Social Work Students' Endorsement of Recovery-Oriented Principles and Practices When Working with Consumers Diagnosed with Severe Mental Illness

Jennifer M. Nikou

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SOCIAL WORK STUDENTS’ ENDORSEMENT OF RECOVERY-ORIENTED PRINCIPLES AND PRACTICES WHEN WORKING WITH CONSUMERS DIAGNOSED WITH SEVERE MENTAL ILLNESS

By

JENNIFER NIKOU

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirement for the degree of Doctor of Philosophy, The City University of New York

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of dissertation requirement for the degree of

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Social Work Students’ Endorsement of Recovery-Oriented Principles and Practices When Working With Consumers Diagnosed with Severe Mental Illness

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Advisor: Jonathan Prince, Ph.D.

In this study, I examined the extent of endorsement of recovery-oriented principles and practices by conducting both a pilot and final study of 143 total social work students in the Masters of Social Work program in an urban school in the Northeast. I explored five variables highlighted in the literature as most frequently influencing extent of endorsement of recovery-oriented principles and practices when working with consumers diagnosed with serious mental illness (SMI). These included knowledge of severe mental illness (mental health literacy), social contact (social distance), concerns regarding safety (dangerousness), knowing someone diagnosed with mental illness (familiarity), and having more than 5 years of employed experienced working with people diagnosed with SMI. A survey design measured these variables, and included four existing instruments: Recovery Knowledge Inventory (Bedregal, O’Connell, & Davidson, 2006); Social Distance Scale (World Psychiatric Association Programme to Reduce Stigma and Discrimination Because of Schizophrenia, 2001); Dangerousness Scale (Link, Cullen, Frank, & Wozniak, 1987); and four vignettes with corresponding questions from the MacArthur Mental Health Module (as part of the General Social Survey in 1996) and the National Survey of Mental Health Literacy. The vignettes were only employed in the final study.
Findings indicated that race and the number of semesters completed in the MSW program were statistically significant. Asian and African Americans reported less endorsement of recovery-oriented principles and practices than other races. The extent of endorsement of recovery knowledge was found to improve the more semesters completed, suggesting that recovery knowledge of professionals in training may improve as their level of knowledge increases. A clinically significant finding pertaining to mental health literacy emerged, indicating that some participants reported less knowledge of psychiatric conditions. Notably, many of the participants who scored lower on the vignettes measuring mental health literacy had completed fewer semesters in the program.
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CHAPTER I: INTRODUCTION AND PROBLEM FORMULATION

In 2014, people diagnosed with mental illness in the US reached nearly 44 million or 18.1% of all adults (Center for Behavioral Health Statistics and Quality, 2015). Of these, nearly 10 million were diagnosed with a severe mental illness (Center for Behavioral Health Statistics and Quality, 2015). The Substance Abuse and Mental Health Services Administration (SAMHSA) found 6 million people diagnosed with severe mental illness (SMI) sought and received treatment over the course of that year (SAMHSA, 2012). However, many did not seek treatment. Reasons people diagnosed with SMI cited for not accepting treatment included professionals’ lack of endorsement of recovery concepts deemed significant by consumers for recovery such as right to self-determination, individualized goal setting, and consumer autonomy (SAMHSA, 2012).

Different professional groups have different perspectives about the etiology of mental illness, and treatment of SMI has changed over time. Physiological interventions from trepanning to electroconvulsive therapy (ECT), to reducing environmental stressors, and addressing the impact of underlying psychological distress are among treatments cited in the literature (Starnino, 2009). The inhumane nature of early interventions and unsanitary conditions of asylums designed to treat people diagnosed with mental illness prompted advocates such as Dorothea Dix to introduce a humanitarian perspective when assisting people with mental illness. This began the mental hygiene movement of the early 1900s (Kemp, 2007). During this period, advances in science in conjunction with the introduction of psychotherapy proposed that mental illness resulted from the person’s interaction with their environment. Psychotherapy addressed underlying problems and considered the dynamic relationship between the patient and their
external environment (Kofman, 2012). Psychotherapy was useful for exploring underlying feelings; however, severe symptoms, such as hallucinations and delusions, remained problematic.

Psychotropic medications emerged during the 1950s. Medications proved effective for symptom management for people with severe symptoms who did not respond to psychotherapy alone (Kofman, 2012). The combination of psychotherapy and medication management assisted in managing severe mental illnesses, although the two treatment approaches lacked a comprehensive stance towards treatment and recovery. This treatment approach did not consider social needs such as housing, employment, social supports, and concrete resources (Kofman, 2012).

Towards the end of the 20th century, mental health professionals began to address these issues. The community support movement acknowledged the bio-psychosocial needs of people diagnosed with SMI not addressed by previous practice models (Kofman, 2012). This new model encouraged equality and advocated for housing, vocational, and educational needs of people diagnosed with SMI. During this time, social workers, in particular, assisted patients with meeting these basic needs through case management interventions (Grob, 1994). Treatment expanded to include other areas considered relevant to the patient; however, consumers of mental health services continued to advocate for additional changes not otherwise met by the bio-psychosocial model.

**Current Approach towards Treatment: The Recovery Model**

In the 21st century, the focus of recovery shifted. Because of the consumer movement, people with SMI no longer identified themselves as “patients” (Anthony & Ashcraft, 2010);
instead, they identified as “consumers.” This differed from earlier movements, which placed little emphasis on consumer participation and collaboration in mental health treatment. According to William Anthony (1993), a pioneer of the current recovery movement, professionals should assist in recovery and avoid taking an authoritative stance towards the consumer. Social supports selected by consumers are wide and varied. In this Recovery Model, the eradication of psychiatric symptoms is not necessary for recovery to occur. Consumers do not view recovery as linear and see setbacks as part of the process. They strive for autonomy and personal growth. This perspective on recovery incorporates the mental, emotional, spiritual, and physical elements of an individual, and is a more comprehensive perspective on recovery.

Key elements of the Recovery Model include concepts such as hope, empowerment, advocacy, life beyond a mental illness, and self-responsibility. These concepts suggest that having greater control over one’s recovery positively influences the process. Subsequently, consumers are able to create satisfying lives reflective of their decisions, desires, and interests (Frese, Knight, & Saks, 2009).

In the Recovery Model, consumers’ goals focus on creating meaning and purpose outside of their mental illness. A purpose-driven life encompasses different facets deemed significant by the consumer. These facets may include finding employment, pursuing a degree, establishing new relationships, creating intimacy and connection, and becoming a contributing member of society. Consumers emphasize that goals are specific to the person, created by the person, and reflect subjective pursuits (Anthony & Farkas, 2012).

Consumers achieve recovery through a transformative process consisting of different factors. Re-defining the self or creating a new identity is a significant part of the Recovery
Model. The person makes decisions in their daily lives, which reflect their efforts at inventing a new self. This may include trying new hobbies, tackling professional or vocational endeavors not previously considered or pursued, joining clubs of interest, increasing interactions with different people, and advocating for change (Frese et al., 2009).

**Person-Centered Elements of the Recovery Model**

**Hope**

Frequently highlighted in the literature, hope is a defining feature of the Recovery Model (Davidson et al., 2005; Fukui et al., 2011). At its most basic level, hope is a person’s belief that recovery is feasible (Deegan, 1988). Hope encourages a person to recognize and accept that a problem exists, while promoting a future-oriented approach towards resolving the problem. Weaknesses are regarded as challenges or adversities to overcome, while strengths foster the courage to overcome them. Since chronic illnesses, such as the diagnosis of a severe mental illness, often prompt feelings of helplessness, hope restores one’s faith in recovery. Hope sustains the person during periods of relapse and hardship, serving as a reminder for the person diagnosed with SMI that recovery is attainable (Deegan, 1988).

**Empowerment**

Empowerment arises in an effort to regain a perceived loss of control and address feelings of helplessness often experienced by people diagnosed with severe mental illness (Jacobson & Greenley, 2001). There are three components of empowerment cited in the literature: autonomy, courage, and responsibility. Autonomy is the ability to make independent decisions and serve as one’s own agent. Courage implies a willingness to take risks and advocate on one’s own behalf, aware of the consequences of one’s actions. Lastly, responsibility is synonymous with
accountability or recognizing one’s own role in the recovery process (Jacobson & Greenley, 2001).

**Life beyond Mental Illness**

Moving beyond mental illness is another key element of the Recovery Model. Studies have found that participants identified the attitudes of professionals most helpful when they promote recovery as living a life beyond mental illness (Legere, 2007). This illness includes acclimating to societal roles and expectations, engaging in activities of daily living, healthy participation in meaningful relationships, and risk taking. Relationships with mental health professionals are significant, because continued engagement in treatment is part of the Recovery Model (Jacobson & Greenley, 2001). In essence, this element encourages the transition from the role of a “sick” person to one of “good” health and improved quality of life.

**Role of Professionals in the Recovery Model**

Although the aforementioned factors of the Recovery Model primarily represent the consumers’ perspective, many consumers assert that professional adherence to these tenets is important for consumer recovery. The attitudes of mental health professionals toward treatment and recovery among people diagnosed with SMI may influence consumer outcomes positively or negatively (Bjorkman, Angelman, & Jonsson, 2008). For instance, professionals who demonstrate a negative attitude towards people diagnosed with SMI may have low expectations of their abilities to recover. In addition, these professionals may not develop effective working partnerships with consumers (Zellman, Madden, & Aguiniga, 2014), minimizing the value of the client-worker relationship within the Recovery Model.
Stigmatizing attitudes by professionals also create barriers to promoting consumer empowerment and proactivity, both of which are vital components of the Recovery Model (Starnino, 2009). Professionals who report stigmatizing attitudes describe their work with consumers as less desirable (Ridgway, 1999). This attitude, in turn, is reflected in approaches toward consumer care and selected interventions (Starnino, 2009). Professionals may employ interventions that are less time consuming and challenging for both the professional and consumer to execute and apply because they believe that recovery is limited (Zellman et al., 2014).

Social Work and the Recovery Model

The profession of social work dates to the 19th century, and its involvement in the mental health field began in 1906 with the establishment of a division in the Social Service Department of the Massachusetts General Hospital where they worked with people diagnosed with mental illness (Aviram, 2002). Psychiatric social workers primarily provided aftercare treatment for patients discharged from hospitals. With the advent of World War I in 1914, psychiatric social work was recognized for its role in the care and treatment of returning soldiers beyond that of discharge planning services. Training programs surfaced in psychiatric casework at Smith College in 1918 and at the New York School of Social Work in 1919, producing qualified and trained graduates in the specialty of psychiatric social work (Aviram, 2002).

During the 1920s, the social work profession adopted the psychiatric approach as the basis for social casework (Wenocur & Reisch, 1989). Over the next three decades, a market for social work among the growing middle class emerged. Mental health institutions and community agencies hired social workers to provide services for patients, families, and communities. In
addition, social workers facilitated discharge and aftercare planning for patients returning to the community following care in institutions (Aviram, 2002). Social work practice continued to flourish after World War II, and the National Institute of Mental Health (NIMH) provided new opportunities for psychiatric social workers. The NIMH also affected social work education, influencing the development of accrediting bodies (Aviram, 2002). The focus for social workers to attend to case management-oriented tasks such as discharge planning at that time, differs from the current Recovery Model, which encourages professionals to offer services that are not only concrete such as empathic listening (Starnino, 2009).

In 1952, the Council on Social Work Education (CSWE) became the accrediting body for graduate MSW programs. By the end of the 1970s, CSWE published a 13-volume evaluation with recommendation for improved social work education known as the Social Work Curriculum Study, indicating the profession’s need and desire to continue for definition (White, 2008). CSWE continues to accredit social work educational programs, determining a need for continuing growth and development.

Currently, there are 235 accredited MSW programs in the US; they are designed to prepare and educate future professionals (CSWE, 2016). Among the many schools and universities that prepare mental health professionals, social work programs prepare the largest number of direct mental health service providers serving the SMI population (Eack & Newhill, 2008). Social workers hold approximately 607,000 jobs working with individuals diagnosed with SMI. Of the 607,000 jobs held by social workers, 41% worked in state and local governments, 31% worked in hospitals (state, local or private), and 27% worked in ambulatory health care services (United
States Department of Labor, 2012). These figures do not reflect social workers in private practice.

Social workers serve the most vulnerable, stigmatized populations in society (Buckles et al., 2008). Since the Recovery Model is endorsed by state and federal entities, it is important for educational and training programs to support the education of students in the recovery.

According to Zellman et al., “The role of social work education is to prepare knowledgeable, competent, and self-aware workers who are capable of providing effective services, reflective of consumers’ desired goals” (Zelman et al., 2014, p. 660).

The Recovery Model promotes the provision of consistent and comprehensive services. This perspective strives to meet the needs of marginalized members of society on both practical and psychological levels. Along with providing direct services to individuals, families and communities, social justice is a principle social workers seek to achieve by challenging social injustices (Buckles et al., 2008). The Recovery Model supports consumer advocacy and empowerment, challenging laws and policies that stigmatize disabled members of society. Consumers advocating for equality may seek assistance from professionals such as social workers, or a consumer may choose to engage in self-advocacy.

Social work values and principles align closely with the Recovery Model. These values include equality, social justice, dignity, worthiness, cultural competency, and self-determination (Buckles et al., 2008). The overlap between social work values and the Recovery Model suggests that social workers and social work students should embrace a recovery perspective when working with consumers. Although social work values and principles may serve as the underpinning for different interventions, they may not consistently be applied. In addition, social
work interventions have been guided by different theoretical orientations over time, not all of which have supported the values and principles of the current Recovery Model.

For example, during the 1950s, social workers embraced the medical model. This model asserts that mental illness is a psychiatric condition with a physical origin (Davidson et al., 2005). As a result, social workers turned towards scientific basis to guide their interventions. Psychiatry served as the cornerstone for social workers, and medical learning guided diagnosis, which dictated the treatment approach utilized by social workers (Schulman, 2005). Simultaneously, psychiatrists oriented towards treatment in the community began to evaluate the existing medical model, finding fault in its approach towards treatment and recovery. As a result, a shift in perspective emerged as psychiatrists viewed integration of psychiatric patients in the community through a social lens and not a strictly medical lens. This produced an alignment in perspective between social workers and psychiatrists as both disciplines began to view recovery in a new way (Kirk, 2005). However, authors such as Kirk (2005), suggest that some social workers continue to identify with the medical model, thus minimizing the application of social work values that are consistent with the Recovery Model. As a result, it is unclear whether social workers and social work education support a recovery perspective. My study sought to explore the extent to which social workers in training endorsed and intended to practice according to the values and principles most commonly associated with the current Recovery Model.

**Research on Social Work Education**

Early studies about social work education found many social work students demonstrated negative attitudes and were reluctant to work with people diagnosed with SMI (Krumri-Nuvo &
Weiss, 2006). Rubin and Johnson (1984) found that students reported a strong interest in providing therapy; however, they selected not to work with people diagnosed with SMI. In contrast, Butler (1990) reported student interest in working with stigmatized populations such as people diagnosed with schizophrenia. Within the past ten years, Krumer-Nevo and Weiss (2006) found that students demonstrated a stronger interest in working with consumers capable of change, reflecting their need to believe that their work was effective as well as meaningful.

Students’ concerns about working with people diagnosed with SMI may be explained in part by a lack of mental health literacy (Eack & Newhill, 2008), coupled with fears about their safety (Happell, Robins, & Gough, 2008). In addition, a lack of personal and professional contact with people diagnosed with SMI may also contribute to a lack of desire to work with the population (Eack & Newhill, 2008). Concerns pertaining to safety and degree of social contact (Rubin & Johnson, 1984) are factors influencing professionals-in training endorsement of recovery-oriented principles and practices, and the Recovery Model. Recent studies, however, indicate social work students are more accepting of work with people diagnosed with SMI than in the past, there are inconsistencies across the limited research in this area (Butler, 1990; Krumer-Nevo & Weiss, 2006).

Because the extent to which mental health workers endorse recovery-oriented principles and practices can adversely influence consumer outcomes (Bjorkman et al., 2008), understanding the particular factors that most frequently influence extent of endorsement of recovery practices is important. Although studies on the extent of endorsement of recovery-oriented principles and practices of mental health professionals toward people diagnosed with SMI are plentiful in the literature (Challapalli Sri, 2011; Hugo, 2001; Smith, 2008), studies on social work students’
extent of endorsement towards recovery principles and practices are much less frequent. My review of the literature found less than ten studies that specifically addressed social work student’s extent of endorsement towards recovery principles and practices, supporting the need for additional research on this subject.

**Statement of the Research**

This study explored the extent to which social work students endorsed recovery-oriented principles and practices in the context of serving consumers diagnosed with severe mental illness. I explored the five variables highlighted in this section as most frequently influencing extent of endorsement of recovery-oriented principles and practices when working with consumers diagnosed with SMI. These included knowledge of severe mental illness (mental health literacy), social contact (social distance), concerns regarding safety (dangerousness), knowing someone diagnosed with mental illness (familiarity), and having more than 5 years of employed experienced working with people diagnosed with SMI.

I used a survey design and included four existing instruments to measure social work students’ recovery knowledge. The first instrument was the *Recovery Knowledge Inventory* (RKI) designed to measure the extent to which social work students reported endorsing recovery-oriented practices and principles (Bedregal et al., 2006). The second instrument, *Social Distance Scale (SDS)*, (World Psychiatric Association Programme to Reduce Stigma and Discrimination Because of Schizophrenia, 2001) is a modified version of the SDS used by Adewuya and Makanjuola (2008); Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola (2005); and Smith and Cashwell (2011). These studies investigated mental health professionals’ attitudes towards social contact and social restrictions, considering factors such as experience, setting, and
professional group. The SDS assesses social distance regarding attitudes toward mental illness; although the SDS measures social distance specifically towards people diagnosed with schizophrenia, my study included all SMI disorders. The Dangerousness Scale (Link et al., 1987) measures the opinions about the dangerousness of people diagnosed with mental illness. Lastly, four vignettes with corresponding questions were selected from the MacArthur Mental Health Module (as part of the General Social Survey in 1996) and the National Survey of Mental Health Literacy was used to measure mental health literacy. In addition to completing the surveys, participants responded to demographic questions such as age, gender, ethnicity, level of education, and years of experience in mental health.

The primary research question addressed was:

1) How does mental health literacy, social contact, concerns regarding safety, knowing someone diagnosed with mental illness, and having more than five years of employed experience working with people diagnosed with SMI, affect the extent to which MSW students report endorsing recovery-oriented principles and practices?

**Hypotheses**

1) MSW students with knowledge about psychiatric conditions will influence endorsement of recovery-oriented principles and practices.

2) MSW students who have social contact with consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

3) MSW students with negative attitudes towards safety around consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.
4) MSW students with more than five years of employed experience working with consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

5) MSW students who identify as having a significant other diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

Summary

This dissertation sought to understand the extent of social work students’ endorsement of recovery-oriented principles and practices when working with consumers diagnosed with a severe mental illness. Factors contributing toward social work students’ extent of endorsement such as lack of knowledge of severe mental illness (mental health literacy), social contact (social distance), concerns regarding safety (dangerousness), knowing someone diagnosed with mental illness (familiarity), and having more than five years of employed experienced working with people diagnosed with SMI were investigated.

The following chapter provides an overview of the historical background and policies that have informed our understanding of mental illness. In addition, contemporary frameworks for understanding and working with severe mental illness, including the Recovery Model is discussed.
CHAPTER II: HISTORICAL AND CONTEMPORARY MODELS OF
MENTAL ILLNESS

Treatment approaches for people with mental illness derive from the theoretical orientation and philosophy of different disciplines. These influence a professional’s perspective on recovery. Society’s perception of mental illnesses shapes treatment approaches and recovery at a given time and changes in response to varying conditions. The following sections discuss mental health treatment approaches and reform movements that have influenced mental health recovery over time. In addition, a conceptual review of how recovery differs based on professional group is also discussed. I describe, compare, and contrast four different dominant models for the treatment of mental illness. The four models include the Medical Model, Biopsychosocial Model, Psychiatric Rehabilitation Model, and the Recovery Model. Elements of the Recovery Model are discussed in more detail than the other models given their relationship to my study.

Historical Overview

During the 16th century in the US, people living in the New England colonies viewed mental illness as deviant behavior caused by demonic possession. Priests treated mental illness, and families concealed their “sick” relatives from the public (Foerschner, 2010). Beginning in the middle of the 17th century, the European Enlightenment discouraged the notion that demons caused mental illness. However, stigma against people diagnosed with mental illness continued to exist throughout Europe (Kemp, 2007). The public viewed people diagnosed with severe mental illness as incapable of maintaining basic skills of living (Servais & Sanders, 2007). As a
result, the use of asylums increased during the 18th century in the interest of assisting this social problem (Kofman, 2012).

In the 19th century, the first psychiatric hospital in the US opened in the basement of Pennsylvania Hospital. However, the practices in these institutions were not free of stigma and exploitation, and some doctors placed people diagnosed with mental illness on public display in exchange for money (Kofman, 2012). In contrast, activists such as Dorothea Dix and Samuel B. Woodward tried to improve conditions for people in psychiatric institutions. Their objectives to achieve fair and humane treatment were the early stages of the mental hygiene movement, (Starnino, 2009). These advocates’ objectives closely resemble the tenets of the Recovery Model, which encourage and promote equality and justice for people diagnosed with mental illness.

Woodward and Dix approached mental illness from a humanitarian perspective. Supporters of these activists believed in freeing patients from unsanitary, inhumane conditions out of moral concern for their well-being. Patients were placed in mental institutions; however, overcrowding soon developed (Grob, 1992). In addition, an increase in the immigrant population in the US led to even more overcrowding and funds initially supplied by religious clergy members and later the government, declined. Consequently, conditions worsened (Anthony & Ashcraft, 2010). Poor environmental conditions coupled with ineffective treatment initiated the notion of mental illness as a chronic condition (Potter, 2010). In addition, a decrease in staff availability led to weaker therapeutic relationships between workers and patients. Efficiency became the goal rather than patient care (Knapp, Beecham, McDaid, Matosevic, & Smith, 2011). Hopefulness seen during the mental hygiene movement and humane
treatment dissipated. Institutions took on the role of custodial care as opposed to agents of social change. Humane treatment of the mentally ill diminished through the remainder of the 19th century (Bartolommei et al., 2012).

As asylums became overcrowded during the 1870s, medical advances convinced the public that science could solve all problems (Kofman, 2012). In 1910, the introduction of psychological treatment ("talk therapy") encouraged optimism for the mental health community and asylum residents. Psychotherapy attempted to address unresolved, unidentified problems within a person, often influenced by social factors (Kofman, 2012).

During the same period, Clifford Beers, a formerly institutionalized mental patient, published a memoir about his inhumane treatment in mental health institutions. This led to the creation of the National Committee for Mental Hygiene in 1909 (Burns, 2008). As a result, the mental hygiene movement sought to improve conditions, establish effective aftercare options, and implement preventative measures (Burns, 2008). Beers’ memoir laid the foundation for further reform movements such as the deinstitutionalization era during the late 1950s/1960s (Burns, 2008).

By the 1930s, new interventions emerged representative of the medical model. Cerletti introduced electroconvulsive therapy to treat depression, and Egas Moniz designed pre-fontal lobotomy to treat chronic psychiatric symptoms (Kemp, 2007). The introduction of antipsychotic drugs occurred in the 1950s, suggesting that symptom reduction could be achieved with fewer complications. Psychopharmacology, or the use of medication to treat psychiatric symptoms, eliminated the need to use physical restraints and contributed to the development of a healthy milieu. Most notably, psychopharmacology aided in the discharge of institutionalized
patients into community settings (Kofman, 2012). The emergence of a recovery framework in the form of psychotropic medication, psychotherapy, and consumer participation presented a fresh perspective on treatment options for mental illness. The culmination of these interventions suggested recovery was attainable, and began to demonstrate early tenets of the current Recovery Model.

In 1955, President John F. Kennedy signed the Mental Health Study Act. This Act called for the evaluation and revision of the public mental health system in the US (Kofman, 2012). Optimism about treatment outcomes for people with mental illness characterized the early 1960s (Starnino, 2009). This shift in attitudes regarding psychiatric care served as one of the major drivers for the deinstitutionalization movement of the late 1950’s through the early 1970s. Incentives to expand psychiatric services, such as John F. Kennedy’s Community Mental Health Centers Act of 1963 and the development of Medicaid and Medicare in 1965, contributed to the shift from treatment in state hospitals to community settings. The expansion of additional programs such as Social Security Disability, Social Security Income, and food stamps during the 1960s, offered assistance to individuals diagnosed with mental illness residing in community settings (Davis, Fulginiti, Kriegel, & Brekke, 2012).

The process of deinstitutionalization meant that numerous people diagnosed with SMI returned to the community. Although medication and psychotherapy addressed psychiatric symptoms, other concerns such as socialization and daily functioning required consideration. Communities were poorly equipped to provide recovery-oriented care as families struggled to assist disabled family members. The identification of a lack of practical support for people diagnosed with SMI in the community by professionals and consumers prompted the
development of the psychiatric rehabilitation model during the 1970s (Anthony & Ashcraft, 2010). Psychiatric rehabilitation is a process of restoration of community functioning and integration; it emphasizes the well-being of the newly integrated people diagnosed with SMI. The objective is to enhance the person’s ability to function, promoting the creation and maintenance of a successful environment. It employs the least amount of professional intervention, focusing the person’s efforts on developing everyday life skills and social supports (Anthony & Ashcraft, 2010). Emphasis on the relevancy of interpersonal relationships and community involvement are significant components of the Recovery Model.

**The Consumer Movement**

The consumer movement emerged during the 1970s, influenced by the earlier work of advocates such as Dix and Beers who fought for the rights of formerly institutionalized patients. People diagnosed with mental illness organized groups such as the Insane Liberation Front, Mental Health Patients’ Liberation Project, and Mental Patients’ Liberation Front around the country, demonstrating a growing interest in mental illness (Jacobson & Curtis, 2000). Participants in these organizations focused on raising awareness about the injustices experienced by people diagnosed with SMI and improving the mental health system for its consumers (Jacobson & Curtis, 2000). Consumer members of these organizations wrote about their experiences and perspectives toward their own recovery. According to these writings, self-empowerment and advocacy were necessary components of recovery. In addition, consumers asserted they benefited from substantial personal involvement in their recovery process (Jacobson & Curtis, 2000). These writings represented the underpinnings of the Recovery Model.
The remaining years of the 20th century was a time of transition. The federal government recognized that consumers could successfully organize and operate programs (Zinman, Budd, & Bluebird, 2009). New consumer-run organizations and programs developed such as The National Empowerment Center. The Center encourages living a personal journey of recovery through empowerment, advocacy, and self-help. Healing from the stigma of mental illness and trauma is best accomplished as a community, with the understanding and support of family and friends. Education and trainings are offered by staff at the Center for people diagnosed with mental illness so that evidence-based practice techniques can be incorporated into the recovery process. The Center exemplifies the underlying paradigm of the Recovery Model, which began to flourish with these developments (Zinman et al., 2009). Multiple stakeholders, however, continued to debate the implications of a recovery model. Table I on the pages below provides a comprehensive understanding of the different epochs and treatment approaches.

Table I

<table>
<thead>
<tr>
<th>Epoch</th>
<th>Approach/Treatment</th>
</tr>
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<tbody>
<tr>
<td>5000 BC</td>
<td>Release the evil spirits through trepanning, religious rituals, atonement, or forms of torture</td>
</tr>
<tr>
<td>5th - 15th Century: Middle Ages</td>
<td>Care for the mentally ill in hospital settings by cleryman and religious scholars More humane treatment Possible organic basis (Hippocrates) suggest early signs of medical model approach</td>
</tr>
<tr>
<td>Time Period</td>
<td>Key Events and Context</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16th Century: Asylum Care</td>
<td>Origins of asylum care&lt;br&gt;Use of purging and bloodletting techniques&lt;br&gt;Unsafe and unsuccessful treatment</td>
</tr>
<tr>
<td>Late 1700s/1800s: Moral Management</td>
<td>Enactment of laws against people with mental illness in cities (Chicago, Denver)&lt;br&gt;Efforts made by early activists, Dorothea Dix, to establish institutions and challenge inequitable law&lt;br&gt;Humanistic approach to treatment centering on social and individuals needs&lt;br&gt;State and government recognition of a problem&lt;br&gt;Develop acceptable levels of care in institutional settings</td>
</tr>
<tr>
<td>Early 1900s: Mental Hygiene Movement</td>
<td>Develop acceptable levels of care in institutional settings&lt;br&gt;Consider the influence of environmental factors on a person</td>
</tr>
<tr>
<td>1930s-1960: ECT, Psychosurgery, and Psychiatric Medication</td>
<td>Somatic treatment approaches, i.e. ECT, psychosurgery/lobotomy, and psychiatric medication</td>
</tr>
<tr>
<td>1960s: Deinstitutionalization Movement</td>
<td>Reintegrate formerly institutionalized patients into community settings&lt;br&gt;Relevant acts passed, i.e. Community Mental Health Centers Act</td>
</tr>
<tr>
<td>Transinstitutionalization (1960s to 1980s)</td>
<td>Subsets of the population diagnosed with mental illness transferred to prisons or nursing homes&lt;br&gt;Patient care suffered due to inadequately trained professionals unable to address needs</td>
</tr>
<tr>
<td>Late 1960s-1970s: The Launch of Psychiatric Rehabilitation</td>
<td>Engage in person-centered treatment, designed to address the objectives of the individual with minimal participation from providers</td>
</tr>
</tbody>
</table>
1960s-1970s: The Development and Expansion of the Ex-Patient/Survivor/Consumer Movement Establishment of united groups and organizations representing the civil rights and liberties of consumers, i.e. Human Rights and Against Psychiatric Oppression, Insane Liberation Front

1980s-Present Day: Mental Health Reform Development and/or improvement of new models of recovery, i.e. Fairweather Lodge, Assertive Community Treatment (ACT)

Comparing Models for the Treatment of Severe Mental Illness

The Medical Model

The medical model asserts a biological basis for mental illness, suggesting that a chemical imbalance in the brain results in a decline in mental health. This implies that disordered behaviors are not learned nor influenced by behavioral choices, but are generated by the disordered brain (Davidson et al., 2005). Since the cause of the illness lies in the patient’s brain, unhealthy thinking patterns or destructive behaviors demonstrated by the person are not believed to prompt the disease. Treatment is problem-focused, and the medical professional’s goal is to achieve stabilization through the use of psychotropic medications designed to decrease negative symptoms (i.e. apathy, anhedonia, and social withdrawal) and positive symptoms (hallucinations, delusions, and paranoia), which vary based on clinical disorders (Davidson et al., 2005). The therapeutic relationship is secondary to the implementation of formalized interventions, with the physician assuming an authoritarian position. As a result, therapeutic alliances may be underdeveloped and easily broken should symptom reduction not occur post-
treatment (Davidson & Roe, 2007). Professionals tend to ascribe less to social, cultural, and other environmental factors, since an organic basis serves as the etiology of mental instability. Therefore, successful recovery is achieved through symptom reduction, either demonstrated and/or reported by the patient (Davidson et al., 2005). The minimization of the relationship between the consumer and professional and the role that psycho-social stressors have on symptomology vastly differs from the Recovery Model which considers factors outside the individual (i.e. family unit, employment status) as well as the value of the consumer-worker relationship.

The Biopsychosocial Model

The biopsychosocial model is associated with the profession of social work; it emphasizes the perception of self in relation to the social environment and recognizes the person’s strengths, knowledge, skills, and potential regarding autonomy (Wolkstein & Harding, 2010). This closely aligns with the tenets of the Recovery Model, which encourages honoring the lived experience of the consumer and his/her personal attributes. George Engel and associates introduced the model during the 1970s, asserting that the biological, psychological, and social factors exist along a continuum, organized according to “systems theory’s conception of hierarchy” (Short, 2006, p. 130). Professionals begin by establishing a strong relationship, demonstrating cooperation, collaboration, and validation (Borrell-Carrio, Suchman, & Epstein, 2004). Next, professionals evaluate the person, proceeding to each level when determining pathology. Interventions consider psychosocial factors in conjunction with the person’s biological make-up (Short, 2006), encouraging a deeper understanding and appreciation of the consumer’s subjective experience (Borrell-Carrio et al., 2004). Recovery occurs when
successful integration and functioning of the mind, body, and social world transpire. Upon achieving stabilization, the consumer should report improvement in degree of functioning, participation in enjoyable activities, social outlets, and achieving meaningful goals (Borrell-Carro et al., 2004).

**The Psychiatric/Psychosocial Rehabilitation Model**

According to the psychiatric rehabilitation model, psychiatric symptoms stem from a biological predisposition prompted by stressful life events. Once a person receives a diagnosis of a mental illness, stigmatization occurs, exacerbating the person’s problems beyond their psychiatric symptoms. The model deems it necessary for the consumer to accept the disability so that they can pursue recovery and wellness (Starnino, 2009). Treatment interventions center on consumers working collaboratively with professionals to learn how to manage as opposed to cure their psychiatric symptoms, because symptoms are regarded as chronic (Anthony & Ashcraft, 2010). Professionals arrange services in the form of supported employment opportunities, educational pursuits, housing, family therapy, workshops to enhance coping skills, and other activities of daily living (Anthony & Ashcraft, 2010). Recovery is the acquisition of resources in multiple areas of the consumer’s life in conjunction with the successful integration into the community setting. This belief regarding recovery endorsed by proponents of the psychiatric rehabilitation model does closely align with the Recovery Model since it includes elements such as employment, leisure activity, development of a support system, and community involvement. Additional steps consumers take, such as establishing short and long-term goals, suggest less interference by previously problematic symptoms (Pratt, Gill, Barrett, & Roberts, 2013). Enhancing consumer self-confidence translates into proactive and healthier decision-making on
the part of the consumer (Pratt et al., 2013). Table II provides additional information about other comparative models of theoretical orientations below.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Biological</th>
<th>Psychodynamic</th>
<th>Behavioral/CBT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Etiology of Mental Illness</strong></td>
<td>Genetic cause; chemical imbalance</td>
<td>Unconscious drives</td>
<td>Distorted or irrational thinking patterns formed in response to external events</td>
</tr>
<tr>
<td><strong>Treatment/Intervention</strong></td>
<td>Psychopharmacology</td>
<td>Resolve three significant unconscious drives (id, ego, and superego) Hypnosis, dream analysis, and free association</td>
<td>Reframe unhealthy thinking patterns to produce desirable feelings and healthy actions</td>
</tr>
<tr>
<td><strong>Professionals' Approach</strong></td>
<td>Evaluate, assess, and diagnose the patient</td>
<td>Identify problem area to address in treatment Acknowledge boundaries and guidelines of treatment</td>
<td>Assist in reframing inaccurate thinking patterns to reduce maladaptive behavioral patterns &quot;Emotional distance&quot; between professional and consumer due to cognition</td>
</tr>
</tbody>
</table>
**The Recovery Model**

William Anthony defined recovery as “a highly personal and unique process that involves a renegotiation of one’s feelings, values, goals, attitudes, skills, and roles” (Anthony, 1993, p. 527). Empowerment refers to “the transformation from passive service recipient” (Chamberlin, 1990, p. 330) “to taking an active role in one’s mental health care” (Schiff, 2004, p. 213). Self-help fosters empowering attitudes toward treatment and recovery as a person begins to recognize his or her active role in the process. Lastly, advocacy involves the execution of changes both personally and on a larger scale, i.e. policy reforms (Schiff, 2004, p. 213).

The development of social supports to assist the consumer attempting to establish his or her identity in conjunction with self-management skills is also representative of the consumer perspective. Without supports, Schiff suggests that recovery may become “unnecessarily difficult.” He notes the value in professionals adopting a humanistic approach toward treatment and recovery, since this perspective promotes connection (Schiff, 2004, p. 214). A shared assessment between professional and consumer is encouraged (LeVine, 2012). Decisions made regarding interpersonal, professional, and educational situations originate from the perspective of the consumer, and they may or may not align with the perspective of the professional. The sense of mastery that develops from navigating the recovery process increases self-confidence, while fostering personal growth (Starnino, 2009).

Self-help programs are a significant part of the Recovery Model and can serve as alternatives to professional treatment. Participants of self-help programs typically express skepticism about the mental health system and traditional psychiatric treatment. These programs are a place for members to support one another while sharing feelings of anger, hurt, and
disappointment in response to personal experiences as mental health consumers. Members begin to feel empowered to have a voice in mental health matters, rejecting the role of passive recipient (Schiff, 2004). Through empowerment, consumers create identities other than that of a “mentally ill person” (Starnino, 2009).

Feelings of empowerment lead to advocacy, which includes working for changes on both macro and micro levels such as abolishing laws, labels, and practices that produce discrimination toward marginalized members of society (Schiff, 2004). Advocates argue that labeling people diagnosed with mental illness as “dangerous” may contribute to unwarranted consumer hospitalizations because of a perceived threat to self or others (Schiff, 2004). Therefore, advocates work towards ending involuntary treatment for consumers deemed a safety risk (Starnino, 2009). Self-advocacy may include any action intended to identify and describe a problem a consumer may be encountering, with the intention of seeking a resolution. A consumer may be self-advocating when refusing to participate in a treatment practice they deem unnecessary or unsafe (Schiff, 2004). The objective of consumer self-advocacy is to use one’s voice as a medium to achieve fair and humane treatment for consumers diagnosed with mental illness. Although consumers may seek support from others (Schiff, 2004), they control their resources and how they are directed. A consumer can decide to remove barriers to needed resources through diplomatic means or measures considered more activist, such as protests or sit-ins (Schiff, 2004).

Consumers often regard the mental health system and its constituents as proponents of traditional psychiatric methods (Watson, 2012). Since consumers consider these limiting, disempowering, and primarily representative of professionals’ objectives, they prefer minimal
participation from mental health professionals in their treatment and recovery. Instead, consumers seek consultation when they cannot attain needed resources on their own (Watson, 2012).

**The Principles of the Recovery Model**

William Anthony and attendees of a conference held by Substance Abuse and Mental Health Administration (SAMHSA, 2012) established the principles of the Recovery model as understood by consumers. Participants of the conference included people diagnosed with severe mental illness such as Patricia Deegan, Daniel Fisher, and Fred Frese. Additionally, mental health professionals from different mental health entities, family members, and administrators attended. The conference was primarily held to develop a working definition of recovery as determined by different stakeholders. The conference addressed consumer rights, equality, and self-advocacy, moving away from a traditional model of treatment and recovery (Frese et al., 2009). Recovery is considered an individual process through which people strive to reach their full potential (SAMHSA, 2012). The conference posited that with appropriate medical intervention and evidence-based treatment, consumers diagnosed with SMI could thrive. Specifically, consumers could control psychiatric symptoms, develop new techniques and coping skills, and adopt significant roles within chosen community settings to allow for optimal functioning (LeVine, 2012).

Ten fundamental components of recovery emerged from the SAMHSA conference. The components included individualized and person driven; social supports; holistic; nonlinear; strengths based/family support; culture; peer support; respect; addressing trauma, and hope (SAMHSA, 2012).
Person-Driven

Self-determination and self-direction are the foundations for recovery as consumers define their own life goals and design their unique path. Subjective experiences serve as the foundation for the manner in which the consumer proceeds (SAMHSA, 2012).

Social Supports

Supportive persons who believe in the consumer’s recovery and are able to offer participation and encouragement represent the social support system. These people advocate for constructive change, offering suggestions and recommendations. Supports collaborate with the consumer on an as needed basis, discouraging power differentials that may have otherwise occurred. Social supports also recognize and appreciate the particular values and ethics of each consumer and how these factors contribute toward goal development (SAMHSA, 2012).

Holistic

The combination of body, mind, and spirit reflect a comprehensive and holistic representation of a being, which is necessary for purposeful recovery. Professionals should evaluate the influence physical distress has on mental well-being when attempting to establish purposeful interventions. In the past, professionals who did not support the relationship among the body, mind, and spirit (SAMHSA, 2012) overlooked physical manifestations of psychological conflict.

Nonlinear

The process of recovery is non-linear and deviates from a straight path. Consumers in recovery experience setbacks and relapses, and recognize that this is indicative of a lifelong
journey toward stability, which the consumer defines. Periods of symptom instability are opportunities for growth and needed changes (SAMHSA, 2012).

**Strengths-Based**

There is an emphasis on consumer’s strengths and assets rather than a focus on weaknesses and limitations. Ideally, family members and others reinforce the unique skills and proficiencies of the consumer, fostering self-esteem and assurance when working toward goal setting. Recognition and support of the consumer’s unique talents and skills reinforces the objectives associated with person-centered treatment and recovery (SAMHSA, 2012).

**Culture**

Cultural background and upbringing influences a consumer’s perception of recovery. Therefore, consideration of diversity in beliefs and values is crucial when creating a distinct recovery path for each consumer. According to traditional approaches to recovery, most closely aligned with the medical model, cultural variation served as a threat to homeostasis, since differences were deemed unfavorable and possibly threatening to the social order. SAMHSA discouraged this belief, shattering the perspective that cultural differences were threatening or serving as a barrier to recovery (SAMHSA, 2012).

**Peer Support**

Consumers experiencing similar issues can offer normalization, support, and assistance in recovery. Formalized peer support or mutual aid groups foster commonality and purpose during recovery. Ideas and strategies assist those less familiar with mental health treatment and recovery (SAMHSA, 2012). The complimentary nature of reciprocity among consumers
experiencing a similar condition reflects principles associated with psychiatric rehabilitation and the consumer movement.

**Respect**

Recognition of the rights and justices of all humanity, including those with an identified disability such as mental illness, is paramount to recovery. Acceptance denotes recognition and appreciation for those with a disability committed to recovery (SAMHSA, 2012). Early advocates of the recovery approach laid the foundation for consumers to work towards achieving respect in the form of civil liberties through establishment of laws such as the Rehabilitation Act of 1973.

**Addressing Trauma**

Professionals should be educated on the cycle of abuse and trauma, and its implications on the human psyche and developing psychiatric symptoms. This allows for greater understanding, empathy, and intervention during recovery. Creating a safe space both psychologically and physically encourages authentic work between consumer and professional, enhancing the recovery experience (SAMHSA, 2012).

**Hope**

Hope is the unadulterated belief that recovery is possible and achievable with the assistance of concrete services and interpersonal supports. The ability to reinforce optimism for one’s future encourages continuation of participation in one’s recovery in the face of adversities (SAMHSA, 2012). This component mitigates the challenges of daily life and major stressors (Frese et al., 2009). Early approaches toward treatment and recovery dismissed the possibility that a consumer diagnosed with SMI should have hope about their condition and prognosis. It
was not until landmark studies (Corrigan & Phelan, 2004; Jacobson & Greenley, 2001; Resnick, Fontana, Lehman, & Rosenheck, 2005) reported different findings, that hope became a legitimate possibility. This component differentiates traditional approaches to mental illness such as the medical model and consumer perspectives.

The culmination of these components represents indicators of recovery as consumers understand it; they are founded on the original views “articulated by consumers who have had personal experience recovering from disorders” at the time of the SAMHSA conference (Frese et al., 2009, p. 374).

**Summary**

This chapter identified different treatment approaches and perspectives towards recovery. In earlier periods, people believed mental illness resulted from demonic possession (Foerschner, 2010). Eventually institutional care removed people from community settings and placed people with serious mental illness in asylums. The emergence of the mental hygiene movement offered a newfound sense of optimism for people diagnosed with SMI, since formerly institutionalized patients such as Clifford Beers wrote at length about the persistence of inhumane practices in institutional settings. His intention was to improve the quality of care. Unfortunately, institutions became overcrowded, understaffed, and poorly funded, resulting in further strain on patient recovery (Bertolote, 2008). Towards the end of this movement, the community mental health movement began, welcoming the era of psychotropic medication, ECT treatment, and psychosurgery. These treatment approaches contributed to the decision to discharge patients into community settings as professionals and patients believed treatment could now take place within the community.
Psychiatric rehabilitation emerged shortly thereafter along with a movement representing consumers’ desires to become more independent and self-sufficient (Wolkstein & Harding, 2010). Consumers called for a collaborative process with professionals, allowing them to pursue individualized treatment plans and goals (Anthony & Farkas, 2009). Currently, the Recovery Model is prominent within mental health as its principles support evidence-based practice, person-centered, and multidisciplinary treatment (Corrigan, Mueser, Bond, Drake, & Solomon, 2008).

Finally, I reviewed the fundamental principles and values of the medical model, biopsychosocial approach, psychiatric rehabilitation approach, and the Recovery Model. Identifying the strengths and weaknesses of each approach/model offers a better understanding of each approaches’ influence on consumer treatment and recovery. Discussing similarities and differences also allows for a comparative analysis of each model. As the section highlights, there is neither a universal definition of recovery nor complete consensus on intervention. Therefore, different perspectives are likely to continue in the literature and influence recovery-oriented care.

The following chapter discusses the role of social workers as well as other professionals in mental health services, the professionalization process, core values associated with the profession of social work, and the manner by which social workers are socialized.
CHAPTER III: MENTAL HEALTH PERSPECTIVES ON RECOVERY

Social work originated in the 19th century within the US and United Kingdom. Impoverished people regarded as a threat to social order prompted the government to create a system to provide care for them. Original caretakers were considered “friendly visitors,” who provided care for people who were disadvantaged, sick, or poor. Although these friendly visitors were well intentioned, their practice was not guided by theoretical orientations or empirically based evidence (Cummings, 1990).

During the late 1800s, Jane Addams founded the US Settlement House Movement, which established settlement houses in impoverished urban communities for volunteer middle-class social workers to assist with poverty. Early social workers arranged for educational, legal, and healthcare opportunities to be made available for poor communities. In response to the need for formalized training, the first school of social work began at Columbia University, consisting of summer workshops and trainings for volunteers and friendly visitors to complete in a one-year educational program (Glicken, 2011).

Although social workers provided services in a variety of agencies, some worked in psychiatric or medical settings, where they specialized as psychiatric social workers or medical social workers. Identifying with medical doctors contributed to their professional status and the development of a professional identity (Cummings, 1990). In addition to a focus on social reform and political activism, social workers engaged in individual practice with patients and their families. Assessment and diagnosis of symptoms distinguished social workers and advanced a professional interest in pursuing a scientific knowledge base (Glicken, 2011). Originally, social workers attempted to establish a professional boundary between their
responsibilities and those of the psychiatrists. However, engagement with patients and the treatment process proved common ground between social workers and psychiatrists. Some authors assert practicing social workers still maintain a reliance and endorsement of the medical model tenets (Glicken, 2011; Healy, 2008). However, social workers are formally trained according to a person-in-environment perspective (Glicken, 2011).

In summary, the approaches that define different professional groups are a direct result of professional socialization (Abbott, 1988). Social workers and other professions are socialized into their profession based on its knowledge base, values, and approach. The educators who prepare psychiatrists, psychologists, psychiatric nurses, and social workers follow guidelines and protocols designed to impart the values, skills, and knowledge of the profession onto the students. Although curricula designs reflect the aforementioned components of the profession, little research has been conducted as to how students become professionals (Barretti, 2004b). The following section discusses the professional socialization process.

**The Professional Socialization Process**

A professional identity develops through a socialization process (MacLellan, Lordly, & Gingras, 2011). Mackintosh (2006) describes professionalization as a detailed, interactive process, by which the professional role is learned and applied in different contexts by the learner. Aspects of professionalization include self-monitoring, subscribing to a code of ethics, and participating in formalized education, and supplemental training opportunities (MacLellan et al., 2011). Bucher and Stelling (1977) emphasize the powerful influence education and training have on professionalization, because both provide an atmosphere that encourages students to develop an identity as a mental health professional.
For all professional groups, investment of personal time and energy to learn more about their professional role assists in advancing a person’s professional identity. Mentoring plays a significant role in professional socialization, because that is how students learn both behavioral and professional standards (Weidman et al., 2001). Mentors convey the values and mores of the profession to the student; the greater the degree of investment on the part of the mentor, the more likely the student will follow these values. The level of professionalization achieved directly relates to the level of commitment felt toward the profession (MacLellan et al., 2011). Active participation between student and mentor encourages students to internalize the attitudes and philosophy of the profession and make them their own. Subsequently, students reach role identification and begin to view themselves as professionals (Weidman et al., 2001).

**Developmental Model**

Professional socialization encompasses both external and internal roles as defined by the educational program’s learning objectives, and the student’s subjective self-conceptualization associated with the role (Shuval, 1980). During the course of the socialization process, the student evolves from a novice to a developing professional, acquiring new knowledge and skill set as the classroom curriculum and field practice are integrated (Shuval, 1980). Thornton and Nardi (1975) were among the first to recognize professional socialization as a developmental process. Their model includes sociological and psychological parameters as an individual learns, adopts, and accepts a new role. These authors highlight the significance of the interaction between the person and the role, how the person changes to fit the role, and modification of the role to fit the person (Thornton & Nardi, 1975). The four stages of socialization are discussed below.
**Anticipatory Stage**

This stage recognizes students’ interest in pursuing the field. Students have preconceived notions about the profession of interest stemming from the media, personal observation, and interactions with a professional. Expectations of a profession are evident during the learning process and include ethical practice, knowledge of theories, and standards of behavior (Thornton & Nardi, 1975). Students demonstrate an eagerness to use the argot of the profession and although they lack the knowledge or skill to take initiative, they are anxious to begin. Students consider the influence of experiences prior to program admission in relation to their current standing (Bucher & Stelling, 1977).

**Formal Stage**

During this stage, students’ exhibit newly found level of comfort with the profession’s expectations, and they formally accept the invitation to apply to the education program. Once admitted, the transition from beginner to the formal stage of professional socialization occurs (MacLellan et al., 2011). This stage differs from the previous stage in that students receive instruction and guidance from trained professionals, which they later apply in professional contexts (Weidman, Twale, & Stein, 2001). Classroom learning is the primary source of learning the practical skills necessary to be a successful professional. Expectations are clear, defined, and explicit through direct communication between educators and students. New learning platforms further assist the student in the learning process (Thornton & Nardi, 1975).

**Informal Stage**

During the informal stage, the primary source of learning shifts to peers and seasoned professionals. Unlike the previous stages, students turn to their cohorts for guidance and
normalization of the adjustment process. According to Thornton and Nardi (1975), groupings of student peers facilitate communication, understanding, and support. In addition, group cohesiveness fosters growth and professional development. As seasoned students, they have mastered the theories and skills needed to succeed in the profession (Austin & McDaniels, 2006).

**Personal Stage**

In the final stage of socialization after graduation, students reconcile previous identities with their newly established professional persona, resolving any underlying struggle between former and current selves. Research, publication opportunities, and educational presentations serve as areas of pursuit during this stage. A new sense of connectedness to fellow professionals emerges as students seek out internships, assistantships, and other field experiences reflective of professional interests (MacLellan et al., 2011).

**Socialization to Social Work**

Relatively little is known about how social work students become professionals (Barretti, 2004b) despite the profession’s duty to socialize social work students to the norms, values, and identity of the profession. Both Miller (2010) and Barretti (2004a) argue that what professional socialization entails and how social workers acquire the values and principles of the profession has not been the focus of research. Barretti (2004a) attributes this to the fact that professional socialization in social work has not been a priority for either social workers themselves or their teachers. Miller (2010) suggests that although professional socialization begins prior to one’s formal education and continues upon completion of the educational process, it is assumed that professional socialization is synonymous with social work education. As a result, the literature on this subject is limited and underdeveloped (Baretti, 2004a).
A revised version of the CSWE *Educational Policy and Accreditation Standards* (EPAS; CSWE, 2008) emphasizes the need to investigate professional socialization. The EPAS identifies field education as social work’s “signature pedagogy,” positing that the professional socialization of students occurs primarily through the internship process (p. 8). Although socialization in the field is of primary importance, it does not occur without the acquisition of knowledge in the classroom setting (Miller, 2010).

The EPAS identifies the implicit curriculum, or the material behind the formal curriculum, as critical in modeling the character and competency of student graduates (CSWE, 2008). The implicit curriculum includes structures and processes relevant for students to develop professional roles, reflective of the underlying values of the profession. Recent development in educational policy, acknowledges and delineates the roles that socialization plays in educating competent and ethical social workers (Holosko & Skinner, 2009; Miller, 2010).

Authors (Miller, 2010; Reamer, 1994) assert that social work education be concerned with both the knowledge and value base of social work. Despite the lack of extensive research on professional socialization, there is a general agreement that shared professional values have held the profession together in the face of adversity (Reamer, 1994). Popple (1991) found that social work educators agreed on the importance of students developing a value system supportive of the profession’s perspective. Although educators consider it essential for social workers to have a set of values rooted in concern for individual well-being and social justice, the contribution of social work education to the development and/or enforcement of desirable values remain unclear. The decline in the number of social work programs offering coursework on values and/or ethics may exacerbate this problem, since the principles on which the profession
was built are not consistently reinforced (Miller, 2010). Essentially, the lack of extensive research on professional socialization of social workers leaves many unanswered questions. Of particular interest here is exactly how students acquire the profession’s values and perspectives and to what extent they influence endorsement of the Recovery Model.

**Core Social Work Values and Perspectives**

According to the CSWE, the underlying ethos of the profession of social work shares a stronger relationship to recovery-oriented principles and practices than other related disciplines (2012). Recovery-informed practice aligns with the ethical standards of the social work profession and the core values of “self-determination, empowerment, and social justice” (CSWE, 2012, p. 3). The profession’s ability to see the world through the lens of the consumer while encouraging collaborative efforts toward goal completion reflects the foundation on which recovery principles were established. The focus on activism and acquisition of human rights at a local, state, and federal level, distinguishes the discipline (CSWE, 2012). The social work paradigm and core principles suggest a specialty informed by recovery with less need for modification in order to practice according to the principles of the Recovery Model. However, CSWE emphasizes the need for social workers to continue to reinforce and apply recovery-oriented practices, suggesting that although the principles may align, the application of these principles lacks consistency (CSWE, 2012).

The person-centered, direct-care approach to helping marginalized members of society is a unique element of social work (Glicken, 2011). Unlike other disciplines, social workers participate in community-oriented events and activities designed to bring about environmental changes. In this way, social workers promote the health and wellness of a community.
Advocates admire social workers for their inclusive approach towards people labeled by society as vagrants, underprivileged, and indigent (Healy, 2008). Social justice and social welfare serve as guiding tenets for the profession, concepts reinforced by the Recovery Model (Forte, 2007). Theoretical orientations extend from developmental considerations represented by attachment theory, to person-in-environment fit most commonly associated with social systems theory. Object relations and family systems also serve as guiding theoretical models for the discipline (Forte, 2007).

In 1886, the Settlement House Movement promoted social justice by focusing on the causes of poverty and establishing employment for impoverished members of society. People associated with this movement believed that environmental factors contributed to poverty and efforts at reform would improve condition. Social work has traditionally believed that environmental factors contributed to maladaptation. Therefore, by adopting an ecological perspective, which promotes individual and environmental adaptation, individuals mitigate discomfort through successfully achieving a healthy relationship with their environment. Among the different theoretical orientations identified, the person-in-environment (PIE) perspective is a defining construct of the profession and a fundamental characteristic of social work practice, evidenced in current social work education accreditation requirements. The emphasis on the relationship between environment and health, as opposed to biologically driven abnormalities adopted by psychiatrists, positions social work apart from other related disciplines (Simmons, 2012).
Summary

This chapter reviewed the roles, skills, and perspectives of different professional groups toward mental illness, treatment, and recovery of people diagnosed with severe mental illness, focusing on social workers. Exploration of professional socialization presented the elements of the socialization process outlined in the developmental model of socialization. Socialization to the profession of social work in particular explored the process by which social work students develop professional identity, recognizing the importance of social work values and principles. Some authors claim there is insufficient research about the professional socialization process of what social work entails (Miller, 2010).

The following chapter reviews the empirical literature on social workers, social work students, and other mental health professionals’ endorsement of recovery-oriented principles and practices. Approaches to studying endorsement of the Recovery Model among social work students and other professionals are also discussed.
CHAPTER IV: REVIEW OF THE EMPIRICAL LITERATURE

The Recovery Model emphasizes equality, social justice, and client-centered treatment, which embody the values of social work (CSWE, 2012). In social work, the relationship between the consumer and the professional requires reciprocity, mutuality, and respect, which are principles of the Recovery Model. Social work embraces a comprehensive understanding of the factors contributing to the development of a mental illness (Glicken, 2011). The question addressed in this study is whether social workers are in fact favorably inclined to endorse recovery-oriented principles and practices. This chapter reviews the empirical literature on social workers and other mental health professionals’ adoption of the tenets of the Recovery Model.

Recovery challenges professionals to develop less formal professional roles and respect consumer expertise based on experience (Cleary & Dowling, 2009; Schrank, Stanghellini, & Slade, 2008). This places the professional in the position of facilitator and not director; hope-inspiring advocate and not pessimistic expert; and autonomous supporter and not paternalistic parent (Sowers, 2005).

Although there is considerable research about other professional groups’ endorsement of recovery practices and principles, less appears about social workers. Where studies exist, there are methodological problems, such as small sample sizes (Ahmead, Rahhal, & Baker, 2010; Cleary & Dowling, 2009; Hansson, Jormfeldt, Salgado, Deane, Crowe, & Oades, 2010; Svedberg, & Svensson, 2011; Tsai, Salyers, & Lobb, 2010). Even less research has been conducted about social work students and the Recovery Model (Covarrubias & Han, 2011; Foster, Morris, & Sirojudin, 2013; Shera & Delva-Taulili, 1996). Findings are either scarce or
inconclusive. This suggests the need for more research to explore social work students’
knowledge and adoption of the Recovery Model. Factors in the literature identified as
influencing social workers and social work students interest in working with people diagnosed
with SMI include lack of knowledge of severe mental illness (mental health literacy), social
contact (social distance), concerns regarding safety (dangerousness), knowing someone
diagnosed with mental illness (familiarity), and having more than 5 years of employed
experienced working with people diagnosed with SMI.

**Empirical Research**

**Professionals’ Perspectives**

Mental health professionals typically encounter consumers diagnosed with mental illness
in vulnerable situations; how professionals treat them can influence their recovery. The
assumption that professionals who have dedicated themselves to care for people diagnosed with
mental illness are benevolent and non-judgmental is not consistently supported in the research
(Wahl & Aroesty-Cohen, 2010).

Some studies exploring the perspectives of a single professional group have found
unfavorable or negative viewpoints among professionals, which negatively influence the extent
of endorsement of recovery concepts (Bjorkman et al., 2008; Erkoc & Atakli, 2004; Linden &
Kavanagh, 2011; Ross & Goldner, 2009; Ucok, Polat, Sartorius, Erkoc, & Atakli. Negative
appraisals by professionals regarding consumers’ ability to recover influence the working
relationship, placing a strain on the professional and consumer; this compromises effective
treatment (Wahl & Aroesty-Cohen, 2010). Studies (Bjorkman et al., 2008; Linden & Kavanagh,
2011; Ucok et al., 2004) report that registered or assistant nurses, student psychiatric nurses, and
psychiatrists have concerns about safety, social contact, proximity of consumers to their residence, and fear of being attacked by consumers diagnosed with schizophrenia. In addition, they view consumers diagnosed with schizophrenia as unpredictable and erratic; therefore, they require strict boundary and limit setting. These authors (Bjorkman et al., 2008; Linden & Kavanagh, 2011; Ucok et al., 2004) utilized different instruments to measure the degree of familiarity with mental illness such as the Level of Familiarity Questionnaire (Corrigan, Green, Lundin, Kubiak, & Penn, 2001); and, attitudes towards different mental illnesses, i.e. Attitudes to Persons with Mental Illness Questionnaire (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000), Community Attitudes towards the Mentally Ill (CAMI) (Taylor & Dear, 1981), and Social Interaction Scale (SIS) (Kelly, Lawrence, Smith, Hood, & Cook, 1987).

Ross and Goldner’s (2009) review of the existing literature revealed that professional exchanges with consumers were contentious, which negatively influenced professionals’ perspectives and subsequently the extent to which they would endorse recovery principles and practices. In particular, psychiatric nurses reported more negative perspectives towards patients’ recovery than the public based on their professional experiences. Linden and Kavanagh (2011) also found mental health nurses working in an inpatient setting in the Republic of Ireland scored higher on the subscale social restrictiveness (CAMI, Taylor & Dear, 1981) than those working in a community setting, indicating a desire for social restrictiveness due to perceptions of patients diagnosed with schizophrenia as being dangerous. Community mental health nurses scored higher on the subscale community mental health ideology (CAMI; Taylor & Dear, 1981), which describes the therapeutic role of the community in caring for someone diagnosed with mental illness, indicating more positive perspectives towards professionals’ engagement in consumer
recovery than mental health nurses working in an inpatient setting. The authors attributed this to the nurses’ ability to remove themselves with less difficulty from a potentially threatening situation than if they were on an inpatient unit.

In contrast, other studies found professional groups reported favorable perspectives towards consumers diagnosed with mental illness, thereby positively influencing the extent of endorsement of recovery principles (Chambers et al., 2010; Martensson, Jacobsson, & Engstrom, 2014). Common factors that contributed to positive viewpoints and subsequent endorsement of recovery practices and principles were knowledge about mental illness, work locations, and contact with someone significant diagnosed with mental illness. Martensson et al. (2014) found that assistant, registered, and licensed nurses employed by one county council in central Sweden and by the ten surrounding municipalities, held more positive perspectives towards people diagnosed with mental illness if they held less stigmatizing beliefs if their work location was deemed desirable and if they currently had or have had a close friend diagnosed with a mental illness. The authors used the Swedish version of the Community Attitudes towards Mental Illness (CAMI-S) questionnaire (Hogberg, Magnusson, Ewertzon, & Lutzen, 2008) to measure staff’s attitudes towards people diagnosed with mental illness. In addition, the Mental Health Knowledge Schedule (MAKS; Evans-Lacko et al., 2010) measured staff members' knowledge of mental health literacy and portions of the Reported and Intended Behavior Scale (RIBS; Henderson, Evans-Lacko, Flach, & Thornicroft, 2012) measured staffs’ contact with people diagnosed with mental illness. Chambers et al. (2010) found that registered nurses employed in five different countries in Europe held a sympathetic view of people experiencing mental health problems, recognizing them as people in need of assistance, based on scores on the CAMI
survey. The authors noted that Portuguese nurses’ perspectives toward consumer recovery were significantly more positive than Lithuanian nurses’ perspectives. Overall, nurses’ positive perspectives towards the role of community care in consumer recovery were comparable to those of psychiatrists surveyed in the study conducted by Lauber and colleagues (2004). They found that psychiatrists held more positive beliefs than the public about the benefits mental health facilities in the community could result in for consumer recovery (Lauber, Anthony, Ajadacic-Gross, & Rossler, 2004).

Most of the studies that sampled participants from a single professional group explored psychiatrists and nurses’ perspectives towards recovery concepts (Bjorkman et al., 2008; Ewalds-Kvist, Hogberg, & Lutzen, 2013; Linden & Kavanagh, 2011; Ross & Goldner, 2009). However, other studies compare the perspectives of different professional groups (Gaffey & Evans, 2016; Hansson et al., 2011; Tsai, Salyers, & McGuire, 2011; Tsai et al., 2010). Wahl and Aroesty-Cohen (2010) reviewed studies conducted before 2010 that explored the viewpoints of different mental health professionals (i.e. psychiatrists, psychologists, nurses, therapists, social workers) towards recovery-oriented principles and practices. Thirteen studies sampled mental health professionals from sixteen different countries including the US. Even among mental health professionals who held more positive perspectives than the public, they reported less endorsement of recovery concepts pertaining to social distance and social restrictions (Wahl & Aroesty-Cohen, 2010). To varying degrees, professionals reported that exposure to people diagnosed with mental illness might place them at risk for becoming victims of violent or aggressive behavior (Ahmead et al., 2010; Mittal et al., 2014).
Ahmead et al. (2010) found that mental health professionals (physician, nurse, psychologist, social worker, and occupational therapist) working on an inpatient unit in Palestine held more pessimistic than optimistic views on recovery, according to findings on the Attitudes Toward Acute Mental Health Scale (ATAMHS; Baker, Richards, & Campbell, 2005). In particular, participants reported less endorsement of recovery concepts that supported fewer social restrictions and stronger mental health literacy (Ahmead et al., 2010). Interactions with patients diagnosed with mental illness were also rated as less favorable, and professionals identified their role in the interaction as being “cold-hearted” at times. This suggests a desire for professionals to maintain social distance from people diagnosed with mental illness.

Mittal et al. (2014) and Kapungwe et al. (2011) reported similar findings regarding social distance. Mittal et al. found that mental health professionals (psychiatrists, psychologists, mental health nurses, and physicians) employed in five different Veterans Affairs (VA) facilities showed a desire for social distance from people diagnosed with mental illness, in particular schizophrenia. They cited negative perceptions of what individuals with mental illness were capable of doing when acutely symptomatic. This study used vignettes to measure mental health literacy, social distance, and stereotyping (2014). The majority of the participants in the study conducted by Kapungwe et al. (2011) in Zambia indicated that they felt extremely uncomfortable (19.8%) or uncomfortable (48.6%) assisting people diagnosed with mentally illness. In addition, participants reported extreme discomfort or general discomfort during exchanges with people diagnosed with mental illness in general.

Studies cited by Wahl and Aroesty-Cohen (Smith & Cashwell, 2011; Sun et al., 2014) found that other factors such as training, education, and experience positively influence
professionals’ perspectives towards people diagnosed with mental illness, subsequently influencing endorsement of recovery-oriented principles and practices. Researchers assert this is because knowledge about mental disorders helps minimize stigmatization, since recognition and understanding enable professionals to know how to assist people better (Starnino, 2009; Wahl & Aroesty-Cohen, 2010). Sun et al. (2014) found that psychiatrists and nurses demonstrated stronger support for social integration than the public, because of their training and experience, while family members reported a desire for less social contact with people diagnosed with mental illness. Smith and Cashwell (2011) also found that mental health trainees and mental health professionals reported less stigmatization when compared to non-mental health professionals after participating in training programs and increasing their level of involvement professionally with people diagnosed with mental illness.

Overall, studies around the world have found substantial evidence of negative perspectives and subsequently, less endorsement of recovery-oriented principles and practices among mental health professionals towards people diagnosed with mental illness (Bjorkman et al., 2008; Farley-Toombs, 2012; Hansson et al., 2011; Linden & Kavanagh, 2011; Mestdagh & Hansen, 2014; Ross & Goldner, 2009; Sweeney et al., 2014; Ucok et al., 2004; Verhaeghe, Bracke, & Christiaens, 2010). Differences between mental health professionals’ perspectives and the public are marginal (Wahl & Aroesty-Cohen, 2010) indicating that professionals’ perspectives and likelihood of endorsing recovery principles and practices are more positive than the public (Sun et al., 2014; Smith & Cashwell, 2011). My review of the literature suggests that mental health professionals may hold similar or more negative perceptions regarding mental illness, treatment, and recovery than the public (Bjorkman et al., 2008; Lauber, Nordt,
Braunscheig, & Rossler, 2006; Nordt et al., 2006; Parcesepe & Cabassa, 2013; Ross & Goldner, 2009; Schulze, 2007). Since some of these studies’ findings indicate that training and contact with people diagnosed with SMI improve endorsement of recovery practices, this area merits further investigation.

**Factors Influencing Professionals’ Endorsement of Recovery-Oriented Principles and Practices**

Some studies consider what factors influence professional endorsement of recovery practices towards people diagnosed with mental illness (Gaffey & Evans, 2016; Hansson et al., 2011; Magliano et al., 2013; Stuber, Rocha, Christian, & Johnson, 2014; Stuber, Rocha, Christian, & Link, 2014). Of the factors identified in the literature, training, experience, and education are frequently cited as contributing to the formation of professionals’ endorsement of recovery-oriented principles and practices (Arvaniti et al., 2009; Stuber, Rocha, Christian, & Johnson, 2014; Wahls & Aroesty-Cohen, 2010).

**Training**

Training is a learning experience offered to professionals in the interest of advancing their knowledge about material relevant to mental health (Tsai et al., 2011). Studies have identified advantages formal training offered for mental health professionals by providing educational opportunities to learn about and adopt the Recovery Model (Crowe, Deane, Oades, Caputi, & Morland, 2006; Tsai et al., 2011; Tsai et al., 2010; Wilrycx, Croon, Van den Broek, & van Nieuwenhuizen, 2012a). These studies report that with appropriate training, professionals are more likely to accept the Recovery Model. In particular, components such as client right to self-determination, the benefits of a support network, and realistic goal setting are readily
endorsed following training (Tsai et al., 2011). Researchers recognize that implementation of the Recovery Model may change as professionals increase in knowledge about the model (Frese et al., 2009; Starnino, 2009).

Different models of training are described in studies (Crowe et al., 2006; Oades et al., 2005; Salgado, et al., 2010). These trainings sought to educate professionals on recovery practices representative of the Recovery Model. Crowe et al. (2006) evaluated the effectiveness of The Collaborative Recovery Model (CRM) to teach clinicians how to use evidence-based skills with consumers in a manner consistent with the Recovery Model. Salgado et al. (2010) replicated this study and found that two days of training in recovery concepts and skills under the Collaborative Recovery Training Program (CRTP; Oades et al., 2005) improved providers' recovery knowledge, hopefulness, and optimism about recovery. Crowe et al. (2006) also found that a two-day, recovery based training program for mental health workers on knowledge and hopefulness improved professionals’ knowledge on recovery principles. In addition, professionals’ belief in the effectiveness of collaboration and consumer autonomy, motivation, and goal striving were reported as improving (Crowe et al., 2006).

In another evaluation of the effectiveness of training, Tsai et al. (2010) reported that staff (i.e. attendants, nurses, psychologists, and social workers) who received training through specific/practical (“hands-on” methods) had a greater increase in consumer outcome and higher consumer optimism scores than staff who received only general/inspirational training or no training. Stuber et al. (2014) found that participating in in-service training on recovery was positively correlated with the recovery-oriented competencies consistent with the Recovery Model. Participants consisting of therapists, psychologists, psychiatric nurses, peer support
counselors, case aides, and other related professional groups reported higher scores of optimism towards people diagnosed with mental illness after the training (Stuber et al, 2014).

Similarly, Wilrycx et al. (2012a) investigated the effectiveness of a recovery-oriented training program on knowledge and perspectives of mental health professionals towards recovery of people diagnosed with SMI. Results suggested that engaging in two-day trainings that consisted of learning the basics of recovery-oriented care and recovery practices led to more positive beliefs towards recovery practices (Wilrycx et al., 2012). Other researchers reported similar findings (Cleary & Dowling, 2009; Meehan & Glover, 2009; Pollard, Gelbard, Levy, & Gelkopf, 2008). Specifically, the researchers reported that mental health professionals held more positive beliefs related to recovery following the training program.

**Experience**

Results of studies linking years of professional experience to perspectives and the formation of professionals’ endorsement of recovery-oriented principles and practices towards people diagnosed with SMI are mixed. Some report younger professionals have more positive perspectives and therefore, stronger endorsement of recovery practices. Cleary and Dowling (2009) found that younger, less experienced professionals have more positive perspectives towards prognosis and outcome, recognizing the recovery concept known as non-linearity. The authors used t-tests to measure for any statistically significant differences between professional groups. The authors found that less-experienced mental health staff employed for shorter lengths of time had more favorable perspectives and knowledge toward recovery than more-experienced staff with longer employment histories. Similarly, Tsai et al. (2010) used t-tests and found that participants with fewer years in their position had significantly higher consumer optimism.
scores. However, Hansson et al. (2011) found that younger staff consistently held more negative beliefs than more experienced workers had. For instance, younger staff scored higher on items on the Perceived Devaluation-Discrimination Questionnaire (Link, 1987) evaluating social contact and the acceptance of a former patient as a teacher of young children or accepting a former patient as a close friend.

One study (Bjorkman et al., 2008) found that professionals with more years of experience reported lower expectations, engagement, and belief in consumer recovery. This finding contradicts the underpinnings of the Recovery Model and suggests some professionals do not entirely adopt the model. Bjorkman et al. (2008) used the Attitudes to Persons with Mental Illness questionnaire (Crisp et al., 2000) to investigate opinions about people diagnosed with mental illness, specifically seven different mental illnesses. Multiple regression analysis measured the association between independent variables and attitudes towards specific mental illnesses. Findings showed that nursing staff with longer professional experience had more negative perspectives and did not endorse recovery practices such as consumer ability to effectively manage setbacks, towards specific mental illnesses. Consumers diagnosed with schizophrenia and/or eating disorders prompted negative responses by nursing staff, while consumers experiencing panic attacks elicited slightly less negative reactions by staff (Bjorkman et al., 2008).

Education

Research indicates that both mental health professionals and the public who completed more years of education endorse more favorable perspectives towards consumers diagnosed with SMI, as well as recovery concepts, than people who completed fewer years of education.
Addison & Thorpe, 2004; Adewuya et al., 2008; Angermeyer & Dietrich, 2006; Arvaniti et al., 2009; Bjorkman et al., 2008; Chikaodiri, 2010; Chong et al., 2007; Corrigan et al., 2001; Klockmo, Marnetoft, Nordenmark, & Dalin, 2012; Reavley et al., 2011; Salyers et al., 2013; Stuber et al., 2014; Tay, Pariyasami, Ravindran, Ali, & Rowsudeen, 2004; Tsai et al., 2010.

The research is scarce in terms of reporting contradictory or mixed findings (Aydin, Yigit, Inandi, & Kirpinar, 2003; Eker & Arkar, 1991; Kumakura et al., 1993; Tsai et al., 2010). Therefore, education appears to have an influential role in how professionals and possibly, professionals-in-training, approach mental health, treatment, and recovery.

Authors (Chikaodiri, 2010; Reavley et al., 2011; Salyers et al., 2013; Stuber et al., 2014) assert that participants with higher levels of education report less of a desire for social distance and restrictiveness, and greater collaboration with consumers working towards recovery. Stuber et al. (2014) compared the viewpoints of the public and of mental health professionals, specifically exploring desire for social distance and perceived dangerousness from people diagnosed with SMI. Level of education was included as a descriptive variable. Findings indicated that professionals with a bachelor’s or advanced degree, compared with professionals with less education (i.e. less than a bachelor’s degree), desired less social distance from vignette characters described as having depression. Professionals with more education (who identified as Caucasian) than those with less than a four-year college degree also reported a desire for less social distance and patient competency, from the character described as having schizophrenia. Overall, professionals with more education endorsed recovery principles such as engaging in social situations with people diagnosed with SMI (Stuber et al., 2014). Tay et al. (2004) also found participants desired less restrictiveness. The authors explored the influence of training on
nurses’ perceptions towards consumer recovery. Findings indicated that among other characteristics, nurses with the professional qualification of an advanced diploma in mental health nursing, nursing degree, or post-basic certificate, reported beliefs that are more favorable about recovery. Their scores on the Attitudes Toward Mental Illness (AMI) (Weller & Grunes, 1988) indicated a desire for less restrictiveness and bias against people living with a mental illness, and greater optimism about prognosis.

Reavley et al. (2011) and Chikaodiri (2010) found that fears or concerns regarding safety as well as endorsement of recovery concepts such as equality and consumer autonomy were more likely to be endorsed by participants with greater education. Reavley et al. (2011) assessed the viewpoints of staff and students towards people diagnosed with SMI, at a university in Australia. Different characteristics were considered, education being one of them. Education levels were categorized as follows: studying full time, bachelor/postgraduate degree, and diploma/certificate. Mental health literacy was assessed by administering a vignette to participants. Findings indicated that students who obtained a higher education level were more likely to correctly identify the person in the vignette as being diagnosed with depression. In addition, these participants reported that they would be more likely to seek treatment from a student counselor if they were struggling with symptoms of depression (Reavley et al., 2011). This suggests participants were comfortable with treatment engagement and working with mental health providers to address problematic symptoms. Lower levels of education were associated with a desire for greater social distance, concerns about safety and unpredictability, and the belief that consumers were not proactively engaging in their recovery (Reavley et al., 2011).
Chikaodiri (2010) assessed different mental health professionals level of exposure to people diagnosed with SMI, and attributions towards someone diagnosed with schizophrenia. Participants’ level of education (post-secondary, university, postgraduate) had a positive correlation to their attributions towards people diagnosed with SMI in aspects of responsibility, anger, dangerousness, fear, and segregation. The aspects are defined as follows: responsibility was defined as who/what is to blame for the cause of his/her mental illness; anger is the degree to which a professional experiences hostile feelings towards someone diagnosed with SMI; dangerousness pertains to safety concerns experienced by a professional when exposed to someone diagnosed with SMI; fear is defined as the extent to which a professional is fearful of someone diagnosed with SMI; and, segregation is degree to which professionals feel people diagnosed with SMI should be separated from others without a mental illness (Chikaodiri, 2012). Participants with postgraduate qualifications reported more positive perspectives towards consumers diagnosed with SMI and endorsement of recovery concepts such as social inclusion than those with university degrees, who in turn were less stigmatizing than participants with post-secondary qualification were. Participants with postgraduate qualifications were less likely to report safety concerns, refrain from social interactions, or blame the consumer for his illness, than participants with university degrees or post-secondary qualification (Chikaodiri, 2010).

Tsai et al. (2010) found mixed results in terms of the relationship between level of education and professionals’ perspectives and endorsement of recovery concepts. The authors examined the effects of recovery-oriented training at two different state hospitals, on staffs’ perspectives towards recovery for people diagnosed with SMI. Findings indicated mixed results in regards to level of education and endorsement of recovery principles and practices.
Participants with higher levels of education (Bachelors, Masters, or Doctorates), scored higher on the Personal Optimism Scale and the Consumer Optimism Scale. The Personal Optimism Scale (Beck, Steer, & Kovacs, 1985) is a self-report used to measure optimism and pessimism. The authors used this scale to determine how professionals’ degrees of optimism may translate into their work with patients. The Consumer Optimism Scale (Grusky, Tierney, & Spanish, 1989) measured optimism regarding patients, including concepts such as recovery, medication use, housing, and employment opportunities. Participants with more education scored higher on both scales, suggesting greater optimism about recovery-oriented principles and practices such as ability to recover from one’s illness, attainment of needed resources, and accessibility to treatment providers. However, these participants scored lower on certain sections of the Recovery Self-Assessment (RSA; O’Connell et al., 2005), measuring the extent of consumer involvement in the development and provision of programs and services, consumers’ rights in the recovery process, and services tailored to the individual needs of the consumer. These findings suggest that participants did not endorse recovery concepts associated with consumer right to self-determination, consumer-centered treatment, and consumer participation in creating services designed to meet their goals.

Review of the literature revealed few if any recent studies reported that professionals with lower levels of education indicated more positive perspectives and endorsement of recovery concepts. For example, Aydin et al. 2003 examined the knowledge of depression and schizophrenia. Hospital staff were sampled and categorized as academicians, resident physicians, nurses, and hospital employees. Vignettes were used to assess mental health literacy (Eker & Arkar, 1991) in addition to a one-paragraph vignette with questions assessing social
distance, prognosis, recognition of mental illness, necessity for hospitalization, and selection of an intervention created by the authors (Aydin et al., 2003). Results indicated that hospital employees who had less education than academicians, resident physicians, and nurses reported more positive responses than the other professional groups. Vignette scores reported by hospital employees suggest that the characters in the vignettes with either schizophrenia or depression were regarded as having a problem to address and not someone who was sick or weak as seen by the other professional groups. Hospital employees appeared to hold less stigmatizing beliefs towards the vignette characters in general. The authors assert that the negative responses towards people diagnosed with schizophrenia or depression expressed by academicians, resident physicians, nurses may occur because of medical education. Kumakura et al. (1993) also found that senior ranked nursing students with more education as defined by completing mental health education courses reported more pessimistic perspectives on recovery than nursing students who had not completed mental health education courses.

**Setting**

Mental health professionals are employed in both inpatient and outpatient settings. Outpatient settings often consist of facilities, clinics, or community-based settings where patients are able to maintain autonomy since they are not necessarily mandated nor expected to reside at these locations. Inpatient settings typically consist of hospitals or other similar settings that influence consumer engagement given their more restrictive nature (Starnino, 2009). According to Anthony and Farkas (2012), mental health workers in outpatient settings are more likely to align with the Recovery Model, since they endorse autonomy, independence, and decision-making by consumers.
Studies have sampled professionals employed in different settings to investigate perspectives and subsequent endorsement of recovery practices (Gaffey & Evans, 2016; Hansson et al., 2011; Hugo, 2001; Martensson et al., 2014). Of the studies reviewed, the following three offer specifics on the influence of work setting on professionals’ endorsement of recovery practices (Gaffey & Evans, 2016; Hansson et al., 2011; Hugo, 2001). Gaffey and Evans (2016) replicated the methodology of Cleary and Dowling (2009) by administering the adapted version of the Recovery Knowledge Inventory (RKI) (Cleary & Dowling, 2009). One-way ANOVA established significant differences for each of the different subscales of the RKI. Professionals employed in dual settings scored higher than professionals working in an acute hospital on the subscale measuring expectations regarding recovery. This suggests that they endorsed this recovery principle. Professionals employed in outpatient settings versus professionals employed in inpatient settings also endorsed items measuring the roles and responsibilities of mental health professionals in consumer treatment and recognition of recovery as being a non-linear process more often. These findings suggest that professionals employed in dual settings support the Recovery Model more consistently than professionals employed only in inpatient, hospital settings.

Hansson et al. (2011) also studied professionals employed in inpatient and outpatient treatment settings and found similar results. Staff working in inpatient settings were less likely to endorse recovery principles in seven out of the twelve items rated on the Perceived Devaluation-Discrimination questionnaire (Link, 1987), than staff working in outpatient settings. They were less likely to support statements about comfortability and contact with people diagnosed with mental illness. For example, statements asking participants if they would accept
a person diagnosed with mental illness teaching children were frequently not supported.

In contrast, Hugo (2001) found that work settings did not significantly influence professionals’ endorsement of recovery-oriented principles and practices. Hugo adapted a questionnaire comparing mental health professionals (i.e. practitioners, psychiatrists, and psychologists) with an Australian community sample (Jorm et al., 1999). Vignettes describing major depression and schizophrenia were administered to participants to investigate knowledge about mental health history as represented as beliefs about prognosis and prognosis. Staff consisting of nurses, psychiatrists, trainee psychiatrists, and medical officers employed in hospitals versus staff employed in community-based settings reported similar views regarding prognosis, long-term outcomes, and degree of consumer involvement in recovery.

**Professional Groups**

Most literature on this topic has investigated two professional groups in particular: nursing and psychiatry (Ahmead et al., 2010; Bjorkman et al., 2008; Ewalds-Kvist et al., 2013; Ewers, Bradshaw, McGovern, & Ewers, 2002; Lauber et al., 2004; Linden & Kavanagh, 2011; McCabe, 2002; Napoletano, 1981; Nordt, Rossler, & Lauber, 2006; Rogers & Kashima, 1998; Ross & Goldner, 2009; Tay et al., 2004). Different professional groups demonstrated differences in knowledge (Pollard et al., 2008), and understanding of the etiology of mental health problems (Linden & Kavanagh, 2011); encouragement of client participation in the recovery process (Hyun, Park, Kim, Kim, & Cho, 2014); and perspectives of their role in the client-worker relationship (Hicks, Deane, & Crowe, 2012). Therefore, it is relevant to review the differences among the multiple professional groups to the extent the literature permits.

Knowledge and beliefs about mental illness, defined as Mental Health Literacy (Jorm et
al., 1997), is one of the more significant factors influencing both professionals and the public’s approach towards recovery (Hicks et al., 2012). Poor mental health literacy reduces the possibility of providing appropriate treatment for a mental health problem, increasing the likelihood of adverse long-term outcomes (Gulliver, Griffiths, & Christensen, 2010; Thompson, Issakidis, & Hunt, 2008). Mental Health Literacy (MHL) has seven defining attributes that are grouped into recognition, knowledge of elements relating to mental health, and attitudes and beliefs about mental illness. Jorm et al. (1997) developed The Vignette Interview to assess MHL, and vignettes are the most extensively used method to measure MHL (O’Connor, Casey, & Clough, 2014).

MHL is a relatively new topic of research (Mendenhall & Frauenholtz, 2013), and many studies examining MHL have investigated depression and schizophrenia (Angermeyer & Dietrich, 2006; Nordt et al., 2006). Some studies have investigated the public’s knowledge of mental illness more often than mental health professionals’ knowledge of mental illness (Amarasuriya, Jorm, & Reavley, 2015; Coles, Heimberg, & Weiss, 2013; Furnham, Abajian, & McClelland, 2011; Furnham & Winceslaus, 2012; Gong & Furnham, 2014; Melas, Tartani, Forsner, Edhborg, & Forsell, 2013; Svensson & Hansson, 2016). This poses a disadvantage for the mental health community as professionals’ degree of MHL is understudied.

Some studies (Hardiman & Hodges, 2008; Reavley, Morgan, & Jorm, 2014) offer insight into how mental health professionals score on MHL measures, as well as report on the differences in knowledge among the professional groups. Reavley et al. (2014) conducted a study with a sample of 1536 mental health professionals (general practitioners, clinical psychologists, and psychiatrists), assessing recognition of different disorders and beliefs about
the helpfulness of interventions by administering vignettes of people diagnosed with different disorders such as major depression and schizophrenia. In addition, the researchers measured psychological distress and desire for social contact, respectively, by administering the Kessler Psychological Distress Scale (K6) (Kessler et al., 2002); and the Social Distance Scale (Link et al., 1987); and the Depression Stigma Scale (Griffiths, Christensen, & Jorm, 2008) assessed stigmatizing attitudes. Participants who had personal experience with someone diagnosed with mental illness scored significantly higher on all mental health literacy scales. This suggests that participants who know someone with a mental illness would be more likely to recognize signs and symptoms of the disorder as well as have knowledge about treatment options. There were no significant differences among the professional groups in relation to correctly identifying the different vignettes. Hardiman and Hodges (2008) also found no significant differences in correctly identifying different disorders based on vignettes, among professional groups. However, ANOVA results indicated that psychologists reported less familiarity with recovery literature than did social workers, and they were less likely to seek employment in agencies that implement the Recovery Model in practice. Psychologists were less likely than psychiatrists and social workers to emphasize recovery as a primary goal when working with consumers (Nordt et al., 2006).

Differences among professional groups correctly recognizing vignettes were identified by Nordt et al. (2006). The first part of the interview consisted of participants responding to 12 items that assessed professionals’ reactions toward stereotypes of mental illness or psychiatric institutions. The second part of the interview consisted of a vignette depicting a person with either major depression, schizophrenia, or experiencing a transitional life change without
demonstrating psychiatric symptoms. Participants were asked to indicate whether the person described suffered from a mental illness or reacted in a normal way to a typical life stressor. Findings indicated that psychiatrists and psychologists correctly identified the circumstances of the person in the vignette, whereas one-third of nurses and other therapists thought that the person described in the vignette did not suffer from mental illness.

**Studies of Social Work and Recovery**

**Studies Comparing Social Workers with other Professional Groups**

Mental health social workers have a significant role in providing support and services to consumers diagnosed with mental illness (Davidson, Brophy, & Campbell, 2016). Authors (Carpenter, 2002; Davison et al., 2016; Pilgrim, 2009; Webber, 2010) assert that practice approaches in social work rest on principles and practices recognized and promoted by the Recovery Model. On the contrary, certain professional groups (psychiatry, psychology, and psychiatric nursing) focus on monitoring symptoms and ascertaining the risks people may present to themselves or others. This focus on deficits has contributed to stigma, discrimination, and exclusion experienced by service users (Davidson et al., 2016; Tew et al., 2012). Subsequently, this perspective has undermined and minimized the essence of the Recovery Model.

Although there are numerous studies regarding the Recovery Model comparing other mental health professionals, (Cleary & Dowling, 2009; Salgado et al., 2010; Tsai et al., 2011), there is a paucity of research on social workers as a professional group in relation to other professional groups (Ahmead et al. 2010; Cleary & Dowling, 2009; Gaffey & Evans, 2016; Hansson et al., 2011; Hugo, 2011; Salgado et al., 2010; Tsai et al., 2010). When studies did
include social workers, they comprised small percentages of the total sample size. In addition, social workers might have been grouped together with “allied professional” so findings specific to social workers were not reported (Arvaniti et al. 2009; Nordt et al., 2006; Stuber, Rocha, Christian, & Johnson, 2014; Stuber, Rocha, Christian, & Link, 2014). The authors’ lack of specification regarding sample populations poses a disadvantage to the research since one cannot determine how to attribute results to a particular professional group.

Hugo (2001) identified 59 allied health staff, which included social workers, general practitioners, psychiatrists, nurses, and clinical psychologists; however, he did not differentiate the findings based on professional groups. Others (Ahmead et al., 2010; Pollard et al., 2008; Salgado et al., 2010; Tsai et al., 2010) used similar professional groups or included few social workers in their samples.

For example, Pollard et al. (2008) included only four social workers in their sample of 55 participants. They reported staff attended trainings designed to educate professionals on recovery principles and practices, and found an increased awareness of evidence-based practices, education about mental illness and treatment, and a sense of optimism that people diagnosed with mental illness could live and thrive in communities (Pollard et al., 2008). Tsai et al. (2010) included eleven social workers in their study that examined attendance of recovery-oriented trainings. They did not report findings by professional group, which included nurses, social workers, and psychologists. However, the authors reported differences among the professional groups based on demographics such as age, position, and the number of trainings attended during a one-year interval (Tsai et al., 2010). Salgado et al. (2010) also investigated professionals after they conducted a training. Findings indicated an improvement in providers’ knowledge,
hopefulness, and optimism regarding recovery. Professionals groups were not differentiated in the findings; social workers comprised 15% of the total sample. Lastly, Ahmead et al. (2010) found that the majority of the 78 participants (included 5 social workers) expressed concern that the public is at risk from people diagnosed with mental illness, and consumers are unable to control their emotions. Again, findings about different professional groups were not identified.

Two frequently cited studies compared different professional groups and included social workers. They allow for a better understanding of how social workers view recovery in relation to other professional groups. Hardiman and Hodges (2008) examined differences among mental health professionals (social workers, psychologists, and psychiatrists) using the Recovery Attitude Questionnaire (RAQ-7; Borkin, Steffen, Ensfield, Krzton, & Yangarber, 2000) and a two-question item questionnaire designed by the researchers (Hardiman & Hodges, 2008) to assess knowledge and principles of recovery. Approximately 93% of professionals reported familiarity with the concepts and principles of the Recovery Model suggesting knowledge about recovery is available for learning and possible application. Slightly more than half of all providers emphasized recovery as a primary goal with consumers, but psychologists were less likely than social workers and psychiatrists to do so (Hardiman & Hodges, 2008). This study found psychologists had significantly less familiarity with the recovery literature than did social workers, suggesting the need for continued education and discussion regarding the Recovery Model for psychologists.

Social workers had significantly higher mean scores reporting consumers as full equals in service planning; this concept is central to the Recovery Model. Psychiatrists were more likely than social workers were to agree that people in recovery sometimes experience adversities and
relapses (Hardiman & Hodges, 2008). Independent of profession, participants considered recovery to be a feasible goal with social workers scoring significantly higher than psychologists and psychiatrists. All participants noted significant room for improvement in the transition from a traditional mental health system to a current recovery-oriented service system (Hardiman & Hodges, 2008).

Tsai et al. (2011) conducted a study one year after investigating whether there was an effect of formal training programs offered for social workers, case managers, nurses, psychologists, and psychiatrists. These authors conducted a randomized controlled study with approximately 700 staff invited to participate in the study. One hundred eighty-four (98 from hospital A and 86 from Hospital B) participants completed questionnaires at both baseline and one year later. They found significant differences between hospitals pertaining to age, position, and number of trainings during the year (Tsai et al., 2011). Participants in nursing, psychology, and psychiatry all scored higher on consumer optimism than social work and case management. In addition, social workers were reported less comfortable working with consumers diagnosed with SMI because of a lack of knowledge as to how to best intervene. Tew et al. (2012) had similar findings. They asserted that despite the theoretical basis of recovery finding synergy with social work, there is limited research informing social workers on how to intervene effectively and to influence the social factors enabling or impeding recovery (Tew et al., 2012).

Social Workers Alone

A national random survey of 2000 NASW members in post-master’s practice in mental health investigated their experiences with and approach towards working with individuals with severe and persistent mental illness (SPMI) (Eack & Newhill, 2008). Through a series of
structural equation models, they examined the influence of different frustrations reported by the respondents on their approaches toward working with individuals with SPMI. Results suggest that social workers are primarily influenced by their frustrations related to client behaviors and treatment issues, rather than frustrations with system related issues. Implications for social work practice and directions for future research are discussed (Eack & Newhill, 2008).

**Social Work Students and Recovery**

Research on social work education and mental illness has focused on the perspectives of educators (Probst, Balletto, & Wofford, 2015). As a result, little is known about what ideas about mental illness, treatment, and recovery MSW students bring to their training. Without understanding the concepts and orientations students already possess, it is challenging to determine how students assimilate material and apply it to practice (Probst et al., 2015). An additional challenge for educators is learning how to prepare students who come to the program with different values, motivations, and expectations gained from life experience. This challenge does not include how to address different ideas about what populations students prefer to serve and why, or how to best approach differences as educators (Probst et al., 2015).

Some studies have explored students’ interest in working with consumers diagnosed with SMI (Covarrubias & Han, 2011; Foster et al., 2013; Shera & Delva-Tautili, 1996). Previous contact and perceived knowledge of mental illness were among key predictors in Werbach and Depoy’s (1993) study, while an early study conducted by Drolin (1993) found that offering instruction in the field rather than classroom settings favorably influenced students’ interest in working with consumers diagnosed with SMI. In contrast, Covarrubias and Han (2011) found that a lack of contact, stigmatizing stereotypes, and the belief that mental illness defines one’s
identity contributed to students’ lack of endorsement of recovery practices.

Overall, there is little, if any, research about social work students and the Recovery Model. Review of the research found that two studies (Shera & Delva-Tauiliiili, 1996; Werbach & DePoy, 1993) offered early findings on this subject, dating back approximately twenty years ago. Werbach and DePoy (1993) investigated the interest level of social work students in anticipation of working with people diagnosed with SMI. The authors sampled ninety BSW and MSW students to determine their interest level, as well as mental health literacy when working with people diagnosed with SMI. Findings indicated no significant differences between BSW and MSW students in terms of interest level and mental health literacy (Werbach & DePoy, 1993). Significant differences were found between students with employment experience in the field of mental health, regardless of setting, and students without employment experience. Students with more employment experience reported a greater interest in working with people diagnosed with SMI than students with less employment experience. This finding supported their hypothesis that more experience working in the field of mental health led to a greater interest level and mental health literacy (Werbach & DePoy, 1993). A thorough review of the literature suggests that the aforementioned study is the most comprehensive attempt thus far to learn about social work students’ relationship to the Recovery Model.

Shera and Delva-Tauiliiili (1996) investigated the influence of an intervention on second-year MSW students to measure students’ mental health literacy. The intervention included a class discussion centering on the personal experiences of people diagnosed with SMI. Participants later viewed an educational video and completed a structured interview with people diagnosed with SMI. Findings indicated that participants who completed the intervention found
that people diagnosed with SMI were more engaged in treatment, had greater prognostic outcomes, demonstrated less dangerous and violent tendencies, and were less erratic in behavior. Participants from the comparison group remained unchanged (Shera & Delva-Tauiliili, 1996).

Recent research offers new findings on social work students’ perspectives towards recovery practices. Several studies (Covarrubias & Han, 2011; Foster et al., 2013; Probst et al., 2015) examined social work endorsement of components of the Recovery Model, including mental health literacy, social distance, safety concerns, and restrictiveness. Covarrubias and Han (2011) found that majority of participants reported a willingness to include people diagnosed with SMI in their social network, neighborhood, and employment setting. However, a majority of participants reported refusal to hire people diagnosed with SMI as a babysitter (nearly 80%), and participants reported reluctance to permit their children to marry a person diagnosed with SMI (Covarrubias & Han, 2011). The majority of participants reported disagreement to restrict liberties on four items: restricting the right to vote (88.6%), revoking driver’s licenses (82.9%), requiring government supervision to be primary caretakers of children (72.9%), and not allowing foster/adoptive parenting (60%) (Covarrubias & Han, 2011). Results found that more intimate social networks with friends but not family diagnosed with SMI was associated with less desire for social distance (Covarrubias & Han, 2011). Previous research by Scheyett and Kim (2004) found that students consistently reported a lowered need for social distance, less concerns about dangerousness, and more positive affective response towards consumers.

Probst et al. (2015) found that MHL improved endorsement of recovery-oriented principles and practices towards consumers diagnosed with SMI. Findings indicated that students who increased their knowledge about mental disorders via classroom learning, reading,
and interactions with consumers diagnosed with mental illness, were more likely to accurately identify different disorders (Probst et al., 2015).

**Summary**

This chapter reviewed research about mental health professionals’ perspectives and subsequent endorsement of recovery-oriented principles and practices towards people diagnosed with SMI. Many of the variables contributing toward professionals’ endorsement of recovery-oriented principles and practices, in particular social workers, such as mental health literacy, social distance, dangerousness, familiarity with someone diagnosed with SMI, and more than five years of employed experience in a mental health setting, have either been understudied or resulted in mixed findings in the literature (Ahmead et al. 2010; Cleary & Dowling, 2009; Gaffey & Evans, 2016; Hansson et al., 2011; Hugo, 2001; Salgado et al., 2010; Tsai et al., 2010). Approaches identified in many of the studies discussed demonstrate a reliance on two or three measurement tools (Bjorkman et al., 2008; Ewalds-Kvist et al., 2013; Linden & Kavanagh, 2011; Ross & Goldner, 2009).

Although social workers provide the majority of services to consumers diagnosed with mental illness (Eack & Newhill, 2008), social workers are not adequately represented in the literature (Arvaniti et al. 2009; Nordt et al., 2006; Stuber, Rocha, Christian, & Johnson, 2014; Stuber, Rocha, Christian, & Link, 2014). Research on social work students is also scarce (Shera & Delva-Tauiliili, 1996; Werbach & DePoy, 1993), suggesting that additional research would contribute to the gap in the literature.

The following chapter presents the methodology employed in the current study.
CHAPTER V: METHODOLOGY

The purpose of the study was to explore the extent to which social work students endorsed recovery-oriented principles and practices. I explored the five variables identified in the literature as most frequently influencing the extent to which professionals endorsed recovery-oriented principles and practices when working with consumers diagnosed with serious mental illness (SMI): knowledge of severe mental illness (mental health literacy), social contact (social distance), concerns regarding safety (dangerousness), knowing someone diagnosed with mental illness (familiarity), and having more than five years of employed experience working with people diagnosed with SMI.

The primary research question addressed was:

1) How does mental health literacy, social contact, concerns regarding safety, knowing someone diagnosed with mental illness, and having more than five years of employed experience working with people diagnosed with SMI, affect the extent to which MSW students report endorsing recovery-oriented principles and practices?

Hypotheses

1) MSW students with knowledge about psychiatric conditions will influence endorsement of recovery-oriented principles and practices.

2) MSW students who have social contact with consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

3) MSW students with negative attitudes towards safety around consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.
4) MSW students with more than five years of employed experience working with consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

5) MSW students who identify as having a significant other diagnosed with SMI will influence endorsement of recovery-oriented principles and practices to a greater extent.

**Method**

I utilized a survey research design that included standard scales and closed ended questions via an online survey. I distributed the survey online. In this context, findings shed light on social work students’ extent of endorsement of recovery-oriented principles and practices. I used standard instruments described later in this chapter to measure the dimensions of interest.

According to Kiesler and Sproull (1986) and McBurney (1994), online surveys allow for better neutrality, compared to face-to-face interviews. The social distance created by using computer-controlled interactions mitigates social desirability concerns. As a result, online methods of data collection may be less susceptible to social desirability effects (Kiesler & Sproull, 1986). People also tend to regard electronic appliances such as computers as being non-bias machines, thereby placing participants in a more comfortable position to respond accurately (McBurney, 1994).

**Instruments**

**Recovery Knowledge Inventory (RKI)**

I used the *Recovery Knowledge Inventory (RKI)* (Bedregal et al., 2006) to measure participants’ knowledge of and adherence to recovery principles and practices. Bedregal et al.
(2006) designed the RKI in 2006 as part of an effort to make all mental health services in Connecticut more recovery-oriented. When constructing the instrument, the authors considered that different stakeholders would endorse different meanings of recovery such as the traditional definition and the more recent understanding of recovery reflected in the Recovery Model (Bedregal et al., 2006). The current version of the RKI consists of 20 items resulting from a thorough review of the recovery literature and empirical validation (Bedregal et al., 2006). The analyses produced four dimensions labeled: Roles and Responsibilities in Recovery; Non-Linearity of the Recovery Process; the Roles of Self-definition and Peers in Recovery; and Expectations regarding Recovery.

The first subscale, Roles and Responsibilities in Treatment, includes seven items pertaining to risk taking, decision-making, and self-determination (2, 6, 7, 9, 10, 11, and 18). The second subscale, Non-Linearity of Recovery, includes six items pertaining to symptom management, integration of illness into one’s life, and recovery process (4, 14, 15, 16, 17, and 19). The third subscale, The Role of Self-Definition and Peers in Recovery, includes five items pertaining to involvement in relevant activities, support system, and development of a healthy identity (1, 3, 8, 12, and 20). The fourth scale, Expectations regarding Recovery, includes 2 items pertaining to hope and extent to which one is capable of engaging in the recovery process (5 and 13).

The instrument uses a 5-point Likert response format ranging from 1 (strongly disagree) to 5 (strongly agree) (Bedregal et al., 2006). Sample items such as “Symptom reduction is an essential component of recovery” and “Expectations and hope for recovery should be adjusted according to the severity of a person’s illness/condition” evaluate hope and symptom
management. Scoring is determined by obtaining the means for each dimension and then judging each factor’s mean according to the Likert Scale. Mean scores of four and five equate to demonstrating strong recovery knowledge, a mean score of three equates to adequate recovery knowledge, and mean scores of two and one equate to poor recovery knowledge. Reliability analysis (Cronbach’s alphas) estimates for the four components were .81, .70, .63, and .47, respectively (Bedregal et al., 2006). Wilrycx, Croon, Van den Broek, & van Nieuwenhuizen (2012b) identified the tool’s lack of established psychometric properties as a limitation.

**Social Distance Scale (SDS)**

The *Social Distance Scale* (SDS; World Psychiatric Association Programme to Reduce Stigma and Discrimination Because of Schizophrenia, 2001) was employed to measure the independent variable, social contact (social distance). Bogardus developed the Social Distance Scale (SDS) as part of a larger study initiated by the World Psychiatric Association Programme to Reduce Stigma and Discrimination Because of Schizophrenia (2001). I used the modified version of the scale used in the Adewuya and Makanjuola study, which consisted of six questions (2005). The instrument uses a 4-point Likert response format ranging from 1 (*definitely yes*) to 4 (*definitely not*) (Adewuya & Makanjuola, 2005). The statement receiving the mean closest to one indicates the most amount of social distance desired, while the statement receiving the mean value closest to four indicates the least amount of social distance desired (Bogardus, 1936).

Items representing the following social relationships include marriage, sharing a room, friendship, working together, conversation, and family relationship (Adewuya & Makanjuola, 2008). For example, the statement inquiring, “Would you feel ashamed if people knew someone in your family has mental illness?” measures participant degree of discomfort knowing someone
diagnosed with mental illness. Link et al. (1987) assert that the original questionnaire obtained a coefficient of reliability of .85. Lastly, good to excellent internal-consistency reliability and construct validity have been reported (Link et al., 1987).

**Dangerousness Scale (DS)**

The Dangerousness Scale (DS; Link et al., 1987) was used to measure the independent variable, concerns regarding safety (dangerousness). The scale consists of eight items designed to assess beliefs about whether or not a person diagnosed with mental illness is likely to be perceived as dangerous or a threat to others. Participants rated each item using a 6-point Likert scale ranging from 0 (*strongly agree*) to 5 (*strongly disagree*). Six of the eight items were reversed scored (except #2 and #6) so that higher scores indicated greater levels of perceived dangerousness. Items on the scale such as, “The main purpose of mental hospitals should be to protect the public from mentally ill people,” assess developing professionals’ perspectives toward treatment and intervention approaches and as recovery-oriented practices. Link et al. (1987) found an adequate internal consistency for the scale of 0.85. Additional information was not available and this is considered a limitation of the study.

**Mental Health Literacy**

Mental health literacy was measured in the form of vignettes, which consisted of questions designed to measure knowledge and recognition of psychiatric conditions, etiology of different illnesses, degree of prognosis, and treatment needs. The first vignette measured participant degree of knowledge of Major Depressive Disorder according to the criteria in the DSM-V. For example, “How serious would you consider Nick’s problem to be—very serious, somewhat serious, not very serious, or not at all serious?” was used to assess knowledge about
the severity of the condition. The remaining item asked participants to respond with either Yes or No to the question, “Does Nick have a mental illness?” Additional questions sought to determine how participants rated the cause of the situation, and whether or not the situation would improve on its own or with treatment. The second vignette measured participant degree of knowledge of Psychosis/Schizophrenia according to the criteria in the DSM-V criteria. Questions inquired about the severity of the problem; whether or not the person has a mental illness; the likely cause of the situation, the possibility the situation will improve without treatment; and the likelihood the situation will improve with treatment. The third vignette measured participant degree of knowledge of Social Phobia according to the criteria in the DSM-V. The same questions identified above were asked of participants. The fourth vignette measured participant knowledge of Post-Traumatic Stress Disorder according to the criteria in the DSM-V. Again, the same questions were asked of participants to determine the extent of knowledge of the psychiatric condition presented.

I used four vignettes in total. The first two vignettes were taken from The MacArthur Mental Health Module developed in 1996 to investigate public perception towards people diagnosed with mental illness (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). These researchers developed vignettes based on criteria for diagnosing schizophrenia, major depressive disorder, alcohol dependence, and drug dependence from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (Pescosolido et al., 1999). I used the two vignettes describing people diagnosed with either Major Depressive Disorder or Psychosis/Schizophrenia in my study since the remaining two vignettes (alcohol and drug dependence) were not relevant to my study’s purpose. Analyses determined the vignettes
produced predictable patterns of response, suggesting the measures have construct validity (Pescosolido et al., 1999). McNeal (2015) cited in her dissertation An Evaluation of the Attitudes, Beliefs, and Mental Health Literacy of Young African American College Graduates that contact with Pescosolido in 2015, confirmed that psychometric properties had yet to be entirely collected on the vignettes and survey instruments, hence the lack of information available on reliability presently. McNeal added that content validity was confirmed by a psychiatric expert who assisted with the development of the vignettes for the MacArthur Mental Health Module.

The remaining two vignettes were selected to create a more robust instrument to measure mental health literacy. One of the two vignettes described a person diagnosed with Social Phobia, while the second vignette described a person diagnosed with PTSD, both according to the criteria in the DSM-V. The content questions identified earlier in this section were used for these vignettes also. These two vignettes (Social Phobia and PTSD) selected for my study were taken from the Australian National Survey of Mental Health Literacy and Stigma in Australia (Reavley & Jorm, 2011). Review of the findings from the Australian National Survey of Mental Health Literacy and Stigma did not reveal discussion on psychometric properties. Information about the reliability and validity of the vignettes taken from the National Survey of Mental Health Literacy and Stigma in Australia (Reavley & Jorm, 2011) is seemingly unavailable.

All four vignettes that I used (i.e. Major Depressive Disorder; Psychosis/Schizophrenia; Social Phobia; and PTSD) were a hybrid taken from the MacArthur Mental Health Module developed in 1996 and Australian National Survey of Mental Health Literacy and Stigma in Australia discussed above. The four vignettes were administrated to and scored by six practicing
mental health professionals (four clinical social workers, one psychiatric nurse, and one psychologist) who acted as an expert panel, all of which were employed in a suburban psychiatric hospital setting in the Northeast. Colleagues were selected based on availability and willingness to participate. Study participants were scored as either correct or incorrect on the vignette questions if their answers matched the majority answer given by the members of the expert panel. Each vignette consisted of 10 total questions that were read and answered by the expert panel first, and later served as a response template when scoring participants’ answers. The first question (identified in a later section) was on a 4-point Likert scale ranging from 1=very serious to 4=not at all serious. The second question (identified in a later section) is a binary variable, with participants choosing either Yes or No as the answer. The third question lists six possible etiological causes for the underlying situation/condition (e.g. his or her own behavior, a chemical imbalance in the brain, the way he was raised, stressful circumstances in his life, a genetic or inherited problem, or God’s will), and asks participants to rate each cause on a 4-point Likert scale ranging from 1=very likely to 4=not at all likely. This question was treated like six total questions or scoring opportunities. The fourth question (identified in a later section) was on a 4-point Likert scale ranging from 1=very likely to 4=not at all likely. The fifth question (identified in a later section) follows the same format. Participants earned a point for every answer that matched the answer selected by the majority of the expert panel. Participants could earn as many as 10 points or as few as 0 points based on this system. Earning the full 10 points indicated excellent knowledge of psychiatric conditions while earning 0 point indicated absolutely no knowledge of psychiatric conditions. A score of seven or higher is considered
adequate or satisfactory on a range from 0-10, with 10 being the highest possible score one could earn.

While the data was not conducive to calculating an inter-rater reliability measure such as kappa, the majority of the expert panel raters selected the same answer for the majority of the questions being asked. When this was not the case, the answers were similar. For example, five of the six participants rated Nick’s condition of Major Depressive Disorder (first vignette) as being Very Serious, while one selected Somewhat Serious. Expert panel results on each item are discussed in detail in the following subheadings.

Vignette A: Major Depressive Disorder

The six participants of the expert panel were necessary since this was not a pre-existing instrument and I had to construct my instrument to measure MHL based on available and appropriate pre-existing instruments. The panel reported the following findings based on vignette. In the first vignette, Nick is diagnosed with Major Depressive Disorder, characterized by symptoms of fatigue, loss of interest in previously enjoyable activities, poor concentration, and apathy. In response to the first question asking how serious Nick’s problem is, five professionals (83%) answered Very Serious to the first question asking the severity of Nick’s problem and one professional answered Somewhat Serious, on a 4-point Likert scale. All six professionals (100%) answered Yes in response to the question if Nick has a mental illness; the alternative answer was No. In response to the question, “Nick’s situation was likely caused by,” participants were given six options and asked to rate each on a 4-point Likert scale ranging from Very Likely, Somewhat Likely, Not Very Likely, to Not at all Likely. Four professionals (nearly 67%) responded Very Likely to the option, A chemical imbalance in the brain, while two
professionals (33%) responded Very Likely to the option, Stressful circumstances in his life. On a 4-point Likert scale, five professionals (83%) answered Not at All Likely in response to the question whether Nick’s situation would improve on its own, and one professional responded Not Very Likely. Lastly, all six professionals (100%) answered Very Likely to the question asking if Nick’s situation will improve with treatment, on a 4-point Likert Scale.

Vignette B: Psychosis/Schizophrenia

In the second vignette, Vicki is diagnosed with Psychosis/Schizophrenia, characterized by symptoms of paranoia, ideas of reference, and auditory hallucinations. In response to the first question, all six professionals (100%) found Vicki’s condition to be Very Serious. All six professionals (100%) answered unanimously Yes, in response to the second question inquiring if Vicki has a mental illness. Four professionals (nearly 67%) rated, A chemical imbalance in the brain, as Very Likely the cause of Vicki’s situation, while two professionals (33%) rated, A genetic or inherited problem, as Very Likely the cause. All six professionals (100%) answered Not at All Likely that Vicki’s situation would improve on its own. Lastly, all six professionals (100%) answered Very Likely to the question asking if Vicki’s situation will improve with treatment.

Vignette C: Social Phobia

In the third vignette, Vicki is diagnosed with Social Phobia, characterized by symptoms of physical anxiety such as trembling or blushing, fear of being judged by others, discomfort talking to strangers, and avoidance tactics. In response to the first question, four professionals (nearly 67%) considered Vicki’s problem to be Very Serious, while two professionals (33%) considered Mary’s problem to be Somewhat Serious. All six professionals (100%) answered Yes
in response to the question if Mary has a mental illness. Professionals showed greater diversity in responses in this vignette, to the question rating the likelihood that the situation was caused by different options. One professional rated *His or her own behavior* as *Somewhat Likely*; one professional rated, *A chemical imbalance in the brain*, as *Very Likely*; one professional rated, *The way he was raised*, as *Somewhat Likely*; and three professionals (50%) rated, *A genetic or inherited problem*, as *Very Likely*. In response to the question, “How likely is it that Mary’s situation will improve on its own,” four professionals (nearly 67%) responded *Not at All Likely* and two professionals (33%) responded *Not Very Likely*. Again, professionals reported differences in answers in response to the last query. Three professionals (50%) reported *Very Likely* that Mary will improve with treatment; two professionals (33%) reported *Somewhat Likely*; and one professional reported *Not Very Likely*.

**Vignette D: Post Traumatic Stress Disorder**

In the fourth vignette, Brady is diagnosed with Post Traumatic Stress Disorder, characterized by symptoms of a hyperactive startle response, fear of returning to a situation where a traumatic event occurred, fear of associated people or places, nightmares/terrors, and isolation. In response to the first question, all six professionals considered Brady’s problem to be *Very Serious*. All six professionals (100%) also responded *Yes* in reply to the question asking if Brady has a mental illness. Five professionals (83%) responded *Very Likely* in reply to the cause of Brady’s situation as, *Stressful circumstances in his life*, while one professional rated, *God’s Will*, as *Somewhat Likely*. Five professionals (83%) responded that Brady’s situation would *Not at All Likely* improve on its own. One professional responded Brady’s situation was
Not Very Likely to improve on its own. Lastly, all six professionals (100%) responded Very Likely to the question asking how likely Brady’s situation will improve with treatment.

The remaining variables were measured by using demographic questions. Participants filled in a number in response to the questions inquiring about age, number of semesters completed in the MSW program, number of years worked as a paid employee in a mental health setting, and number of years worked as a volunteer in a mental health setting. Questions such as ethnicity/race, gender, prior possession of a Bachelor of Social Work degree, type of Master of Social Work program pathway, type of field practice specialization, engagement in a personal relationship with someone diagnosed with SMI, type of relationship with someone diagnosed with SMI, primary caretaker to someone diagnosed with SMI, and type of relationship to the person diagnosed with SMI if serving as his/her primary caretaker were answered in a multiple-choice format.

**Pilot Study**

**Sampling**

The pilot study took place at an urban School of Social Work in the northeast with Masters of Social Work (MSW) students in the program. I conducted it to determine if the selected instruments were accurately measuring my variables. In addition, the pilot study offered information as to what changes needed to be made to recruit a larger sample. A survey consisting of three instruments (Recovery Knowledge Inventory, Social Distance Scale, and Dangerousness Scale), and a demographic page was given to approximately 475 first year MSW students enrolled in one of the five program pathways at the urban School of Social Work in the northeast, to assess their degree of endorsement of recovery-oriented principles and practices.
On approval by the institutional review board, students enrolled for the Fall 2015 semester were invited to participate. Surveys and informed consent materials were sent via blast email by the Director of Student Services during the first month (September) of the Fall 2015 semester. This was an anonymous survey, and I did not have access to student emails or accounts. Correspondence regarding the survey were exchanged between me and the Director of Student Services during the Fall 2015 semester for this study.

Participants identified with one of three genders (male, female, or transgender); identified English as their primary language; and represented diversity in backgrounds. A minimal total sample size of 50 was deemed necessary by G*Power general power analysis program (Faul, Erdfelder, Lang, & Buchner, 2007). This sample size allows for adequate power (0.80) in order to identify a moderate effect size (.50) (Cohen, 1988).

**Recruitment**

Participants were recruited from first-year class in the urban School of Social Work in the northeast for the pilot study. A typed recruitment letter described the purpose of the study, approximate length of time to complete the survey, indicated that participation was voluntary, and directed all participants to the web link where the survey and demographic questions could be accessed. Since this was an online survey, respondents could participate in the study at a location, time, and type of electronic device of their choosing. Upon gaining approval by Hunter College’s Institutional Review Board, the Director of Student Services sent blast emails to first-year MSW students requesting participation in the study, maintaining students’ anonymity.
Data Collection Procedures and Instruments

A survey was created on the Qualtrics platform. Qualtrics software enables online data collection for academic research, market research, and employee feedback. It is a web platform for the development and distribution of online surveys. The platform allows analysis export to SPSS (Statistical Package for the Social Science) (www.qualtrics.com).

A recruitment letter (see Appendix G) announced the study and invited first-year MSW students at the urban School of Social Work in the northeast to participate in the study via blast email distributed by the Director of Student Services. The recruitment letter explained the study’s purpose and instructions to follow should they choose to participate. A link to the consent information sheet and the survey instruments were included in the email.

I intended to keep the survey open for two months to allow for participants’ participation. The pilot study was open for approximately seven weeks. Dillman (1978) developed a method to optimize response rate. Dillman recommends sending the initial request for survey participation during the first week, a reminder postcard during week two, a replacement survey to non-participants during week four, and a second replacement survey to non-participants during week seven. Since I conducted my survey via the internet, modifications were made to Dillman’s method (i.e. follow-up emails versus postcards), with the intention of optimizing responses. Blast emails were sent on three separate occasions to increase participant response rate by the Director of Student Services. Each instrument should have taken approximately 30 minutes to complete according to previous findings (Bedregal et al., 2006, World Psychiatric Association Programme to Reduce Stigma and Discrimination Because of Schizophrenia, 2001;
Link et al., 1987). However, the average length of time, excluding outliers (more than one hour to complete the survey), was eleven minutes from start to completion.

The pilot study included three instruments: Recovery Knowledge Inventory (RKI; Bedregal et al., 2006), Social Distance Scale (SDS; World Psychiatric Association Programme to Reduce Stigma and Discrimination Because of Schizophrenia, 2001), and Dangerousness Scale (DS; Link et al., 1987). A demographic page consisted of 15 questions for participants to answer (See Appendix E).

**Data Analysis Plan**

All data were analyzed using the Statistical Package for Social Science (SPSS) version 22.0 software. The model was run using the 46 participants that were fully observed on the relevant variables. I employed a multiple regression model to determine the relationship between the outcome variable, RKI, and the predictor variables, social contact to a person diagnosed with mental illness, concerns regarding safety posed by people diagnosed with mental illness, years of paid experience working with someone diagnosed with SMI, and knowing someone diagnosed with SMI. The model controlled for the following control variables: age, race, gender, length of time enrolled in the MSW program, years of experience working as a volunteer in a mental health setting, number of semesters of MSW fieldwork assignment in a mental health setting, type of practice specialization, and MSW program pathway.

Research Question 1: How do social contact, concerns regarding safety, knowing someone diagnosed with mental illness, and working for more than five years of employed experience with people diagnosed with SMI, effect the extent to which MSW students report endorsing recovery-oriented principles and practices?
Analysis 1: A multiple regression model was used to predict scores on the RKI from social contact, concerns regarding safety, knowing someone diagnosed with mental illness, working for less than 5 years of employed experience with people diagnosed with SMI, and control variables.

Hypothesis 1: MSW students with negative attitudes towards safety around consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

Rationale: Research (Ahmead et al., 2010; Bjorkman et al., 2008; Mittal et al., 2014; Linden & Kavanagh, 2011) suggests that professionals and professionals in training who regard people diagnosed with SMI as erratic or dangerous are less likely to endorse recovery-oriented principles and practices.

Analysis 2: A multiple regression model was used to predict scores from the Recovery Knowledge Inventory (RKI) from the score on the Dangerousness Scale (DS), after accounting for all the other independent variables.

Hypothesis 2: MSW students with more than 5 years of employed experience working with consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

Rationale: Review of the literature (Hansson et al., 2011; Jorm et al., 1999) illustrates that professionals who report more years of paid employment working with people diagnosed with SMI report hope regarding prognosis and recovery, reflective of recovery-oriented principles and practices.
Analysis 3: A multiple regression model was used to predict the score on the Recovery Knowledge Inventory (RKI) from having more than 5 years of employed experience working with people diagnosed with SMI, after accounting for all the other independent variables.

Hypothesis 3: MSW students who identify as having a significant other diagnosed with SMI will influence endorsement of recovery-oriented principles and practices to a greater extent.

Rationale: Research (Chung, Chen, & Liu, 2001; Corrigan et al., 2001; Couture & Penn, 2003; Covarrubias & Han; 2011; Martensson et al., 2014) suggests that professionals and professionals in-training who have familiarity with someone significant diagnosed with SMI report endorsing recovery-oriented principles and practices.

Analysis 4: A multiple regression model was used to predict the score on the Recovery Knowledge Inventory (RKI) from the score of how many participants reported having a significant other diagnosed with SMI, after accounting for all the other independent variables.

I determined that the variables were not clearly stated in the pilot study’s research question, and I did not have an instrument to measure mental health literacy, resulting in changes being made for the final study to the research question and hypothesis (discussed in the following chapter).

Final Study

Method

I utilized a survey research design utilizing standard scales and largely closed ended questions via an online survey.
Sampling

The study was conducted during the Spring 2016 semester and was modified based on the findings from the pilot study, which indicated that the independent variable, mental health literacy was not measured based on the instrument originally selected (RKI). As a result, a Mental Health Literacy Scale was selected to measure knowledge of psychiatric conditions. Lastly, a larger sample size was selected to draw a higher response rate.

For the study, a survey consisting of four instruments and a demographic page invited approximately 975 MSW students regardless of their year in the program, to participate in the study. Each student was enrolled in one of the five program pathways at the urban School of Social Work in the northeast. On approval by the institutional review board, students enrolled for the Spring 2016 semester were asked to participate. Surveys and informed consent materials were sent via blast email by the Director of Student Services during January of the Spring 2016 semester. This was an anonymous survey, and I did not have access to student emails or accounts. All correspondences regarding the survey were exchanged between me and the Director of Student Services during both the Fall 2015 and Spring 2016 semesters.

The convenience sample of 112 comprised the Spring 2016 sample. Participants identified with one of three genders (male, female, or transgender); identified English as their primary language; and represented diverse backgrounds.

Recruitment

Participants were recruited from any year enrolled in the urban School of Social Work in the northeast for the final study. The recruitment letter for the survey was modified to include a more thorough description about my professional experiences in mental health in the interest of
engaging with participants since it was an online survey. A recruitment letter described the purpose of the study, approximate length of time to complete the survey, indicated that participation was voluntary, and directed all participants to the web link where the survey and demographic questions could be accessed. Since this was an online survey, respondents could participate in the study at a location, time, and type of electronic device of their choosing. Blast emails were sent weekly by the Director of Student Services to students upon gaining approval by the College’s Institutional Review Board. Results from the pilot study indicated that more frequent emails (emails sent at least three times to each student over the course of multiple weeks) resulted in higher return rates by students.

**Data Collection Procedures and Instruments**

The pilot survey was revised as discussed above (inclusion of the mental health literacy measure) for final data collection. The final survey was also created using the Qualtrics platform. The platform allows analysis export to SPSS (www.qualtrics.com). A recruitment letter (see Appendix H) announced the study and invited all MSW students at the urban School of Social Work in the northeast, to participate in the study. The Director of Student Services distributed the recruitment letter and the survey in an email blast. All MSW students were included to increase potential sample size. The recruitment letter explained the study’s purpose and instructions to follow should students choose to participate in the process. In addition, the letter included more information about my professional experiences in the interest of engaging participants. A link to the consent information sheet and the survey instruments were included in the email. A demographic page consisted of 13 questions for participants to answer (See Appendix F).
The study was open for approximately four months. Based on participant response rate for the pilot study, I coordinated with the Director of Student Services, requesting that she send blast emails on a weekly basis instead of biweekly. Sending the blast email weekly for the final study improved the response rate by three times.

**Data Analysis Plan**

All data were analyzed using the Statistical Package for Social Science (SPSS) version 22.0 software. A multiple regression model was used to conduct the analysis. The model was run using 112 participants who had completed all the relevant variables. All of the variables were entered into the model simultaneously, including all of the independent and control variables identified in a previous section.

Research Question 1: How does mental health literacy, social contact, concerns regarding safety, knowing someone diagnosed with mental illness, and working for more than five years of employed experience with people diagnosed with SMI, affect the extent to which MSW students report endorsing recovery-oriented principles and practices?

Analysis 1: A multiple regression model was used to determine the relationship between scores on mental health literacy, social contact, concerns regarding safety, knowing someone diagnosed with mental illness, and working for more than five years of employed experience with people diagnosed with SMI, and scores on the Recovery Knowledge Inventory (RKI), after accounting for all the other independent variables.
Hypothesis 1: MSW students with knowledge about psychiatric conditions will influence endorsement of recovery-oriented principles and practices.

Analysis 1: A multiple regression model was used to predict scores on the Recovery Knowledge Inventory (RKI) from scores on the Mental Health Literacy Scale, after accounting for all the other independent variables.

Hypothesis 2: MSW students who have social contact with consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

Analysis 2: A multiple regression model was used to predict scores on the Recovery Knowledge Inventory (RKI) from scores on the Social Distance Scale (SDS), after accounting for all the other independent variables.

Hypothesis 3: MSW students with negative attitudes towards safety and consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

Analysis 3: A multiple regression model was used to predict scores on the Recovery Knowledge Inventory (RKI) from scores on the Dangerousness Scale (DS), after accounting for all the other independent variables.

Hypothesis 4: MSW students with more than five years of employed experience working with people diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.
Analysis 4: A multiple regression model was used to predict scores on the Recovery Knowledge Inventory (RKI) from the score of how many participants reported more than 5 years of employed experience working with people diagnosed with SMI, after accounting for all the other independent variables.

Hypothesis 5: MSW students who identify as having a significant other diagnosed with SMI will influence endorsement of recovery-oriented principles and practices to a greater extent.

Analysis 5: A multiple regression model was used to predict scores on the Recovery Knowledge Inventory (RKI) from the score of how many participants reported having a relationship with a significant other diagnosed with SMI, after accounting for all the other independent variables.

Protection of Human Subjects

Participants were informed of the study procedures and potential risks and benefits via an implicit consent cover page of the survey in my recruitment letter. I obtained passive consent from all participants, and honored confidentiality by using identification numbers to further minimize potential risks to disclosure.

Data were entered via the Qualtrics platform and stored online. Only my dissertation committee and I had access to the information. There were no known risks associated with participation in this study, since it was a voluntary, anonymous survey done from obtaining email addresses.

A potential benefit to participants was the possibility that reflecting on the questions and answers may have offered an opportunity for self-reflection and possible changes in approaches towards recovery, mental illness, or consumers diagnosed with mental illness.
CHAPTER VI: STUDY RESULTS

The purpose of the study was to explore the extent to which social work students endorsed recovery-oriented principles and practices. I explored the five variables identified in the literature as most frequently influencing extent of endorsement of recovery-oriented principles and practices when working with consumers diagnosed with SMI. These were knowledge of severe mental illness (mental health literacy), social contact (social distance), concerns regarding safety (dangerousness), knowing someone diagnosed with mental illness (familiarity), and having more than five years of employed experience working with people diagnosed with SMI. The pilot study employed an online survey method sent via blast email by the Director of Student Services to first-year MSW students at the urban School of Social Work in the northeast. The final study included all MSW students at the urban School of Social Work in the northeast to increase potential sample size.

Pilot Study

Descriptive Findings

One hundred and one participants agreed to participate in the survey. Of the 101, 46 met the criteria for inclusion in the study, although 55 people who completed the survey were not first year MSW students and were excluded from the study. The majority of the participants (80%) who completed the survey identified as female (n=37). Seventeen percent (n=8) of the participants identified as male. One individual identified as transgender. Seventeen participants identified as Caucasian; 12 participants identified as Hispanic/Latino; 11 participants identified as African American; four participants identified as Other; and two identified as Asian. The mean age of participants was 30.09. Twenty-seven participants (59%) reported falling in the 20-
29 age range; nine participants (20%) reported falling in the 30-39 age range; five participants (11%) reported falling in the 40-49 age range; and two participants (4%) reported falling in the 50-59 age range. Three participants (nearly 7%) did not provide data in response to this query.

The majority of the participants (76%) reported they did not have a Bachelor of Social Work degree prior to entering the MSW program. Of the possible pathways MSW students could be currently enrolled in at the social work school, 48% (n=22) reported enrollment in the two-year program; 35% (n=16) reported enrollment in the one-year residency program; 15% (n=7) reported enrollment in the advanced standing program; and 2% (n=1) reported enrollment in the accelerated one-year residency program. No participants reported enrollment in the accelerated full-time program. Nine percent (n=4) reported already earning another Master’s degree from an accredited institution. Of a possible 101 participants who completed the survey, only 46 met the criteria in terms of being first-year MSW students at the social work school (completed less than two enrolled semesters in the program).

The mean response to the question, “How many years have you worked as a paid employee in a mental health setting before you entered the MSW program?” was 2.89. In response to the question regarding years worked as a volunteer in a mental health setting prior to entering the MSW program, the mean was 0.94. Lastly, the mean was 0.34 in response to the question, “How many semesters of your MSW field work assignment has been in a mental health setting?” The majority of participants (61%, n=28) reported Health and Mental Health as their current field of practice specialization. Twenty percent (n=9) reported Child Welfare: Children, Youth, and Families as their current field of practice specialization; 11% (n=5) reported Global Social Work and Practice with Immigrants and Refugees as their current field of practice specialization.
specialization; 4% (n=2) reported Aging as their current field of practice specialization; and 4% 
(n=2) reported World of Work as their current field of practice specialization.

The majority of the participants (76%) reported having had a personal relationship with 
someone diagnosed with a severe mental illness. Of the 37 participants who answered yes to the 
aforementioned question, 22 participants identified the person as a family member, four 
participants identified the person as their Significant Other/Partner, seven participants identified 
the person as their Friend, one participant identified the person as his/her Co-worker, and three 
participants identified the person as Other. Nearly all of the participants (n=43) reported not 
serving in the role of primary caretaker to someone with mental illness. For the three 
participants who reported yes to this query, all reported stated their relationship as falling in the 
category of Family Member.

The majority (n=30) of all the participants completed approximately one semester in the 
program. Approximately half of all participants (n=24) reported working as a paid employee in a 
mental health setting. Of these 24 participants, 17 reported having paid employment in a mental 
health setting for five years or less (averaging under three years of total employment). Seven 
participants reported paid employment in a mental health setting for more than five years. 
Eighteen participants reported working as a volunteer in a mental health setting. On average, 
these participants had worked in a volunteer setting for just over three years. Descriptive 
statistics appear in Table III.
Table III  
*Characteristics of Participants (N=46)*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
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<td></td>
</tr>
<tr>
<td>Female</td>
<td>37</td>
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</tr>
<tr>
<td>Male</td>
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<td>17.39</td>
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<td>Transgender</td>
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<td>2.17</td>
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<td><strong>Ethnicity</strong></td>
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</tr>
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<td>African American</td>
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<td>23.91</td>
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<tr>
<td>Asian</td>
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<td>4.34</td>
</tr>
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<td>Hispanic/Latino</td>
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<td>26.08</td>
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<tr>
<td>Native American</td>
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<td>0</td>
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<tr>
<td>Other</td>
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<td>8.69</td>
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<td><strong>Possess a Bachelor of Social Work Degree</strong></td>
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<tr>
<td>Yes</td>
<td>11</td>
<td>23.91</td>
</tr>
<tr>
<td>No</td>
<td>35</td>
<td>76.09</td>
</tr>
<tr>
<td><strong>Master of Social Work Program Pathway</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two-year program</td>
<td>22</td>
<td>47.83</td>
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<tr>
<td>One-year residency program</td>
<td>16</td>
<td>34.78</td>
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<td>Advanced standing program</td>
<td>7</td>
<td>15.22</td>
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<tr>
<td>Accelerated full-time program</td>
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<td>0</td>
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<tr>
<td>Accelerated one-year residency program</td>
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<td>2.17</td>
</tr>
<tr>
<td>Not applicable</td>
<td>0</td>
<td>0</td>
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<td>Masters Degree from accredited institution</td>
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<td></td>
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<tr>
<td>Yes</td>
<td>4</td>
<td>8.7</td>
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<td>91.3</td>
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<td><strong>Type of Field of Practice Specialization</strong></td>
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<td>Aging</td>
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<td>4.35</td>
</tr>
<tr>
<td>Child Welfare: Children, Youth, and Families</td>
<td>9</td>
<td>19.57</td>
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<tr>
<td>Global Social Work and Practice with Immigrants and Refugees</td>
<td>5</td>
<td>10.87</td>
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<tr>
<td>Health and Mental Health</td>
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<td>60.87</td>
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<tr>
<td>World of Work</td>
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<td>4.35</td>
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<td><strong>Personal Relationship with someone with SMI</strong></td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35</td>
<td>76.09</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>23.91</td>
</tr>
<tr>
<td><strong>Type of relationship to someone with SMI</strong></td>
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<tr>
<td>Family member</td>
<td>22</td>
<td>59.46</td>
</tr>
<tr>
<td>Significant other/partner</td>
<td>4</td>
<td>10.81</td>
</tr>
</tbody>
</table>
Mean and Standard Deviation of the Dependent Variable

Scoring and interpretation of the findings for the Recovery Knowledge Inventory (RKI) were learned through email contact with the author, Dr. Luis Bedregal. Means were determined for each of the four subscales of the RKI, and then each subscale means were judged according to a Likert scale. Mean scores of four and five are considered good, indicating strong knowledge of and adherence to recovery principles and practices, a mean score of three indicates satisfactory knowledge of and adherence to recovery principles and practices and mean scores of two and one are considered poor, suggesting limited knowledge of and adherence to recovery principles and practices.

The Recovery Knowledge Inventory (RKI) consisted of 20 items on a 5-point Likert-type scale (1=strongly disagree to 5=strongly agree). The total mean score was 66.08 (SD = 7.89), on a scale from 1-100. The higher the score indicated greater endorsement of recovery-oriented principles and practices by participants. This mean score suggested satisfactory to good (or strong) endorsement of recovery-oriented principles and practices.

The first subscale consisted of seven items out of the total 20 items on the RKI. The mean score was 25.95 (SD = 3.37), on a scale of 1-35. This score indicated satisfactory
endorsement of recovery-oriented principles and practices by participants. Nine participants (20%) selected a score of five indicating strong endorsement of recovery-oriented principles and practices; 31 (67%) participants selected a score of four indicating strong endorsement of recovery-oriented principles and practices; and six (13%) participants selected a score of three indicating satisfactory endorsement of recovery-oriented principles and practices. Overall, the majority of the participants selected a score of four or five (87%) suggesting greater endorsement of recovery-oriented principles and practices by participants.

The second subscale consisted of 6 items out of the total 20 items on the RKI. The mean score was 15.51 ($SD = 3.67$), on a scale of 1-30. This score indicated satisfactory endorsement of recovery-oriented principles and practices by participants. This suggests that participants have yet to fully develop an understanding of how to integrate mental illness into a consumer’s daily life so that they may eventually thrive. As a result, participants may not be entirely hopeful about symptom management and the recovery process, possibly negatively influencing consumer outcome. One participant (2%) selected a score of five indicating strong endorsement of recovery-oriented principles and practices; ten (22%) participants selected a score of four indicating strong endorsement of recovery-oriented principles and practices; 31 (67%) participants selected a score of three indicating satisfactory endorsement of recovery-oriented principles and practices; three (7%) participants selected a score of two indicating poor endorsement of recovery-oriented principles and practices; and one (2%) participants selected a score of one indicating poor endorsement of recovery-oriented principles and practices. Overall, the majority of the participants selected a score of three (67%), while scores of four and five
combined totaled 24%, suggesting satisfactory endorsement of recover-oriented principles and practices by participants.

The third subscale consisted of 5 items out of the total 20 items on the RKI. The mean score was 18.89 ($SD = 2.46$), on a scale of 1-25. This score indicated good (or strong) endorsement of recovery-oriented principles and practices by participants. Thirteen (28%) participants selected a score of five indicating strong endorsement of recovery-oriented principles and practices; 29 (63%) participants selected a score of four indicating strong endorsement of recovery-oriented principles and practices; and four (9%) participants selected a score of three indicating satisfactory endorsement of recovery-oriented principles and practices. Overall, the majority of the participants selected a score of four or five (91%) suggesting greater endorsement of recovery-oriented principles and practices.

The fourth subscale consisted of two items out of the total 20 items on the RKI. The mean score was 5.65 ($SD = 1.67$), on a scale of 1-10. This score indicated satisfactory endorsement of recovery-oriented principles and practices by participants. Three (7%) participants selected a score of five indicating strong endorsement of recovery-oriented principles and practices; ten (22%) participants selected a score of four indicating strong endorsement of recovery-oriented principles and practices; 19 (41%) participants selected a score of three indicating satisfactory endorsement of recovery-oriented principles and practices; and 14 (30%) participants selected a score of two indicating poor endorsement of recovery-oriented principles and practices. Overall, the majority of the participants selected a score of three (41%), while scores of four and five combined totaled 29%, suggesting satisfactory endorsement of recovery-oriented principles and practices. Descriptive statistics appear in Table IV.
**Mean and Standard Deviation of the Independent Variables**

Mean and standard deviations of the independent variables were calculated. On the Social Distance Scale (SDS), the mean score was 11.28 ($SD = 2.51$), on a scale from 1-24. This score indicated that on average participants desired less than more social distance; however, they desired some social distance in certain situations, i.e. sharing a room with someone diagnosed with SMI. On average, the majority of the participants ($n=31; 69\%$) selected scores of either one or two indicating a desire for less social distance. Fourteen (31\%) participants selected a score of three indicating a moderate desire for social distance.

On the Dangerousness Scale (DS), the mean score was 20.11 ($SD = 2.79$) on a scale from 0-40. This score indicated participants did not perceive their safety to generally be at risk. However, like the social distance scale, participants reported some apprehension in terms of allowing their child to play next door to a house where the occupant was diagnosed with SMI. On average, most of the participants ($n=38; 83\%$) selected scores of either two or three indicating some concerns about safety but generally fewer concerns. The remaining participants ($n=9; 17\%$) selected scores of either four or five suggesting greater safety concerns.

Descriptive statistics appear in Table IV.
### Table IV

**Mean Scores and Standard Deviations of Variables**

<table>
<thead>
<tr>
<th>Scales and Subscales</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery Knowledge Inventory</td>
<td>66.08</td>
<td>7.89</td>
</tr>
<tr>
<td>Roles and Responsibilities</td>
<td>25.95</td>
<td>3.37</td>
</tr>
<tr>
<td>Non-linearity of Recovery</td>
<td>15.51</td>
<td>3.67</td>
</tr>
<tr>
<td>The Role of Self-Definition and Peers in Recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectations Regarding Recovery</td>
<td>18.89</td>
<td>2.46</td>
</tr>
<tr>
<td></td>
<td>5.65</td>
<td>1.67</td>
</tr>
<tr>
<td>Social Distance Scale</td>
<td>11.28</td>
<td>2.51</td>
</tr>
<tr>
<td>Dangerousness Scale</td>
<td>20.11</td>
<td>2.79</td>
</tr>
</tbody>
</table>

### Multiple Regression

The pilot study posed the question: how does social contact, concerns regarding safety, knowing someone diagnosed with mental illness, and working for more than five years of employed experience with people diagnosed with SMI, effect the extent to which MSW students report endorsing recovery-oriented principles and practices?

I employed a multiple regression model to determine the relationship between the outcome variable, RKI, and the predictor variables, social contact to a person diagnosed with mental illness, concerns regarding safety posed by people diagnosed with mental illness, years of paid experience working with someone diagnosed with SMI, and knowing someone diagnosed with SMI. The model controlled for the following control variables: age, race, gender, length of time enrolled in the MSW program, years of experience working as a volunteer in a mental health setting, number of semesters of MSW fieldwork assignment in a mental health setting, type of practice specialization, and MSW program pathway.
Results showed the model was not statistically significant $F(22,14) = 0.6, p=.86$. The model’s $R^2 = .48$, the $R^2_{\text{Adjusted}} = -.32$. Nothing was statistically significant in the model. The coefficients for the variables directly pertaining to the modified research question are as follows, relationship $\beta_{\text{relationship}} = -4.15$, $t(14) = -.60, p = .56$, $\beta_{\text{social distance}} = -.11$, $t(14) = -.1, p = .92$, and $\beta_{\text{safety}} = .005$, $t(14) = .01, p = .996$. The findings are in Table V on the following page.

Hypothesis 1: MSW students with negative attitudes towards safety around consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

This hypothesis was not supported $\beta_{\text{safety}} = .005$, $t(14) = .01, p = .996$.

Hypothesis 2: MSW students with more than 5 years of employed experience working with consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

This hypothesis was not supported $\beta_{\text{more than } 5} = -.22$, $t(14) = .02$, $p = .98$.

Hypothesis 3: MSW students who identify as having a significant other diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

This hypothesis was not supported $\beta_{\text{relationship}} = -4.15$, $t(14) = -.60, p = .56$. 
Table V
Multiple Regression

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Coefficient</th>
<th>Std. Err.</th>
<th>t</th>
<th>P value</th>
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<td>0.44</td>
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<td>10.46</td>
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<td>0.00</td>
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<td>World of Work</td>
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<tr>
<td>Number of semesters in mental health setting</td>
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<td>5.89</td>
<td>0.53</td>
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<td>9.24</td>
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<tr>
<td>Over 5 years paid employee</td>
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<td>9.18</td>
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<td>Personal relationship with someone with SMI</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>-4.14</td>
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<td>Social Distance Total</td>
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<td>Intercept</td>
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</table>
Final Study

Descriptive Findings

Two hundred and twelve participants agreed to participate in the survey and four declined to participate after clicking on the I decline option. Of the 212, 123 participants provided responses to the first ten questions of the survey but as the survey continued 112 participants were recorded as responding to all of the 58 survey questions and 14 demographic questions. Of the 112 participants, 97 participants responded to all or almost all of the 70 survey questions and were included when employing the multiple regression model discussed later in this chapter.

Similar to the pilot study, most of the MSW students who participated in this survey were female. Eighty-three percent (n=93) identified as female and 17% (n=19) identified as male. The majority of the participants identified as Caucasian for the final and pilot study. For the final study, fifty-seven percent (n=63) identified as Caucasian; eighteen percent (n=20) identified as Hispanic/Latino; approximately thirteen percent (n=14) identified as African American; six percent (n=7) identified as Asian; and approximately five percent (n=6) identified as Other. The mean age of participants was 33.63. The majority of the participants for both the final and pilot study reported falling in the 20-29 age range. For the final study, (53%) reported falling in the 20-29 age range; 23 participants (21%) reported falling in the 30-39 age range; 17 participants (15%) reported falling in the 40-49 age range; ten participants (9%) reported falling in the 50-59 age range; and three participants (3%) reported falling in the over 60 year age range.

The majority of the participants for both the final and pilot study did not report possessing a Bachelor of Social Work degree prior to entering the Master of Social Work program. Specifically, 88% of the participants in the final study reported this finding. Of the
possible pathways MSW students could be currently enrolled in at the school of social work, 60% (n=67) reported enrollment in the two-year program; 20% (n=22) reported enrollment in the one-year residency program; 13% (n=15) reported enrollment in the accelerated full-time program; 4% (n=4) reported enrollment in the advanced standing program; and 4% (n=4) reported enrollment in the accelerated one-year residency program. The majority of the participants in the pilot study also reported enrollment in the two-year program. However, none of the participants reported enrollment in the accelerated full-time program, which differs from the findings in the final study.

Queries about length of experience in mental health are relevant to my study since experience has been identified as a factor influencing social workers’ attitudes towards recovery (Cleary & Dowling, 2009; Ewalds-Kvist et al., 2013). The mean response to the question, “How many years have you worked as a paid employee in a mental health setting before you entered the MSW program?” was 2.25. This was a slightly shorter length of time in comparison to the pilot study (2.89), which indicated nearly 3 years of paid employment in a mental health setting. In response to the question regarding years worked as a volunteer in a mental health setting prior to entering the MSW program, the mean was 1.16. Findings from the pilot study differed in response to this query as participants reported just under a year of volunteer work in a mental health setting. Lastly, the mean was less than one (0.85) in response to the question, “How many semesters of your MSW field work assignment has been in a mental health setting?” This indicates participants have not had significant experience interning in a mental health setting as mental health students as of their first or last semester enrolled in the program. However, a majority of participants (59%, n=66) reported Health and Mental Health as their current field of
practice specialization. Eighteen percent (n=20) reported Child Welfare: Children, Youth, and Families as their current field of practice specialization; 13% (n=14) reported Global Social Work and Practice with Immigrants and Refugees as their current field of practice specialization; 8% (n=9) reported Aging as their current field of practice specialization; and 3% (n=3) reported World of Work as their current field of practice specialization. The majority of participants in the pilot study also reported Health and Mental Health as their current field of practice specialization, followed by Child Welfare: Children, Youth, and Families.

Queries about degree of contact and social proximity to people diagnosed with severe mental illness were also significant to my study since social contact has been identified in the literature as a factor influencing social workers’ attitudes towards recovery (Each & Newhill, 2008; Happell et al., 2008). The survey queried whether participants have had a personal relationship with someone diagnosed with a severe mental illness. The majority of the participants (71%) reported having had a personal relationship with someone diagnosed with a severe mental illness; they reported the relationship to the person as falling in one of the following categories: parent, significant other, friend, or co-worker. Findings from the pilot study were close in percentage (76%) in response to this query, indicating that majority of participants in both studies do report having a significant relationship to someone diagnosed with SMI. However, nearly all of the participants in the final study (n=102) answered no in response to the question, “Were you ever the primary caretaker for someone with severe mental illness?” Again, this aligns with findings from the pilot study.

The majority of all the participants completed two semesters in the program ($M=2, SD = 1.68$). Approximately 60 participants reported never working as a paid employee in a mental
health setting. Seven reported working as a paid employee in a mental health setting for at least five years, and twelve reported working as a paid employee in a mental health setting for over five years. Similar to the finding regarding paid employment, approximately 60 participants reported never working as volunteer in a mental health setting. Thirty participants reported working between one to two years in a volunteer setting. Descriptive statistics appear in Table VI on the following pages.

Table VI

*Characteristics of Participants (N=112)*

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<td>59</td>
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<td>World of Work</td>
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### Personal Relationship with someone with SMI

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<td>Yes</td>
<td>80</td>
<td>71</td>
</tr>
<tr>
<td>No</td>
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### Primary Caretaker to someone with SMI

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<tr>
<td>No</td>
<td>102</td>
<td>91</td>
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---

**Mean and Standard Deviation of the Dependent Variable**

Scoring and interpretation of the findings for the Recovery Knowledge Inventory (RKI) were learned vis-à-vis email contact with the author, Dr. Luis Bedregal and discussed in the pilot section.

The Recovery Knowledge Inventory (RKI) consisted of 20 items on a 5-point Likert-type scale (1=strongly disagree to 5=strongly agree). The total mean score was 69.18 ($SD = 8.72$), on a scale from 1-100. The higher the score indicates greater endorsement of recovery-oriented principles and practices by participants. This mean score suggests satisfactory to good (or strong) endorsement of recovery-oriented principles and practices.

The first subscale consisted of 7 items out of the total 20 items on the RKI. The mean score on the first subscale is 27.15 ($SD = 3.93$), on a scale of 1-35. This score indicated good (or strong) endorsement of recovery-oriented principles and practices by participants. The mean score on the pilot study for the first subscale was similar (25.95), suggesting that participants endorse concepts pertaining to consumer right to decision-making and self-determination. Forty (36%) participants selected a score of five indicating strong endorsement of recovery-oriented
principles and practices; 64 (57%) participants selected a score of four indicating strong endorsement of recovery-oriented principles and practices; and eight (7%) participants selected a score of three indicating satisfactory endorsement of recovery-oriented principles and practices. Overall, the majority of the participant scored a four or five (93%) indicating strong endorsement of recovery-oriented principles and practices.

The second subscale consisted of 6 items out of the total 20 items on the RKI. The mean score was 16.16 ($SD = 3.37$), on a scale of 1-30. This score indicated poor to satisfactory endorsement of recovery-oriented principles and practices by participants. The mean score for the second subscale on the pilot study was similar (15.51), suggesting that participants’ perspectives towards symptom management and ability to thrive with a mental illness lack some degree of hopefulness. Two (2%) participants selected a score of five indicating strong endorsement of recovery-oriented principles and practices; 30 (27%) participants selected a score of four indicating strong endorsement of recovery-oriented principles and practices; 69 (61%) participants selected a score of three indicating satisfactory endorsement of recovery-oriented principles and practices; and 11 (%) participants selected a score of two indicating poor endorsement of recovery-oriented principles and practices. Overall, the majority of the participants selected a score of three (61%), while scores of four and five combined totaled 29%, suggesting satisfactory endorsement of recovery-oriented principles and practices.

The third subscale consisted of five items out of the total 20 items on the RKI. The mean score was 19.56, ($SD = 2.10$), on a scale of 1-25. This scored indicated good (or strong) endorsement of recovery-oriented principles and practices by participants. The pilot study reported a mean score of 18.89, which is close to the finding in the final study. Thirty-six (32%)
participants selected a score of five indicating strong endorsement of recovery-oriented principles and practices; 74 (66%) participants selected a score of four indicating strong endorsement of recovery-oriented principles and practices; and two (2%) participants selected a score of three indicating satisfactory endorsement of recovery-oriented principles and practices. The overwhelming majority of the participants selected a score of four and five (98%) indicated strong endorsement of recovery-oriented principles and practices.

The fourth and final subscale consisted of 2 items out of the total 20 items on the RKI. The mean score was 5.97 (SD = 1.67), on a scale of 1-10. This score indicated satisfactory endorsement of recovery-oriented principles and practices by participants. The pilot study also found the mean to fall in this range (5.65). Nine (8%) participants selected a score of five indicating strong endorsement of recovery-oriented principles and practices; 30 (27%) participants selected a score of four indicating strong endorsement of recovery-oriented principles and practices; 46 (41%) participants selected a score of three indicating satisfactory endorsement of recovery-oriented principles and practices; and 27 (24%) participants selected a score of two indicating poor endorsement of recovery-oriented principles and practices. Overall, the majority of the participants selected a score of three (41%), while scores of four and five combined totaled 35%, suggesting satisfactory endorsement of recovery-oriented principles and practices. Descriptive appear in Table VII.

**Mean and Standard Deviation of the Independent Variables**

Mean and standard deviations of the independent variables were calculated. On the Social Distance Scale (SDS), the mean score was 10.79 (SD = 2.32) on a scale from 1-24. This score indicated that on average participants desired less than more social distance; however, they
desired some social distance in certain situations, i.e. sharing a room with someone diagnosed with SMI. This finding was similar to the pilot study. On average, most of the participants (n=87; 78%) selected a score of two suggesting a desire for less social distance. Twenty-four (22%) participants selected a score of three suggesting a desire for slightly more social distance.

On the Dangerousness Scale (DS), the mean score was 20.59 (SD = 2.49) on a scale from 0-40. This score indicated participants did not perceive their safety to generally be at risk. However, like the social distance scale, participants reported some apprehension in terms of allowing their child to play next door to a house where the occupant was diagnosed with SMI. On average, most of the participants (n=94; 84%) selected a score of two or three indicating some concerns about safety but generally fewer concerns. Thirteen (12%) participants selected scores of either four or five suggesting greater safety concerns. The remaining participants (n=5; 4%) selected a score of less than two indicating few if any concerns about safety.

Scoring and interpretation for the four vignettes was determined by the six mental health professionals who served as my expert panel. Participants were scored as either correct or incorrect on the vignette questions if their answers matched the majority answer given by the members of the expert panel. Scoring was discussed in greater detail in the previous chapter.

The mean score for the vignettes was 28.02 (SD = 3.22) on a scale of 0-40. On the first vignette, the mean score was 7.30 (SD = 1.34) on a scale of 0-10. Participants scored 73% on a range from 0-10, which indicated adequate knowledge of Major Depressive Disorder. Approximately 65% of participants reported the condition as being only Somewhat Serious, whereas Major Depressive Disorder is categorized as a severe mental illness according to the DSM-V criteria, suggesting the need for further education about the disorder. On the second
vignette, the mean score was 7.27 ($SD = 1.01$). Participants scored approximately 73% again on a range from 0-10, which indicated adequate knowledge of Psychosis/Schizophrenia. Participants’ responses to the query degree of seriousness of the condition again suggested a lack of knowledge about the severity of the condition. On the third vignette, the mean score was 6.59 ($SD = 1.60$). Participants scored under 70%, which indicated inadequate knowledge of Social Phobia. Participants’ responses to the Yes or No question, “Does Mary have a mental illness?” were close in percentage with approximately 55% replying Yes and 45% replying No. Social Phobia is considered a severe mental illness according to the DSM-V criteria. Lastly, on the fourth vignette, the mean score was 6.84 ($SD = 1.41$). Participants scored under 70%, which indicated inadequate knowledge of Post Traumatic Stress Disorder (PTSD). PTSD was considered by 30% of participants to be caused by a chemical imbalance in the brain and not a traumatic life event, which is the etiology of the condition. Findings on this scale were of particular concern to me given the importance of professionals to demonstrate accurate mental health literacy when assessing, diagnosing, and applying an appropriate intervention for clients. These scores appear in Table VII. Means for the vignettes are interpreted on a scale of 0-10, with 70% indicating passing knowledge of mental health literacy. Participants scored approximately 70% on all four vignettes.

The following paragraphs identify correct scores (or the majority answer) reported by members of the expert panel and the approximate percentage of participants who also reported the same score, on each of the four vignettes. This allows for a better understanding of how the members of the expert panel and the participants compare to each other in terms of mental health literacy. In the first vignette describing Major Depressive Disorder, nearly all members of the
expert panel answered *Very Serious* to the first question regarding seriousness of Nick’s condition, while approximately 25% of the participants answered the first question regarding seriousness of Nick’s condition as being *Very Serious*. In response to the second question, all members of the expert panel identified Nick as having a mental illness, and approximately 68% of the participants also identified Nick as having a mental illness. In response to the question, “Nick’s situation was likely caused by one of the following,” the majority of the members of the expert panel responded *Very Likely* to the option, *A chemical imbalance in the brain*, while majority of the participants did not identify this option as being *Very Likely*. The majority of the participants reported, *Stressful circumstances in his life*, as being *Very Likely*. The majority of the members of the expert panel answered *Not at All Likely* in response to the question whether Nick’s situation would improve on its own, and the majority of the participants (approximately 62%) also responded with *Not at All Likely*. All members of the expert panel answered *Very Likely* to the question asking if Nick’s situation will improve with treatment, and approximately 72% of the participants responded similarly.

In the second vignette describing Psychosis/Schizophrenia, all members of the expert panel answered *Very Serious* to the first question regarding seriousness of Vicki’s condition, and nearly all of the participants answered *Very Serious*. In response to the second question, all members of the expert panel identified Vicki as having a mental illness, and, again, nearly all of the participants identified Vicki as having a mental illness. In response to the question, “Vicki’s situation was likely caused by one of the following,” the majority of the members of the expert panel responded *Very Likely* to the option, *A chemical imbalance in the brain*, while majority of the participants (approximately 70%) also identified this option as being *Very Likely*. All
members of the expert panel answered *Not at All Likely* in response to the question whether Vicki’s situation would improve on its own, and the majority of the participants also responded with *Not at All Likely*. All members of the expert panel answered *Very Likely* to the question asking if Vicki’s situation will improve with treatment. Participants were nearly evenly divided between responses *Very Likely* and *Somewhat Likely* in response to this question.

In the third vignette describing Social Phobia, the majority of the members of the expert panel answered *Very Serious* to the first question regarding seriousness of Mary’s condition, while approximately 15% of the participants answered the first question regarding seriousness of Mary’s condition as being *Very Serious*. In response to the second question, all members of the expert panel identified Mary as having a mental illness, and answers offered by the participants indicated a close percentage between *Yes* and *No* as stated earlier. In response to the question, “Mary’s situation was likely caused by one of the following,” at least half of the members of the expert panel responded *Very Likely* to the option, *A genetic or inherited problem*, while the remaining members of the expert panel identified different options as being *Very Likely*. Majority of the participants responded *Very Likely* to the option, *Stressful circumstances in his life*. The majority of the members of the expert panel answered *Not at All Likely* in response to the question whether Mary’s situation would improve on its own, while approximately 44% of the participants responded with *Not Very Likely*. Three members of the expert panel reported *Very Likely* that Mary will improve with treatment while the remaining members selected different options. Participants overwhelmingly agreed that Mary’s situation is *Very Likely* to improve with treatment.
In the fourth vignette describing PTSD, all members of the expert panel answered *Very Serious* to the first question regarding seriousness of Brady’s condition, while approximately 44% of the participants answered the first question regarding seriousness of Brady’s condition as being *Very Serious*. In response to the second question, all members of the expert panel identified Brady as having a mental illness, and approximately 58% of the participants identified Brady as having a mental illness. In response to the question, “Brady’s situation was likely caused by one of the following,” the majority of the members of the expert panel responded *Very Likely* to the option, *Stressful circumstances in his life*, while the overwhelmingly majority of the participants also identified this option as being *Very Likely*. The majority of the members of the expert panel answered *Not at All Likely* in response to the question whether Brady’s situation would improve on its own, and the majority of the participants (approximately 55%) also responded with *Not at All Likely*. All members of the expert panel answered *Very Likely* to the question asking if Brady’s situation will improve with treatment, and approximately 69% of the participants responded similarly.

Table VII
*Mean Scores and Standard Deviation of Dependent Variable*

<table>
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<tr>
<th>Scales and Sub-Scales</th>
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<tr>
<td>Non-linearity of Recovery</td>
<td>16.16</td>
<td>3.37</td>
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<td>The Role of Self-Definition and Peers in Recovery</td>
<td>19.56</td>
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<td>Expectation Regarding Recovery</td>
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</tbody>
</table>
Note. Means for the vignettes are interpreted on a scale of 0-10, with 70% indicating passing knowledge of mental health literacy. Participants scored approximately 70% on all four vignettes.

Multiple Regression

A regression model was employed to investigate the relationship between predictor variables such as mental health literacy, social contact to a person diagnosed with mental illness, concerns regarding safety posed by people diagnosed with mental illness, years of experience paid working with someone diagnosed with SMI, and knowing someone diagnosed with SMI, and the outcome variable endorsement of recovery-oriented principles and practices as reported by MSW students. The model was run using the 97 participants that were fully observed on the relevant variables. All of the variables were entered into the model simultaneously. The model was significant (F(23,73) = 2.15, p < .007), and explained 40% of the variance in the Recovery Knowledge Inventory ($R^2 = .40$, $R_{\text{Adjusted}}^2 = .22$).

Research Question 1: How does mental health literacy, social contact, concerns regarding safety, knowing someone diagnosed with mental illness, and working for less than 5 years of employed experience with people diagnosed with SMI, affect the extent to which MSW students report endorsing recovery-oriented principles and practices?
Hypothesis 1: MSW students with knowledge about psychiatric conditions will influence endorsement of recovery-oriented principles and practices.

Analysis 1: A multiple regression model was used to predict scores on the Recovery Knowledge Inventory (RKI) from scores on the Mental Health Literacy Scale. While controlling for demographic variables, there was no relationship ($\beta = 1.03$, $p = .08$) between the two variables.

Hypothesis 2: MSW students who have social contact with consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

Analysis 2: A multiple regression model was used to predict scores on the Recovery Knowledge Inventory (RKI) from scores on the Social Distance Scale (SDS). While controlling for demographic variables, there was no relationship ($\beta = -.50$, $p = .23$).

Hypothesis 3: MSW students with negative attitudes towards safety and consumers diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

Analysis 3: A multiple regression model was used to predict scores on the Recovery Knowledge Inventory (RKI) from scores on the Dangerousness Scale (DS). While controlling for demographic variables, there was no relationship ($\beta = -.11$, $p = .78$).

Hypothesis 4: MSW students with more than 5 years of employed experience working with people diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.
Analysis 4: A multiple regression model was used to predict scores on the Recovery Knowledge Inventory (RKI) from the score of how many participants reported more than 5 years of employed experience working with people diagnosed with SMI.

While controlling for demographic variables, there was no relationship ($\beta = 4.84, p = .07$)

Hypothesis 5: MSW students who identify as having a significant other diagnosed with SMI will influence endorsement of recovery-oriented principles and practices.

Analysis 5: A multiple regression model was used to predict scores on the Recovery Knowledge Inventory (RKI) from the score of how many participants reported having a relationship with a significant other diagnosed with SMI.

While controlling for demographic variables, there was no relationship ($\beta = .89, p = .66$).

Descriptives appear in Table VIII.

Additional findings that are relevant to my discussion are as follows. Variables such as age and gender were not statistically significant. However, findings pertaining to participants’ race was statistically significant at the .05 level for both Asian ($\beta = -8.84, p = .01$) and African Americans ($\beta = -6.63, p = .05$). This means that on average Asians scored about nine points lower on the RKI than Caucasian people, and that African Americans scored about seven points lower on the RKI than Caucasian people.

Possession of a Bachelor of Social Work degree, MSW program pathway, years worked as a volunteer in a mental health setting, and field of practice specialization yielded no statistically significant findings at the .05 level. However, participant responses to the number of semesters completed in the MSW program was statistically significant ($\beta = 1.54, p = .02$). This
indicates that on average for each semester a student has completed his or her RKI score will increase by one and a half points.

**Table VIII**  
*Multiple Regression*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Coefficient</th>
<th>Std. Err.</th>
<th>t</th>
<th>P value</th>
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<tr>
<td>Age</td>
<td>0.08</td>
<td>0.08</td>
<td>1.01</td>
<td>0.31</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>-0.87</td>
<td>2.40</td>
<td>0.36</td>
<td>0.72</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>-6.63</td>
<td>3.36</td>
<td>1.98</td>
<td>0.05</td>
</tr>
<tr>
<td>Asian</td>
<td>-8.85</td>
<td>3.63</td>
<td>2.43</td>
<td>0.02</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
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</tr>
<tr>
<td>Native American</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Other</td>
<td>-1.89</td>
<td>5.23</td>
<td>0.36</td>
<td>0.72</td>
</tr>
<tr>
<td>Possess BSW</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.32</td>
<td>3.17</td>
<td>0.42</td>
<td>0.68</td>
</tr>
<tr>
<td>MSW Pathway</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One-year residency program</td>
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<td>2.92</td>
<td>1.02</td>
<td>0.31</td>
</tr>
<tr>
<td>Advanced standing program</td>
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<td>6.00</td>
<td>0.29</td>
<td>0.78</td>
</tr>
<tr>
<td>Accelerated full-time program</td>
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<td>2.75</td>
<td>0.25</td>
<td>0.81</td>
</tr>
<tr>
<td>Accelerated one-year residency program</td>
<td>-4.56</td>
<td>5.77</td>
<td>0.79</td>
<td>0.43</td>
</tr>
<tr>
<td>Type of Practice Specialization</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Welfare: Children, Youth, and Families</td>
<td>0.22</td>
<td>3.66</td>
<td>0.06</td>
<td>0.95</td>
</tr>
<tr>
<td>Global Social Work and Practice with Immigrants</td>
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<td>3.92</td>
<td>1.41</td>
<td>0.16</td>
</tr>
<tr>
<td>Health and Mental Health</td>
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<td>3.22</td>
<td>0.97</td>
<td>0.34</td>
</tr>
<tr>
<td>World of Work</td>
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<td>6.23</td>
<td>0.72</td>
<td>0.47</td>
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<tr>
<td>Number of semesters in mental health setting</td>
<td>0.78</td>
<td>0.90</td>
<td>0.88</td>
<td>0.38</td>
</tr>
<tr>
<td>Years worked as a paid volunteer</td>
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<td>0.57</td>
<td>1.81</td>
<td>0.07</td>
</tr>
<tr>
<td>Number of semesters completed in the program</td>
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<td>0.65</td>
<td>2.37</td>
<td>0.02</td>
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<td>2.65</td>
<td>1.83</td>
<td>0.07</td>
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<td>Personal relationship with someone with SMI</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>0.89</td>
<td>2.00</td>
<td>0.44</td>
<td>0.66</td>
</tr>
<tr>
<td>Vignette total</td>
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<td>0.31</td>
<td>0.76</td>
</tr>
<tr>
<td>Safety Total</td>
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<td>0.40</td>
<td>0.28</td>
<td>0.78</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Social Distance Total</td>
<td>-0.49</td>
<td>0.41</td>
<td>1.22</td>
<td>0.23</td>
</tr>
<tr>
<td>Intercept</td>
<td>66.40</td>
<td>16.10</td>
<td>4.12</td>
<td>0.00</td>
</tr>
</tbody>
</table>
CHAPTER VII: STUDY IMPLICATIONS

This chapter discusses my study’s findings in detail, comparing my results with the results of previous research. Significant findings pertaining to race and mental health literacy are discussed in greater depth. Limitations of the study are identified and possible changes to improve upon areas of weakness are suggested. Finally, implications for future research are indicated along with concluding remarks. Mental health literacy, social contact (social distance), concerns regarding safety (dangerousness), knowing someone diagnosed with mental illness (familiarity), and having more than five years of employed experience working with people diagnosed with SMI are among the variables identified in the literature as influencing endorsement of recovery-oriented principles and practices. My study yielded two statistically significant findings in relation to race and education. Asian Americans and African Americans were found to score lower on the RKI, indicating less endorsement of recovery-oriented principles and practices than other races. MSW students’ RKI scores increased per semester, indicating greater endorsement of recovery-oriented principles and practices as students’ progress in the program.

Discussion

Statistically Significant Findings

Race. The first statistically significant finding related to race. Race was found to be statistically significant for both Asian and African Americans. On average Asians scored about nine points lower on the RKI than Caucasian people, and African Americans scored about seven points lower on the RKI than Caucasian people. This suggests that Asians reported less endorsement of recovery-oriented principles and practices than Caucasians. African Americans
also reported less endorsement of recovery-oriented principles and practices than Caucasian people, but slightly more endorsement of recovery concepts than Asians. Recovery concepts included empowerment, advocacy, client right to self-determination, hope, development of support systems, managing adversity and setbacks, and collaboration with treatment providers.

My final study sample consisted of seven participants who identified as Asian American. Of the seven participants, six reported enrollment in the two-year program. This program is designed for students who can participate full-time, attending classes at least two days per week, and field placement three days per week. Anticipated graduation is two years from the start of the program. My findings indicated that nearly all seven participants have not completed coursework beyond the first year in the two-year program. Therefore, their knowledge is primarily based on the core curriculum taken during the first year in the program, which provides a foundation for incoming MSW students but is not considered advanced material. For example, courses such as Human Behavior and the Social Environment III taken during the fall semester of year two, educate students on concepts of mental health and illness, classification systems, diagnosis and treatment, and theories of etiology, providing a more comprehensive understanding of recovery concepts than Human Behavior and the Social Environment II taken during the first year in the program. It is reasonable to suggest that these students scored lower on the RKI and reported less endorsement of recovery-oriented principles and practices because they have yet to complete coursework that would advance their understanding of recovery concepts than Caucasian participants. In addition, five of the seven participants reported having never been employed in a paid position in a mental health setting, indicating that the majority of the participants have little to no experience in a practice setting working with consumers.
diagnosed with SMI. As a result, material learned in the classroom has little if any opportunity to be applied in a clinical setting with consumers. Overall, these participants had little mental health experience both academically and anecdotally based on my findings.

Findings for African Americans also suggest that program pathway in conjunction with years of experience may have influenced scores on the RKI. Out of 14 participants who identified as African American, the majority (nine) reported enrollment in the one-year residency program. The one-year residency program (OYR) is designed to offer an education to students who are currently working in the mental health field and have been employed at their agency for at least two years, with the intention of completing their field placement at their place of employment. The goal is to continue to maintain employment while earning credits towards the MSW degree. This program was established for students with more experience than the two-year program discussed previously. Students enrolled in this program (OYR) should have greater knowledge of recovery concepts having completed more advanced coursework such as Social Welfare Policy, Human Behavior and Social Work Practice Learning Lab, and worked at least two years in the field, than students in the two-year program. Since my finding indicates that African Americans scored higher than Asian Americans on the RKI, this assertion seems plausible. However, African American participants did not score higher than Caucasian participants, who comprised the larger sample size. Of the 63 participants who identified as Caucasian, more than 65% reported completing more than two years in the program. This indicates that Caucasian participants had completed more coursework and had participated in placement settings for a longer period of time. It is reasonable to suggest that more education
coupled with field placement experience contributed to greater endorsement of recovery concepts.

The nine African American participants enrolled in the OYR program averaged nearly six and one half years of employed experience working in a mental health setting. This is considered a judicious amount of employed time working in a mental health setting. At least half of the total number of African American participants (n=14) had completed two or more years in the program thus far (the program is designed to take approximately two and a half years). Overall, these participants had a reasonable amount of academic experience as well as paid employed experience working in a mental health setting. However, the overall sample identified as predominantly Caucasian, hence the likelihood Caucasian participants would demonstrate a broader distribution of RKI scores than any other race. It is noteworthy to state that the disproportionate number of Caucasians in comparison to other races serving as my sample reflects the racial distribution of the students in the school.

In previous research race was not identified as a significant contributing factor influencing professionals’ endorsement of recovery-oriented principles and practices. In fact, many of the studies reviewed pertaining to this subject did not include race. Salyers and Brennan (2013), however, reported that based on race, participants did not score differently on recovery scales measuring for recovery knowledge. Other studies (Salyers, Brennan, & Kean, 2013; Sullivan & Floyd, 2013; Tsai et al., 2011; Murray & Steffen, 1999) that did include race as a demographic variable were limited because they included a disproportionate number of Caucasians in comparison to other races (i.e. African American, Asian, Native American, and
Other) and did not discuss differences among races. This was also the case in both my pilot and final study with majority of participants identifying as Caucasian.

**Education.** The second statistically significant finding pertained to the number of semesters students had completed in the MSW; the further along they were in the program, the more likely they were to greater embrace recovery principles. Specifically, on average for each semester a student has completed his or her RKI score increased by one and a half points. This suggests that endorsement of recovery-oriented principles and practices will improve as students advance in the program. Analysis of my findings indicated that the majority of participants had completed less than two years in the program based on the number of semesters completed. Therefore, there was a small percentage who completed “more” (2 years or greater) semesters; my statistically significant finding is based on twelve participants only. These twelve participants completed advanced level coursework as indicated by the urban school of social work’s syllabus, where discussion of recovery knowledge and concepts would be learned beyond a foundation level. Of these participants, nearly all have been participating in field placement/internship settings and are learning first-hand what it is like to engage with consumers diagnosed with SMI. The application of textbook knowledge to practice setting is feasible for these participants and, as indicated by previous studies (Salyers et al., 2013; Stuber et al., 2014), this has a positive influence on mental health professionals and professionals in-training attitudes towards recovery and recovery knowledge. The Recovery Model is currently embraced or at least is consistent with the practice in social work education since the more education participants have the more likely they are to endorse recovery concepts. Granted, the number of participants (12) who make-up this category is small.
Extensive review of the literature revealed that there have not been any studies conducted specifically comparing extent of recovery knowledge of MSW students in relation to the number of semesters (or years) completed in the program. In general, most studies have shown that perspectives towards people diagnosed with mental illness are more favorable among professionals and the general public with more educational levels completed, and are more likely to endorse recovery concepts (Adewuya et al., 2008; Addison & Thorpe, 2004; Angermeyer & Dietrich, 2006; Arvaniti et al., 2009; Bjorkman et al, 2008; Chikaodiri, 2010; Tsai et al., 2010; Chong et al., 2007; Corrigan et al., 2001; Klockmo et al., 2012; Reavley et al., 2011; Salyers et al., 2013; Stuber et al., 2014; Tay et al., 2004). Professionals with more education endorsed recovery principles such as engaging in social situations with people diagnosed with SMI (Stuber et al., 2014). Fears or concerns regarding safety as well as endorsement of recovery concepts such as equality and consumer autonomy were also more likely to be endorsed by participants with greater education (Chikaodiri, 2010; Reavley et al., 2011). Lastly, less desire for social discrimination and restriction were found to be associated with more education completed by mental health professionals and the public (Arvaniti et al., 2009). There are few studies (Aydin et al., 2003; Eker & Arkar, 1991; Kumakura et al., 1993; Tsai et al., 2010) that report alternative or mixed findings, i.e. professionals with less education reporting greater endorsement of recovery principles and practices.

A study conducted by Tay et al. (2004) supports my findings with another professional group. The authors explored the influence of training on nurses’ perceptions. Findings indicated that among other characteristics, nurses with the professional qualification of an advanced diploma in mental health nursing, nursing degree, or post-basic certificate, reported more
favorable a desire for less restrictiveness and bias against people living with a mental illness, and greater optimism about recovery and prognosis. Overall, my findings support majority of previous studies that education improves mental health professionals’ perspective towards people diagnosed with SMI, and subsequent endorsement of recovery-oriented principles and practices.

**Connection and Interaction with Persons with Serious Mental Illness**

Past studies have suggested that exposure and connections to persons who are mentally ill are associated with more knowledge of recovery principles and greater acceptance of the recovery paradigm and greater comfort interacting with people diagnosed with SMI (Covarrubias & Han; 2011; Martensson et al., 2014). Work experience and personal relationship to someone with a mental illness were two of the factors that were explored in this study. A third aspect is social interaction, which includes responses towards social distance, safety, and dangerousness. Mental health literacy is the last factor explored in my study.

**Personal Relationship**

The majority of participants (76% for the pilot study; 71% for the final study) identified having a personal relationship with someone diagnosed with mental illness. Possible relationships to participants included mother, father, sibling, romantic partner, friend, neighbor, roommate, or co-worker. Both the pilot and final study found no relationship between having a significant other diagnosed with SMI and endorsement of recovery-oriented principles and practices.

This finding contradicts previous studies (Chung et al., 2001; Corrigan et al., 2011; Couture & Penn, 2003; Covarrubias & Han, 2011; Martensson et al., 2014), suggesting that
professionals and professionals in-training who have a relationship with someone significant diagnosed with SMI report less stigma and endorse recovery concepts. Martensson et al. (2014) found that nursing staff consisting of assistant, registered, or licensed nurses reported more favorable attitudes towards consumers diagnosed with SMI if they currently had or have had a relationship with someone diagnosed with SMI. Covarrubias and Han (2011) sampled second-year MSW students and reported similar findings. MSW students who reported having more intimate social relationships with someone diagnosed with SMI such as a friend, felt less desire for distance and endorsed more recovery concepts such as equality and access to treatment. I surmised that this finding could be due to the large degree of exposure in my sample.

**Employment Experience**

Some studies (Hansson et al., 2011; Jorm et al., 1999) found that professionals who have more experience as paid employees working with people diagnosed with SMI report hope and optimism regarding recovery-oriented principles and practices. Findings for the pilot and final study did not support this literature, indicating that there was no relationship between working for more than five years as a paid employee in a mental health setting and endorsement of recovery-oriented principles and practices. Ten or fewer participants reported more than five years of paid employment in a mental health setting between both studies, suggesting most participants combined (N=143) have not had long-term experience working in a mental health setting. Closer analysis of the data revealed that the mean ages for the pilot and final study were approximately 30 and 34 years, respectively. Since the majority of the participants fell in the 20-29 age range for both studies, they simply would have been unlikely to have had tenured employment in mental health settings. If more participants had identified as older (>30 years),
they may have had more opportunities for different types of employment in mental health
settings, possibly producing a finding that supports the previous literature.

**Dangerousness and Stigma**

Research (Ahmead et al., 2010; Bjorkman et al., 2008; Linden & Kavanagh, 2011; Mittal et al., 2014) found that professionals and professionals in training regard people diagnosed with
SMI, specifically a psychotic illness such as schizophrenia, as dangerous and unsafe. This
finding influences the extent to which professionals and professionals in training endorse
recovery-oriented principles and practices. I used the Dangerousness Scale (DS) to measure
unpredictability and dangerousness of people diagnosed with SMI. Findings for the pilot and
final study did not support a relationship between concerns about safety and consumers
diagnosed with SMI, and a lack of endorsement of recovery-oriented principles and practices.
Responses in both the pilot and final study show that most participants did not view people with
SMI as dangerous to themselves or others. For example, the majority of participants in both the
pilot and final study disagreed with the query, “If a group of mental health patients lived nearby,
I would not allow my children to go to the movie theater alone?” Respondents offered the same
response (disagree) on both the pilot and final study for a similar query, “If a former mental
health patient lived nearby, I would not hesitate to allow young children in my care to play on
the same sidewalk?” This is a hopeful finding since stigma towards people diagnosed with SMI
has impeded recovery efforts (Starnino, 2009).

Review of the literature revealed two studies that sampled MSW students, and reported
similar findings to my study (Scheyett & Kim, 2004; Shera & Delva-Tuaiiliili, 1996). Shera and
Delva-Tuaiiliili (1996) sampled second-year MSW students and found that participants who
engaged in a class discussion and later spoke with consumers diagnosed with SMI, found the consumers to be less dangerous and unlikely to demonstrate violent tendencies (Shera & Delva-Tauilili, 1996). Scheyett and Kim (2004) also found that a dialogue experience with consumers diagnosed with SMI resulted in MSW students’ perception of dangerousness improving towards consumers (Scheyett & Kim, 2004).

Contrary to these studies’ findings as well as my own, the prevailing literature indicated professionals tend to regard people diagnosed with mental illness as dangerous (Bjorkman et al., 2008; Linden & Kavanagh, 2011; Ucok et al., 2004). Linden and Kavanagh (2011), Bjorkman et al. (2008), and Ucok et al. (2004) found that participants (nurses and psychiatrists) held more socially restrictive attitudes indicating that they felt individuals diagnosed with schizophrenia were dangerous. Lauber et al. (2006) offered a comparison among different professional groups. Psychiatrists demonstrated less favorable attitudes towards prognosis and recovery concepts, expressing concerns about their safety when around consumers diagnosed with different mental disorders, than did psychologists, nurses, and other therapists, which included social workers.

**Mental Health Literacy**

Researchers (Hardiman & Hodges, 2008; Hugo, 2001; Kapungwe et al., 2011; Lauber et al., 2004; Magliano et al., 2013; Nordt et al., 2006; Reavley et al., 2014) identify mental health literacy as influencing professionals’ perspectives towards and approaches used when working with people diagnosed with SMI. Vignettes measured mental health literacy among MSW students in my sample. Results indicated that there was no relationship between mental health literacy and endorsement of recovery-oriented principles and practices. Review of participants’ responses (N=97) to each of the four vignettes designed to measure mental health literacy
revealed that many participants demonstrated difficulty in identifying the correct diagnosis and etiology of a condition. In addition, when participants (N=97) did reply to the query asking what caused the person’s condition, their responses were incorrect based on proven origins of the four different conditions (Major Depressive Disorder; Psychotic/Schizophrenia; Social Phobia; Post Traumatic Stress Disorder). Overall, a lack of certainty emerged as the consensus. A possible explanation for participants’ lack of knowledge may be the year in which students were in the MSW program and the type of coursework completed thus far. Since RKI scores were found to improve with each semester completed, mental health literacy should improve over the course of the MSW program.

Previous studies (Ay, Save, & Fidanoglu, 2006; Eack & Newhill, 2008; Hardiman & Hodges, 2008; Hugo, 2001; Kapungwe et al., 2011; Lauber et al., 2001; Magliano et al., 2013; Nordt et al., 2006; Reavley et al., 2014) offered mixed results in terms of the relationship between mental health literacy and recovery knowledge. In addition, few studies sampling MSW students only (Eack & Newhill, 2008; Probst et al., 2015) reported variety in findings as well. Eack and Newhill (2008) sampled first and second-year MSW students, measuring students’ knowledge about schizophrenia by implementing the Knowledge About Schizophrenia Questionnaire (KASQ) (Ascher-Svanum, 1999) as opposed to vignettes. Findings indicated that MSW students who knew more about the condition of schizophrenia were more likely to endorse recovery concepts such as demonstrating a helpful, non-biased approach when working with consumers with this diagnosis. Probst et al. (2015) sampled first-year MSW students. Results indicated that students offered numerous perspectives on the cause(s) of a mental origin, sometimes suggesting a mental disorder emerged because of spirit possession, spiritual
imbalance, or punishment for past sins. This finding overlaps with some responses supplied by students in my survey; God’s Will was selected by at least four students as a likely cause for mental illness.

**Limitations of Study**

Limitations associated with quantitative methodology include threats to internal validity, such as social desirability, self-selection sampling, and sample size. Social desirability or responding to questions in a perceivably correct way (Rubin & Babbie, 2001), may result in participants selecting answers that are in alignment with recovery concepts. Self-sampling is likely to lead to a degree of self-selection bias. A smaller sample size does not allow for more robust findings. In addition to the identified limitation, I also identified other changes that could be made to items on the survey in the interest of clarification. These limitations are discussed below.

First, since the students in my study were aware that I am a licensed clinical social worker who is currently employed and working in a mental health setting, there is a tendency to respond to questions that will not contradict or discourage support of recovery concepts, which I (the researcher) likely endorses. The use of reverse scoring is one way to counteract social desirability (Rubin & Babbie, 2001). Despite efforts at counteracting this potential limitation, I did consider when analyzing the data, that findings may not accurately represent the participant’s perspective on recovery.

Secondly, self-selection sampling is a non-probability sampling technique based on the judgement of the researcher. The researcher allows subjects to participate in the study on their own accord. One significant advantage to self-selection sampling is that it can reduce the
amount of time needed to search for appropriate units, i.e. people, who meet the selection criteria. Disadvantages include some degree of self-selection bias, which did not appear in my study.

Lastly, my sample size was not as large as I anticipated given the total number of possible participants for the pilot and final study were approximately 475 and 975, respectively. A larger sample size might have allowed additional findings to emerge, especially in regards to race; my sample participants identified disproportionately as Caucasian. Thus, the smaller sample size and lack of diversity may make it harder to generalize to the wider student body. Possible reasons for a lack of participation might include limited time, inconsistent access to completing an online survey, disinterest in the topic, or prioritizing other responsibilities ahead of participation in a research study. Additional limitations aside from threats to internal validity are identified and discussed in this section.

Exact numeric values could not be determined in response to the query, “How many years have you worked as a paid employee in a mental health setting before you entered the MSW program?” In other words, had I provided a list of single numbers as opposed to having them handwrite in a number, I would have learned exactly how long they have been employed in a mental health setting. Some students did specify, i.e. 3 months or 6 months, but nearly all (for both studies) wrote a numeric value on the blank line. Thus, it is unclear for those who answered five years if they have worked exactly five years or more than five years (i.e. five years and one day). This is relevant because my hypothesis is worded as “more than five years” not five years or more. This also applies for the query, “How many years have you worked as a volunteer in a mental health setting before you entered the MSW program?”
In response to the query, “What was your relationship to that person or persons” who participants identified as having a severe mental illness, participants used different terms to identify the same relationship. For example, some participants wrote in the term “housemate” while others wrote in the term “roommate,” which is usually understood as a person one resides with in a living situation. Providing participants with specific options might have avoided any potential confusion in terms of how to define and/or interpret their answers.

Lastly, I stated earlier in this chapter, that the use of vignettes might benefit from further evaluation because a few participants left out portions of the query asking them to rate the potential cause of the condition. These questions were skipped more often than other questions on both the pilot and final study. It may be that having to read four different descriptions of different mental disorders after already responding to approximately twenty questions and having more questions to answer after the final vignette, becomes laborious for some participants. Therefore, participants may have preferred to skip some of these items to minimize mental distress.

**Implications for Practice**

Level of education has been identified in the research as a contributing factor to mental health professionals’ perspectives and subsequent endorsement of recovery-oriented concepts when working with people diagnosed with SMI (Klockmo et al., 2012; Reavley et al., 2011; Stuber et al., 2014). Specifically, the majority of studies report that professionals with higher levels of education are more likely to endorse recovery principles and practices (Adewuya et al., 2008; Arvaniti et al., 2009; Chikaodiri, 2010; Tsai et al., 2010). Recovery principles and practices representative of the Recovery Model include collaboration between the treatment team
and the client, goal-oriented and directed treatment, hope and optimism about recovery, inclusion of a support system, and development of autonomy (Anthony & Farkas, 2009).

Similar to previous studies (Chikaodiri, 2010; Klockmo et al., 2012; Reavley et al., 2011; Salyers et al., 2013; Stuber et al., 2014; Tsai et al., 2010), my findings indicate that with each semester completed, MSW students are more likely to endorse recovery concepts. Hence, further education is associated with better endorsement of recovery concepts while less education is associated with stigma, bias, and compromised consumer outcome (Reavley et al., 2011). Chikaodiri (2010) found that professionals with postgraduate qualifications as opposed to those with university degrees or post-secondary qualification were less likely to report safety concerns, refrain from social interactions, or blame the consumer for his/her condition. These findings are relevant because the perspective and approach of professionals when working with people diagnosed with SMI directly affect the client’s approach to recovery, treatment, and prognosis (Starnino, 2009). Therefore, it is beneficial for professionals to further their education with the encouragement and assistance of supervisors, organizations, and educators, in the interest of improving consumer relationships, and recovery outcome.

As stated in the previous section, race was found to be a statistically significant variable. Race has not been identified as a significant contributing factor influencing professionals’ attitudes or endorsement of recovery principles and practices, nor has race been included in many studies pertaining to the Recovery Model. When race was included as a demographic variable, it was typically disproportionate with most participants identifying as Caucasian (Salyers et al., 2013; Sullivan & Floyd, 2013; Tsai et al., 2011). This finding was apparent in my study as well as the majority of participants identified as female.
Implications for Education

Researchers (Hardiman & Hodges, 2008; Hugo, 2001; Kapungwe et al., 2011; Lauber et al., 2004; Magliano et al., 2013; Nordt et al., 2006; Reavley et al., 2014) identify mental health literacy as a contributing factor to professionals’ perspectives towards people diagnosed with SMI, and endorsement of recovery concepts. Vignettes are often used to measure mental health literacy since they are an informative way to determine both professional and public knowledge about mental illness (Ay et al., 2006; Eack & Newhill, 2008; Hardiman & Hodges, 2008; Hugo, 2001; Kapungwe et al., 2011; Lauber et al., 2004; Magliano et al., 2013; Nordt et al., 2006; Reavley et al., 2014). Review of responses indicated uncertainty when responding to mental health literacy queries. This suggests to me that more emphasis should be placed on courses that address clinical disorders and treatment interventions such as Assessment and Diagnosis or Psychopathology classes, to ensure that students are graduating with stronger mental health literacy and are better equipped to participate in consumers’ recovery. In addition, application of this material in practice settings should also have a positive influence on students’ attitudes. Having said that, my findings indicate that when participants completed more advanced coursework, they were more likely to be supportive of recovery concepts. Therefore, introducing some of this content earlier in the curriculum may have a positive influence on students’ endorsement of recovery-oriented principles and practices.

The professional socialization process discussed in an earlier chapter also influences the educational process and the extent to which students endorse recovery concepts. Classroom learning is the primary source of learning during parts of the socialization process and the educator plays a significant role in this part of the process. Authors (Miller, 2010; Barretti
2004a) suggest that professional socialization in social work has not been a priority for social work educators despite agreeing on its importance. As a result, MSW students may not be engaging in discussions nor learning material that reinforce the values and principles associated with the profession, and ultimately the Recovery Model. This is an area for educators to evaluate in the interest of approaching classroom learning differently so as to possibly improve students’ endorsement of recovery principles and practices.

Race was found to be a statistically significant variable in my study. Asians were found to have the least recovery knowledge followed by African Americans. This finding suggests that educators should consider incorporating cultural competency material into the curricula, with the understanding that different races may demonstrate differences in how they view mental illness, treatment, and recovery. This material may include lectures, role-playing, and class exercises designed to make students more aware of differences in attitudes towards mental illness and recovery based on race or ethnicity. Educators’ intention to help professionals-in-training improve their own recovery knowledge, would better prepare them for their work with consumers. Although current curricula include cultural competency material, it generally relates to the consumer and not the developing professional. Therefore, programs may consider incorporating relevant material for both consumers and students.

**Implications for Future Research**

Adding to the limited, existing body of literature by comparing MSW students’ endorsement of recovery-oriented principles and practices with the general population is another consideration for researchers to explore since there were fewer, more recent studies that could be found during my literature review. Specifically, comparing MSW students’ endorsement of
recovery concepts with members of the general population who identify as having little to no prior knowledge of mental illness and recovery, or experience with people diagnosed with mental illness might allow for different findings to emerge between these two samples.

Early research (Rubin & Johnson, 1984) indicated that social workers expressed a disinterest in working with chronic populations (SMI), and current research indicates similar findings (Eack & Newhill, 2008; Krumer-Nevo & Weiss, 2006). Future studies that explore social work students’ extent of endorsement of recovery principles and practices would allow for a better understanding of how social workers’ presently regard recovery concepts. Since social workers provide most services to consumers diagnosed with mental illness (Eack & Newhill, 2008), their perspective towards people diagnosed with SMI is influential to the treatment and outcome for severely mentally ill consumers.

Focusing more closely in future studies on specific field placements selected by or assigned to MSW students might shed light on how field assignments influence knowledge and endorsement of recovery concepts. For example, students who are interning with the elderly population may regard recovery differently from those interning with children, suggesting that the age of the client and developmental phase may influence students’ attitudes. Differences identified in student’s attitudes based on field placements (elderly versus children) may inform curricula development or classroom discussion.

Although demographic factors such as gender and race were considered in my study, these variables should be included in future studies since the already existing literature does not often include gender and race nor does the literature consider either or both factors as possibly
influencing participants’ endorsement of Recovery Model concepts. There is generally little discussion on race or comparisons among race in the literature.

Lastly and most importantly, future studies may consider evaluating the influence of training on social workers only, since the majority of the studies focus on other mental health professionals (i.e. psychiatrists, psychologists, and nurses). In general, research on social workers in relation to Recovery Model concepts would be helpful since there is scarce information about this sample population in comparison to other mental health professionals.
Appendix A

RECOVERY KNOWLEDGE INVENTORY

Please rate the following items on a scale of 1 to 5:

1 2 3 4 5

Strongly Disagree  Disagree  Not Sure  Agree  Strongly Agree

1. The concept of recovery is equally relevant to all phases of treatment.

2. People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.

3. All professionals should encourage clients to take risks in the pursuit of recovery.

4. Symptom management is the first step towards recovery from mental illness/substance abuse.

5. Not everyone is capable of actively participating in the recovery process.

6. People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.

7. Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.

8. The pursuit of hobbies and leisure activities is important for recovery.

9. It is the responsibility of professionals to protect their clients against possible failures and disappointments.

10. Only people who are clinically stable should be involved in making decisions about their care.

11. Recovery is not as relevant for those who are actively psychotic or abusing substances.

12. Defining who one is, apart from his/her illness/condition, is an essential component of recovery.

13. It is often harmful to have too high of expectations for clients.

14. There is little that professionals can do to help a person recover if he/she is not ready to accept his/her illness/condition or need for treatment.

15. Recovery is characterized by a person making gradual steps forward without major steps back.

16. Symptom reduction is an essential component of recovery.

17. Expectations and hope for recovery should be adjusted according to the severity of a person’s illness/condition.

18. The idea of recovery is most relevant for those people who have
completed, or are close to completing, active treatment.

19. The more a person complies with treatment, the more likely he/she is to recover.

20. Other people who have a serious mental illness or are recovering from substance abuse can be as instrumental to a person’s recovery as mental health professionals.
### Appendix A Continued

#### RKI Scale Scoring Key

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Raw score 1 becomes a 5; raw score 2 becomes a 4; raw score 3 remains a 3; raw score 4 becomes a 2; raw score 5 becomes a 1
Appendix B

SOCIAL DISTANCE SCALE
Please respond to the following by indicating Definitely Not Probably Not, Probably Yes, and Definitely Yes.

1. Would you feel ashamed if people knew someone in your family has mental illness?
   Definitely Not  Probably Not  Probably Yes  Definitely Yes

2. Would you be afraid to have a conversation with someone with mental illness?
   Definitely Not  Probably Not  Probably Yes  Definitely Yes

3. Would you be disturbed about working on the same job with someone with mental illness?
   Definitely Not  Probably Not  Probably Yes  Definitely Yes

4. Would you be unable to maintain a friendship with someone with mental illness?
   Definitely Not  Probably Not  Probably Yes  Definitely Yes

5. Would you feel upset or disturbed about sharing a room with someone with mental illness?
   Definitely Not  Probably Not  Probably Yes  Definitely Yes

6. Would you marry someone with mental illness?
   Definitely Not  Probably Not  Probably Yes  Definitely Yes
Appendix B continued

### SDS Scale Scoring Key

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Raw score 1 equals no social distance; raw score 2 equals low social distance; raw score 3 equals moderate social distance; raw score 4 equals high social distance
Appendix C

DANGEROUSNESS SCALE

Please respond to the following questions by indicating Strongly Agree, Agree, Not Sure but Probably Agree, Not Sure but Probably Disagree, Disagree, Strongly Disagree.

1) If a group of former mental health patients lived nearby, I would not allow my children to go to the movie theater alone?

Strongly Agree  Agree  Not Sure but Probably Agree  Not Sure but Probably Disagree  Disagree  Strongly Disagree

2) If a former mental patient applied for a teaching position at a grade school and was qualified for the job I would recommend hiring him.

Strongly Agree  Agree  Not Sure but Probably Agree  Not Sure but Probably Disagree  Disagree  Strongly Disagree

3) One important thing about mental patients is that you cannot tell what they will do from one minute to the next.

Strongly Agree  Agree  Not Sure but Probably Agree  Not Sure but Probably Disagree  Disagree  Strongly Disagree

4) If I know a person has been a mental patient, I will be less likely to trust him.

Strongly Agree  Agree  Not Sure but Probably Agree  Not Sure but Probably Disagree  Disagree  Strongly Disagree

5) The main purpose of mental hospitals should be to protect the public from mentally ill people.

Strongly Agree  Agree  Not Sure but Probably Agree  Not Sure but Probably Disagree  Disagree  Strongly Disagree

6) If a former mental patient lived nearby I would hesitate to allow young children in my care to play on the sidewalk.

Strongly Agree  Agree  Not Sure but Probably Agree  Not Sure but Probably Disagree  Disagree  Strongly Disagree

7) Although some mental patients may seem all right it is dangerous to forget for a moment that they are mentally ill.

Strongly Agree  Agree  Not Sure but Probably Agree  Not Sure but Probably Disagree  Disagree  Strongly Disagree

8) There should be a law forbidding a former mental patient the right to obtain a hunting license.

Strongly Agree  Agree  Not Sure but Probably Agree  Not Sure but Probably Disagree  Disagree  Strongly Disagree
Appendix C continued

### DS Scale Scoring Key

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Raw score 6 equals Very Dangerousness; raw score 5 equals Mostly Dangerousness; raw score 4 equals Dangerousness More than Not; raw score 3 equals Somewhat Dangerous; raw score 2 equals Not Very Dangerous; raw score 1 equals Not Dangerous at All
Appendix D

MENTAL HEALTH LITERACY SCALE (FINAL STUDY ONLY)

Vignette A
Nick is a 34-year old African American man who has completed a Master’s Degree in Electrical Engineering. For the last two weeks Nick has been really down. He wakes in the morning with a flat, heavy feeling that sticks with him all day long. He isn’t enjoying things the way he normally would. In fact, nothing seems to give him pleasure. Even when good things happen, they don’t seem to make Nick happy. He pushes on through his days, but it is really hard. The smallest tasks are difficult to accomplish. He finds it hard to concentrate on anything. He feels out of energy and out of steam. And even though Nick feels tired, when night comes he can’t get to sleep. Nick feels pretty worthless and very discouraged. Nick’s family has noticed that he hasn’t been himself for about the last month and he has pulled away from them. Nick just doesn’t feel like talking.

1) How serious would you consider Nick’s problem to be - very serious, somewhat serious, not very serious, or not at all serious?

<table>
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<th>Very Serious</th>
<th>Somewhat Serious</th>
<th>Not Very Serious</th>
<th>Not at All Serious</th>
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2) Does Nick have a mental illness?

Yes          NO

3) Nick’s situation was likely caused by (rate: 1 Very likely, 2 Somewhat likely, 3 Not very likely, 4 Not at all likely)

- Very Likely
- Somewhat Likely
- Not Very Likely
- Not at All Likely

His own behavior
A chemical imbalance in the brain
The way he was raised
Stressful circumstances in his life
A genetic or inherited problem
God’s will

4) In your opinion, how likely is it that Nick’s situation will improve on its own?

Very likely
Somewhat Likely
Not Very Likely
Not at All Likely

5) In your opinion, how likely is it that Nick’s situation will improve with treatment?

Very likely
Somewhat Likely
Not Very Likely
Not at All Likely

Vignette B
Vicki is a 33-year old Caucasian woman who is a successful attorney. Up until a year ago, life was pretty okay for Vicki. But then things started to change. She thought that people around her were making disapproving comments and talking behind her back. Vicki was convinced that
people were spying on her and that they could hear what she was thinking. Vicki lost her drive to participate in her usual work and family activities and retreated to her home, eventually spending most of her day in her room. Vicki became so preoccupied with what she was thinking she skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, she was walking back and forth in her room. Vicki was hearing voices even though no one else was around. These voices told her what to do and what to think. She has been this way for six months.

1) How serious would you consider Vicki’s problem to be- very serious, somewhat serious, not very serious, or not at all serious?

Very Serious  Somewhat Serious  Not Very Serious  Not at All Serious

2) Does Vicki have a mental illness?

Yes  NO

3) Vicki’s situation was likely caused by (rate: 1 Very likely, 2 Somewhat likely, 3 Not very likely, 4 Not at all likely)

Very Likely  Somewhat Likely  Not Very Likely  Not at All Likely

His own behavior
A chemical imbalance in the brain
The way he was raised
Stressful circumstances in his life
A genetic or inherited problem
God’s will

4) In your opinion, how likely is it that Vicki’s situation will improve on its own?

Very likely  Somewhat Likely  Not Very Likely  Not at All Likely

5) In your opinion, how likely is it that Vicki’s situation will improve with treatment?

Very likely  Somewhat Likely  Not Very Likely  Not at All Likely

Vignette C

Mary is a 33-year old who lives alone. Since moving to a new town last year she has become even more shy than usual and has made only one friend. She would really like to make more friends but is scared she will do or say something embarrassing when she’s around others. Although Mary’s work is OK she rarely says a word in meetings and becomes incredibly nervous, trembles, blushes and seems like she might vomit if she has to answer a question or speak in front of her workmates. Mary is quite talkative with her close relatives, but becomes quiet if anyone she doesn’t know well is present. She never answers the phone and she refuses to
attend social gatherings. She knows her fears are unreasonable but she can’t seem to control them and this really upsets her.

1) How serious would you consider Mary’s problem to be- very serious, somewhat serious, not very serious, or not at all serious?

2) Does Mary have a mental illness?

3) Mary’s situation was likely caused by (rate: 1 Very likely, 2 Somewhat likely, 3 Not very likely, 4 Not at all likely)

4) In your opinion, how likely is it that Mary’s situation will improve on its own?

5) In your opinion, how likely is it that Mary’s situation will improve with treatment?

Vignette D
Brady is a 30-year old who lives with his wife. Recently his sleep has been disturbed and he has been having vivid nightmares. He has been increasingly irritable, and can’t understand why. He has also been jumpy, on edge and tending to avoid going out, even to see friends. Previously he had been highly sociable. These things started happening around two months ago. Brady owns a newsagent shop with his wife and found work difficult since a man armed with a knife attempted to rob the cash register while he was working four months ago. He sees the intruder’s face clearly in his nightmares. He refuses to talk about what happened and his wife says she feels that he is shutting her out.

1) How serious would you consider Brady’s problem to be- very serious, somewhat serious, not very serious, or not at all serious?
2) Does Brady have a mental illness?
   
   Yes  NO

3) Brady’s situation was likely caused by (rate: 1 Very likely, 2 Somewhat likely, 3 Not very likely, 4 Not at all likely)

   Very Likely  Somewhat Likely  Not Very Likely  Not at All Likely
   
   His own behavior
   A chemical imbalance in the brain
   The way he was raised
   Stressful circumstances in his life
   A genetic or inherited problem
   God’s will

4) In your opinion, how likely is it that Brady’s situation will improve on its own?
   Very likely  Somewhat Likely  Not Very Likely  Not at All Likely

5) In your opinion, how likely is it that Brady’s situation will improve with treatment?
   Very likely  Somewhat Likely  Not Very Likely  Not at All Likely
Appendix E

DEMOGRAPHIC PAGE (PILOT STUDY)

1) How old are you? Fill in the blank below.

2) Which gender best describes you?
   1) Male
   2) Female
   3) Transgender

3) What is your ethnicity/race?
   1) White/Non-Hispanic
   2) African American
   3) Asian
   4) Hispanic/Latino
   5) Native American
   6) Other

4) Do you possess a Bachelor of Social Work degree?
   1) Yes
   2) No

5) Which Master of Social Work program pathway are you currently enrolled in at your School of Social Work?
   1) Two-year program
   2) One-year residency program
   3) Advanced standing program
   4) Accelerated full-time program
   5) Accelerated one-year residency program
   6) Not Applicable

6) Have you already earned a Masters degree from an accredited institution?
   1) Yes
   2) No

7) How many semesters have you completed in the Masters program in Social Work not including the current semester? Fill in the blank below.

8) How many years have you worked as a paid employee in a mental health setting before you entered the MSW program? Fill in the blank below.
9) How many years have you worked as a volunteer in a mental health setting before you entered the MSW program? Fill in the blank below.

10) How many semesters of your MSW field work assignment has been in a mental health setting? Fill in the blank below.

11) Which type of field of practice specialization are you participating in while enrolled in your School of Social Work?
   1) Aging
   2) Child Welfare: Children, Youth, and Families
   3) Global Social Work and Practice with Immigrants and Refugees
   4) Health and Mental Health
   5) World of Work

12) Have you had a personal relationship with someone with a severe mental illness?
   1) Yes
   2) No

13) What was your relationship to that person or persons? Check all that apply.
   1) Family member
   2) Significant other/partner
   3) Friend
   4) Neighbor
   5) Co-worker
   6) Other _____

14) Were you ever the primary caretaker for someone with severe mental illness?
   1) Yes
   2) No

15) If you answered yes above, who were you the primary caretaker for? Check all that apply.
   1) Family member
   2) Significant other/partner
   3) Friend
4) Neighbor
5) Co-worker
6) Other _____
Appendix F

DEMOGRAPHIC PAGE (FINAL STUDY)

1) How old are you? Fill in the blank below.

2) Which gender best describes you?
   1) Male
   2) Female
   3) Transgender

3) What is your ethnicity/race?
   1) White/Non-Hispanic
   2) African American
   3) Asian
   4) Hispanic/Latino
   5) Native American
   6) Other

4) Do you possess a Bachelor of Social Work degree?
   1) Yes
   2) No

5) Which Master of Social Work program pathway are you currently enrolled in at your School of Social Work?
   1) Two-year program
   2) One-year residency program
   3) Advanced standing program
   4) Accelerated full-time program
   5) Accelerated one-year residency program

6) How many semesters have you completed in the Masters program in Social Work not including the current semester? Fill in the blank below.

7) How many years have you worked as a paid employee in a mental health setting before you entered the MSW program? Fill in the blank below.

8) How many years have you worked as a volunteer in a mental health setting before you entered the MSW program? Fill in the blank below.
9) How many semesters of your MSW field work assignment has been in a mental health setting? Fill in the blank below.

10) Which type of field of practice specialization are you participating in while enrolled in your School of Social Work?
   1) Aging
   2) Child Welfare: Children, Youth, and Families
   3) Global Social Work and Practice with Immigrants and Refugees
   4) Health and Mental Health
   5) World of Work

11) Have you had a personal relationship with someone with a severe mental illness?
   1) Yes
   2) No

12) What was your relationship to that person or persons? Fill in the blank with the title of that person(s), e.g. mother, father, friend, coworker.

13) Were you ever the primary caretaker for someone with severe mental illness?
   1) Yes
   2) No
Appendix G

RECRUITMENT LETTER (PILOT STUDY)

Dear Students:

You are being asked to participate in a study conducted by Jennifer Nikou, a doctoral candidate in the PhD Program in Social Welfare at the CUNY Graduate Center. Your participation in this research study is requested because you are a student currently enrolled in a graduate program in the Silberman School of Social Work at Hunter College. The purpose of this research study is to learn about social work students’ views towards recovery of those individuals diagnosed with severe mental illness. You do not need to be currently serving this population in order to participate in the study. If you agree to participate, I will ask you to complete an online survey that should take approximately less than one hour to complete. No one will be aware of your participation or responses. There are no identified risks for participating in the study. I will not have direct access to any emails because recruitment for the study will be done via a mass email system of the school of social work. The survey will not contain any identifying information and data will be kept under a password protected computer. Your participation in this research is voluntary. If you have any questions, you can contact Jennifer Nikou at jnikou@gradcenter.cuny.edu. If you have any questions about your rights as a research participant or if you would like to talk to someone other than the researchers, you can contact CUNY Research Compliance Administrator at 646-664-8918.
By clicking on the “I agree” option on this consent form, I am electronically giving consent for Jennifer Nikou to use my results towards the study. By clicking on the “I Decline” option on this form, I am stating that I wish to not complete the study.
Appendix H

RECRUITMENT LETTER (FINAL STUDY)

Dear Students:

My name is Jennifer Nikou and I am a doctoral candidate in the Silberman School of Social Work at Hunter College since 2008. I have completed my course work and qualifying examinations, and am currently in the process of conducting my dissertation study so that I may earn a PhD in Social Welfare. I began working in the field of mental health when I was 19 years old as a mental health worker and have since remained employed in the field as a licensed clinical social worker for the past 17 years during the course of my undergraduate, graduate, and doctoral studies. In addition, I teach a course in domestic violence to graduate students and maintain a private practice.

You are being asked to participate in my study. Your participation in this research study is requested because you are a student currently enrolled in a graduate program in the Silberman School of Social Work at Hunter College. The purpose of this research study is to learn about social work students’ views towards recovery of those individuals diagnosed with severe mental illness. You do not need to be currently serving this population in order to participate in the study. If you agree to participate, I will ask you to complete an online survey that should take approximately twenty minutes. No one will be aware of your participation or responses. There are no identified risks for participating in the study. I will not have direct access to any emails because recruitment for the study will be done via a mass email system of the school of social work. The survey will not
contain any identifying information and data will be kept under a password protected computer. Your participation in this research is voluntary. If you have any questions, you can contact Jennifer Nikou at jnikou@gradcenter.cuny.edu. If you have any questions about your rights as a research participant or if you would like to talk to someone other than the researchers, you can contact CUNY Research Compliance Administrator at 646-664-8918.

By clicking on the “I agree” option on this consent form, I am electronically giving consent for Jennifer Nikou to use my results towards the study. By clicking on the “I Decline” option on this form, I am stating that I wish to not complete the study.
References


[http://www.cswe.org/accreditation.aspx](http://www.cswe.org/accreditation.aspx)


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