psychiatry lacked a scientific foundation (Malhi et al., 2003). Packer, Prendergast, Wasylenski, Toner, and Ali (1994) sought to test various ways or improving psychiatry residents’ attitudes toward patients with mental illness. Although no correlations were found between attitudes and years of residency training or knowledge of mental health, positive correlations were found between resident attitudes and receiving training in settings where patients were found to receive quality care and residents felt as though they had supervisors who were good role models. This suggests that whereas psychiatry residents and psychiatrists may be taught all the proper knowledge related to mental health care, there may be discrepancies compared to other specializations with the way in which they are taught to apply this knowledge in a clinical setting and in their work with patients.

Variance in stigma shown by psychiatrists compared to other providers. Research that has in fact separated out psychiatrists has shown a trend of more negative views of mental health service users compared to both the general public and other health care providers. Lauber, Anthony, Ajdacic and Rossler (2004) surveyed 90 psychiatrists as well as the general public and found that while psychiatrists had a more favorable view of community integrated psychiatry compared to the general public, they did not differ in terms of their desire for social distance. Both the general public and psychiatrists reported desiring high levels of social distance from those with mental illness. Lauber and colleagues (2006) utilized a questionnaire and vignette in their study which sought to determine if mental health professionals stigmatize their patients. Results indicated that psychiatrists had the most stigmatizing attitudes related to people with mental illness in comparison to all other clinical groups including psychologists, nurses, and other therapists.
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Psychiatrists rated people with mental illness as more dangerous, less skilled, and more socially disturbing.

Jorm and colleagues (1999) and Caldwell and Jorm (2000) did similar studies consisting of stigma questionnaires and vignettes (depression and schizophrenia). Within both these studies, psychiatrists tended to have more overall pessimistic views regarding recovery in those with mental illness when compared to clinical psychologists and general physicians. Jorm (1999) hypothesized that perhaps clinical psychologists tended to have more favorable attitudes due to having less interaction with those who have severe mental illness; however, due to the datedness of Jorm’s study and the fact that more current research that has obtained similar results, this is an unlikely explanation. Therefore, further research is warranted to explain these differences among various professional groups.

**Burnout and its Impact on Stigma**

Qualitative studies examining possible factors related to sources of mental health stigma among providers have seen a trend among professionals related to organizational and systematic pressures. Many providers interviewed endorsed feeling as though they were stuck in a system which emphasized deficits, symptoms, pathology, and a patient’s inability to comply with treatment (Flanagan, Miller & Davidson, 2009). This overall negative focus led to overwhelming feelings of hopelessness among patients and providers, thereby making mental illness seem like a life sentence to an internal prison. Patients struggle to get better in this environment and providers become at risk for what is commonly known as burnout.

Burnout is a consequence of repeated exposure to stress, specifically when one is dealing with people who are struggling with physical, psychological, and/or social problems (Maslach & Schaufeli, 1993; Schulze, 2007). Symptoms of burnout include emotional exhaustion, cynical
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attitudes about client/patient, and negative attitudes related to oneself as the provider of care (Maslach & Schaufeli, 1993; Bakker et al., 2000). These can be especially taxing on individuals who spend most of their time working with severe mental illness, high-risk patients, those dealing with trauma, and other emotionally demanding duties.

Maslach and colleagues (1993) proposed a process model of burnout in which there are three dimensions to burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment. When providers have an emotionally demanding and/or difficult patient (or several) they may start to feel overextended and emotionally drained. This feeling is heightened when the patient is also exhibiting resistant and/or high-risk behavior. Depersonalization may then start to develop when the provider starts to feel cynical or develops negative attitudes toward the specific patient or the work in general. If it feels as though progress is slow or stopped and there is a lack of effort on the part of the patient, the provider may start to doubt him or herself and develop a reduced self-efficacy.

Equity Theory (Adams, 1865) focuses on reciprocity and investment in relation to the development of burnout. For example, when providers feel as though their investment is not matched and are not receiving a similar level of effort back, they may become distressed and first try to increase their effort in order to restore equity; however, this increased effort may only increase the rate of burnout, during which clinicians may become detached and distance themselves from the source of that lack of reciprocity.

This phenomenon is seen in all human relationships, but it can be related to a patient/doctor relationship despite the perceived differences in power according to Social Exchange Theory (Blau, 1964) which proposes that all human relationships find some way to balance through social
exchange. In a doctor-patient relationship, this can be observed as a provider’s expectation (even unconsciously) of symptom improvement and gratitude from the patient (Bakker et al., 2000).

As with all human relationships, the detachment from the relationship initiated by one person tends to be higher the more emotionally demanding the other person is or is perceived to be and the lower the perceived level of effort from that person (Bakker et al., 2000). These perceived roadblocks may also result in questions regarding the professional’s competence and ability to be a useful practitioner. These two theories are exemplified when thinking about a clinician who has a patient who requires more work in and out of session and seems to be making very slow progress or showing resistance, thus the clinician’s level of distress may increase. Although a clinician’s relationship with his or her patient is very different from other types of relationships, there is still a human need to want to feel as though the other person is putting in effort. Additionally, clinicians also want to feel like their work is productive and is making a difference, thus the idea of reciprocity still holds true.

Burnout has found to be most common in health-service and public-service related fields, specifically within mental health care (Awa, Plaumann & Walter, 2010). However, most studies have not compared burnout rates across disciplines, rather only focusing on one specific group of interest. There are also few studies that examine burnout over time. One of these few studies examined general physicians over a five-year period using a questionnaire that included a patient demands scale, reciprocity scale, and the Maslach Burnout Inventory (Bakker et al. 2000). The study results suggest that the more demanding and taxing a patient is, the greater the lack of reciprocity which exhausts clinicians and creates emotional distance thereby increasing the chance of burnout which supports the theoretical framework proposed by Equity Theory. The study also discovered that emotional exhaustion was positively correlated with depersonalization and
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negatively correlated with personal accomplishment supporting the suggested model that emotional exhaustion could reduce a provider’s feelings of competence and efficacy and result in negative attitudes toward the patient. The study also determined that those who scored higher on burnout factors at the initial assessment tended to still score high after five years, thereby suggesting burnout may remain stable or increase over time.

As this study highlights, research also indicates that these internal feelings of burnout can result in negative attitudes and further behaviors toward patients (Bakker et al., 2000; Gibb, Beautraise, Surgenor, 2010). Just as one may increase effort when a lack of reciprocity is first observed, one is likely to decrease effort and investment after a prolonged period of distress and equity within the relationship resulting in patients feeling rejected by their providers. Burnout related to a lack of reciprocity with one patient has the potential to impact the rest of the provider’s caseload as the effects of burnout can spread into other aspects of the provider’s work such as other therapeutic relationships. These ruptures in the relationship and barriers to the treatment may result in doubts related to the ability of the patient to improve and/or recover, thus potentially lowering outcome expectations.

The Role of Therapeutic Optimism in Treatment

The organizational and systemic pressures that many providers face, as well as issues of patient reciprocity and equity, can ultimately lead to burnout. Burnout has been shown to increase negative attitudes towards patients and may results in stigma among providers; however, these stigmatizing attitudes related to a patient’s investment and effort in treatment also relate to a provider’s beliefs about a patient’s ability to recover. When the focus is on the things that are wrong with the patient and the patient’s high emotional demands, particularly if the provider has a high caseload or is treating several emotionally demanding patients, the provider may become
burnt out and both patient and provider may develop strong feelings of hopelessness. This hopelessness impacts both the patient and provider’s beliefs about the outcome of treatment, more specifically, both patient and provider may lack therapeutic optimism. The lack of optimism about recovery can become a self-fulfilling prophecy as the effort coming from both the patient and provider to work toward recovery may diminish. In the provider, this hopelessness and lack of effort may come across as stigma toward the patient. Additionally, as the provider’s level of burnout increases, his or her outcome expectations related to all patients may become more pessimistic and therapeutic optimism may decrease overall.

Whereas a highly demanding case load may lead to decreases in therapeutic optimism and increased burnout, research has also found that therapeutic optimism may help patients with cognitive processing and coping with negative information (Aspinwall et al., 2001). Among clinicians, therapeutic optimism has been correlated with dedication and persistence in treatment as well as reduced burnout (Bruckner, 1979; Aspinwall, et al., 2001). Clinician optimism may also increase positive health outcomes for patients (Byrne et al., 2006). Though the normative sample included psychologists, much of the research on therapeutic optimism has been focused on psychiatric nurses and has failed to examine this phenomenon in doctoral-level health care providers (Happell & Koehn, 2011).

Therapeutic Optimism can be thought of in relation to three main factors (Byrne et al., 2006). General treatment outcome expectancy is an overall assessment of how well providers expect treatment to work. Personal treatment outcome expectancy is related to the provider’s confidence in their own ability to facilitate that process. A focus on pessimism as a factor helps assess the provider’s tendency to have an overall negative outlook, thus including internal and interpersonal aspects as one factor of the model. This three-factor model may help in determining
what specific factor is causing a provider to have a lack of optimism if one is detected, that is, does the provider put blame on the patient, him or herself, or both? If a provider seems to feel confident in his or her own ability, but is lacking optimism in the overall treatment outcome, this could potentially be an indication of stigmatizing attitudes toward the patient from the provider.

Few studies have examined the correlation between stigma and therapeutic optimism. Peris, Teachman, and Nosek (2008) examined implicit and explicit stigma among different types of healthcare providers and discovered that explicit biases predicted more negative patient prognoses. The researchers hypothesized that those with more negative attitudes toward patients may lack optimism generally regarding recovery from mental illness, thereby suggesting a possible connection between levels of stigma and outcome expectations.

Another study sought to examine therapeutic optimism and burnout in relation to potentially stigmatizing behaviors (seclusion of patients). Happell and Koehn (2011) utilized a sample of 123 psychiatric nurses and assessed these variables of interest using the Therapeutic Optimism Scale and the Maslach Burnout Inventory, as well as measures of seclusion of patients and job satisfaction. Results suggested that nurses who were more optimistic about a patient were less likely to seclude the patient. Although seclusion is not necessarily equivalent to stigma, it can be a behavior that is cause by negative attitudes toward the patient. Emotional exhaustion was also found to be correlated with seclusion. Unfortunately, the study did not evaluate interactions between burnout, or specifically emotional exhaustion, and therapeutic optimism. Though the study did not utilize doctoral-level health care providers, it did set a precedent by suggesting possible relationships between burnout, therapeutic optimism and stigmatizing behaviors.
The Influence of Time Spent in the Field

It appears that the impact of time may be far reaching, specifically in relation to stigma among professionals. While some may assume that with experience comes wisdom, today’s working world has become more and more focused on the idea of “more,” more time spent working, more productivity, and more profits. In terms of healthcare, this may be observed as more patients seen per day or more procedures/tests conducted. This emphasis on more has created a society in which stress and anxiety are extremely prevalent. In healthcare providers, an emphasis on more and an increase in stress and anxiety increases a provider’s risk of burnout, frustration directed toward the system in which he or she works, increased negative attitudes toward patients, as well as a risk of inadequate or improper evaluation and treatment of patients. Calicchia (1981) compared psychiatrists, psychologists, and social workers with each other as well as to graduate students and non-mental health professionals. These groups were compared across five different dimensions of stigma: perceived worth, dangerousness, effectiveness, comprehensibility, and desirability. Along with additional evidence to support that psychiatrists hold the highest amount of mental health stigma toward patients, Calicchia also discovered that the mental health professionals (psychiatrists, psychologists, and social workers) collectively showed more stigma than mental health graduate students, showcasing the potential impact of more time spent in the field. Increased time in the field also increases the likelihood of having severe and/or complex patients that could also contribute to a provider’s level of stigma due to the difference in numbers of patients seen and types of presentations over time (Jorm et al., 1999).

Few studies have isolated this variable due to its high correlation with other important factors. There is also a lack on longitudinal research among the different variables being examined within this study. For example, an older study conducted by Burke and Richardsen (1993) found
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that burnout may become a chronic condition. The study results indicated that a year after the study, 40% of participants were still within the same level of burnout and 30% were actually more burnt out. Unfortunately, this study failed to conduct later follow-ups to determine the rate of burnout past one year. One study previously discussed that examined burnout over a five-year period discovered that those who reported higher levels of burnout at time-point one tended to also score high after five years indicated that burnout tends to remain stable over time, but also has the potential to worsen as years go by (Bakker et al., 2000).

Another way to determine the importance of time spent in the field is to determine factors related to both burnout and aging. Acker (2010) discovered that high-levels of burnout in 591 social workers were significantly correlated with more flu-like symptoms and gastroenteritis. Toppinen-Tanner and colleagues (2005) examined non-mental health workers and discovered that burnout predicted future sick leave and determined that the higher the burnout the greater the risk of mental health issues as well as circulatory, respiratory, and musculoskeletal diseases. To take these findings one step further, absences have been linked with reduced commitment to evidence-based practices, something becoming more routinely required by insurance companies (Rollins, Salyers, Tsai, & Lydick, 2010). This suggests that perhaps more time in the field wears not only on the mental/emotional aspect of the job (i.e., burnout), but also on the physical well-being of the provider. Both these factors appear to contribute to increased absenteeism which has been found to reduce commitment to treatment, specifically treatments which have been found to be more effective, potentially also impacting therapeutic optimism and the overall quality of care received by the patient. This also relates to Equity Theory and ideas of reciprocity in the therapeutic relationship. If the patient does not feel commitment and effort from the provider he/she may feel stigmatized and may also reduce his/her own commitment and effort in treatment, which may
continue to impact burnout, optimism, and overall well-being of the provider, thus continuing this unfortunate cycle.

The Impact of Gender on Mental Health Stigma

Research on stigma has examined the correlations between patient gender and mental health stigma in both the public and providers. Borowsky and colleagues (2000) discovered that among the thousands of patients evaluated in their study of close to 350 physicians or various specialties, females who were older, white, unmarried, less educated, and lower socio-economic status (SES) had the highest likelihood to be given a mental health diagnosis compared to men with similar demographic variables. Data shows significant discrepancies in the detection of mental health issues between men and women, with issues being undetected in women more often, showcasing a discrepancy in treatment of patients of different genders. Although patient gender is clearly an important variable to study when attempting to determine possible predictors of stigma, one may also consider the gender of the provider as well.

Few studies have investigated provider demographic variables as predictor of stigma in health care professionals. Those that have sought to examine the phenomenon seem to have found a discrepancy between males and females. Lauber and colleagues (2006) sought to examine stigma among mental health professionals, specifically compared to the general public as well as between the different professional specialties. Using a quantitative questionnaire as well as vignettes, the researchers discovered that female professionals tended to view those with mental illness as more creative compared to male providers. Despite this being the only significant interactions, mean scores were higher for male professionals compared to female professionals when considering the following stereotypes of those with mental illness: abnormal, unreliable, weird, and stupid. Additionally, female providers had slightly higher mean scores when thinking about those with
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mental health concerns as healthy and highly skilled. An additional observation is that this trend appears to be reversed in the general population (females tended to have higher means related to stereotypes and lower means related to positive attributes). Overall, female professionals found those with mental illness to be less socially disturbing compared to male providers.

Summary and Conclusions

Differences have been observed in the levels of mental health stigma shown by various types of health care providers, specifically doctoral-level providers. Variation has been found between physical health providers and mental health providers, as well as between physicians, psychiatrists, and psychologists. Breaking these groups down even further, differences in stigma have been discovered between different training models, specifically between clinical and counseling psychology and internal medicine and family medicine. Psychiatry literature has been mixed due to its inclusion in both groups due to having both physical and mental health training, but overall, has displayed the highest levels of stigma. These differences, combined with the many ways the groups have been categorized in previous literature, have provided evidence for more research into the impact of professional specialty and training model on stigma shown toward patients.

Additionally, it is evident from the literature that other factors may also contribute to the stigma shown by health care providers, specifically burnout, therapeutic optimism, time spent in the field, as well as gender of the provider. Previous research indicates that the longer a provider has been in the field, the higher that provider’s risk of burnout. Burnout has been linked to lower therapeutic optimism, indicating that those who experience more symptoms or burnout are more likely to have lower expectations related to a patient’s treatment outcome and ability to recover. Both factors have been linked to increase stigma shown toward patients in various way, but few
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have looked specifically at doctoral-level providers and compared groups while also incorporating all these factors. Further, literature has indicated that the provider’s gender may also play a role in the level of stigma shown toward patients and thus also requires additional study as research has shown that male providers tend to show more stigma toward patients, but few have studied this based on both gender and professional specialty. This type of research has implications for the quality of patient care as well as the integration of health care called for by current health care reform.
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CHAPTER III

Methodology

This section will discuss the methodology of the study, specifically participants, measures, and study procedures. Descriptions of instruments used are provided complete with psychometric properties of each measure. Additionally, power analyses were conducted to determine appropriate participant numbers and have been included in this section as well.

Participants

The total sample size for the study was 95; however, only 83 providers completed the entire survey. The total sample sizes for the groups based on an N of 83 were as follows: Clinical Psychology, $n = 32$ (38.6%), Counseling Psychology, $n = 11$ (13.3%), Family Medicine, $n = 13$ (15.7%), Internal Medicine, $n = 8$ (9.6%), and Psychiatry, $n = 19$ (22.9%). Participants were recruited through listservs from professional organizations and email solicitation at health care centers. Professional organizations included Division 17 of the American Psychological Association (Society of Counseling Psychology), state psychological associations, state chapters of the American Psychiatric Association, state chapters of the American Academy of Family Physicians, state chapters of the Society of General Internal Medicine, and state chapters of the American College of Physicians. Participants all had doctoral degrees and belonged to one of five professional groups: Internal medicine physician, family medicine physician, psychiatrist, clinical psychologist, or counseling psychologist. Participants were all licensed and currently practicing full-time, including any clinical responsibilities such as supervision of trainees and consultation. Table 1 provides the characteristics of the resulting sample of respondents. As seen in the table, the sample was primarily female and primarily Caucasian.
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Table 1
*Characteristics of sample. N=83.*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean or n (%)</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>20 (24.1%)</td>
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</tr>
<tr>
<td>Female</td>
<td>61 (73.5%)</td>
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</tr>
<tr>
<td>Transgender Male</td>
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</tr>
<tr>
<td>Transgender Female</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Other (“nonbinary”)</td>
<td>1 (1.2%)</td>
<td></td>
</tr>
<tr>
<td><strong>Age (Years)</strong></td>
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<td>15.04</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
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<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>64 (77.1%)</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>11 (13.3%)</td>
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</tr>
<tr>
<td>Other</td>
<td>4 (4.8%)</td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>3 (3.6%)</td>
<td></td>
</tr>
<tr>
<td><strong>Work Setting</strong></td>
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</tr>
<tr>
<td>Private Practice</td>
<td>29 (34.9%)</td>
<td></td>
</tr>
<tr>
<td>Hospital-Psychiatry</td>
<td>17 (20.5%)</td>
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</tr>
<tr>
<td>Family Medicine Practice</td>
<td>8 (9.6%)</td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>7 (8.4%)</td>
<td></td>
</tr>
<tr>
<td>“Other”</td>
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<tr>
<td>Hospital-Primary Care</td>
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<tr>
<td>Hospital-Specialty</td>
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<tr>
<td>College Counseling Service</td>
<td>2 (2.4%)</td>
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<tr>
<td><strong>Time in Practice (Years)</strong></td>
<td>12.82</td>
<td>12.17</td>
</tr>
</tbody>
</table>

**Measures**

**Demographic Questionnaire.** Participants provided basic demographic information including age, race, gender, professional orientation, and time spent in the field. The demographic questionnaire also inquired about professional responsibilities and work setting. The entire survey can be found in Appendix A.

**Maslach Burnout Inventory- Human Services Survey (MBI-HSS).** Burnout symptoms were assessed using the Maslach Burnout Inventory (Maslach & Jackson, 1981). A Human Services version of the scale was created for use with professionals in human services related fields.
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(van Dierendonck, Schaufeli, & Buunk, 2001). The measure includes 22 self-report items phrased as statements about personal attitudes using a 7-point frequency scale ranging from “never” to “every day.” The MBI assesses three dimensions of burnout: emotional exhaustion, depersonalization, and personal accomplishment (Maslach & Jackson, 1981). Higher scores on the Emotional Exhaustion and Depersonalization subscales indicate higher burnout, as do lower scores on the Personal Accomplishment subscale. Sample items include “I feel emotionally drained from my work” and “I don’t really care what happens to some recipients.” Subscale scores are computed by taking the mean of the scores making up each subscale. Tests of normality indicated that the Emotional Exhaustion subscale was normally distributed. The Depersonalization and Personal Accomplishment subscales were modestly skewed (in the range of ±1.5), but still in the acceptable range (Gravetter & Wallnau, 2014). In the present study, each dimension subscale demonstrated acceptable to excellent internal reliability: Emotional Exhaustion $\alpha = .90$; Depersonalization, $\alpha = .81$; and Personal Accomplishment $\alpha = .74$.

**Mental Illness: Clinicians’ Attitudes (MICA v4).** Clinician attitudes toward mental illness were evaluated using Mental Illness: Clinician Attitudes scale (MICA; Kassam, Glazier, Leese, Henderson, & Thornicroft, 2010). This scale was developed to assess attitudes of both students and professionals from many different healthcare fields toward people with mental illness. The MICA is a 16-item self-report measure that employs a 6-point Likert scale ranging from “strongly agree” to “strongly disagree.” Scores range from 16-96 and higher scores indicate more negative and stigmatizing attitudes. The 4th version of the scale was found to be both valid and reliable (Gabbidon et al., 2013). In the present study, Cronbach’s alpha was .72. Questions from the scale include “I feel as comfortable talking to a person with a mental illness as I do talking to
a person with a physical illness” and “If a person with a mental illness complained of physical symptoms (such as chest pain) I would attribute it to their mental illness.”

**Therapeutic Optimism Scale (TOS).** Optimism regarding provider’s outcome expectations of patients was assessed using the Therapeutic Optimism Scale (TOS; Byrne, Sullivan, & Elsom, 2006). The scale consists of 10 self-report items and utilizes a 5-point Likert scale. Overall scores range from 10-50, with higher scores indicating higher optimism about patient outcomes. Developmental work on the scale was conducted by Byrne, Sullivan and Elsom (2006), who reported an internal reliability of the scale of \( \alpha = .68 \). They also reported that the scale was consistent over a one-month period \( (r = .68, p<.01) \), and significantly correlated with other similar measures of optimism, indicating moderate convergent validity. Questions include “Even the most challenging patients can benefit from my intervention” and “My contribution to positive outcomes is insignificant in comparison to other treatments for example, medications.” The internal reliability of the scale in the present sample was \( \alpha = .78 \).

**Procedures**

Participants were contacted via email messages sent to professional listservs or centers of care (See Appendix B). Participants were directed to the Qualtrics web site via a study-specific link to complete the survey. Measures within the questionnaire were counterbalanced to reduce risk of order effects.

**Study Design and Analyses**

This study was a cross-sectional quantitative survey seeking to determine if attitudes towards patients with mental illness differed as a function of professional specialty, provider gender, burnout, experience in the field, and therapeutic optimism. The dependent variable in these analyses was scores on the MICA, assessing attitudes toward patients with mental illness (stigma).
The independent variable for Hypothesis 1 was self-identified professional specialty. The influence of professional specialty on MICA scores was tested using one-way analysis of variance.

Hypotheses 2, 3, and 4 examined the influences of therapeutic optimism, burnout, and time spent in the field on MICA scores. These relationships were evaluated using bivariate correlations. An independent-samples t-test was used to test the impact of gender on attitudes towards patients with mental illness as discussed in Hypothesis 5. A hierarchical multiple regression analysis was also used to test the individual factors in one single model. Hypothesis 6 was tested using a series of hierarchical multiple regression analyses examining interaction effects of professional specialty with job-related characteristics. The assumptions of normality and homogeneity of variance of the continuous independent and dependent variables were assessed beforehand.

**Power Analysis**

Power for this study was determined by the most sample-intensive analysis planned, the one-way ANOVA of MICA score by professional category. Data provided by Gabbidon and colleagues (2013) and by Kassam and colleagues (2010) suggested that between-profession differences in attitudes (stigma) were large, with a between-profession effect size of $d = .46$. Given this effect size, a one-way ANOVA with 5 groups of unequal size would require an $N$ of 65 to achieve a two-tailed power of at least .80, with alpha set at .05. Given that $N$, the remaining analyses were sufficiently powered to detect effects if they exist.
CHAPTER IV

Results

The purpose of this study was to examine differences in attitudes towards patients with mental illness among doctoral-level healthcare providers, specifically clinical psychologists, counseling psychologists, family medicine physicians, internal medicine physicians, and psychiatrists. The study also sought to explore the contribution of burnout, therapeutic optimism, time spent in the field, and gender attitudes toward patients with mental illness. This chapter provides demographic variable testing, results of hypothesis tests, and a summary of the findings of this study.

Bivariate Correlations

Correlation coefficients were computed to determine bivariate relationships among variables of interest. This was done to detect statistical redundancy among the measures (i.e., different variables essentially measuring the same construct). The variables entered for analyses were as follows: Depersonalization (Burnout), Emotional Exhaustion (Burnout), Personal Accomplishment (Burnout), mental illness stigma, therapeutic optimism, gender, and time spent in the field. The results of correlation analyses are presented in Table 2.
A positive correlation was found between scores on the MICA and Depersonalization on the MBI, indicating that having higher stigma towards patients with mental illness is associated with increased feelings of depersonalization. Therapeutic Optimism was negatively correlated with both depersonalization and MICA scores. Depersonalization was also positively correlated with emotional exhaustion and negatively correlated with therapeutic optimism and gender, indicating that men tended to have higher scores on depersonalization. Not surprisingly, personal accomplishment was negatively correlated with depersonalization, emotional exhaustion, and stigma, and positively correlated with therapeutic optimism and experience in the field. This is further explored in Chapter V.
Primary Analyses

Hypothesis 1

Mean MICA scores by profession are shown in Table 3. A one-way analysis of variance (ANOVA) was conducted to compare the effect of professional orientation on attitudes towards patients with mental illness. Results showed a significant main effect for profession, $F(4,78) = 4.62$, $p = .002$. Post-hoc analyses using Tukey's HSD (honest significant difference) test indicated that attitudes toward patients with mental illness differed between family medicine and three of the four remaining groups, psychiatry ($p = .049$), counseling psychology ($p = .020$), and clinical psychology ($p = .014$); it did not differ from internal medicine ($p = .909$). Family medicine and internal medicine physicians tended to score significantly higher on mental health stigma relative to the mental health professionals.

Table 3  
*MICA scores by professional specialty*

<table>
<thead>
<tr>
<th>Specialty</th>
<th>$n$</th>
<th>Mean</th>
<th>$SD$</th>
<th>$SE$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry</td>
<td>19</td>
<td>30.11</td>
<td>5.85</td>
<td>1.34</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>8</td>
<td>37.38</td>
<td>8.02</td>
<td>2.83</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>13</td>
<td>37.77</td>
<td>12.13</td>
<td>3.36</td>
</tr>
<tr>
<td>Counseling Psychology</td>
<td>11</td>
<td>28.00</td>
<td>6.71</td>
<td>2.02</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>32</td>
<td>31.54</td>
<td>7.61</td>
<td>1.12</td>
</tr>
</tbody>
</table>

Hypotheses 2, 3, and 4

Pearson correlations were used to examine the influences of individual provider variables on stigma toward those with mental illnesses. Hypothesis 2 predicted that experience in the field would be a predictor of more negative attitudes towards patients with mental illness. No significant correlations were found between these variables, $r = -.184$, $p = .096$. These results do not support the hypothesis that more experience in the field would result in increased stigma.
Hypothesis 3 predicted that burnout would be positively associated with stigma. As seen in Table 2, MICA scores were significantly correlated with two of the MBI’s subscales, depersonalization and personal accomplishment. The emotional exhaustion subscale was not correlated with MICA scores. Depersonalization was found to be positively correlated with stigma, $r = .341, p = .002$, indicating that those who experience more depersonalization at work hold more negative attitudes toward patients with mental illness. Personal accomplishment was found to be negatively correlated with stigma, $r = -.266, p = .015$, suggesting that those who feel more personal accomplishment at work hold more positive attitudes towards patients with mental illness. These results partially support the hypothesis that burnout increases negative attitudes towards patients with mental illness.

The impact of therapeutic optimism on attitudes towards patients with mental illness was also examined. A negative correlation was found between scores on the TOS and scores on the MICA, $r = -.328, p = .002$. This indicates that the more therapeutic optimism participants had, the less stigma they held toward patients with mental illness. This supports Hypothesis 4.

**Hypothesis 5**

An independent-samples $t$-test was conducted to determine if attitudes toward those with mental illness differed as a function of gender. Hypothesis 5 predicted that female providers would show less stigma than male providers. No significant difference was found, $t (79) = .90, p = .372$. This suggests that male and female providers did not significantly differ in their attitudes towards patients with mental illness.

**Table 4**

*MICA scores by gender*

<table>
<thead>
<tr>
<th></th>
<th>$N$</th>
<th>Mean</th>
<th>$SD$</th>
<th>$SE$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>20</td>
<td>33.90</td>
<td>7.51</td>
<td>1.68</td>
</tr>
<tr>
<td>Female</td>
<td>61</td>
<td>32.10</td>
<td>7.87</td>
<td>1.10</td>
</tr>
</tbody>
</table>
Additional Analyses

A hierarchical multiple regression analysis was run to assess the provider variables in a single model. Results indicated that therapeutic optimism was the only variable to emerge as a uniquely significant predictor of stigma, accounting for 14% of the variance, suggesting that the TOS encompasses the majority of what is being measured by the burnout subscales. Results of the analysis are shown in Table 5.

Table 5
Results of Simultaneous Regression Analysis Predicting MICA Stigma Score.

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>t</th>
<th>95% CI for B</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBI Depersonalization</td>
<td>1.618</td>
<td>.963</td>
<td>.231</td>
<td>1.68</td>
<td>-.301 - 3.538</td>
</tr>
<tr>
<td>MBI Personal Accomplishment</td>
<td>-.849</td>
<td>1.688</td>
<td>-.064</td>
<td>-0.50</td>
<td>-4.213 - 2.515</td>
</tr>
<tr>
<td>MBI Emotional Exhaustion</td>
<td>-.759</td>
<td>.742</td>
<td>-.119</td>
<td>-1.02</td>
<td>-2.237 .719</td>
</tr>
<tr>
<td>Therapeutic Optimism</td>
<td>-.377</td>
<td>.141</td>
<td>-.308</td>
<td>-2.67**</td>
<td>-.658 -.096</td>
</tr>
<tr>
<td>Gender</td>
<td>.202</td>
<td>1.955</td>
<td>.011</td>
<td>0.10</td>
<td>-3.693 - 4.096</td>
</tr>
<tr>
<td>Experience in Field</td>
<td>-.038</td>
<td>.069</td>
<td>-.059</td>
<td>-0.55</td>
<td>-.177 .100</td>
</tr>
</tbody>
</table>

** p < .01.

Model R = .48; R² = .23.

Hypothesis 6

Hypothesis 6 predicted that interaction effects would be found amongst the variables, particularly between professional orientation and the other study variables. Hierarchical multiple regression analyses were used to examine interaction effects between professional orientation and gender, professional orientation and burnout, professional orientation and experience in the field, and professional orientation and therapeutic optimism on stigma levels. Professional orientation groups were split into mental health providers versus non-mental health providers with psychiatry, counseling psychology, and clinical psychology being placed in the mental health provider group. This categorization was supported by the significant differences seen
between family medicine and internal medicine physicians and the three behavioral health provider groups. In these analyses, the professional categorization variables were entered first, followed by the interacting variable of interest, and then followed by the interaction term.

Results of these analyses are summarized in Table 6.

<table>
<thead>
<tr>
<th>Model</th>
<th>Step</th>
<th>Effect</th>
<th>B</th>
<th>SE</th>
<th>t</th>
<th>R²</th>
<th>ΔR²</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Mental Health Provider (Yes-No)</td>
<td>-7.39</td>
<td>1.54</td>
<td>-4.81***</td>
<td>.22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Experience in Field</td>
<td>-0.10</td>
<td>0.05</td>
<td>-1.80</td>
<td>.25</td>
<td>.03</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>MH Provider x Experience</td>
<td>0.27</td>
<td>0.12</td>
<td>2.25*</td>
<td>.30</td>
<td>.05</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Mental Health Provider (Yes-No)</td>
<td>-7.42</td>
<td>1.55</td>
<td>-4.80***</td>
<td>.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Gender (1=Male, 2=Female)</td>
<td>-1.24</td>
<td>1.59</td>
<td>-0.78</td>
<td>.23</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>MH Provider x Gender</td>
<td>46.46</td>
<td>2.26</td>
<td>20.5***</td>
<td>.2</td>
<td>.02</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>Mental Health Provider (Yes-No)</td>
<td>-6.72</td>
<td>1.73</td>
<td>-3.89***</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Therapeutic Optimism</td>
<td>-0.31</td>
<td>0.16</td>
<td>-1.90</td>
<td>.19</td>
<td>.04</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>MH Provider x Optimism</td>
<td>0.39</td>
<td>0.37</td>
<td>1.04</td>
<td>.20</td>
<td>.01</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>Mental Health Provider (Yes-No)</td>
<td>-8.55</td>
<td>1.72</td>
<td>-4.96***</td>
<td>.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Burnout-Depersonalization</td>
<td>1.82</td>
<td>0.67</td>
<td>2.71**</td>
<td>.30</td>
<td>.06</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>MH Provider x MBI- DP</td>
<td>-3.06</td>
<td>1.34</td>
<td>-2.28*</td>
<td>.34</td>
<td>.04</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>Mental Health Provider (Yes-No)</td>
<td>-8.55</td>
<td>1.72</td>
<td>-4.96***</td>
<td>.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Burnout-Emotional Exhaustion</td>
<td>0.02</td>
<td>0.63</td>
<td>0.04</td>
<td>.23</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>MH Provider x MBI-EE</td>
<td>2.45</td>
<td>1.49</td>
<td>1.64</td>
<td>.26</td>
<td>.03</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>Mental Health Provider (Yes-No)</td>
<td>-8.55</td>
<td>1.72</td>
<td>-4.96***</td>
<td>.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Burnout-Personal Accomplishment</td>
<td>-2.90</td>
<td>1.26</td>
<td>2.31</td>
<td>.28</td>
<td>.05</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>MH Provider x MBI-PA</td>
<td>5.76</td>
<td>2.49</td>
<td>2.32*</td>
<td>.33</td>
<td>.05</td>
</tr>
</tbody>
</table>

Note: *p < 0.05; **p < 0.01; ***p < .001

As shown in Table 6, several significant interaction effects were found. Analyses showed significant interactions between professional orientation and experience in the field such that while mental health provider’s stigma levels remained relatively stable regardless of their years of experience, non-mental health providers showed high levels of stigma early in their careers, which steadily declined as more experience was gained. This interaction is illustrated in Figure 1.
Mental health stigma predicted by years of experience in the field among mental health providers and non-mental health providers.

Whereas no significant difference was found between male and female providers overall, a significant interaction effect was found when adding professional orientation to the analyses. Non-mental health provider males showed the highest stigma while female mental health providers reported the least stigma among the respondents. This is illustrated in Figure 2.
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Significant interactions effects were also found for professional orientation and two of the burnout subscales. There was a significant interaction found between professional orientation and depersonalization, indicating that non-mental health providers who had higher rates of depersonalization also scored higher on stigma. Mental health providers remained stable with low levels of stigma regardless of their felt depersonalization. This interaction is shown in Figure 3.

![Figure 3](image-url)

*Figure 3.* Mental health stigma predicted by depersonalization among mental health providers and non-mental health providers.

There was also a significant interaction between professional orientation and personal accomplishment on stigma. Again, mental health providers showed relatively low levels of stigma regardless of feelings of personal accomplishment. Non-mental health providers, however, reported lower stigma levels as personal accomplishment increased. This relationship is displayed in Figure 4.
Conclusion

The results of this study suggest partial support for the original hypotheses presented. Professional orientation was found to be a predictor of stigma, such that those who were not mental healthcare providers reported greater levels of negative attitudes toward patients with mental illness compared to mental health providers.

The original hypothesis was that psychiatrists would report the greatest negative attitudes toward those with mental illness. Instead, however, family medicine and internal medicine physicians were found to show the most negative attitudes towards patients with mental illness. Gender was not found to have an impact on its own; however, when separated by professional orientation there were significant differences with male non-mental health providers reporting the most stigma.

Burnout did appear to play a role in stigmatizing those with mental illness. Those who scored higher on the depersonalization subscale also indicated more negative attitudes toward
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patients with mental illness. It was hypothesized that this relationship may be explained by spending more time in the field and therefore experiencing more stress; however, time in the field was found to have no impact on stigma levels. When broken down by orientation, however, time spent in the field was found to have a positive impact on the stigma levels of non-mental health professionals, as early career physicians showed very high stigma levels that reduced over time.
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CHAPTER V

Discussion

This study sought to examine differences in attitudes towards patients with mental illness among doctoral-level healthcare providers. Hypothesis 1 predicted that a significant difference would be found among clinical psychologists, counseling psychologists, family medicine physicians, internal medicine physicians, and psychiatrists, with psychiatrists showing the most stigma followed by internal medicine physicians. Clinical and counseling psychologists were hypothesized to show the least degree of stigma. This hypothesis was partially supported by the present study. Contrary to Hypothesis 1, family medicine and internal medicine physicians were found to show the most stigma. As predicted in Hypothesis 1, psychologists were found to report the least stigma toward patients. This supported previous research that found that primary healthcare providers have significantly more negative attitudes towards people with mental illness compared to people without mental illness, a difference that was not found among mental health providers (Corrigan et al., 2014).

The first research question examined differences in levels of mental health stigma between internal medicine physicians, family medicine physicians, psychiatrists, clinical psychologists, and counseling psychologists. Hypothesis 1 predicted that psychiatrists would show the most stigma, followed by internal medicine and family medicine physicians, with psychologists showing the least amount of stigma. This hypothesis was partially supported as psychologists did report the least amount of stigma. Psychiatrists were found to be in the middle, just above psychologists, in terms of stigma. It had been hypothesized that there would be significantly greater stigma among internal medicine physicians than among family medicine physicians due to the fact that internal medicine residency programs often offer less mental health training than family medicine
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programs (Leigh et al., 2006a; 2006b; Smith et al., 2014; Williamson et al., 2016). The present study raises questions regarding the quality of training in family medicine and internal medicine programs. Few studies have compared family medicine and internal medicine attitudes towards patients with mental illness. Results found in this study, however, should be interpreted with caution due to low numbers of internal medicine participants in the sample.

The second research question addressed the impact of years of experience on levels of mental health stigma. Hypothesis 2 predicted that stigma would increase as years spent working in the field increased. This was based on previous research that suggested that education and supervision were correlated with more positive attitudes toward mental illness (Smith & Cashwell, 2010) as research examining this exact phenomenon is rare. Results did not support this hypothesis. Time in the field was neither negatively correlated nor positively correlated with attitudes toward patients with mental illness. Additionally, no correlation was found between time spent in the field and burnout. This indicates that spending more time in a taxing field may not be the cause of burnout and consequently increased stigma. Though previous research suggested a possible correlation, few studies have been able to isolate this variable due to its high correlation with many other factors, including aging, medical absenteeism, and workplace seniority/authority.

The third research question examined burnout as a predictor of mental health stigma. This variable was measured by the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1986) and therefore broken down into three subscales: Emotional Exhaustion, Depersonalization, and Personal Accomplishment. Emotional exhaustion was not correlated with stigma; however, depersonalization and personal accomplishment were found to be significantly related to stigma. As hypothesized, higher levels of factors related to burnout resulted in more negative attitudes towards those with mental illness. Depersonalization, or impersonal feelings towards patients, was
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associated with more negative attitudes, while personal accomplishment was associated with less negative attitudes towards those with mental illness. When discussing correlations between burnout subscales in her original paper, Maslach and Jackson (1981) emphasized that personal accomplishment was not to be viewed as the opposite of depersonalization or emotional exhaustion. The current study’s results suggest that participants may be able to manage emotional exhaustion if they feel valued by their employer and connected to their patients. It also suggests that they may require a feeling of accomplishment in order to cope with emotional exhaustion or perhaps may be more desensitized to feelings of emotional exhaustion as doctoral degrees are often emotionally exhausting. Providers may have already learned to cope with these feelings or have become avoidant and disconnected from such feelings leading to a lack of self-awareness and thereby normal levels of emotional exhaustion being detected on the MBI, but higher levels of depersonalization. This can be challenging when working with more ambivalent/resistant patients and/or those with severe mental illness. This was part of the rationale for the inclusion of therapeutic optimism as a variable as a feeling of accomplishment may be tied to outcome expectancy.

The fourth research question looked at the role of therapeutic optimism in attitudes towards those with mental illness. Hypothesis 4 predicted that regardless of professional orientation, those with higher therapeutic optimism would show lower stigma. This was based on prior studies that found that increased optimism reduced burnout, while lower optimism predicted more negative therapeutic outcomes (Bruckner, 1979; Peris et al., 2008). This hypothesis was supported; those with higher levels of optimism reported lower levels of stigma. The results of this study are also consistent with prior research in that increased personal accomplishment was associated with higher optimism, whereas increased depersonalization was associated with lower optimism.
The fifth research question examined whether there are differences in stigma based on gender. Hypothesis 5 predicted that male providers would show more stigma than female providers. Results did not support this hypothesis and indicated that male and female average stigma scores were not significantly different. Few prior studies have examined specific provider demographic variables which makes results of this study difficult to compare. Those that have found female providers to show lower stigma (Lauber et al., 2006). Lack of significant results may be accounted for by Hypothesis 6 which suggests that professional orientation may impact this relationship.

The sixth research question concerned interaction effects among predictor variables. Hypothesis 6 predicted that provider specialty would interact with other characteristics to predict higher stigma scores. These interactions were examined by comparing mental health providers and non-mental health providers, as internal and family medicine physicians received the highest stigma scores. All analyses of interaction effects showed stigma among mental health providers to remain relatively stable regardless of the level of other characteristics. Changes in reported stigma were, however, found in non-mental health providers as a function of other characteristics. This is consistent with prior research that found that medical doctors have more negative attitudes towards patients with mental illness compared to non-physician mental health professionals (Bjorkman et al., 2008; Hori et al., 2011; Smith & Cashwell, 2010;).

Whereas results indicated that there was no main effect between gender and stigma, additional analyses discovered a significant interaction effect between professional specialty and gender, with non-mental health providers who are male showing the strongest stigmatizing attitudes, and female mental health providers showing the least. This indicates that professional
orientation may be a stronger predictor of stigma than gender, but that some differences do exist between males and females when separated into their respected professional groups.

There were significant interactions between professional orientation and burnout subscales. Whereas mental health professionals showed consistently low levels of stigma regardless of burnout, non-mental health providers differed. Those who reported higher depersonalization levels also showed increased stigma scores. Stigma scores were found to decrease when personal accomplishment increased. This was not found among mental health professionals indicating that non-mental health professionals are possibly more susceptible negative consequences related to burnout, specifically negative attitudes towards patients with mental illness.

Although an interaction effect was found between time spent in the field and professional orientation, results only partially supported Hypothesis 6, which predicted that non-mental health providers with more time spent in the field would show the highest levels of stigma. Results indicated that while mental health providers tend to have low levels of stigma that remain stable regardless of time spent in the field, non-mental health providers show a significant decline. This interaction suggests that early career non-mental health providers begin their careers with high levels of stigma that steadily decrease the more time they spend in the field. The mental health providers and non-mental health providers in this study showed equally low levels of stigma when they had been in the field for 35 years. This is a very significant finding as it supports the idea that physicians may not have adequate exposure and training with patients coping with mental illness when they begin their training. The more experience these providers obtain, and potentially the more contact they have with providers in other disciplines, the more positive (or less negative) their attitudes towards patients with mental illness may be. This finding is also significant as previous studies have failed to isolate these variables and test them together to determine how
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stigma among specific disciplines of doctoral-level health providers may change over time. Past studies have examined graduate students versus professionals while grouping many different levels of training (Calicchia, 1981).

Finally, due to the lack of strong correlation between burnout and time spent in the field as hypothesized, workplace setting was utilized as an exploratory variable to determine if this could be a significant area of exploration for future studies. Paired comparisons found significant mean differences by setting, $F(8, 74) = 5.33, p < .001$. Those working in hospitals, either in primary or specialty care, were found to have the highest average levels of stigma towards patients with mental illness. Post hoc comparisons using Tukey HSD found that stigma scores in primary care settings in hospitals were significantly different than those in psychiatry/mental health settings in hospitals as well as those from outpatient mental health centers and private practices with providers in primary care settings reporting higher stigma levels. Stigma scores from specialty care settings in hospitals were also found to be significantly different from private practice with specialty care providers reporting more stigma. These preliminary results indicate a potential impact of workplace setting/environment on attitudes toward patients with mental illness. Hospital settings may be more unpredictable and busier, as they may treat more severe mental illness compared to outpatient and private practice settings. This finding is also meaningful given recent pushes to better integrate primary care settings with multidisciplinary professionals.

In conclusion, male non-mental health providers, earlier in their careers, with higher levels of depersonalization and reduced levels of personal accomplishment, appear to have the most negative attitudes towards patients with mental illness. Time spent in the field per se does not appear to impact levels of stigma and is not correlated to factors related to burnout. However, for
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those in non-mental health fields, time spent in practice appears to yield greater understanding and lower stigma toward those with mental illness.

Clinical and Practical Implications

Differences found between providers, particularly between medical providers and mental health providers, and the impact of the factors assessed in this study suggest that improvements made to primary care mental health integration and residency training programs would be helpful in reducing negative attitudes toward patients with mental illness and the stigma they may feel when seeking any type of healthcare service. These results have highlighted the importance of inclusive education that provides extensive exposure to patients with mental illness, as well as sensitivity training on how to treat all patients appropriately, not just those diagnosed with a mental illness or suspected to be struggling with one. Standardized clinical interviews that ask targeted questions may help to identify mental illness in those who do not show obvious symptoms or are unwilling to disclose without being specifically asked in appropriate ways.

Medical residents may be under the assumption that they may only encounter patients with mental illness within a psychiatry rotation; however, a patient’s first contact with the healthcare system is often in primary care (Unutzer et al., 2006). The CDC reports that 20% of all primary care visits in 2010 included one or more mental health concern (Cherry & Schappert, 2014), while Unutzer and colleagues (2006) found that half of treatment for common mental disorders was provided in primary care; a number that rises to two-thirds among minorities. Patients may either be unaware that their symptoms could be linked to a mental disorder, or afraid of potential labeling and stigma and therefore go to primary care rather than seeking out specialty services. Disparities in access and availability to specialty services may also be to blame which may force patients to go to primary care facilities for mental health concerns. These problems must be appropriately
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assessed and treated in a way that allows the patient to feel cared about and respected while also getting quality care. Gabbidon and colleagues (2014) reported that 31% of participants had experienced discrimination due to a mental illness diagnosis while attempting to utilize physical healthcare services. Expanded training may help to ameliorate for these differences found among providers.

Lack of adequate training and exposure may account for some of the differences between groups; however, this study also highlighted the impact of burnout and therapeutic optimism on attitudes towards patients with mental illness. This speaks to the work environment and the overall mission of the healthcare system. Health systems that are not responsive to the needs of their providers, while also fostering an atmosphere of strength, positivity, and recovery among patients, may be more likely to have providers who hold more negative attitudes to their patients struggling with mental health challenges. Flanagan, Miller, and Davison (2009) found many providers reported feeling like their healthcare system emphasized deficits and pathology which led to feelings of hopelessness among both patients and providers. Awa, Plaumann, and Walter (2010) found that burnout is most common in health-service and public-service related fields, particularly related to mental healthcare.

Though recent scandals related to wait times and inappropriate scheduling within the VA system and other health systems have highlighted the lack of response to needs of the patients, they have not examined the lack of response to provider needs in their quest to deliver appropriate care. The results of this study indicate that many providers, particularly in the medical domain, may be feeling burnt out. This should be addressed when creating scheduling systems.

Results of this study indicate evidence of depersonalization, a factor of burnout most closely related to negative interaction with recipients of care, particularly in non-mental health
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providers. One potential explanation for this result may be that providers are using depersonalization as a coping skill. Higher levels of depersonalization may help providers deal with the emotionally taxing nature of this work and could account for the lack of significant results related to emotional exhaustion. While depersonalization may be used as a coping skill by providers, research suggests that this particular factor related to burnout results in lower patient satisfaction and longer post discharge recovery time for patients with physical illness (Halbesleben & Rathert, 2008). This study also determined that higher levels of burnout were not related to more time spent in the field. However, examination of exploratory variables found possible links between increased burnout and healthcare setting. This suggests that more focus on workplace characteristics of specific healthcare environments would be helpful, particularly those known for being more fast-paced, chaotic, and unpredictable. Additional measures to prevent burnout should be considered in these work environments.

This connection may also be explained by Equity Theory (Adams, 1865) and Social Exchange Theory (Blau, 1964) which relate to the reciprocity in any human relationship. In doctor-patient relationships, this can be observed as the provider’s expectation of treatment adherence, symptom improvement, and/or gratitude from the patient (Bakker et al., 2000). If doctors are experiencing low levels of effort from patients, particularly with mental illness, it may increase their feelings of depersonalization.

The lack of connection between burnout and time spent in the field also suggests that burnout and stigma may be higher earlier in provider’s careers. Results indicating that stigma steadily declines across the careers of non-mental health providers also support this suggestion. These findings highlight the need for continued professional development rather than just increased education at the trainee level. Healthcare systems may consider implementing programs
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to address factors such as burnout and stigma similarly to seminars on professional development. Additional attention may also be paid to appropriate clinical interviewing as this may be one area which stigma is directed toward patients. Patient race, gender, and coexisting medical conditions have found to be factors that impact the detection of mental health concerns in primary care (Borowsky et al., 2000). Additionally, proclivity for providing depression counseling has been found to be associated with detection of mental health concerns. This may include role plays and professional feedback from trained mental health providers. This may help to not only reduce negative attitudes, but also reduce burnout as clinicians may feel more confident and comfortable with working with patients with mental health concerns.

Limitations

There are several limitations to the study, which should be noted. The first is related to limitations in sampling. Sampling methods originally only included recruitment through professional organizations. This proved difficult, as many healthcare professional groups did not allow survey distribution. Others required membership in order to survey members, while others required large fees. Though it is understandable that these groups are trying to protect their members’ time, it creates challenges in obtaining a representative sample with approximately equal groups. Internal medicine physicians were especially difficult to recruit. The sample size in this study reflects this problem.

Recruitment challenges may have affected several of the variables being studied. Previous research has found high rates of burnout among healthcare professionals. It has been found to be twice as prevalent in physicians compared to workers in other fields within the US (Shanafelt et al., 2015). Bakker and colleagues (2000) examined general physicians and found that emotional exhaustion was positively correlated with depersonalization and negatively correlated with
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personal accomplishment. Bakker et al. also found that those who scored higher on burnout initially tended to also score higher five years later. It is one of few studies who have examined burnout for a specific discipline over time rather than just obtaining a single data point. Bakker’s study, however, was not able to track participants over periods of time longer than five years and only examined one discipline of health providers. Additionally, few studies have compared burnout rates across disciplines, making it difficult to compare burnout results to the present study. Difficulty in recruiting these specific specialties may also explain the lack of prior research.

One potential contributor to burnout could be overbooked schedules in order to maximize the number of patients seen. This may contribute to the correlation between burnout and attitudes towards patients with mental illness who may potentially require longer appointments due to the amount and/or complexity of their problems. Overbooked schedules may also contribute to the response rates as providers who are already pressed for time may be less likely to complete a survey without high incentives. This study also did not assess hours worked per week which may be highly relevant to a provider’s level of burnout.

Additionally, social desirability bias may have played a role in survey participation and in responses. As with any type of study on bias, obtaining truthful responses can be challenging if participants are aware of what is being measured and understand the social implications of the attitudes they may display in their responses. A survey specific to clinicians was used to try to account for the educational level and perceptiveness of clinicians; however, some respondents may have still recognized the constructs being measures and answered in ways that did not display their true attitudes.

Finally, due to study limitations, other forms of stigma and bias were unable to be assessed within this particular study; therefore, it is unclear the role other forms of prejudice may have the
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patient-doctor relationship. It is likely that multiple demographic factors may create complex layers of bias that contribute toward stigma toward patients with mental illness.

**Future Directions**

Based on the limitations of this study, future studies may investigate alternative ways to obtain participants among healthcare professionals. Larger sample sizes would also allow for other analyses including structural equation modeling, which would allow for multiple pathways to be examined (e.g., the role of all the factors studied) in order to determine the best model that could explain higher negative attitudes toward patients with mental illness. Obtaining equal group sizes may also allow for stronger comparisons between groups. Including a measure of social desirability bias can assist in accounting for unexpected results or respondents who are underreporting on certain factors.

Due to results that found no correlation between time spent in the field and burnout, future studies should examine factors that contribute to this phenomenon. Both burnout and time spent in the field are complicated constructs with many contributing factors. Both factors can be impacted by professional and personal circumstances. The Maslach Burnout Inventory unfortunately does little to account for impacts of providers’ personal lives. This study also did not utilize data related to hours worked per week which may also impact burnout. Future research may find it helpful to explore these factors.

Exploratory analyses found some association between workplace setting and burnout, with those in hospital-based settings showing more burnout than outpatient centers. Research into the impact of work environment may help to determine not only what contributes to higher burnout in inpatient settings, but into how these environments may foster increased stigma toward patients with mental illness. Brief literature review found a significant lack of research in this area. Studies
that appeared to examine setting seemed to only do so in order to increase external validity rather than compare to additional types of health settings.

One potential factor that may be of interest is the medical hierarchy and how each provider feels about her or his role when collaborating with other providers. Previous research has examined associative stigma, or stigma felt by professionals in relation to their occupation (Halter, 2008; Verhaeghe & Bracke, 2012). Mental health professionals may experience stigma from the general population and other professionals due to their association with patients with mental illness and/or media portrayal. This may impact workplace relationships and the cohesion between providers working together, particularly in integrated care and high stress settings (i.e., primary care and hospital inpatient settings). In a study examining the impact of associative stigma on patient experiences, researchers found a significant correlation between associative stigma and patient stigma (Verhaeghe & Bracke, 2012).

Another study examining the role of individual and group expertise in collaborative health care teams acknowledged that often hierarchies do not extend cross-disciplinary (Patel, Cytryn, Shortliffe & Safran, 2000). Within this study, groups were found to respect each other’s hierarchies and consult appropriately when the provider was unfamiliar with a problem or procedure. This study did not address, however, the potential conflict that can arise when roles overlap or time is short (i.e., crisis situation). This study also focused on physicians, psychiatrists, nurses, and social workers, and failed to include other types of doctoral-level providers such as psychologists.

Additional studies examining medical hierarchy have found that all members of interprofessional teams have often agreed on the importance of collaborative leadership and that many leaders often reported that their teams did not operate with a hierarchy; however, reports from non-physician clinicians, particularly psychologists, indicated that these members held the
opposite perspective (Linegard et al., 2012). This emphasizes the implicit nature of medical hierarchy bias similar to the construct of stigma and other implicit biases. Providers may not be consciously aware of this phenomenon being implemented. Further research examining the impact of these implicit or explicit hierarchies and their impact on stigma would be helpful in expanding this body of literature, as well as to improve healthcare integration.

As noted in the limitation section, this study was unable to examine multiple levels of minority status and bias among providers. Future studies should examine multiple demographic factors of both providers and patients to determine if other forms of prejudice are impacting negative attitudes towards those with mental illness. Providers may potentially hold both implicit and explicit biases related to race/ethnicity, sexual orientation, gender identity, and other demographic factors. Further research into the role of multi-layer bias may help to inform research related to stigma towards patients with mental illness.

Finally, an important future direction for this type of research would be related to the patient experience. Future studies should investigate how negative attitudes of providers may contribute to the patient’s experience of stigma. Previous research has found that depersonalization results in lower patient satisfaction and longer recovery time in patients coping with physical illness (Halbesleben & Rathert, 2008). A similar experience of stigma among patients with mental illness may lead to increased ambivalence or resistance to treatment, as well as decreased service utilization, thereby reducing the rate of recovery among patients with mental illness. A lack of treatment for mental health concerns may also result in a decreased attention to physical health and thereby an increase in medical conditions. This type of research is also important to generalize outward, as providers can be role models to the general population and their view of mental health treatment as those struggling with mental health challenges. Working to reduce stigma among
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professionals may also help to reduce stigma in the general population. Examination into these factors could also lead to increased program development and workplace improvement, improved healthcare integration, as well as research into improved training for students, interns, residents, and fellows.
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References

Acker, G. M. (2010). The challenges in providing services to clients with mental illness: Managed care, burnout and somatic symptoms among social workers. *Community Mental Health Journal, 46*(6), 591-600.


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APPENDIX A

Survey

Please indicate your agreement to participate.

- I consent to participate in this study.
- I DO NOT consent to participate in this study (the survey will end).

Eligibility: Are you a licensed health care provider?

- Yes
- No

Train: Please select your type of training program:

- Psychiatry
- Internal Medicine
- Family Medicine
- Counseling Psychology
- Clinical Psychology
- Other

Time Status: How often do you conduct clinical work? (i.e. How often do you work with patients?)

- Full-time
- Part-time
- Not at all (i.e. work only in Academia)

Response. If part-time was selected, please briefly list your main professional responsibilities.
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MICA 1 I just learn about mental health when I have to and would not bother reading additional material on it.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

MICA 2 People with a severe mental illness can never recover enough to have a good quality of life.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

MICA 3 Working in the mental health field is just as respectable as other fields of health and social care.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree
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MICA 4 If I had a mental illness, I would never admit this to my friends because I would fear being treated differently.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

MICA 5 People with a severe mental illness are dangerous more often than not.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

MICA 6 Health/social care staff know more about the lives of people treated for a mental illness than do family members or friends.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

MICA 7 If I had a mental illness, I would never admit this to my colleagues for fear of being treated differently.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

MICA 8 Being a health/social care professional in the area of mental health is not like being a real health/social care professional.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

MICA 9 If a senior colleague instructed me to treat people with a mental illness in a disrespectful manner, I would not follow their instructions.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

MICA 10 I feel as comfortable talking to a person with a mental illness as I do talking to a person with a physical illness.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

MICA 11 It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

MICA 12 The public does not need to be protected from people with a severe mental illness.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

MICA 13 If a person with a mental illness complained of physical symptoms (such as chest pain) I would attribute it to their mental illness.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

MICA 14 General practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

MICA 15 I would use the terms ‘crazy’, ‘nutter’, ‘mad’ etc. to describe to colleagues people with a mental illness who I have seen in my work.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

MICA 16 If a colleague told me they had a mental illness, I would still want to work with them.

- Strongly Agree
- Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

TOS 1 Mental health clinicians have the capacity to positively influence outcomes for people with mental disorders.

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

TOS 2 There is little that can be done to help many people with mental disorders.

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

TOS 3 My contribution to positive outcomes is insignificant in comparison to other treatments, for example, medications.

- Strongly disagree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

TOS 4 I can make a positive difference to outcomes for most people with mental disorders.

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

TOS 5 Positive outcomes are directly related to the quality of mental health clinician skills and knowledge.

- Strongly agree
- Agree
- Somewhat agree
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOS 6 There are always new skills and knowledge I can acquire to improve my work.</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>TOS 7 The outcome of mental disorders is not significantly affected by clinician interventions.</td>
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</tr>
</tbody>
</table>
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

TOS 8 With my assistance most people with mental disorders will recover.

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

TOS 9 Often there is little I can do to help people with their mental illness.

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

TOS 10 Even the most challenging patients can benefit from my intervention.

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

Disagree

Strongly disagree

MBI Ins. On the following pages are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, please select "never." If you have had this feeling, indicate how often you feel it by selecting the option that best describes how frequently you feel that way.

MBI 1 I feel emotionally drained from my work.

Never

A few times per year or less

Once a month or less

A few times a month

Once a week

A few times a week

Every day

MBI 2 I feel used up at the end of the workday.

Never

A few times per year or less

Once a month or less

A few times a month

Once a week

A few times a week

Every day
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

MBI 3 I feel fatigued when I get up in the morning and have to face another day on the job.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day

MBI 4 I can easily understand how my patients feel about things.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day

MBI 5 I feel I treat some patients as if they were impersonal objects.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

☐ A few times a week

☐ Every day

MBI 6 Working with people all day is really a strain for me.

☐ Never

☐ A few times per year or less

☐ Once a month or less

☐ A few times a month

☐ Once a week

☐ A few times a week

☐ Every day

MBI 7 I deal very effectively with the problems of my patients.

☐ Never

☐ A few times per year or less

☐ Once a month or less

☐ A few times a month

☐ Once a week

☐ A few times a week

☐ Every day
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

MBI 8 I feel burned out from my work.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day

MBI 9 I feel I'm positively influencing other people's lives through my work.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day

MBI 10 I've become more callous toward people since I took this job.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

MBI 11 I worry that this job is hardening me emotionally.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day

MBI 12 I feel very energetic.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

MBI 13 I feel frustrated by my job.

○ Never

○ A few times per year or less

○ Once a month or less

○ A few times a month

○ Once a week

○ A few times a week

○ Every day

MBI 14 I feel I’m working too hard on my job.

○ Never

○ A few times per year or less

○ Once a month or less

○ A few times a month

○ Once a week

○ A few times a week

○ Every day

MBI 15 I don’t really care what happens to some patients.

○ Never

○ A few times per year or less

○ Once a month or less

○ A few times a month

○ Once a week
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

MBI 16 Working with people directly puts too much stress on me.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day

MBI 17 I can easily create a relaxed atmosphere with my patients.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day
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MBI 18 I feel exhilarated after working closely with my patients.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day

MBI 19 I have accomplished many worthwhile things in this job.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day

MBI 20 I feel like I'm at the end of my rope.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

MBI 21 In my work, I deal with emotional problems very calmly.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day

MBI 22 I feel patients blame me for some of their problems.

- Never
- A few times per year or less
- Once a month or less
- A few times a month
- Once a week
- A few times a week
- Every day
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

Gender:

- Male
- Female
- Transgender-Male
- Transgender-Female
- Other
- Prefer Not to Answer

Age:

Ethnicity:

- White ...
- Other

Ethn. Other If "Other" was selected, please specify.
MENTAL HEALTH STIGMA AMONG HEALTHCARE PROVIDERS

Clinical Years: How many years have you been a licensed professional doing clinical work? (If less than one year, please round up to one)

▼ 1 ... 75

Setting: Please select the setting in which you work:

- Hospital-Psychiatry/Mental Health
- Hospital-Primary Care
- Hospital-Specialty
- Outpatient Mental Health Clinic
- Outpatient Medical Clinic
- Private Practice
- Family Medicine Practice
- College Counseling/Health & Wellness Center
- Other

Sett. Other If "Other" was selected, please specify.

________________________________________________________________
Dear Volunteer:

Purpose and Duration of Research
Thank you for your interest in this survey. This researcher, a student in the Counseling Psychology PhD program in the Department of Professional Psychology and Family Therapy at Seton Hall University. This project aims to develop and extend psychological research on the factors that contribute to attitudes towards patients with mental illness among doctoral-level healthcare providers. More specifically, this study aims to understand the relationship between professional training model, burnout, therapeutic optimism, time spent in the field, and attitudes toward mental illness. It also aims to identify group differences based on gender. Such research can help inform education and training, potentially improve patient outcomes, and assist integrated healthcare systems and interdisciplinary treatment teams with supervision, consultation and collaboration among providers.

Procedures and Voluntary Participation
Licensed doctoral-level providers who conduct clinical work full-time and fall into one of the following categories (Clinical Psychologist, Counseling Psychologist, Family Medicine Physician, Internal Medicine Physician, or Psychiatrist), are invited to participate in this survey. Participation is completely voluntary. Participants may withdraw from this study at any time without consequence. Consent will be given by going to the survey link. When the link is clicked, participants are taken to an outside survey website called Qualtrics to complete the study. This survey constitutes a demographic questionnaire, and three scales that measure burnout, therapeutic optimism, and attitudes toward patients with mental illness. Total participation time is about 15 minutes.

Anonymity Preservation and Confidentiality
Researchers will take all possible steps to maintain anonymity throughout the study; however, participants may wish to exercise caution when using the internet. You are free to withdraw at any time by closing your browser window. Completed responses will be kept in a secure location and will only be viewed by Lindsay Blevins, M.A., her research mentor Pamela Foley, PhD., and members of her dissertation committee. Data will be stored electronically on a USB memory key and kept in a locked, secure office.
Anticipated Risks and Discomfort
There are little to no foreseen risks or discomfort involved in the completion of this study. If participants become distressed, there is 24-hour assistance available. Toll free number: 1-800-273-TALK (8255). If you wish to speak with a professional, the American Psychological Association offers free location-based referral services at http://locator.apa.org.

Benefits to Research
Participation in this study will provide valuable information in further understanding the factors that contribute to attitudes toward patients with mental illness and potentially assist in improving integrated healthcare systems. Results may also assist training programs to improve education in collaboration, consultation, and integrated healthcare.

Contact Information
If participants have questions about this study, they may contact the researcher using the information list below. If participants have questions about their rights as research participants, please contact the Director of the Institutional Review Board at Seton Hall University: Dr. Mary F. Ruzicka, Ph.D. at (973) 313-6314.

Thank you,

Lindsay Blevins, M.A.
Counseling Psychology Doctoral Student
Seton Hall University
blevini@shu.edu
May 31, 2017

Lindsay Blevins

Dear Ms. Blevins,

The Seton Hall University Institutional Review Board has reviewed your research proposal entitled “Examining Mental Health Stigma among Doctoral-Level Healthcare Providers: The Impact of Burnout, Therapeutic Optimism, and Gender on Attitudes toward Patients with Mental Illness” and has categorized it as exempt.

Enclosed for your records is the signed Request for Approval form.

Please note that, where applicable, subjects must sign and must be given a copy of the Seton Hall University current stamped Letter of Solicitation or Consent Form before the subjects’ participation. All data, as well as the investigator’s copies of the signed Consent Forms, must be retained by the principal investigator for a period of at least three years following the termination of the project.

Should you wish to make changes to the IRB approved procedures, the following materials must be submitted for IRB review and be approved by the IRB prior to being instituted:

- Description of proposed revisions;
- If applicable, any new or revised materials, such as recruitment fliers, letters to subjects, or consent documents; and
- If applicable, updated letters of approval from cooperating institutions and IRBs.

At the present time, there is no need for further action on your part with the IRB.

In harmony with federal regulations, none of the investigators or research staff involved in the study took part in the final decision.

Sincerely,

Mary F. Ruzeika, Ph.D.
Professor
Director, Institutional Review Board

cc: Dr. Pamela Foley