

Social Distance and Mental Illness: Attitudes Among Mental Health and Non-Mental Health Professionals and Trainees

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Abstract:

Social distance towards adults with mental illness was explored among mental health and non-mental health trainees and professionals. Results suggested mental health trainees and professionals desired less social distance than non-mental health trainees and professionals, and that women desired less social distance than men, with male non-professionals demonstrating the greatest desire for social distance to individuals diagnosed with mental illness. Social distance also is related to attitudes towards adults with mental illness. Implications of such findings are presented.

Keywords: social distance | adult mental illness | mental health professionals | stigma | discriminatory behavior

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Social distance towards adults with mental illness was explored among mental health and non-mental health trainees and professionals. Results suggested mental health trainees and professionals desired less social distance than non-mental health trainees and professionals, and that women desired less social distance than men, with male non-professionals demonstrating the greatest desire for social distance to individuals diagnosed with mental illness. Social distance also is related to attitudes towards adults with mental illness. Implications of such findings are presented.

Keywords: social distance, adult mental illness, mental health professionals, stigma, discriminatory behavior

Stigma has been defined as a product of disgrace that sets a person apart from others (Byrne, 2000). Stigma towards adults with mental illness, defined here as a serious medical condition such as schizophrenia, bipolar disorder, or major depression that disrupts a person's thinking, feeling, mood, ability to relate to others, and daily functioning (National Alliance on Mental Illness [NAMI], 2009), is both a longstanding and widespread phenomenon (Byrne, 2000; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Researchers seem clear that stigma still exists as a detrimental occurrence in the lives of those diagnosed with a mental illness (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Link, Yang, Phelan, & Collins, 2004; Perlick et al., 2001). In fact, some have argued that the impact of mental illness stigma is so immense that the stigma can be as damaging as the symptoms (Feldman & Crandall, 2007). In the last decade, there have been attempts to highlight to the general population the topic of stigma towards adults with mental illness. For instance, Surgeon General David Satcher spoke in a recent report of the need to recognize stigma as a barrier within the field of mental health. He 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 the mental illness stigma literature, authors have used the construct of social distance (the proximity one desires between oneself and another person in a social situation) to assess expected discriminatory behavior towards adults with mental illness (Baumann, 2007; Link & Phelan, 2001; Marie & Miles, 2008). Scholars have described low social distance as characterized by a feeling of commonality, or belonging to a group, based on the idea of shared experiences. In contrast, high social distance implies that the person is separate, a stranger, or an outsider (Baumann, 2007). It has been suggested that social distance research can provide valuable insight into factors that influence mental illness stigma (Marie & Miles, 2008).

Social Distance and Non-Mental Health Professionals

Factors that are associated with social distance in the general population towards adults with mental illness have been discussed in the literature (Corrigan, Backs, Edwards, Green, Diwan, & Penn, 2001; Feldmann & Crandall, 2007; Hinkelman & Haag, 2003; Marie & Miles, 2008; Penn, Kohlmaier, & Corrigan, 2000; Phelan & Basow, 2007; Shumaker, Corrigan, & Dejong, 2003). One such factor that has been studied as it relates to social distance is gender, both of the target (person with the mental illness) (Phelan & Basow, 2007) and perceiver (person who desires social distance) (Hinkelman & Haag, 2003; Marie & Miles, 2008; Phelan & Basow, 2007).

Researchers (Marie & Miles, 2008; Phelan & Basow, 2007) have found that women tend to be more willing than men to engage in a relationship with someone diagnosed with depression. Marie and Miles (2008) investigated familiarity of the perceiver with various mental illnesses. A significant main effect was found for gender, with women perceivers rating the characters in vignettes as more dangerous than men participants (Marie & Miles, 2008). Phelan and Basow (2007)

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found that gender of the target character was a significant predictor of social distance, with female targets being more socially tolerated than male targets. This may be due to the fact that participants perceive male characters in vignettes as more dangerous than female characters. Hinkelman and Haag (2003) also have assessed how gender and adherence to strict gender roles impact attitudes toward mental illness. Interestingly, adherence to strict gender roles rather than gender was related to attitudes about mental illness. Those with strict gender roles were less likely to have positive attitudes. Thus, gender alone did not account for differences in attitudes; instead it was gender roles that related to attitudes towards mental illness.

Social Distance and Mental Health Professionals

Researchers have suggested that stigma also exists among mental health professionals (Lauber, Anthony, Ajdacic-Gross, & Rossler, 2004; Nordt, Rossler, & Lauber, 2006). Lauber et al. (2004) found no significant differences between psychiatrists and the general population on their preferred social distance from people with a mental illness. Both psychiatrists and the general population indicated that the closer the psychological proximity (e.g., allowing the person with mental illness to marry into their family compared to working with someone with a mental illness), the more social distance they desired. Similar results were found when comparing mental health professionals (i.e., psychiatrists, psychologists, nurses, social workers, and vocational workers) and the general population regarding social distance attitudes (Nordt et al., 2006). Both professionals and the general public reported many stereotypes about mental illness, and wanted an equal amount of social distance towards a mentally ill character in a vignette. Professionals, however, endorsed to a much lesser degree that adults with mental illness should have restrictions to rights such as voting or marriage. The public significantly accepted the restriction of the right to vote more than each professional group.

Professional Counselors and Social Distance

Although professional counselors might work in the same settings as other mental health professionals, the training background of this subgroup includes some noteworthy differences. Relative to other mental health disciplines, counselor training programs are largely, but not exclusively, grounded in developmental perspectives and strength-based orientations (Ivey & Ivey, 1998; Ivey, Ivey, Myers, & Sweeney, 2005; Ivey & Van Hesteren, 1990) as well as humanistic values and assumptions (Hansen 1999, 2000b, 2003), with a primary focus on the counseling relationship. Given these substantial differences as well as authors' (Lauber et al. 2004; Nordt et al., 2006) suggestions that it is idealistic to assume that stigma does not exist among mental health professionals, it is important to consider counselors in comparison to other mental health professions and the general public. Further, particular types of counseling programs (clinical mental health counseling or school counseling) might differ when compared to each other on stigma towards adults with mental illness, given the variations of curriculum and clinical training associated with each.

Previous researchers have examined psychiatrists, psychologists, and social workers, but not professional counselors. Professional counselors should be included in this type of empirical examination, as professional counselors have reported that they are seeing more clients in severe distress (Ivey et al., 2005). Additionally, although attitudes towards mental illness and social distance have been examined in the literature, the relationship between these constructs has not been examined using the current study's instruments. Further, researchers have not examined simultaneously the attitudes and desired social distance of students. Thus, the purpose of this study was to gain a more comprehensive understanding of social distance by including counselors and counseling students in addition to other mental health professionals and students, non-mental health professionals, and students outside of a mental health discipline.

The following research questions (RQ) were developed to organize this study:

- (RQ1) What differences exist in social distance toward adults with mental illness between mental health professionals in-training, non-mental health professionals in-training, mental health professionals, and non-mental health professionals?
- (RQ2) What differences exist in social distance toward adults with mental illness between mental health trainees and professionals based on professional orientation (i.e., counseling, social work, or psychology)?
- (RQ3) What differences exist in social distance towards adults with mental illness between mental health trainees and professionals based on gender?
- (RQ4) What is the relationship between social distance and other attitudes toward adults with mental illness?

Method

Participants: The total sample included 188 participants. Of these, 62.8% ($n = 118$) were female and 37.2% ($n = 70$) were male. The majority of respondents described themselves as Caucasian (89.4%, $n = 168$) with other participants identifying as African American (4.2%, $n = 8$), Asian Pacific Islander (2.1%, $n = 4$), Hispanic (2.1%, $n = 4$), Multiracial (1.1%, $n = 2$), and other (1.1%, $n = 2$). Age of participants ranged from 21 years to 65 years ($M = 39.63$, $SD = 13.23$). Response rate of the participants could not be determined, since participants responded to the survey online via a link provided in an email.

The total sample was divided into four subgroups. 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 mid-sized university in the southeast United States. Business students ranged from 21 to 53 years of age ($M = 36.05$, $SD = 9.19$).

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

The third subgroup included 76 mental health professionals who self-identified as counselors ($n = 24$), social workers ($n = 20$), or psychologists ($n = 32$) who were working in the mental health field and had been employed as such for a minimum of one year. Professional counselors ranged in age from 27 to 61 ($M = 45.42$, $SD = 10.79$), professional social workers ranged in age from 28 to 64 ($M = 53.30$, $SD = 9.45$), and professional psychologists ranged in age from 28 to 65 ($M = 47.16$, $SD = 12.25$). Mental health professionals ranged in years of mental health experience from one 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 southeast United States. Only professional level participants were included in this group to provide some control for education level as a potential confounding influence. Non-mental health professionals ranged in age from 25 to 64 ($M = 43.76$, $SD = 10.62$).

Instrumentation

Social Distance Scale. Social distance was measured by a modified version of a Social Distance Scale developed from the World Psychiatric Association Programme to Reduce Stigma and Discrimination Because of Schizophrenia (2001). Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, and Kola (2005) modified this scale to assess social distance regarding attitudes toward mental illness, as the original scale was designed to measure social distance specifically towards adults with schizophrenia. Gureje et al.'s modified version was used in the current study. Six statements assess various levels of intimacy. For example, the first question asks, "Would you feel afraid to have a conversation with someone who has a mental illness?" Answers are given on a 4-point likert-type scale ranging from definitely (1) to definitely not (4). Item scores are added together to get a total social distance score, with high scores indicating less social distance and lower scores indicating more social distance. The Social Distance Scale had sufficient evidence of internal consistency ($\alpha = .81$) with the current sample.

Community Attitudes Toward the Mentally Ill. The Community Attitudes Toward the Mentally Ill (CAMI; Taylor & Dear, 1981) was used to assess attitudes towards adults with mental illness. The CAMI was developed from the Opinions of Mental Illness Scale (OMI; Cohen & Struening, 1962) and is a 40-item self-report survey that uses a 5-point likert-type scale (5 = "Strongly agree" to 1 = "Strongly disagree"). Four scales are included on the CAMI: Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology. Authoritarianism is defined by 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, or the belief that adults with mental illness should get treatment, but not in close

proximity to me (Taylor & Dear, 1981).

Evidence for internal consistency of the CAMI was clear for three of the four scales with the current sample: Community Mental Health Ideology ($\alpha = .86$), Social Restrictiveness ($\alpha = .80$), and Benevolence ($\alpha = .81$). Only the Authoritarianism subscale ($\alpha = .62$) was problematic in this research.

Marlowe-Crowne Social Desirability Scale. The Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) was included in order to assess the extent to which participants were answering in a socially desirable manner to further validate the attitudes captured by the CAMI and the Social Distance Scale. The MCSDS is the most commonly used social desirability assessment (Leite & Beretvas, 2005) and has demonstrated strong reliability. The original authors obtained a Kuder-Richardson reliability coefficient estimate of .88 (Crowne & Marlowe, 1960). A Cronbach's alpha of .85 with the current sample provides evidence of reliability with this sample.

Procedure

Potential participants were invited to respond to the survey via electronic email. Email addresses of potential mental health professional participants were obtained from comprehensive statewide lists of the various subgroups of interest. To collect the sample of students, graduate students were contacted via various departmental listservs. Non-mental health professionals were reached through an alumni listserv obtained from a non-mental health training program. Participants were told that the following survey was designed to investigate attitudes towards adults with mental illness. Included in the email was a link to the survey, which was housed at a commercial online site for electronic survey research.

Results

As a preliminary analysis, scores on the Social Distance Scale and the CAMI were correlated with scores on the MCSDS to investigate whether participants were answering in a socially desirable manner. It has been suggested by authors (Leite & Beretvas, 2005) that a low correlation between the Marlowe-Crowne Desirability scale and the scale of interest indicates honest responses. No scores of interest correlated significantly at a .05 level with scores on the MCSDS. This provides evidence that social desirability did not have a substantive role in participant responses and that participants answered questions on the Social Distance Scale and the CAMI with a reasonable level of honesty.

To answer RQ1 and RQ3, a 2 X 2 X 2 ANOVA (professional level [trainee vs. professional] X status [mental health vs. non-mental health] X gender [female vs. male] X Social Distance) was used to investigate the desired social distance toward people with a mental illness. This analysis assessed for main effects based on professional level (trainee vs. professional), main effects based on status (mental health vs. non-mental health), main effects based on gender (female vs. male), and possible interaction effects between professional level, status, and gender. There was a significant main effect found for status $F(1, 184) = 16.44, p < .05, \eta^2 = .08$. Mental health trainees and professionals had higher mean scores on the Social Distance Scale ($M = 3.4, SD = .38$) than non-mental health trainees and professionals ($M = 3.0, SD = .54$). Results indicated a main effect for gender $F(1, 184) = 6.63, p < .05, \eta^2 = .04$. Women desired less social distance than men ($M = 3.38, SD = .39$ vs. $M = 3.13, SD = .54$) and an interaction effect for gender X mental health status $F(1, 184) = 12.17, p < .05, \eta^2 = .07$. Marginal means revealed that the non-mental health male sub-group was most important in separating the groups. There were no other significant main or interactive effects.

A 2 X 3 ANOVA (professional level [trainee or professional] X professional orientation [counseling, social work, psychology] X Social Distance) was used to investigate the differences in desired social distance. Results indicated that there was a main effect for professional orientation $F(2, 184) = 17.67, p < .05, \eta^2 = .16$. Univariate follow-up analyses indicated that participants with the professional orientation of counselor and psychologist desired significantly less social distance ($M = 3.40, SD = .34; M = 3.40, SD = .4$, respectively), than those who identified as social worker and non-mental health professional ($M = 2.89, SD = .62; M = 3.06, SD = .49$).

Finally, although attitudes towards mental illness and social distance have been discussed in the literature (Gureje et al., 2005; Taylor & Dear, 1981), the relationship between attitudes towards mental illness and social distance towards mental illness had not been explored using the CAMI and the Social Distance Scale. Therefore, bivariate correlations were

calculated. Because multiple bivariate correlations were being conducted, a more stringent alpha level of .01 was used. There was a significant negative relationship between social distance and Authoritarianism ($r(186) = -.52, p < .01$) and social distance and Social Restrictiveness ($r(186) = -.64, p < .01$). There was a significant positive relationship between social distance and Benevolence ($r(186) = .51, p < .01$) and social distance and Community Mental Health Ideology ($r(186) = .60, p < .01$).

Discussion

Previous researchers have examined social distance attitudes of mental health professionals and trainees with samples of psychiatrists, psychologists, and social workers, but not professional counselors. In addition, researchers had not examined simultaneously the attitudes and desired social distance of students. Both the mental health professional group and the mental health trainee group included professional counselors, a group previously excluded from this research.

Authors had suggested that those associated with the mental health field hold the same social distance attitudes towards adults with mental illness as the general population (Lauber et al., 2004; Nordt et al., 2006). Results of the present study suggested that non-mental health trainees and professionals desired more social distance than those associated with the mental health field. This implies that members of the general population hold more negative attitudes toward those with mental illness than mental health professionals and trainees. These results are encouraging and imply that training programs and experience might have a positive effect on reducing social distance towards adults with mental illness. Regarding gender and social distance, a consistent finding in previous research (Marie & Miles, 2008; Phelan & Basow, 2007) suggested that women desired less social distance than men from those diagnosed with mental illness. Results from this study are consistent with those findings.

Since mental illness stigma can be as damaging as the symptoms (Feldman & Crandall, 2007), professional counselors can advocate for adults with mental illness in order to lessen stigma. These messages can be shared with the general population through national groups such as the National Alliance for the Mentally III and the National Mental Health Association, as well as through international programs such as the World Health Organization and NBCC International's Mental Health Facilitator Program. Further, professional counselors might broach the topic of social distance with their clients, as sharing thoughts and feelings related to discrimination as a result of stigma might be therapeutic for those who are dealing with the phenomenon.

Professional orientation was of particular interest in this study. As counselors come from distinct training programs that largely, but not exclusively emphasize developmental perspectives and strength-based orientations (Ivey & Ivey, 1998; Ivey et al., 2005; Ivey & Van Hesteren, 1990), how this subgroup compared to other disciplines was of interest. If there were noteworthy differences in the ways in which professional counselors viewed adults with mental illness, for example, results could serve as an indication that counselor training is indeed unique in the way that professional counselors view clients, as the aforementioned literature has suggested.

Findings suggested that professional counselors and psychologists desired less social distance than both social workers and non-mental health professionals. Despite distinguishing aspects of counselor training (i.e., developmental, strength-based orientation), however, there were no significant differences in attitudes of professional counselors and counselor trainees when compared to those in the psychology field. The lack of difference between counselors and psychologists may be attributed to similarities in training. Alternatively, though, it may be that the types of people drawn to counseling and psychology programs are more similar than different, and that the similarities might not be based on training.

Social work trainees and professionals and non-mental health professionals desired significantly more social distance. This might imply that there are some fundamental differences in the training and coursework of social workers as compared to other professional orientations. For example, it is possible that the focus on macrosystems, more uniquely the purview of social work, leads to an external orientation to change relative to an individual or microsystem approach more common to counseling and psychology. Thus, this focus on larger systems might be a differentiating factor related to proximity to persons with mental illness. Conversely, training and coursework might not be differentiating factors related to social distance. Perhaps students already possess social distance preferences when they enter into mental health training programs.

Of particular interest was how the gender of mental health professionals impacted desired social distance towards adults with mental illness. There was a significant main effect found for status as well as for gender. This finding is consistent with previous literature (Marie & Miles, 2008; Phelan & Basow, 2007) that suggested that women desired less social distance than men from those diagnosed with mental illness. In addition, there was an interaction between the two variables. The social distance scores of women were highly similar between mental health professionals and non-mental health professionals. For men, however, there was a substantive gap based on status. Men who were not mental health professionals desired the highest level of social distance. Although there is a within-group difference, this suggests that targeted advocacy efforts might be tailored to men in the general population who seem to desire a greater social distance from people diagnosed with mental illness.

This study looked at social distance attitudes of participants as one group in order to explore the relationship social distance had with other attitudes towards mental illness. It seems that social distance and other attitudes towards mental illness are related. All correlations were in the hypothesized direction. There was a significant negative relationship between social distance and both Authoritarianism and Social Restrictiveness. There was a significant positive relationship between social distance and both Benevolence and Community Mental Health Ideology. This is because higher social distance scores indicate less social distance while higher mean scores on the CAMI indicate more of each attitude. Scores on the more negative attitude subscale of the CAMI, such as Authoritarianism and Social Restrictiveness were related to more social distance, while more positive attitudes on the CAMI such as Benevolence and Community Mental Health Ideology were related to less social distance.

This implies that social distance, or proximity to adults with mental illness, can be related to attitudes. People who hold more negative attitudes towards mental illness, such as Authoritarianism (belief that people with mental illness are inferior) and Social Restrictiveness (limiting the rights for people with mental illness) might manifest this in behavior such as the desire for more social distance. More positive attitudes towards mental illness such as Benevolence (a kindly or sympathetic attitude towards mental illness) and Mental Health Ideology (the belief that mental illness deserves treatment but “not in my back yard”) are related to the desire for less social distance. Those who hold a more positive attitude towards adults with mental illness will tend to be more comfortable with situations such as working at the same place of employment or maintaining a friendship with someone with a mental illness. Since the two constructs are related, perhaps advocacy efforts need to be geared towards both attitudes and social distance in order to combat mental illness stigma. For example, only focusing on attitudes might miss the proximity associated with stigma toward an adult with mental illness. These efforts might especially be geared towards those in the general population, since this study suggested that non-mental health professionals and students desired the most social distance.

Mental health professionals of any type can begin to consider social distance as it relates to attitudes towards adults with mental illness, since the construct of social distance can be used to assess expected discriminatory behavior towards adults with mental illness (Baumann, 2007; Link & Phelan, 2001; Marie & Miles, 2008). As well, professional counselors might begin to explore their own comfort level with proximity and closeness to adults with mental illness, since it relates to attitudes. Counselor educators might consider including people with mental illness as a marginalized group in multicultural training and challenging students to examine their knowledge and self-awareness related to mental illness. Although results of this study suggested that mental health professionals desired less social distance than those in the general population, other recent research has suggested that it would be too simplistic to assume that mental health professionals do not indeed hold stigmatizing attitudes (Nordt et al., 2006).

Limitations and Future Directions

As with all research, the current study has limitations that both contextualize the findings and provide direction for future research efforts. First, replication with larger and more diverse samples is warranted. It is unknown the extent to which respondents in this study differ from non-respondents. In particular, it is possible that there is a systematic bias (either positive or negative) among those who chose to respond to the study request. Future researchers should include a more racially diverse sample, as these findings are based on the responses of participants who largely identified as Caucasian.

Additionally, replication and extension efforts are warranted that use alternative methods of measuring social distance, which is important for at least two reasons. First, the current study relied solely on self-report and, although

responses were not overly influenced by social desirability, it is unknown to what extent a mono-method bias exists. Future researchers could use other methods of assessing social distance to account for this potential bias. Furthermore, the present study is limited because of the cross-section scope of the data. Scholars interested in social distance might longitudinally examine mental health trainees before and after training to better understand the developmental nature of social distance and stigma towards adults with mental illness. Specifically, it would be useful to know what types of experiences impact one's desired social distance and stigma. Such a longitudinal study also would provide information about whether mental health trainees enter their training program already desiring less social distance than the general population. While previous researchers explored attitudes towards mental illness before and after a single course during mental health training, thus assuming attitude changes were a result of the course, future research might survey students at the beginning of the training program, before starting any coursework, and at the end of training in order to investigate social distance over time. If desired proximity remains the same, this might imply that mental health students naturally possess less stigmatizing attitudes and are drawn to helping professions rather than assuming that low levels of desired social distance are an artifact of training. Further, future research could examine different types of counseling students, so that any differences related to particular types of counseling programs (i.e., clinical mental health counseling or school counseling) would be revealed. Given the variations of curriculum and clinical training associated with each, differences in attitudes might suggest attitude changes as a result of curriculum and training.

The topic of gender and social distance may be an area for continued study. Qualitative designs might assist researchers in gaining a deeper understanding of desired social distance of men and women, and whether gender is most important in understanding desired social distance with adults with mental illness. Depending on themes that might arise related to social distance, counselors can aim advocacy efforts and anti-stigma campaigns to assist with this.

Conclusion

Many people have attempted to highlight to the public that stigma towards adults with mental illness is as damaging to those diagnosed as the illness itself. Missing, however, is a comprehensive understanding of the stigma process. In this study, the focus was on social distance as it relates to stigma towards adults with mental illness. Factors such as mental health training, professional orientation, and gender seem to result in differences related to social distance. Individuals not associated with the mental health field continue to have mental illness stigma, as previous research suggested. Results of the current research can assist in a deeper understanding of the factors involved in the phenomenon. With a deeper understanding of social distance and stigma, practitioners can create advocacy efforts and targeted interventions with the overall goal of eradicating mental illness stigma.

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