Mental Health Stigma about Serious Mental Illness among MSW Students: Social Contact and Attitude

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In this study, the attitudes toward and beliefs about serious mental illness (SMI) held by a group of graduate social work students in the northwestern United States were examined. Mental health stigma was examined with relation to the following factors: participants' level of social contact with SMI populations, adherence to stereotypes about SMI populations, belief in the ability to recover from SMI, and the belief that SMI defines an individual's identity. Measures used to identify mental health stigma included the desire for social distance and restrictions with relation to the SMI population. Survey results from 71 graduate social work students found that a significant number of participants who engaged in friendships with SMI-diagnosed individuals had less desire for social distance from and restrictions toward SMI populations. Participants who indicated that they believed in stereotypes of dangerousness and believed that SMI defines an individual's identity were more likely to express desire for both social distance and restrictions. Implications for social work and further research on the matter are discussed.

KEY WORDS: *graduate social work students; serious mental illness; social contact; stigma*

Stigma is universally experienced in all cultures and at various stages of life; stigmatizing or negative attitudes against those living with mental illnesses are prevalent among the general U.S. population (Hinshaw, 2005; Pinto-Foltz & Logsdon, 2008). Although there are various definitions of *serious mental illness* (SMI), the most commonly used definition is having—at some time within a given year—a diagnosable mental, behavioral, or emotional disorder meeting criteria specified in the *DSM–IV* (American Psychiatric Association [APA], 1994). More recently, the *DSM–IV–TR* (APA, 2000) defined SMI as referring to a diagnosis of schizophrenia, bipolar disorder, or major depression. Stigmatization has many detrimental effects on the population living with SMI, including refusal to seek treatment, decreased quality of life, fewer job opportunities, decreased opportunities for obtaining housing, decreased quality in health care, and decreased self-esteem (Corrigan, 2004; Lawrie, 1999; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Stigmatization, given its detrimental effects, is an important issue for the social work field to examine.

The promotion of client empowerment and client partnership are integral to social work practice values (Hepworth, Rooney, & Larsen, 2002; Miley, O'Milea, & DuBois, 2004), but stigmatizing attitudes may create barriers to forming partnerships and empowering clients. Indeed, a study shows that professionals, such as social workers, working with populations that are diagnosed with mental illness have equally negative attitudes toward mental illness as those found in the general public (Nordt, Rossler, & Lauber, 2006). Thus, stigma seems to be one of the greatest barriers for social workers to promote empowerment and client partnership (Corrigan, 2004), and this deserves our close attention. Mental health stigma and its effects on social work students has been understudied.

This study attempted to examine the issue of mental health stigma among social work students. Existing literature on desire for social distance from and restrictions toward individuals living with SMI was explored. We used previous research findings to support the formation of our four study hypotheses: (1) Social contact within intimate relationships would be associated with less desire for social distance and restrictions, (2) adherence to stereotypes of dangerousness would be associated with higher stigma measures, (3) belief in recovery would be associated with less desire for social distance and

317

restrictions, and (4) participants with professional training on SMI would have significantly lower levels of stigma.

LITERATURE REVIEW

Stigmatization and the Social Work Profession

Stigmatization by professionals who work with SMI populations may be explained in part by what P. Cohen and Cohen (1984) referred to as the "clinician's illusion." The clinician's illusion is the belief that people with SMI are always low functioning; cannot get along in society; and exhibit socially undesirable behaviors, like being violent. On P. Cohen and Cohen's theory, social workers may experience the clinician's illusion because of their exposure to clients experiencing the most severe symptoms of mental illness during periods of decomposition. Social workers' exposure to mentally ill individuals during periods of decomposition may lead to overgeneralizations and negative assumptions surrounding the functioning and behavior of individuals living with SMI. As Link and Phelan (2001) asserted, the process of stigmatization begins at the micro level, when a particular group of people is ascribed a label and experiences social exclusion because of negative beliefs associated with that label.

Social Distance and Restrictions

Both increased desire for social distance and willingness to place restrictions are considered important measures of stigma (Couture & Penn, 2003). Researchers have measured social distance by the desire, or lack of desire, to include people living with SMI in one's social network (Link, Yang, Phelan, & Collins, 2004). Some examples of the items measured are willingness to date, have one's children marry, or rent to someone diagnosed with an SMI and willingness to hire someone with an SMI to babysit one's children (Nordt et al., 2006; Read & Harre, 2001). Restrictions, or believing that people with mental illness should be isolated from full participation in their communities, were commonly measured by willingness to revoke driver licenses, to revoke the right to vote, and to mandate compulsory admission into psychiatric care hospitals (Nordt et al., 2006).

Beliefs that Influence Desire for Social Distance and Restrictions

Labeling is the first step of the stigmatization process (Link & Phelan, 2001) and may include seeing the SMI label as the most salient part of an individual's personality or identity. Some stigma studies make indirect attempts at identifying the degree to which participants link a mental illness label to a person's identity (Link et al., 2004), but existing studies have failed to directly ask participants the extent to which they believe an individual's SMI diagnosis is linked to his or her identity. The present study directly asked participants to identify the extent to which they connect the SMI label to an individual's identity.

Stigma literature has shown that the most prominent stereotype toward people living with SMI is that they are dangerous because they are violent (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). This stereotype, however, is not supported by evidence (Link et al., 1999). Because stereotypes of violence are likely associated with desire for social distance and restrictions (Couture & Penn, 2003), the current study measured participants' adherence to these stereotypes.

Another factor that influences mental health stigma is one's belief in recovery. Studies have shown that the course of SMI is diverse for every individual and can move toward significant improvement over time (Harding, 2003). Despite the vast amount of literature confirming individuals' ability to recover from SMI, a study conducted by Hayward and Bright (1997) suggested that stigma leads to the general belief that people living with SMI will not recover with treatment. Harding asserted that professionals may also believe that recovery from SMI is unlikely. The present study further explored the connection between belief in recovery and stigma with regard to the desire for social distance and restrictions.

Social Contact

A number of studies have found that increased social contact may decrease the desire for social distance (Chung, Chen, & Liu, 2001; Corrigan et al., 2001; Read & Harre, 2001) and the desire for placing social restrictions on those diagnosed with SMI (Vezzoli et al., 2001). Couture and Penn (2003) noted that most studies on social contact, however, fail to explore the quality of contact relationships. One study did measure relationship quality after contact with an SMI-diagnosed volunteer but did not measure naturally occurring friendships or familial relationships (Couture & Penn, 2006). The current study asked participants to rate quality or

perceived intimacy levels within their relationships with individuals in the SMI population.

Because existing research states that relationships within the context of family or friends may lead to decreased desire for social distance (Alexander & Link, 2003), the various contexts in which social contact occurs were explored in this research. Lastly, formal training on SMI has also been found to decrease stigmatizing attitudes in those receiving training (Corrigan et al., 2001); therefore, formal training was also explored as a possible influence on the desire for social distance and restrictions.

METHOD

Sample and Procedure

The study used a survey format and cross-sectional design. Seventy-one MSW students (about 78 percent) out of about 91 second-year, full-time students enrolled in their last semester of the MSW program in 2007 at a public university in the northwestern United States participated in this study. A combination of convenience sampling and snowball sampling was used. The participants' ages ranged from 23 to 59 years, with a mean age of 34 (SD = 9.69). Most respondents were female, forming 83.1 percent of the total sample. European Americans were the largest group (36.6 percent), followed by 19.7 percent Asians, 18.3 percent Latinos, 8.5 percent African Americans, and 8.5 percent biracial individuals. Years of experience in social work practice ranged from one to 19 years, with a mean of 5.6 years (SD = 3.68). Also, 15 percent of participants (11 of the 71) identified themselves as a person with an SMI (bipolar disorder, schizophrenia, or major depression).

Before initiation of the study, consent was obtained from the participating school's human subjects review board. The researcher obtained consent from professors teaching second-year MSW courses to recruit participants during their class time and went to various second-year MSW courses and explained to the students the purpose of the current study, issues of confidentiality, and the protocol for participation. Seventy-one completed survey questionnaires and signed consent forms were returned to a designated drop box located in the student lounge.

Variables and Measures

Dependent Variable. Negative stigma toward people with SMI was measured by two constructs: restrictions and social distance. Restrictions were determined by summing five questions about participants' willingness to revoke the driver's license, restrict the range of employment, and place other restrictions on the social liberties of those in the SMI population. Each question was coded on a four-point scale: 1 = strongly agree, 2 = agree, 3 = disagree, and 4 = strongly disagree. Once the five items were summed, the range of possible scores was 5 to 20; higher scores indicated more willingness to restrict the liberties of people living with SMI. The items' alpha reliability was .64 in the current sample. Social distance was measured by five questions that inquired about participants' desire or lack of desire to include people living with SMI in their social network. These questions asked about participants' willingness to rent, hire, hire for babysitting, have someone marry, and work with someone with SMI. Responses were coded on a four-point Likert-type scale (1 = strongly agree, 2 = agree, 3 = disagree, 4 = strongly disagree). After reverse coding of two negatively worded items, the five items were summed to create the social distance score, with a possible range of 5 to 20. A higher score indicated a greater desire for social distance. Alpha internal reliability for the subscales was .73.

Contextual and Belief Independent Variables. Level of social contact with friends and families with SMI was measured by the combination of responses to two questions: The first question asked individuals to check "yes" = 1 or "no" = 0 in response to inquiries about having a friend and having a family member who had been diagnosed with SMI. The second question asked participants to identify the level of intimacy in their relationships with individuals having an SMI diagnosis; level of intimacy was coded on a three-point scale: 1 = not intimate, 2 = somewhat intimate/close, and 3 = very intimate/close. When the participant answered "no relationship with someone diagnosed with SMI" to the first question, this response was coded as 0 on the second question. By combining these two items, the level of social contact score was created, with a possible range of 0 to 4: 0 = no social contact with SMI, and 4 = highest level of social contact with either friends or family members separately. Participation in SMI trainings was measured by one item rated "yes" = 1 or "no" = 0 on whether the participants have ever participated in trainings about SMI that focus on consumer perspectives.

SMI stereotype was measured by 12 items assessing participants' beliefs about the dangerous and vio-

lent tendencies of those living with bipolar disorder (four items), schizophrenia (four items), and major depression (four items). These items were as follows: People diagnosed with any of these three SMIs are "more dangerous than the general public," "more violent than the general public," "more aggressive than the general public," and "more of a risk to others if not medicated." Each question was coded on a four-point Likert-type scale (1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree). The sum score of the 12 items was used for measuring the stereotype. The possible range of the sum of SMI stereotype was from 12 to 60, and higher scores indicated higher levels of adherence to stereotypes of dangerousness and violence. The 12 items' internal reliability was .84 in the current sample.

Belief in recovery was assessed by one item about participants' beliefs surrounding the ability of someone living with SMI to recover. The response was coded on a four-point scale: 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree. SMI as an identity was measured also by one item: "For someone diagnosed as seriously mentally ill, the *most* important aspect of that person's identity is his or her mental health diagnosis." Responses were rated on a four-point Likert-type scale: 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree.

Other Measurement Notes. With one exception, stereotype toward SMI (70 percent, $n = 5$), there were negligible amounts of missing data (less than 2 percent) in these surveys. More specifically, missing data were present in the following study variables: the social distance score (1.4 percent, $n = 1$), the restrictions score (1.4 percent, $n = 1$), participant has SMI diagnosis (1.4 percent, $n = 1$), and participation in SMI training (1,4 percent, $n = 1$). To preserve the sample size, we used the "hot deck" single imputation method by matching each individual with missing data to one having similar trends in other variables and replacing the missing data cell with a known value from the matched individual (Reilly & Pepe, 1997). As a result, responses from all 71 participants were used for the subsequent data analyses.

RESULTS

The levels of social distance and restrictions toward people with SMI in our sample are presented in Table 1. The social distance summed scores ranged from 5 to 16, with a mean of 11.2 ($SD = 2.48$). Most participants showed willingness to include people living with SMI in their social network, for instance renting an apartment to people with SMI (80.3 percent), being a colleague with people with SMI (88.6 percent), and hiring people with SMI (85.7 percent). However, the majority of the sample

Table 1: Univariate Statistics for Responses to Questions on Social Distance and Restrictions

Item	Strongly Agree %	Agree %	Disagree %	Strongly Disagree %
Social distance				
Feel comfortable having colleagues with SMI	33.8	53.5	11.3	0
Rent an apartment to individual with SMI	21.1	59.2	19.7	0
Not hire someone diagnosed with SMI[a]	1.4	14.1	62.0	22.5
Hire someone with SMI to babysit my children	5.6	15.5	47.9	31.0
Object to son/daughter marrying someone with SMI[a]	7.0	39.4	43.7	9.9
Average score = 11.2 ($SD = 2.48$)				
Restrictions				
Approve of restricting the right to vote	4.2	7.0	26.8	60.6
Approve of revoking drivers' license	2.8	14.1	40.8	40.8
Approve of requiring government supervision to be primary caretakers of children	0	26.8	46.5	25.4
Approve of allowing foster/adoptive parenting	9.9	29.6	43.7	15.5
Approve of allowing employment as mental health providers	16.9	66.2	11.3	4.2
Average score = 12.37 ($SD = 2.71$)				

Note: Although similar, the wording of items in the table differs from that found on the survey.
[a]Reverse coded.

reported that they would not hire people with SMI as a babysitter (78.9 percent), and respondents were nearly evenly split on whether they would allow their children to marry people with SMI (53.5 percent, $n = 38$, agreed; 46.5 percent, $n = 33$, disagreed). With regard to restrictions, our sample showed scores ranging from 7 to 19, with a mean of 12.37 ($SD = 2.71$). The majority of participants reported disagreement to restrict liberties on four items: restricting the right to vote (88.6 percent, $n = 62$), revoking driver's licenses (82.9 percent, $n = 58$), requiring government supervision to be primary caretakers of children (72.9 percent, $n = 51$), and not allowing foster/adoptive parenting (60.0 percent, $n = 42$). Only 15.7 percent ($n = 11$) agreed, in general, that people with SMI should not be allowed to obtain employment as mental health service providers.

After elaborating on general patterns of participants' attitudes toward people with SMI, we wanted to identify the factors associated with such sentiments. The study research questions were answered using a series of multiple regressions and their effect sizes. Before conducting regressions, we checked the main linear regression assumptions. As expected,

our data met the assumptions for linear regression such as linearity, homoscedasticity, and an absence of outliers. Also, as per J. Cohen (1988), effect size was calculated as the proportion of variance explained by the independent variables divided by the proportion of variance attributed to error $[R^2/(1 - R^2)]$.

The multivariate results for the independent variables and the two dependent variables are presented in Tables 2 and 3. Separate multiple regressions for two dependent variables were conducted. Each time, we ran four multiple regressions to establish the degree to which the variance in the attitude toward SMI could be explained by the independent variables as using a significance test measuring strength of relationship and the relative predictive significance of each variable by comparing beta weights. The first three regressions separated the distinctive effects of the demographic, contextual, and belief-related variables; the last included all variables.

In both the social distance and restrictions models, the full model appeared to fit the data better than other separate models: 21 percent of the variation in social distance in comparison with 11 percent, 8 percent, and 15 percent in demographic-only, contextual-only, and belief-only models,

Table 2: Regression of Demographic, Contextual, and Beliefs Variables on Social Distance

Variable and Measure	Demographics	Contexts	Beliefs	Demographics + Contexts + Beliefs
Demographics				
Gender (female = 1)	.19			.13
Age	.28*			.34**
Race (white = 1)	−.27*			−.22
Participant has SMI diagnosis	−.15			−.07
Contexts				
Social contact: friends		−.30**		−.21*
Social contact: family		.05		−.04
Participation in trainings		−.15		−.03
Beliefs				
Stereotype toward SMI			.17[a]	.26*
SMI as identity			.25*	.17
Belief in recovery			.11	.11
Adjusted R^2	.11	.08	.15	.21
F	2.97*	3.00*	4.53**	2.62*
Effect size	.21	.15	.11	.51

Note: SMI = serious mental illness.
[a]Approaching significance.
*$p < .05$. **$p < .01$ (one-tailed test).

Variable and Measure	Demographics	Contexts	Beliefs	Demographics + Contexts + Beliefs
Demographics				
Gender (female = 1)	.10			−.02
Age	.15			.13
Race (white = 1)	−.32*			−.28*
Participant has SMI diagnosis	−.40**			−.41**
Contexts				
Social contact: friends		−.30*		−.08*
Social contact: family		.08		.12
Participation in trainings		−.05		.12
Beliefs				
Stereotype toward SMI			.10	.21*
SMI as an identity			.39**	.31**
Belief in recovery			.16	.08
Adjusted R^2	.23	.06	.19	.37
F	5.65***	2.34a	6.29***	4.66***
Effect size	.37	.11	.30	.89

Note: SMI = serious mental illness.
aApproaching significance.
*$p < .05$. **$p < .01$. ***$p < .001$ (one-tailed test).

respectively, and 37 percent of the variation in comparison with 23 percent, 6 percent, and 19 percent in demographic-only, contextual-only, and belief-only models, respectively, were explained. Thus, we focused on the interpretation of the full models. Most of the factors maintained significant links to social distance attitude; variables of race, age, and SMI as an important identity lost significance after belief factors were included. Results suggest that social contact with friends having SMI was associated with lower levels of social distance attitude ($\beta = -.21, p < .05$, one-tailed test), and stereotype toward SMI was associated with higher levels social distance attitude ($\beta = .26, p < .05$, one-tailed test).

For the restriction models, both stereotype toward SMI and SMI as an important identity were significantly associated with more desire for restrictions ($\beta = .21, p < .05$, and $\beta = .31, p < .01$, one-tailed test, respectively). Participants' own SMI diagnosis was negatively associated with restrictions ($\beta = -.41, p < .01$, one-tailed test) but not with social distance. Contrary to our expectation, social contact with family members having SMI, participation in SMI training, and belief in recovery were not significantly associated with either dependent variable.

DISCUSSION

Although the subsequently described relationships were identified within the context of the current study and its limited sample, these results may suggest relationships that merit further investigation. The primary purpose of the current study was to look at possible elements within social contact relationships and participants' beliefs systems and how these elements are associated with participants' levels of mental health stigma.

The results showed that the first research hypothesis was partially supported; more intimate social contact with friends with SMI was associated with less desire for social distance, but the relationship did not hold for contact with family members with SMI. The latter results should be interpreted with caution due to the limits related to sample size, but they should not be discarded as they are supported by previous research findings indicating that increased social contact has a positive influence on the reduction of stigma (Couture & Penn, 2003). Contrary to the findings of Alexander and Link (2003), however, not all types of social contact were associated with less stigmatizing attitudes. It may be that adding quality of contact measures to the current study

allowed for the context of relationship to surface as an important aspect of the association between stigma and social contact.

Our findings suggest that among the current study's population, friendships, rather than familial relationships, were associated with lower stigmatizing attitudes. Although not statistically significant, the results suggest that having more familial SMI contact actually has a positive contribution to participants' desire for social distance and restrictions. Couture and Penn (2003) affirmed that voluntary contact is best at reducing stigma; thus, one possible explanation for these differences may be that friendships tend to be more voluntary than familial relationships. It is likely that other, as yet unidentified variables may explain the differential influence between family and friendship contacts on stigma toward SMI. A study with a more generalizable sample could further explore the possibility that family relationships have a different impact on stigma than do friendships.

With regard to the study's second hypothesis, results were consistent with previous research findings that link belief in stereotypes about SMI to stigmatizing attitudes (Corrigan et al., 2001; Crisp et al., 2000). Participants' belief in stereotypes of dangerousness significantly predicted both dependent variables. The findings may or may not reflect trends found in the larger population of social work graduate students; further research is needed to examine how stereotypes influence larger social work populations and their perceptions of SMI. The current findings suggest that stereotypes of dangerousness may perpetuate stigma toward individuals living with SMI. In addition, participants having an SMI diagnosis expressed less desire to place restrictions. This may be due to the fact that an individual diagnosed with SMI may be less likely to agree to restrictions that could potentially limit his or her own freedoms.

Participants' belief in recovery was not a significant predictor of either dependent variable, which differs from the expected finding that participants with the belief in recovery would be more likely to be associated with lower levels of stigma. This result may have been influenced by the nature and size of the sample. The literature shows that for individuals seeking social work careers, the value of working with people and helping them is their primary reason for selecting social work as an occupation (Limb & Organista, 2003; Rubin, Johnson, & DeWeaver, 1986); thus, one might assume that the social work students in this study also value the ability to help

others. If a social worker values the ability to help clients with SMI, it may also be likely that the social worker believes in the ability of clients with SMI to recover. Thus, the belief in recovery may not have been influenced by stigma beliefs.

No significant link between stigma and SMI training was found; this is inconsistent with previous research findings linking SMI training with a decrease in stigma (Corrigan et al., 2001). The low number of study participants may explain this inconsistency. A larger sample might have included more participants with SMI training and allowed for a better analysis of the association between SMI training and stigma measures.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The majority of study participants believed that individuals with SMI diagnosis should not be banned from working as mental health professionals and would feel comfortable working with someone having an SMI diagnosis. The acceptance of individuals with SMI as coworkers, collaborators, or colleagues in professional contexts is particularly important in states where legislation, like the California Mental Health Initiative, promotes the use of mental health consumers as providers of service. Current policy trends encourage hiring of service providers with mental health diagnoses; therefore, the social work profession should continue efforts aimed at identifying any possible effects that stigma may have on service providers diagnosed with SMI.

The current study found that increased adherence to stereotypes of dangerousness and believing that identity is connected to SMI diagnosis may perpetuate some aspects of stigma. Therefore, schools of social work interested in the reduction of stigma may benefit from using interventions that aim to decrease stereotypes of dangerousness and challenge the belief that identity is connected to SMI diagnosis.

Results surrounding the association between social contact and lower levels of stigma suggest that social contact may be used in antistigma education efforts. Antistigma interventions may benefit from using social contact as a strategy to reduce stigma. There are various ways that increased social contact with SMI populations may be promoted, such as providing social work students with opportunities to develop friendships with individuals living with SMI, opportunities to be exposed to personal stories about living with SMI, field practice opportunities in

which students work collaboratively with individuals having an SMI diagnosis, and opportunities to interact with mental health consumers in a nonclinical setting. Antistigma interventions targeting social work students may lead to decreased stigma and increased willingness on the part of social workers to take steps to reduce stigma in their communities, agencies, and policy work.

LIMITATIONS AND FUTURE RESEARCH

The results of the study should be interpreted with caution due to several limitations. The sampling method limits the representativeness and the generalizability of the current findings. Sample limitations include small size, possible geographical effects, and recruitment that relied on convenience and snowball sampling. The self-selected sample may not be reflective of those who chose not to participate. Future studies should recruit a more representative sample of the social work student population across education levels and geographical locations.

This study suffers from several limited operationalizations of variables. For example, belief in recovery and participation in SMI training were measured by using a single-item question, which may not have fully represented the multidimensional construct that we attempted to measure. The items assessing social distance and restrictions showed a modest internal reliability ($\alpha = .73$ and $\alpha = .64$, respectively). This may partially be due to the complexity involved in determining one's levels of stigmatizing attitudes and partially due to effects of social desirability (Beyers & Goossens, 1999; Crowne & Marlowe, 1960). Sensitive issues like stigma may lead social work students to change survey answers on the basis of their desire to convey a particular image as representatives in the field.

The current data were cross-sectional, making it is impossible to draw any definitive conclusions on the basis of causal effect. For example, it is possible that people with positive attitudes about SMI are more likely to develop friendships with people with SMI. A prospective, longitudinal design would determine the direction of the relationships between these variables.

Lastly, in the current study, we grouped major depression, schizophrenia, and bipolar disorder together to define SMI. This grouping has been acceptable in much of the literature on mental health stigma. There are, however, significant differences among these diagnoses. Major depression in particular is much more socially accepted and than schizophrenia and bipolar disorder. Future research would benefit from disaggregating the various SMIs to determine the differences in their relationships to factors of mental health stigma.

In spite of noted limitations, the current findings are valuable as they raise important questions for future research and advise antistigma interventions. Future research may expand on current findings by examining qualities found in relationships that allow them to buffer stigmatizing attitudes. Qualitative research may help expand on current findings by exploring why social work students report overall willingness to include individuals with SMI diagnoses in professional relationships but are less willing to include individuals with SMI diagnosis in personal spheres. Stigma is poorly understood and often remains unrecognized by social work practitioners, students, or both. Such unrecognized stigma can create a barrier to understanding clients' needs and providing individualized empathic care. **SW**

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