Stigma and Mental Illness: Investigating Attitudes of Mental Health and Non-Mental-Health Professionals and Trainees

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Abstract:

The authors explored attitudes toward adults with mental illness. Results suggest that mental health trainees and professionals had less stigmatizing attitudes than did non-mental-health trainees and professionals. Professionals receiving supervision had higher mean scores on the Benevolence subscale than did professionals who were not receiving supervision. Implications for teaching, practice, and research are discussed.

Keywords: mental health | mental health professionals | non-mental-health professionals | stigma

Article:

Researchers have investigated and substantiated that the general population stigmatizes individuals who have been diagnosed with a mental illness (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005; Lauber, Anthony, Ajdacic-Gross, & Rossler, 2004; Levey & Howells, 1994; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). *Mental illness* is defined in this article as medical conditions such as schizophrenia, bipolar disorder, or major depression that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning (National Alliance on Mental Illness, 2009, 1). Researchers have discussed a number of common stigmatizing attitudes toward adults with mental illness (Corrigan, 2004). Such attitudes include beliefs that adults with mental illness are dangerous and need to be avoided, are to blame for their illness, are weak in character, and are incompetent and need oversight and care.

It seems clear, then, that stigma still exists as a detrimental phenomenon in the lives of individuals diagnosed with a mental illness (Link, Yang, Phelan, & Collins, 2004; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Perlick et al., 2001).

In the last decade, there have been attempts to highlight to the general population the topic of stigma toward adults with mental illness. For instance, in his report, Surgeon General David

Satcher spoke of the need to recognize stigma as a barrier within the field of mental health. In fact, it was suggested that mental health care could not be improved without the eradication of mental health stigma (U.S. Department of Health and Human Services, 1999).

In addition, stigma is a barrier to recovery for adults diagnosed with a mental illness (Link et al., 2001; Perlick, 2001; Perlick et al., 2001; Sirey et al., 2001). A number of negative consequences of stigma related to mental illness, both internal and external, have been highlighted in the literature. Internal consequences include a decrease in self-esteem and an increase in shame, fear, and avoidance (Byrne, 2000; Corrigan, 2004; Link et al., 2001; Perlick et al., 2001). External consequences of stigma include exclusion, discrimination, prejudice, stereotyping from others, and social distance (Byrne, 2000; Corrigan, 2004; Link et al., 2004). Furthermore, adults who experience stigma are more inclined to be noncompliant with recommended mental health care and prescribed medications (Sirey et al., 2001). Researchers have found that persons diagnosed with a mental illness were more likely to adhere to a medication regimen when they perceived lower levels of stigma associated with their mental illness and to discontinue medication when they feared stigmatization from others (Sirey et al., 2001).

Unfortunately, stigma toward adults with mental illness originates not only from the general population but also from mental health professionals. Authors (Lauber et al., 2004; Nordt, Rossler, & Lauber, 2006) have warned that it would be simplistic to assume that mental health professionals have more positive attitudes toward adults with mental illness than does the general public. These authors urged mental health professionals to investigate more closely their attitudes toward people with mental illness. Early researchers hypothesized that stigma originates from feelings of helplessness and futility among mental health professionals (N. Cohen, 1990). Others have stated that stigmatizing attitudes might be associated with feelings of resistance from professionals toward providing services and treatment to clients (N. Cohen, 1990; Minkoff, 1987). Inadequate training and lack of preparedness to work with the population and setting before starting in the mental health field might result in negative attitudes (Hromco, Lyons, & Nikkel, 1995; Minkoff, 1987). Additionally, it has been suggested that mental health professionals do not receive adequate support and validation to function successfully in this type of work (Minkoff, 1987). There is little consensus regarding what might assist with lessening stigmatizing attitudes toward adults with mental illness. Scholars have implied that numerous factors might decrease stigma and negative attitudes, including contact and experience with the population and setting (Procter & Hafner, 1991; Wallach, 2004) and education and knowledge regarding the field of mental health (Bairan & Farnsworth, 1989; Penny, Kasar, & Sinay, 2001). Primarily, however, researchers have examined professionals in the medical, occupational therapy, and case management fields (Bairan & Farnsworth, 1989; J. Cohen & Struening, 1962; Murray & Steffen, 1999; Penny et al., 2001; Procter & Hafner, 1991) to explore the topic of stigma and the mental health professional.

Early researchers investigated how professional orientation might be related to adults with mental illness. In their 1962 article, J. Cohen and Struening investigated professionals' attitudes toward adults with mental illness. The participants worked in two large psychiatric hospitals and ranged from psychiatrists to staff such as kitchen personnel. Participants' responses to an opinions questionnaire (i.e., Opinions of Mental Illness Scale [OMI]; J. Cohen & Struening, 1962) indicated the following attitudes toward adults with mental illness: *authoritarianism* (the

belief that those with mental illness are inferior and require coercive handling), *benevolence* (a moral, kindly, and sympathetic belief of mental illness), *mental hygiene ideology* (the belief that adults with mental illness are normal and mental illness is an illness like any other), *social restrictiveness* (wanting to restrict adults with mental illness to protect society), and *interpersonal etiology* (mental illnesses arise from interpersonal experiences, particularly from an absence of love and attention from parents and families).

Psychologists, psychiatrists, and social workers had low mean scores on the Authoritarian subscale of the OMI, indicating less stigma, whereas kitchen personnel and aides scored higher. On the Benevolence subscale, psychologists occupied the low extreme, indicating more stigma, whereas nurses, special service workers, and clerical personnel had high scores, indicating less stigma. Aides and kitchen workers had the lowest means on the Mental Hygiene Ideology subscale, indicating more stigma, and social workers, psychiatrists, and psychologists had the highest means, suggesting less stigma. Nonpsychiatric physicians scored the highest (more stigma) and psychologists the lowest (less stigma) on the Social Restrictiveness subscale. Psychiatrists and psychologists had the highest means on Interpersonal Etiology (less stigma), whereas aides and kitchen workers scored the lowest (more stigma). Overall, J. Cohen and Struening (1962) noted that mental health professionals tended to score quite differently than did aides and staff. On both Authoritarian and Benevolence, professionals tended to have less of both of these attitudes than did nonprofessional staff. However, there was still variation between professional disciplines. For example, nonpsychiatric physicians and psychologists had the highest and lowest scores, respectively, on the Social Restrictiveness subscale (J. Cohen & Struening, 1962).

Since early research on stigma and mental health professionals (J. Cohen & Struening, 1962), professional counselors have emerged as a type of mental health professional who often works in settings with adults diagnosed with a mental illness (Hinkle, 1999). In fact, professional counselors have reported that they are seeing more clients in severe distress (Ivey, Ivey, Myers, & Sweeney, 2005). Although this subgroup of mental health professionals might work in the same professional settings as other mental health professionals, the training background of professional counselors includes some noteworthy differences. When compared with other mental health disciplines, counselor training programs are grounded in humanistic values and assumptions (Hansen, 1999, 2000b, 2003) with a primary focus on the counseling relationship. Although counselors-in-training learn a variety of approaches to working with clients, humanism is at the core of counselor professional identity (Hansen, 2000a).

With differences existing in education and training of professional counselors and other mental health professionals, the question arises as to what differences might exist between these professional groups in how they stigmatize clients diagnosed with a mental illness. Little is known, however, about how professional counselors, whose training is more oriented toward humanistic perspectives than is the training of other mental health professionals, might differ from other mental health professionals in their tendency to stigmatize persons diagnosed with a mental illness. Perhaps the emphasis on the counseling relationship leads professional counselors to be less stigmatizing toward adults diagnosed with a mental illness. On the other hand, because the training programs of professional counselors tend to emphasize mental illness and pathology to a lesser extent than do other mental health training programs, it is possible that counselors are less

knowledgeable about mental illness. Such a lack of knowledge has been hypothesized to increase the potential to stigmatize (Bairan & Farnsworth, 1989; Penny et al., 2001). This remains an empirical question that, to date, has been unexamined.

Furthermore, current research on the topic of stigma and mental health professionals has been done outside the United States (Lauber et al., 2004; Nordt et al., 2006). When these investigators examined mental health professionals' attitudes, it seemed that professionals harbored some of the same stigmas as does the general population.

The purpose of the current study, then, was to examine stigma toward mental illness among a U.S. sample that included professional counselors. To our knowledge, this was the first study in which stigma toward mental illness among professional counselors was considered empirically. Also of interest was the impact of time in the field on attitudes. This was explored by investigating those who were preparing for professional work in a mental health field (i.e., graduate students) and those who were experienced mental health professionals working in direct care settings. Non-mental-health professionals were also included to provide a reference group. Other factors related to professionalism, such as clinical supervision and licensure status, were explored for their role in stigmatizing attitudes. Previous researchers had assumed homogeneity of experience among mental health professionals that may or may not have existed.

Method

Participants

Of the 188 participants in this study, 118 (62.8%) were women and 70 (37.2%) were men. The majority of respondents described themselves as Caucasian (89.4%, $n = 168$) with other participants identifying as African American (4.3%, $n = 8$), Asian/Pacific Islander (2.1%, $n = 4$), Hispanic (2.1%, $n = 4$), multiracial (1.1%, $n = 2$), and other (1.1%, $n = 2$). Respondents ranged in age from 21 years to 65 years ($M = 39.63$, $SD = 13.23$).

There were four subgroups of interest in this study. The first group, the non-mental-health student group, included a sample of students ($n = 20$) who were enrolled in graduate programs in business administration at a midsized university in the southeastern United States. Business students ranged in age from 21 to 53 years ($M = 36.05$, $SD = 9.19$).

A second group consisted of students in the areas of counseling ($n = 17$), social work ($n = 20$), and psychology ($n = 21$). These students were enrolled in master's-level graduate training programs and were in at least their 2nd year of graduate study. Counselors-in-training ranged in age from 21 to 48 years ($M = 27.94$, $SD = 5.97$). Social workers-in-training ranged in age from 22 to 31 years ($M = 30.45$, $SD = 8.56$). Psychologists-in-training ranged in age from 21 to 32 years ($M = 24.29$, $SD = 2.72$). Three programs of each discipline (counseling, social work, and psychology) at midsized universities in the southeastern United States were used to recruit volunteers. These professionals-in-training comprised the mental health student group.

The third group included 76 mental health professionals with the professional identity of counselor ($n = 24$), social worker ($n = 20$), or psychologist ($n = 32$) who were working in the

mental health field and had been employed as such for a minimum of 1 year. These participants self-identified as a professional counselor, social worker, or psychologist to qualify for participation in the study. Professional counselors ranged in age from 27 to 61 years (M = 45.42, SD = 10.79), professional social workers ranged in age from 28 to 64 years (M = 53.30, SD = 9.45), and professional psychologists ranged in age from 28 to 65 years (M = 47.16, SD = 12.25). Mental health professionals ranged in years of mental health experience from 1 to 20 years (M = 14.32, SD = 6.25).

The fourth subgroup of interest included 34 non-mental-health professionals. These were professionals who were working in a non-mental-health field (business) in the southeastern United States. Only professional-level participants were included in this group to provide a minimal control for education level as a potential confounding influence. Non-mental-health professionals ranged in age from 25 to 64 years (M = 43.76, SD = 10.62).

Instruments

Community Attitudes Toward the Mentally Ill (CAMI; Taylor & Dear, 1981). The CAMI was used to assess attitudes toward adults with mental illness. The instrument was developed from the OMI and is a 40-item self-report survey that uses a 5-point Likert-type scale (5 = *strongly agree* to 1 = *strongly disagree*). There are 10 statements for each of four subscales. The CAMI is scored by assigning values to each of the items, and five of the 10 items for each factor are reverse coded. Responses to each item of a subscale are added together to obtain one score for each factor, ranging from 10 to 50 for each factor. A mean score is then calculated for each total subscale score. Thus, attitudes are measured by mean item responses for each subscale. Four subscales comprise the CAMI: Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology. The following are brief descriptions of these subscales provided by Taylor and Dear (1981): Authoritarianism is the belief that obedience to authority is necessary and people with mental illness are inferior and demand coercive handling by others. Benevolence is defined as being kind and sympathetic, supported by humanism rather than science. Social Restrictiveness involves beliefs about limiting activities and behaviors such as marriage, having children, and voting among people with a mental illness. Community Mental Health Ideology is defined as a "not in my backyard" attitude toward adults with mental illness. That is, this is the belief that adults with mental illness should get treatment, but not in proximity to me.

Evidence for internal consistency of the CAMI is clear for three of the four subscales: Community Mental Health Ideology (a = .88), Social Restrictiveness (a = .80), and Benevolence (a = .76). Only the Authoritarian- ism subscale (a = .68) has been shown to be problematic in past research (Taylor & Dear, 1981).

Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960). Social desirability is defined as an individual's need for approval (Leite & Beretvas, 2005). To ensure that participants were not answering the CAMI in a socially desirable way and to validate the attitudes captured by the instrument, we administered the MCSDS during data collection. This instrument is the most commonly used scale for assessing social desirability bias (Leite & Beretvas, 2005). The MCSDS has demonstrated strong reliability. The original authors obtained

a Kuder-Richardson reliability coefficient estimate of .88 (Crowne & Marlowe, 1960).

Demographic questionnaire. Along with the aforementioned instruments, participants completed a demographic questionnaire specifically developed for this study. The questionnaire provided the researchers with information such as participants' personal characteristics (e.g., gender, age, ethnicity), professional characteristics (e.g., professional orientation, degree status, licensure status, clinical supervision status, years of professional experience, and terminal degree), and characteristics of work/internship environment (i.e., type of mental health facility).

Procedures

Potential participants were invited to respond to the survey via e-mail. The e-mail contained a link to the survey, which was located on a commercial online site for electronic survey research. To collect the sample of students in non-mental-health training programs, we contacted graduate students via departmental electronic mailing lists. Professional counselors, psychologists, and social workers were reached via e-mail and asked to participate by completing the survey online. The survey was sent to potential professional counselors, psychologists, and social workers whose e-mail addresses were obtained from comprehensive statewide lists. Non-mental-health professionals were reached via e-mail using an electronic alumni mailing list obtained from a non-mental-health training program.

Results

All subscale reliability estimates for the CAMI were found to be within an acceptable range (α = .80 to .86) for conducting research (Heppner, Kivlighan, & Wampold, 1999), with the exception of the Authoritarianism subscale, which had an alpha of .62. The 33-item MCSDS had acceptable evidence of reliability with an alpha of .85. All correlations between scores on the MCSDS and CAMI subscales were low, with absolute values ranging from .16 to .23: Authoritarianism, $r(186) = .20$, $p < .01$; Benevolence, $r(186) = -.23$, $p < .01$; Social Restrictiveness, $r(186) = .21$, $p < .01$; and Community Mental Health Ideology, $r(186) = -.16$, $p < .05$. These data suggest that social desirability did not have a substantive role in participants' responses, and participants answered questions on the CAMI with a reasonable level of honesty.

Descriptive statistics of the CAMI were run for each of the four sub-groups of participants. These results are presented in Table 1. In addition, a 2 × 2 × 4 multivariate analysis of variance (MANOVA; Professional Level [student vs. professional] × Status [mental health vs. non-mental-health] × Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology) was used to investigate the differences in attitudes toward mental illness. This analysis assessed for main effects for professional level (student vs. professional), main effects for status (mental health vs. non-mental-health), and possible interaction effects between professional level and status.

TABLE 1

Descriptive Statistics for the CAMI Subscales by Subgroup

Subgroup and CAMI Subscale	Minimum	Maximum	*M*	*SD*
Non-mental-health student (*n* = 20)				
Authoritarianism	1.6	3.2	2.23	0.46
Benevolence	3.1	4.9	3.89	0.51
Social Restrictiveness	1.7	3.2	2.28	0.44
Community Mental Health Ideology	2.1	4.2	3.42	0.60
Mental health student (*n* = 58)				
Authoritarianism	1.0	2.6	1.96	0.32
Benevolence	2.6	5.0	4.36	0.43
Social Restrictiveness	1.1	2.7	1.92	0.33
Community Mental Health Ideology	2.6	4.6	3.83	0.46
Mental health professional (*n* = 76)				
Authoritarianism	1.3	2.9	2.06	0.41
Benevolence	3.4	5.0	4.31	0.38
Social Restrictiveness	1.1	3.0	1.89	0.42
Community Mental Health Ideology	2.4	4.9	3.78	0.50
Non-mental-health professional (*n* = 34)				
Authoritarianism	1.5	3.8	2.22	0.52
Benevolence	1.8	4.9	3.73	0.66
Social Restrictiveness	1.4	5.0	2.31	0.67
Community Mental Health Ideology	1.4	4.6	3.26	0.66

Note. CAMI = Community Attitudes Toward the Mentally Ill.

As presented in Table 2, a significant main effect was found for status, $F(4, 181) = 14.73$, $p < .05$, $h^2 = .33$. Univariate follow-up analyses indicated significant main effects for status on Authoritarianism ($F = 9.40$, $p < .05$), Benevolence ($F = 46.61$, $p < .05$), Social Restrictiveness ($F = 26.69$, $p < .05$), and Community Mental Health Ideology ($F = 28.07$, $p < .05$). Mental health trainees and professionals had lower mean scores on Authoritarianism than did non-mental health trainees and professionals ($M = 2.02$, $SD = .376$ vs. $M = 2.22$, $SD = .494$), higher scores on Benevolence ($M = 4.33$, $SD = .400$ vs. $M = 3.79$, $SD = .606$), lower scores on Social Restrictiveness ($M = 1.90$, $SD = .381$ vs. $M = 2.30$, $SD = .591$), and higher scores on Community Mental Health Ideology ($M = 3.80$, $SD = .482$ vs. $M = 3.31$, $SD = .637$). No significant main effect was found for professional level, and no interaction effect was found between professional level and status.

TABLE 2

Multivariate and Univariate *F* Tests for Professional Level, Status, and Clinical Supervision

	Multivariate Analysis		Univariate Analysis			
Source	Θ	*F*	A *F*	B *F*	SR *F*	CMHI *F*
Professional level	.03	1.22	0.45	1.74	0.00	1.29
Status	.33	14.73*	9.40*	46.61*	26.69*	28.07*
Professional Level × Status	.02	0.98	0.60	0.53	0.15	0.40
Clinical supervision	.13	2.10*	3.72	7.09*	3.51	0.52

Note. Degrees of freedom for multivariate analyses = (1, 188). Degrees of freedom for univariate analyses = (1, 69). A = Authoritarianism; B = Benevolence; SR = Social Restrictiveness; CMHI = Community Mental Health Ideology; Professional level = student versus professional; Status = mental health versus non-mental-health; Clinical supervision = mental health professionals who are currently receiving clinical supervision.
*$p < .05$.

A 2 × 3 × 4 MANOVA (Professional Level [student vs. professional] × Professional Orientation [counseling vs. social work vs. psychology] × Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology) was used to investigate the differences in attitudes toward mental illness and assessed for main effects for professional orientation, main effects for professional level (student vs. professional), and possible interaction effects between professional orientation and professional level. Results indicated that there was no main effect for professional orientation (counseling, social work, and psychology), $F(4, 126) = 1.71$, $p = .152$. There was no main effect for professional level (student vs. professional), $F(4, 125) = 1.06$, $p = .382$, and no interaction effect between professional orientation and professional level, $F(4, 126) = 1.13$, $p = .348$. Because the omnibus multivariate analysis was nonsignificant, univariate follow-up analyses were not interpreted.

A 2 × 2 × 4 MANOVA (Licensure Status × Clinical Supervision Status × Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology) was originally intended to assess the effect of licensure and clinical supervision on attitudes toward mental illness among mental health professionals, as well as an interaction effect between licensure status and clinical supervision status. Because of a small sample of professionals who did not hold a professional license ($n = 1$), however, this factor was taken out of the data analysis. After this change, a MANOVA was run to investigate clinical supervision and its effect on attitudes toward mental illness. A significant difference was found for professionals who were receiving clinical supervision, $F(4, 64) = 2.10$, $p < .05$. Because of the significant results, post hoc univariate analyses were run. These revealed that there was a significant difference between the groups on one of the four CAMI subscales, Benevolence. Mental health professionals who were receiving clinical supervision had higher mean scores on the Benevolence subscale than did mental health professionals who were not receiving clinical supervision ($M = 4.46$, $SD = .345$ vs. $M = 4.21$, $SD = .371$). Results of the multivariate and univariate analyses are presented in Table 2.

Discussion

In previous research, scholars explored mental health professionals' attitudes and found that professionals had some of the same stigmas as did the general population (N. Cohen, 1990; Lauber et al., 2004; Nordt et al., 2006). In this study, a main effect was found for mental health status, suggesting that mental health training, education, and experience resulted in more positive attitudes toward mental illness. Because mental health trainees and professionals seemed to have less stigmatizing attitudes toward adults with mental illness on all of the subscales of the CAMI when compared with non-mental-health trainees and professionals, training programs and experience appear to have a positive effect on attitudes toward adults with mental illness by reducing negative attitudes and increasing positive attitudes.

Furthermore, results from this study suggested that participants who were not associated with the mental health field still held stigmatizing attitudes toward adults with mental illness. Unfortunately, stigma toward adults with mental illness still exists as a long-standing and widespread phenomenon, as authors have suggested in previous literature (Byrne, 2000; Crisp et al., 2000).

Professional level (student vs. professional) did not have a significant effect on attitudes toward mental illness. Earlier research showed conflicting results about factors that might assist with attitudes of mental health professionals toward adult with mental illness, including contact and experience (Procter & Hafner, 1991; Wallach, 2004) and education and training (Bairan & Farnsworth, 1989; Penny et al., 2001). The main effect for status, along with the lack of a main effect for professional level and the lack of an interaction effect between professional level and status, suggested that experience might not play as important a role as education and training. The average age of professionals was approximately 17 years greater than the average age of professionals-in-training (M = 46.85, SD = 11.32 vs. M = 29.68, SD = 8.22), yet there were no main effects.

Professional orientation did not seem to have an effect on attitudes toward mental illness. This may suggest that despite theoretical differences in training programs with conceptualization and treatment of mental illness, these differences in professional orientation might not result in differences in attitudes toward adults with mental illness. In particular, even though counselor training programs are rooted in humanistic theory (Hansen, 1999, 2000b, 2003), counselors-in training did not differ from others regarding attitudes toward this population. Although humanistic perspectives are unique to counselors, the theoretical framework might not manifest itself in different levels of stigma toward adults with mental illness.

Counselor educators might use this information and include other components in courses related to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; American Psychiatric Association, 2000), community counseling, or multiculturalism. For example, it might be beneficial to students for a practicum or contact experience to involve adults with mental illness so that the students are exposed to this population. Requiring that students volunteer at a community agency or homeless shelter to meet clients diagnosed with particular disorders could assist with attitudes. Exposure, along with the underlying humanistic theoretical perspective inherent in counselor training (Hansen, 2000a), might lessen stigma toward adults with mental illness.

The encouraging implications for mental health educators are that mental health trainees and professionals as a group had less stigmatizing attitudes than did those not associated with the mental health field. It is possible that mental health educators are providing training that is contributing to the positive attitudes of mental health students. Alternatively, mental health students might already possess these positive attitudes when they enroll in mental health graduate programs. Results suggested that non-mental-health trainees and professionals had more stigmatizing attitudes than did those associated with the mental health field. Members of the general population still hold attitudes associated with mental illness that might result in internal and external consequences for adults with mental illness, such as secrecy and shame, poor social adaptation, and low self-esteem (Link et al., 2001; Perlick et al., 2001). Mental health trainees and professionals can advocate for adults with mental illness to lessen mental illness stigma and share this information with the general population, as well as those not associated with the mental health field, through national and international advocacy groups.

The lack of significant differences between mental health trainees and professionals also suggests that there is similarity in training and course work across disciplines. Despite

humanistic values being embedded in counselor training (Hansen, 2000a), course work related to diagnosis and treatment for adults with mental illness, common to most mental health training programs, might assist with lessening stigma toward adults with mental illness. Another possibility is that individuals who are drawn to helping professions (counseling, social work, and psychology) already have less stigma toward adults with mental illness when they enter a mental health program.

Clinical supervision had not been previously explored in the literature as it related to attitudes toward adults with mental illness. Results suggested that receiving clinical supervision is an important component of professional work once a mental health professional is in the mental health field. In particular, clinical supervision appears to assist with increasing benevolence, or more kindly, sympathetic attitudes toward adults with mental illness, so that being supervised while in the mental health field is associated with more favorable attitudes among mental health professionals toward mental illness.

It seems that clinical supervision for mental health professionals might serve as a valuable tool for support and coping for working with adults with mental illness. Mental health professionals who work in private practice, for example, might need to make supervision a part of their own routine and meet weekly or monthly with other mental health professionals who are in such a setting. Similarly, mental health professionals in community agencies might advocate for agency standards to include clinical supervision as part of a team meeting or other routine practice. For mental health educators, the importance of clinical supervision during clinical practice can be stressed while trainees are still in mental health training programs so that trainees are entering into the field with this expectation. Educators might also highlight and demonstrate various types of supervision formats such as group, triadic, or individual so that trainees are familiar with each type.

Finally, because supervision is part of most mental health training pro- grams, trainees might have a chance during their degree programs to reflect on their attitudes toward and assumptions about adults with mental illness. After trainees enter the mental health field, however, if clinical supervision is not a part of practice, attitudes and assumptions might not be explored. Results of this study indicate that this type of reflection seems to assist with lessening stigmatizing attitudes, thus suggesting supervision as a helpful tool for both professionals and trainees.

Although this study was intended to investigate differences in attitudes toward adults with mental illness according to professional orientation, no difference was found between the groups. This might have been due to a limited number of participants in each subgroup, particularly counseling professionals-in-training (n = 17). Future research studies might focus solely on mental health trainees rather than professionals and trainees, with an aim of increasing within-group sample sizes. Future research might examine mental health trainees before and after exposure to or training with adults diagnosed with a mental illness to explore attitudes related to mental illness in ways other than the use of self-report data.

Another direction for future research might be exploring whether mental health trainees already hold less stigma than do members of the general population before starting a mental health training program. Previous studies have explored attitudes toward mental illness before and after

a single course during mental health training, thus assuming that attitude changes were a result of the course. Future research, however, might survey students at the beginning of the training program, before starting any course work, and at the end of training, to explore attitudes over time. If attitudes remain the same, this might imply that mental health students naturally possess less stigma and are drawn to helping professions. If this were the case, mental health training and course work might not be as much of a contributor to lessening mental illness stigma as previously assumed.

Because clinical supervision status had an effect on benevolent attitudes toward adults with mental illness, future research might look more closely at how supervision influences such attitudes. Group, triadic, or individual supervision, for example, might have different effects on attitudes toward adults with mental illness. In addition, whether the professional has had clinical supervision at all, or how often, during her or his career might be a related direction for future research, because we only asked whether participants were currently receiving clinical supervision. Finally, researchers might consider whether supervision has a direct impact on stigma or whether the impact is more indirect, mediated by counselor self-efficacy. N. Cohen (1990) asserted that, in many instances, stigma was a coping strategy against a perceived inability to be helpful to clients diagnosed with a mental illness. It is possible, then, that the mechanism through which supervision occasions change is more indirect, with supervision enhancing counseling self-efficacy, which in turn decreases stigma.

In conclusion, it is noteworthy that no differences were found between the mental health disciplines (counseling, social work, and psychology) on attitudes toward persons diagnosed with a mental illness. This was the first study of this nature to include professional counselors in the sample. Overall, mental health professionals and students reported significantly lower levels of stigma than did professionals and students outside mental health fields. Finally, clinical supervision had an effect on level of benevolence. Participants outside the mental health field, however, reported a high level of stigma. Clearly, the work of educating the public and advocating for people diagnosed with a mental illness is far from complete.

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