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STIGMA OF MENTAL ILLNESS AND MULTICULTURAL COUNSELING SELF-EFFICACY: INVESTIGATING THE IMPLICATIONS OF THE MULTICULTURAL TRAINING ENVIRONMENT, MENTAL HEALTH LITERACY, AND EMPATHY

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in
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University of Louisville
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ABSTRACT

STIGMA OF MENTAL ILLNESS AND MULTICULTURAL COUNSELING SELF-EFFICACY: INVESTIGATING THE IMPLICATIONS OF THE MULTICULTURAL TRAINING ENVIRONMENT, MENTAL HEALTH LITERACY, AND EMPATHY

Sarah E. Tucker

April 14, 2017

Research has shown that the stigma of mental illness is a pervasive social issue, in the United States and globally (Arboleda-Florez, 2008), one that has been considered by the surgeon general to be one of the single greatest barriers to addressing mental health care in the United States (U.S. Department of Health and Human Services, 1999). Furthermore, research has indicated that mental health care providers hold stigmatizing views toward people with mental illnesses at rates equal to or higher than the general public (Nordt, Rössler, & Lauber, 2006). This experience of being stigmatized because of a mental illness diagnosis by the individuals who treat those illnesses has been found to be heightened for those individuals who identify as members of racial or ethnic minorities (Knifton, 2012).

Mental illness stigma is included in a category of therapist effects or relational factors suspected of contributing to variance in counseling outcomes (Okiishi, Lambert, Nielsen, & Ogles, 2003). Other therapist effects include factors such as multicultural counseling self-efficacy and empathy. Although the study of a relationship among mental illness stigma and multicultural counseling self-efficacy has not been studied jointly, the tenets of Relational Cultural Theory (RCT; Miller, 1976) offer a framework

that supports the study of such therapist relational factors and their possible interactional relation with client outcomes.

The purpose of the study was to investigate the extent to which mental illness stigma and multicultural counseling self-efficacy are related, as well as the moderating effects of empathy and the multicultural training environment on this relationship among a sample of graduate counseling trainees. Differences in mental illness stigma scores and multicultural counseling self-efficacy scores based on select demographic factors and program affiliation were also examined.

Results indicated that a statistically significant relationship did not exist among mental illness stigma and multicultural counseling self-efficacy. The four factors of empathy, however, as described by Davis (1980) were found to be related individually and separately to the primary constructs. This may indicate that, although the stigma of mental illness cannot be expected to be affected by a counseling trainee's level of multicultural counseling self-efficacy, other relational factors, such as empathy, may serve to influence both.

TABLE OF CONTENTS

	PAGE
ACKNOWLEDGMENTS	iii
ABSTRACT	v
LIST OF TABLES	xiii
I. INTRODUCTION	1
Background of the Problem	3
Mental Health Care Providers.....	4
Culture and Mental Illness Stigma.....	5
Multicultural Counseling Self-Efficacy	6
Multicultural Training and the Training Environment	9
Mental Health Literacy	11
Empathy	13
Theoretical Framework.....	15
Purpose of the Study	21
Significance.....	21
Delimitations.....	22
Research Questions	22
Definition of Terms	23
Organization of the Dissertation Study	27

II. REVIEW OF LITERATURE.....	28
Stigma.....	29
Stigma and Mental Illness	30
Stigma of Mental Illness and Mental Health Disparities	33
Mental Illness Stigma and Attitudes Toward Treatment Seeking.....	35
Mental Illness Stigma and Disparities in Diagnosis	36
Mental Illness Stigma and Disparities in Utilization of Mental Health Care Services	40
Types of Mental Illness Stigma	41
Public Stigma.....	41
Self-Stigma or Internalized Stigma.....	48
Courtesy Stigma or Associative Stigma	52
Structural Stigma	55
Power and the Structural Support of Stigma.....	60
Power and Emotional Response in Stigma	63
Stigma of Mental Illness among Mental Health Care Providers	65
Mental Health Literacy	71
Social Distance Preference	74
Familiarity with Mental Illness.....	76
Multicultural Counseling Self-Efficacy.....	79
Multicultural Counseling Self-Efficacy and Multicultural Counseling Competence	83
Multicultural Training and the Training Environment	87

The Multidimensional Nature of Empathy	93
Empathy and the Counseling Relationship	97
Mental Illness Stigma, Counselor Attitudes, and Counselor Anxiety	99
Counselor Attitudes	100
Counselor Anxiety	107
Relational Cultural Theory (RCT)	111
Summary	115
III. METHODOLOGY	117
Research Questions	117
Research Design	118
Participants	119
Sampling	119
Procedures	120
Instrumentation	121
Demographic Questionnaire	121
Familiarity with Mental Illness	122
Mental Illness: Clinicians' Attitude Scale v. 4	122
Reliability	123
Validity	123
Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form	124
Reliability	125
Validity	125
Multicultural Environmental Inventory - Revised	126

Reliability	127
Validity	127
Mental Health Knowledge Schedule	127
Reliability	128
Validity	128
Interpersonal Reactivity Index	128
Reliability	129
Validity	129
Marlowe-Crowne Social Desirability Scale	130
Reliability	131
Validity	131
Data Analysis	132
Summary	134
IV. RESULTS	135
Participants	135
Descriptive Statistics	140
Mental Illness Stigma	141
Multicultural Counseling Self-Efficacy	142
Empathy	143
Mental Health Literacy	144
Multicultural Training Environment	146
Major Analyses	147
Research Question 1: Bivariate Correlations	147

Research Question 2: Prediction of Multicultural Counseling Self-Efficacy by Mental Illness Stigma	150
Research Question 3: Empathy as a Moderator	151
Perspective Taking (IRI-PT)	151
Fantasy Scale (IRI-FS)	154
Empathetic Concern (IRI-EC)	155
Personal Distress (IRI-PD)	156
Research Question 4: Multicultural Training Environment as Moderator	157
Research Question 5: Group Differences Based on Demographic Factors and Program Affiliation.....	157
Research Question 6: Group Differences Based on Familiarity with Mental Illness	163
Summary	165
Conclusion	166
V. DISCUSSION	167
Summary of Major Findings.....	167
Mental Illness Stigma	168
Multicultural Counseling Self-Efficacy	172
Limitations of the Study.....	184
Recommendations.....	186
Recommendations for Future Research	186
Recommendations for Counseling Programs.....	189
Recommendations for Counseling Practice	191

Conclusion	194
REFERENCES	197
APPENDIX A: Selected Schools for Inclusion in Dissertation Study	246
APPENDIX B: Request for Permission to Conduct Research	249
APPENDIX C: Letter to Course Instructors	251
APPENDIX D: Subject Informed Consent Document	253
APPENDIX E: List of Survey Instruments	257
APPENDIX F: Permission for Instrument Use	275
CURRICULUM VITA	279

LIST OF TABLES

TABLE	PAGE
1. Study Sample Demographic Data.....	137
2. Descriptive Statistics by Variable.....	140
3. Component Matrix for the 5-item MAKS Instrument.....	146
4. Intercorrelations Among Major Variables.....	149
5. Summary of Simple Regression Analysis for Mental Illness Stigma Predicting Multicultural Counseling Self-Efficacy	151
6. Summary of Multiple Regression Analyses with IRI Empathy Scales as Moderator Variables.....	152
7. Analysis of Variance for Mental Illness Stigma by Demographic Variable	158
8. Analysis of Variance for Multicultural Counseling Self-Efficacy by Demographic Variable	161
9. Analysis of Variance for Mental Illness Stigma and Multicultural Counseling Self-Efficacy by Level of Familiarity with Mental Illness.....	164

CHAPTER I

INTRODUCTION

Despite decades of research documenting its deleterious effects, the stigma of mental illness and its impact on those who are its targets remain a pervasive social issue in the United States and globally (Arboleda-Florez, 2008; Sickel, Seacat, & Nabors, 2014). Alongside the geographic lateral spread of mental illness stigma is its depth and vertical reach in the lives of individuals with mental illness. For children who have a mental illness, stigma means that they and their families are often ridiculed or blamed for the disorder (Heflinger, Wallston, Mukolo, & Brannan, 2014). Adolescents tend to fare worse, suffering social exclusion from peers and differential treatment by adults in schools (Moses, 2010). Adults with mental illness encounter a variety of barriers to work and social interaction (Pescosolido et al., 2010), and older individuals often remain undiagnosed (Bor, 2014), are misdiagnosed (Reeves, Parker, Burke, & Hart, 2010), or discontinue treatment prematurely due to perceived mental illness stigma (Sirey et al., 2001).

In 1999, the surgeon general identified stigma as one of the single greatest barriers to addressing mental health issues in the United States (U.S. Department of Health and Human Services, 1999). A few years later, the New Freedom Commission, in its 2003 report to the president, listed stigma as a primary hurdle to quality of life for individuals diagnosed with a mental illness. In the years since, numerous studies have

continued to support both assertions. A recent study of military personnel found that concerns regarding denial of rank promotions or deployment orders kept individuals from requesting mental health services (Wade et al., 2015). This finding is notable, given the media coverage of expanded mental health services by the Veterans Administration due to increased need for such services by United States veterans. It also highlights the temporal longevity of mental illness stigma as a focus of study, given the surgeon general's comments 16 years earlier.

Among those contributing to mental illness stigma are professional members of the health care community, including mental health care providers (Thornicroft, 2006; Üçok, 2008). Studies of mental illness stigma among general healthcare providers have shown high levels of stigmatizing attitudes toward patients with mental illness, even when those patients are seeking treatment exclusively for physical ailments (Clarke, Dusome, & Hughes, 2007; Harangozo et al., 2013). Additionally, studies have indicated that mental health care providers, such as psychotherapists and mental health counselors, hold stigmatizing attitudes toward individuals with mental illnesses at rates equal to or higher than rates found among the general public (Nordt et al., 2006; Panayiotopoulous, Pavlakis, & Apostolou, 2013). These findings may be reason to place mental illness stigma squarely as an area of urgent concern for counselor educators and counselor preparation programs.

Research that investigates mental illness stigma from the perspective of the individuals who are stigmatized suggests additional questions, as ethnic and racial minorities report more frequent experiences of stigma from general health care providers and mental health care providers than do their majority peers (Knifton, 2012). This

perception of mental illness stigma by ethnic and racial minority mental health care consumers was a reported reason by those individuals for not seeking treatment or for shorter treatment duration (Conner et al., 2010; Dobalian & Rivers, 2008). Although counselor preparation programs are aware of the need for graduates to be multiculturally competent, there is little indication in the literature that the role of mental illness stigma has been considered alongside multicultural counseling in the counselor education and training environment context.

Background of the Problem

Defined as a discredited state caused by some external mark or condition, such as mental illness, by Goffman (1963), stigma was considered a problem of individuals. As such, the solution was the separation of those individuals by placing them in institutions (e.g., Arboleda-Florez, 2008), where the affected individuals would presumably be treated, and society would be spared contact. Ultimately, the United States and other countries dismantled many of these “mental institutions,” and moved treatment to a community-based model in which individuals with mental illnesses were not institutionalized strictly for the purpose of separation.

Although neither the segregation of those with mental illnesses nor the return of those individuals to communities reduced the severity of mental illness stigma, the return to the community prompted a reconceptualization of mental illness stigma (Stuart, Arboleda-Florez, & Sartorius, 2012). Once a problem that was presumably contained in the individual, the nature of stigma as a social construct began to emerge. A more modern conceptualization of mental illness stigma, offered by Arboleda-Florez (2002), is that it is “a social construction whereby a distinguishing mark of social disgrace is

attached to others in order to identify and devalue them” (p. 25). With this definition, stigma requires not only the distinguishing mark and the devalued status, but also two participants: (a) the person or group with the identifying mark that is being stigmatized and (b) the person or group that engages in the devaluating and stigmatizing. It becomes a social phenomenon that is supported by power and a power differential (Link & Phelan, 2001).

Mental Health Care Providers

With the conceptual expansion of mental illness stigma from bias and discrimination that affects individuals to a social issue, the groups involved in the processes of stigma have been more clearly defined. With one of these groups being health care providers, mental illness stigma has been studied primarily among general practice physicians and nurses, with relatively fewer studies published that address mental illness stigma among mental health care providers such as psychiatrists and psychologists (Schulze, 2007). Even fewer focus on stigma among nonmedical counseling professionals, such as social workers and mental health counselors (Ahmedani, 2001; Henderson et al., 2014; Smith & Cashwell, 2011).

There is evidence in this research that mental illness stigma among mental health care providers may have a tangible part to play in access to mental health services. Researchers of the relatively few studies investigating mental illness stigma among mental health care providers have found that it not only exists, but may be more pronounced than in the general public (Lauber, Nordt, Braunschweig, & Rössler, 2006; Schulze, 2007). Other researchers have found that mental illness stigma among mental health care providers may have a role in reduced treatment seeking and service receipt

among those with mental illness diagnoses (Horsfall, Cleary, & Hunt, 2010; Stuart et al., 2012), particularly those individuals who identify as members of racial or ethnic minorities (Broman, 2012; Dobalian & Rivers, 2008).

Smith and Cashwell (2011) found that professional counselors were consistently absent as participants in the majority of the published literature that included mental health care providers, and investigated whether this professional population might be different from other mental health providers due to differences in theoretical background and training. The authors reasoned that humanistic values, such as empathy, and focus on the counseling relationship endemic to counseling as supported by Hansen (2007) could impact the extent to which counselors stigmatize their clients who are diagnosed with a mental illness and the nature of any stigmatization that does occur. This humanistic focus also speaks to an issue raised by other researchers who have indicated that the conceptualization of mental illness from the perspective of a medical model has been ineffective in reducing mental illness stigma (Hinshaw, 2007; Pescosolido et al., 2010; Stuart et al., 2012).

Culture and Mental Illness Stigma

Although cultural differences include a large variety of sociodemographic variables, race and ethnicity have been found to be highly pertinent to the study of mental illness stigma (Stickney, Yanosky, Black, & Stickney, 2012). Of primary concern to health care, including mental health care, is the impediment of mental illness stigma to treatment seeking among racial and ethnic minorities (Gary, 2005; Knifton, 2012). In a study of Black American and White American older adults, Conner, Koeske, and Brown (2009) investigated the effect of mental illness stigma on the relationship between race

and attitudes toward mental health treatment. Their findings showed that the Black Americans in their sample had a more negative view of mental health services than did the White American adults.

In another study of Latino American, Black American, and White American young adults, Broman (2012) found significant effects for race and ethnicity with regard to mental health service receipt. Although levels of depression were highest among Latino Americans, followed by Black Americans, the latter group was significantly less likely to have received treatment, with White Americans and Latino Americans having received higher levels of mental health services. This finding supports earlier research that indicated the influence of mental illness stigma on the level of mental health services received among ethnic minorities in need of mental health services (Alvidrez, Snowden, & Kaiser, 2008; Nadeem et al., 2007). Similarly, Kohn-Wood and Hooper (2014) suggested that a more thorough understanding of mental illness stigma may inform understanding of differences in treatment seeking and receipt of mental health services among racial and ethnic minorities.

Multicultural Counseling Self-Efficacy

Many empirical studies of the multicultural training of counselors assess the efficacy of such training by measuring multicultural counseling competence. An investigation of the intersection of mental illness stigma and multicultural counseling competence is made more complex by literature indicating that measures based on this model have yielded mixed findings (e.g., Constantine & Ladany, 2000). In addition, and relevant to a discussion of multicultural counseling competencies (MCC; Sue, Arredondo, & McDavis, 1992), is the recent revision of these competencies, now entitled

the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). The revised version takes a more humanistic and relational approach to counselor competence, evidenced by language that indicates diversity among both clients and counselors. Where the previous version of the MCC (1996) outlined expectations for “culturally skilled counselors,” the revised version speaks to “privileged and marginalized counselors,” indicating that the intersectionality that multiculturalism appreciated in clients also exists among counselors. Additionally, the revised version includes a section entitled “III. Counseling Relationship,” which states clearly that the identity development of both the client and the counselor serve to shape the counseling relationship, leading to an implied sense of egalitarianism and equalization of power.

As previously mentioned, researchers have raised concern regarding the measurement of multicultural counseling competence, including the suggestion that widely used self-report measures of multicultural counseling competence appear to assess multicultural counseling self-efficacy (Ottavi, Pope-Davis, & Dings, 1994). Subsequently, Constantine and Ladany (2001) posited that the two constructs were, in fact, distinct, and in the wake of the difficulties associated with the measurement of multicultural counseling competence, multicultural counseling self-efficacy emerged as an alternate and related construct found by researchers to be associated with counselor multicultural effectiveness (Sheu & Lent, 2007). Prior studies using multicultural counseling competence measures found that these instruments measured self-efficacy rather than competence, and also indicated that results may have been influenced by demographics, training variables, and a respondent’s worldview (Worthington, Soth-

McNett, & Moreno, 2007).

Other multicultural counseling researchers have also questioned whether multicultural counseling competence and multicultural counseling self-efficacy are different aspects of the same construct or distinct constructs (Barden & Greene, 2015; Sheu, Rigali-Oiler, & Lent, 2012). Similarly, Sheu et al. (2012) determined that many multicultural counseling competence scale items intended to measure skills were often confounded with items measuring knowledge or awareness. These authors concluded that a narrower focus on multicultural counseling self-efficacy would offer the opportunity to assess unique competencies rather than the more general competencies of multicultural counseling competence.

Concern had been raised by Constantine and Ladany (2001) that self-report measures of multicultural counseling self-efficacy may have more construct validity than self-report measures of multicultural counseling competence. In a content analysis of 20 years of multicultural counseling competence literature, Worthington et al. (2007) concluded that, “whereas the measurement of self-efficacy by definition is inherently amenable to a self-report format, . . . the self-report measurement of competencies has been described as susceptible to inherent biases that are difficult to control” (p. 359). Given the emergence of means of assessing counselor characteristics, such as multicultural counseling self-efficacy, conclusions of Worthington et al. (2007), and the revised MSJCCs, moving in this new direction seems both timely and professionally responsible. Furthermore, examining the relation between mental illness stigma and multicultural counseling self-efficacy has the potential to add to important areas of study in mental illness stigma, particularly among mental health care providers.

Multicultural Training and the Training Environment

Multiculturalism in counseling has become salient enough to the counseling profession that counselor preparation and training programs have begun to look critically at the multicultural efficacy of their curricula (Pope-Davis, Liu, Nevitt, & Toporek, 2000). Findings from studies using instruments such as Ponterotto, Alexander, and Grieger's (1995) Multicultural Competency Checklist for Counseling Training Programs elicited concern that students were not receiving adequate multicultural training, particularly students who identified as members of racial or ethnic minorities (McNeill, Hom, & Perez, 1995). A more comprehensive measure, the Multicultural Environment Inventory (MEI), developed by Pope-Davis and Liu (1997), followed with the goal of expanding upon the scope of the checklist. The revised version of this instrument, the MEI-R (Pope-Davis et al., 2000) assesses not only the presence of multicultural training elements in program areas such as curriculum and supervision and multicultural research, but seeks to identify students' perceptions of the training environment's climate and comfort, as well as perceptions of the program's honesty in recruitment.

Multiculturalism is now expected to be an integral part of counselor preparation programs and a counselor's practice lexicon, as evidenced by specific standards of the Council for Accreditation of Counseling and Related Programs (CACREP, 2009) and the MSJCCs (Ratts et al., 2016). Since the birth of the multicultural counseling in the 1950s (Robinson & Morris, 2000), the field of counseling has gradually adapted to the needs of the diversity of groups it serves by making multiculturalism an important part of counselor training and professional practice.

The stigma of mental illness has seen far less attention from professional

counselors and the programs that train them, despite the mention of mental illness stigma being a barrier to effective health care as far back as the early 20th century (Clouston, 1911). It has not, however, gone completely unnoticed. Early studies of mental illness stigma among college students focused largely on nursing students (Dixon, 1967; Napoletano, 1981), and gradually came to include medical students and general health care professionals, and eventually those in the mental health care fields. Of this last group, little is mentioned in the literature of counselors, either as students or as practitioners (Smith & Cashwell, 2011). With the findings in the few studies that have been published indicating that mental health care providers may hold more stigmatizing attitudes toward mental illness than does the general public (Lauber et al., 2006; Schultz, 2007), it seems that education and awareness of mental illness stigma may be important pieces to consider in counselor training programs.

This is not to say that the focus on multicultural effectiveness in counselor education programs necessarily obscures attention to mental illness stigma. It may, however, point to a blind spot that allows an assumption that counselors are free from stigma in this domain. Research indicates that this may be a faulty assumption. Studies have found that members of racial and ethnic minorities who have mental illness reported more instances of mental illness stigma from mental health care treatment providers than did their racial and ethnic majority counterparts (Gary, 2005) or that concerns about stigma caused them to delay or avoid seeking treatment (Alvidrez et al., 2008; Conner et al., 2010). Additionally, individuals in racial and ethnic minority groups were found to have received mental health services at lower rates, despite assessed need that was equal to or greater than that of the racial and ethnic majority (Broman, 2012; Corrigan, Pickett,

Kraus, Burks, & Schmidt, 2015).

Given findings such as these, the intersection of mental illness stigma and multicultural training of counselors becomes important. If the focus by counselor education programs and their training environment on multicultural effectiveness does not also affect the mechanisms that support mental illness stigma, then mental health care providers, including counselors, may not be adequately meeting the needs of their clients, particularly those clients who belong to racial or ethnic minority groups. The very individuals who are theoretically the beneficiaries of the multicultural movement in counseling may remain underserved, as counselor trainees are at risk of remaining unaware that they may hold stigmatizing attitudes toward many of the individuals they intend to treat.

Mental Health Literacy

The stigma of mental illness among counseling trainees may represent only a portion of the hypothetical blind spot that exists in counselor preparation programs. Wei, McGrath, Hayden, and Kutcher (2015) found in their review of 401 studies using measures of mental health literacy, of which 117 were conducted in the context of postsecondary education, that only 9 of the studies addressed the mental health literacy of the associated educators. This finding is relevant to the study of mental illness stigma among graduate counseling trainees in that knowledge imparted to trainees may limit their awareness of stigma and its impact, if that knowledge base does not encompass mental health literacy.

Mental health literacy, once conceptually equivalent to mental health knowledge, has expanded to include not only knowledge of mental health and the diagnostic criteria

associated with mental illness, but also attitudes toward mental illness and help-seeking efficacy (Wei et al., 2015). Where knowledge of mental illnesses was previously considered to be separate from, and even protective against, the stigma of mental illness, research has shown that knowledge is not necessarily a protective factor (Lauber et al., 2006; Schulze, 2007), and that attitudes of mental health professionals are influenced by a number of factors that may mediate the effects of knowledge (Crowe & Averett, 2015).

Certain types of knowledge do appear to reduce stigma of mental illness. Sadow, Ryder, and Webster (2002) for example, found among a sample of nursing students that only those students who had a friend with mental illness had lower levels of mental illness stigma. In the same study, students' work experience with a person who had a serious mental illness had no relationship with stigma scores or were associated with increased levels of stigma. This points to potential differences in the nature of the contact that supports increased knowledge. Similar findings have been reported by other researchers (Corrigan & Penn, 1999; Hansson, Jormfeldt, Svedberg, & Svensson, 2011), who concluded that the severity of the mental illness with which an individual has contact, as well as the nature of that relationship, may contribute to stigmatizing attitudes, particularly with regard to severe mental illnesses.

Although contact with individuals who have a mental illness gained through relatively equitable relationships with those individuals, such as friendships, are generally associated with lower levels of stigma (Boyd, Katz, Link, & Phelan, 2010), research on familiarity with mental illness and its relationship to mental illness stigma has indicated mixed findings (e.g., Gyllensten et al., 2011). Even familiarity with and knowledge of mental illness gained through one's personal experience with their own mental illness

may not be assumed to reduce stigma. Research has indicated that individuals who report having depression, while more willing than nondepressed individuals to engage with a person who has a mental illness, exhibited stigmatizing attitudes regarding their beliefs about responsibility for the mental illness (Aromaa, Tolvanen, Tuulari, & Wahlbeck, 2011).

Based on their review of studies focused on mental illness stigma in mental health care settings, Henderson et al. (2014) found that mental health professionals and early career professionals were among those most in need of stigma reduction interventions. They concluded that knowledge of mental illness needs to be supplemented with educational components designed to increase professionals' confidence and skills (self-efficacy) to provide counseling for people with mental illnesses. Research has indicated that knowledge alone does not protect individuals from developing stigmatizing attitudes, just as knowledge of multiculturalism alone will not necessarily lead to multicultural counseling self-efficacy. Knowledge in both instances needs to be joined with practical experience, awareness of one's attitudes, and development of meaningful relationships to be truly valuable to mental health care consumers and the counselors who seek to strengthen therapeutic relationships through understanding and empathy.

Empathy

Research on therapist empathy declined sharply in the mid-1970s and remained largely unaddressed until the mid-1990s, due to disagreement among researchers as to a definition of empathy as a "single thing" (Gibbons, 2011, p. 243) and questions related to its universal effectiveness as a therapeutic technique (Elliott, Bohart, Watson, & Greenberg, 2011). In the years since, social psychology and social neuroscience have

reinvigorated interest in the study of empathy, as its roles in intergroup relations (e.g., Finlay & Stephan, 2000) and shared neural activations (Lamm & Majdandzic, 2015) have emerged. If the disappearance of empathy studies can be attributed to frustrated efforts to define and measure empathy as a single entity (Gibbons, 2011), more recent research presents the return of empathy to the research literature as a complex and multidimensional construct that is much more comprehensive in its reach than previously considered.

Despite the changes that have surrounded empathy in the last few decades, it remains integral to the work of mental health service providers as they develop therapeutic relationships with their clients (Moyers & Miller, 2013; Watson, Steckley, & McMullen, 2014). More recent work on therapist empathy, however, has conceptualized empathy not as a discrete necessary and sufficient item (Rogers, 1957) on a list of therapeutic techniques, but rather one of any number of therapist characteristics or therapist effects that work synergistically to support (or hinder) a healthy therapeutic relationship (Anderson, Ogles, & Patterson, 2009; Norcross & Wampold, 2011). Additionally, related to empathy's role as an essential therapist characteristic, Elliott et al. (2011) found that it was the client's perception of having been understood by the therapist, rather than the self-perception by the therapist of successful empathic response, that was associated with outcome. It is this relational space in which authentic empathic response occurs where counselor attitudes, such as those surrounding race, ethnicity, and other individual differences may have the most damaging effects. Here, too, is the space in which the stigma of mental illness can separate client and counselor, affecting the therapeutic relationship and the progress it supports.

Theoretical Framework

To properly frame this study of relationships among mental illness stigma, multicultural counseling self-efficacy, mental health literacy, multicultural training environment, and empathy among graduate counseling trainees, it was appropriate to look to theorists who have studied therapist and counselor effects on the therapeutic relationship. Although counselors and therapists have been the focus of study for many years, investigations of the influence of the therapist and therapist nonspecific relational factors (Freedberg, 2007) have been more recent. These studies address parts and pieces of a category of individual therapist effects suspected of contributing to variance in counseling outcomes and which, because they remain difficult to specify, have been referred to simply as “something else” (Okiishi, Lambert, Nielsen, & Ogles, 2003, p. 370). It is conceivable that these unspecified qualities would include factors such as multicultural counseling self-efficacy, empathy, and attitudes, such as stigma of mental illness. Although some therapist effects, such as empathy and multicultural counseling self-efficacy have been the focus of recent research, mental illness stigma has received relatively little attention in the literature. Of the studies of stigma that do include mental health care providers, counselors are either not included or are included as part of a pooled group of nonmedical mental health providers (e.g., Nordt et al., 2006; Panayiotopoulos, 2013).

Empathy is again a focus of research after years of scant attention from scholars of the therapeutic relationship. As such, it has gained new life as a therapist effect that may have a role in the therapeutic success experienced by marginalized individuals and groups, such as those who are stigmatized because of mental illness, oppressed because

of race/ethnicity, or both. Relational Cultural Theory (RCT), originally developed by the Stone Center for Clinical and Developmental Studies at Wellesley College, offers a framework that supports the study of therapist beliefs, attitudes, and relational factors such as empathy, as critical determinants of client growth and change.

RCT grew out of the work of Miller (1976) and expanded as additional theorists and scholars joined the efforts to further develop and study a theory that illuminated the importance of relationship in human development (Jean Baker Miller Training Institute, 2015). An area to which these scholars paid particular attention is that of the relationship between therapist and client. Although their work originally centered on women as a marginalized group, the theory has conceptually expanded to include the impact of power and culture in sociocultural contexts on any individual or group who may be treated differentially due to known or presumed identities that result in exclusion from a majority group.

Foundational to RCT is the premise that the self develops and matures through a process of self-differentiation, a “dynamic process in which an individual carves out a sense of who she or he is while maintaining emotional connectedness and proximity to others” (Freedberg, 2007, p. 254). A relational self grows and develops in the context of relationship with others, as the relationships with those others refine and change. This conceptualization of the self differs fundamentally from the individuation models of human development espoused by mid-20th century theorists such as Erikson (1963) in which a gradual but defined move toward emotional independence was considered a clinically sound marker of health development.

Among the fundamental tenets of RCT is the concept of connectedness, which

heals the pain of isolation, the primary source of suffering from the perspective of the theory (Jordan, 2001). Acute disconnections occur when people fail each other empathically or do not understand another's pain. This clarifies the critical role that therapist empathy plays in the healing process, as well as the potentially devastating effect that a lack of empathy on the part of a therapist may have. As Jordan (2001) points out, many mental health clients often have maintained unhealthy or power-differentiated relationships with others at the personal, and perhaps societal levels, depending on the nature and levels of marginalization. If a therapist repeats the same patterns previously experienced by their clients, growth and change will not occur.

Therapist characteristics that may be associated with empathy and empathic response include the stigma of mental illness. Although a direct link between empathy and mental illness stigma remains less empirically supported, there is evidence that empathy is related to indicators of stigmatizing attitudes. In their study of mental health clinicians (medically and nonmedically trained), Lebowitz and Ahn (2014) found that biological explanations for symptoms of mental illness significantly decreased clinician's empathy for clients. The authors suggested that the biological explanations of mental illnesses may categorize symptomatic individuals as "systems of interacting mechanisms" (Lebowitz & Ahn, 2014, p. 17788), effectively reducing an individual to a dehumanized state similar to that described by Goffman (1963) as stigma. It is conceivable that therapist beliefs and attitudes, which may include mental illness stigma, comprise what Okiishi et al. (2003) referred to as the "something else" (p. 370) that affected variability in client outcomes when therapist demographics were controlled.

Laing, Tracy, Taylor, and Williams (2002) provided empirical support for RCT in

a study in which they found that mentoring relationships characterized by relational qualities such as authenticity and empathy predicted higher self-esteem and less loneliness among college students, beyond that predicted by other relationship components and demographics. Similarly, Frey, Tobin, and Beesley (2004) found, among women and men engaged in counseling at a college counseling center, that increased relational quality predicted decreased psychological distress, even after controlling variables of troubling family experiences. The study supported the authors' RCT-based assumption that relational qualities would predict distress, the reverse of the more traditional view that psychological distress predicts the quality of relationships.

Qualitative research has also supported RCT, as in the study of youth and adults in which relational themes of respect, mutuality, and active engagement surfaced as being instrumental to positive relationships (Spencer, Jordan, & Sazama, 2004). In a mixed-method study of counseling outcomes of an RCT-based intervention among women receiving psychotherapy at a community clinic, Oakley et al. (2013) found significant improvement in specific clinical areas and general psychological well-being, as well as strong satisfaction with the treatment model.

Empathy has been found to be significantly associated with multicultural counseling, particularly multicultural counseling competence. With Ridley and Lingle's (1996) development of a thorough and complex model of cultural empathy, the multidimensionality of empathy and its applicability to multiple domains, including multiculturalism, became a more frequent focus of research. Findings from Wang et al.'s (2003) study indicated that ethnocultural empathy was significantly correlated to measures of general empathy among a sample of undergraduate college students. In a

study of general empathy and multicultural counseling among a sample of graduate level school counseling trainees, Constantine (2001a) found that measures of general empathy contributed significant variance to self-reported multicultural counseling competence among practicing school counselors, over and above those students' prior multicultural counseling training and their reported theoretical orientation.

Subsequent research by Constantine and Gainor (2001) indicated that, although empathy scores contributed to school counselors' self-reported multicultural counseling knowledge, empathy was not found to be a predictive of self-perceived multicultural counseling awareness, a construct that operationalized subtle Eurocentric worldview bias. Similarly, in their study of White American graduate-level psychology and counseling trainees, Spanierman, Poteat, Wang, and Oh (2008) found that affective responses, including empathy, played a more central role in the development of multicultural counseling knowledge than it did for multicultural counseling awareness.

Findings from the Spanierman et al. (2008) study also indicated that empathy among participants significantly predicted supervisor ratings of multicultural counseling competence, and that trainees' affective response was a stronger predictor than knowledge of their use of client racial data into their case conceptualizations. Given the findings of Spanierman et al. (2008) that counselors' affective responses to clients who differed from them were stronger predictors of the counselors using racial data in case conceptualizations, RCT provides a lens through which the role of affective responses such as empathy may be a viable means of assessing counselor skill levels, particularly with clients who identify as members of racial or ethnic minority groups.

Although studies of empathy and its relevance to multicultural counseling

competence have become more numerous in the conceptual and empirical literature (e.g., Kirmayer, 2013; Spanierman et al., 2008), there is scant evidence of investigations of affective responses, such as empathy, and their relationship to multicultural counseling self-efficacy. In their study of general counseling self-efficacy and empathy levels among graduate social work trainees, Gockel and Burton (2014) found that gains in general counseling self-efficacy were not accompanied by gains in empathy. A subsequent study that included multicultural counseling self-efficacy as a variable with empathy and multicultural counseling competence found that, while multicultural counseling competence correlated significantly with cognitive empathy (perspective-taking), affective empathy (empathic concern), and multicultural counseling self-efficacy, only cognitive empathy correlated with multicultural counseling self-efficacy (Soheilian & Inman, 2015). Furthermore, the same study found that, while there were significant differences between White American trainees and trainees of color on measures of multicultural counseling competence and multicultural counseling self-efficacy, there were no significant differences between these two groups on measures of empathy.

Findings from the study by Soheilian and Inman (2015) are relevant to the inclusion of empathy in the current study, given that the differences in the associations of multicultural counseling competence and multicultural counseling self-efficacy with different dimensions of empathy indicate that empathy may have different and separate effects on competence and self-efficacy. Additionally, results from the Soheilian and Inman (2015) study indicated differences among White American trainees and trainees of color on measures of multicultural counseling competence and multicultural counseling self-efficacy, but not on empathy. This suggests additional reason to heed the authors'

call for research that investigates other counselor variables, such as counselor attitudes and level of racial and ethnic identity, that may relate differently and separately to multicultural counseling self-efficacy and multicultural counseling competence.

RCT fills a theoretical gap that has become the repository for devalued individuals and groups for whom traditional models of psychotherapy have offered a poor fit. Furthermore, the context of relational development for these individuals and groups is directly linked to their race, culture, and social identities (Comstock et al., 2008). As a framework supporting the study of graduate counseling trainees, RCT offers a means by which therapist beliefs and attitudes, such as those that form the bases of cultural bias and stigma of mental illness, can be investigated alongside other non-specific relational qualities, such as therapist empathy, perhaps impacting treatment seeking and treatment adherence among racial and ethnic minority clients.

Purpose of the Study

The purpose of the current study is to examine the extent to which mental illness stigma scores and multicultural counseling self-efficacy scores are related, as well as the moderating effects of empathy and the multicultural training environment on this relationship. A secondary purpose is to determine differences in mental illness stigma scores and multicultural counseling self-efficacy scores, as well as differences associated with demographic factors, among students in selected counselor preparation programs, including mental health counseling, school counseling, college student personnel, art therapy, counseling psychology, and counselor education and supervision.

Significance

This current study seeks to further the investigation of therapist effects that have

been found to contribute to variance in mental health counseling client outcomes, but that have been difficult to identify and measure. Although RCT is grounded in these nonspecific relational factors (Freedberg, 2007), and has been closely tied to multicultural efficacy in counseling (Comstock et al., 2008), mental illness stigma among mental health counseling trainees has not been closely, independently, or jointly investigated.

Delimitations

- The study sample included only currently enrolled graduate level counseling trainees, and only those licensed or certified practitioners who are currently enrolled in a degree-seeking graduate level counselor training program.
- Data collection for the study was scheduled to occur during the fall semester 2016.
- The study did not investigate mental illness stigma from the perspective of the individuals and groups who are stigmatized, as the purpose of the study is to determine relationships among stigmatizing attitudes and other therapist effects in counselor trainees.
- Data for the study were obtained through self-report survey instruments.

Research Questions

To achieve this study's purposes, the following research questions were addressed:

1. To what extent is there a significant relation among mental illness stigma, multicultural counseling self-efficacy, multicultural training environment, mental health literacy, and empathy among graduate counseling trainees?

2. Does mental illness stigma predict multicultural counseling self-efficacy among graduate counseling trainees?
3. To what extent is the relation between mental illness stigma and multicultural counseling self-efficacy moderated by empathy among graduate counseling trainees?
4. To what extent is the relation between mental illness stigma and multicultural counseling self-efficacy moderated by the multicultural training environment among graduate counseling trainees?
5. Are there differences in mental illness stigma scores and multicultural counseling self-efficacy scores based on select demographic factors and program affiliation among graduate counseling trainees?
6. Are there differences in mental illness stigma scores and multicultural counseling self-efficacy scores based on individuals' reported level of familiarity with mental illnesses among graduate counseling trainees?

Definition of Terms

1. Empathy–Empathy is broadly defined as a cognitive and affective response process that allows one to experience and understand what another person is feeling, without overidentification with that feeling and “without confusion between oneself and others” (Decety & Lamm, 2006, p. 1146). The role of empathy has been studied in the research contexts of general stigma (Tarrant & Hadert, 2010), mental illness stigma (Howell, Ulan, & Powell, 2014; Phelan & Basow, 2007), multicultural counseling (Wang et al., 2003) and counseling self-efficacy (Greason & Cashwell, 2009).
2. Familiarity with mental illness–Familiarity with mental illness refers to the level of an

individual's knowledge and experience with mental illness. These levels vary widely in terms of intimacy, and "may range from seeing a television portrayal of mental illness, to having a friend or coworker with a mental illness, to having a family member who has a mental illness, to having a mental illness oneself" (Corrigan, Green, Lundin, Kubiak, & Penn, 2001, p. 954).

3. Graduate counseling trainees—Master's or doctoral-level students enrolled in a college or university-based counselor preparation program, which includes but may not be limited to programs in mental health counseling, school counseling, college student personnel, art therapy, counseling psychology, and counselor education and supervision.
4. Health care providers—Health care providers are those individuals who provide direct general health care service to clients or patients, and may include physicians, nurses, and other medical or laboratory staff in medical offices and health care facilities.
5. Mental health care providers—Mental health care providers are individuals who provide mental health care services such as counseling or psychotherapy. These providers may include psychiatrists, psychologists, counseling psychologists, mental health or psychiatric nurses, social workers, art therapists, and professional counselors.
6. Mental health literacy—Mental health literacy, also known as mental health knowledge, refers to the level of mental health and mental illness related knowledge an individual has with respect to symptomatology, recognition, and awareness of treatment options. A more expanded conceptualization of mental health literacy includes three components: (a) knowledge, (b) attitudes, and (c) mental health help-

- seeking efficacy (Wei et al., 2015). As attitudes include negative views, such as bias and stigma, mental health literacy is conceptualized as a primary construct of mental illness stigma (Evans-Lacko et al., 2010).
7. Mental illness stigma–Mental illness stigma is defined by Arboleda-Florez (2002) as “a social construction whereby a distinguishing mark of social disgrace is attached to others in order to identify and devalue them” (p. 25). Like many other forms of social separation and bias, it is conceptualized as social phenomenon supported by power and a power differential (Arboleda-Florez, 2002; Link & Phelan, 2001).
 8. Multicultural counseling self-efficacy–Multicultural counseling self-efficacy is based on Bandura’s (1993) self-efficacy theory and is defined as a counselor’s belief in their ability to work with individuals from diverse backgrounds (Barden & Greene, 2015).
 9. Multicultural training environment–The multicultural training environment refers to the elements of counselor training programs and the extent to which they are, or are transitioning toward, multiculturalism in counselor training. These program elements include curriculum and supervision, climate and comfort, honesty in recruitment, and multicultural research areas of focus, as assessed by the Multicultural Environmental Inventory-Revised (MEI-R; Pope-Davis et al., 2000). The MEI-R was designed to assess students’ perceptions of these multicultural program elements, grounded in the theory that therapists are influenced by the multicultural environment of their graduate training programs, and that the daily practices of these programs contribute to or detract from a program’s stated commitment to multiculturalism (Peters et al., 2011).
 10. Program affiliation–Program affiliation refers to the master’s or doctoral-level

professional counselor preparation tracts within a college or university counseling department (or other department that may house such programs). Specific program affiliations include but are not limited to mental health counseling, college counseling, school counseling, art therapy, counseling psychology, school psychology, and counselor education and supervision.

11. Relational Cultural Theory (RCT)—A comprehensive theory of human growth and development originally conceived by Jean Baker Miller of the Stone Center for Clinical and Developmental Studies at Wellesley College. It emerged from the awareness that traditional models of psychotherapy do not address the relational experiences of women and other devalued groups. The primary base for the theory is that emotional and psychological healing occur in the context of growth-fostering egalitarian relationships that encourage mutual empathy (Comstock et al., 2008).
12. Social distance—Social distance is considered to be a dimension of stigma, and refers to a person's desire to maintain distance from an individual known to have a mental illness (Kassam, Papish, Modgill, & Patten, 2012).
13. Stigmatizing attitude—Stigmatizing attitude is a general orientation or tendency to regard a target individual or group as having a stigma, or an identifier of difference. These negative attitudes are influenced by societal or cultural stereotypes and beliefs about the stigma. Stigmatizing attitudes have been found to adversely affect mental health treatment seeking, treatment persistence, and life goals, such as education and career choices, of the individual or group that is stigmatized (Reavley & Jorn, 2011).
14. Therapist effects—Therapist effects are qualities or traits of individual therapists that may include theoretical orientation, gender, level of training, and race/ethnicity

(Okiishi et al., 2003). Therapist effects also encompass nonspecific relational factors that may characterize the counseling relationship, such as capacity for empathy, authenticity, attention, and emotional responsiveness (Freedberg, 2007).

Organization of the Dissertation Study

This study is organized into five chapters, a bibliography, and appendices. Chapter II presents a review of related literature that addresses mental illness stigma, mental health literacy, multicultural counseling self-efficacy, multicultural training environment, empathy, and the theoretical framework of the study, RCT. Chapter III delineates the research design and methodology of the study. The instruments used to gather data, the procedures that were followed, and the study sample are described. Chapter IV describes the statistical analyses that were conducted and the results of those analyses, and Chapter V connects the findings of the study to the literature and offers recommendations for future research, counseling programs, and counseling practice. The study concludes with a bibliography and appendices.

CHAPTER II

REVIEW OF LITERATURE

Despite awareness of the deleterious effects of mental illness stigma, professionals working in the field of mental health care are not immune. These mental health care providers, including counselors and psychotherapists, cannot consider themselves protected by their knowledge and experience from the attitudes that are the foundation of bias, prejudice, and discrimination experienced by individuals who have a mental illness. This chapter presents the rationale for conducting research that investigates relationships among mental illness stigma and constructs pertinent to counselor training and practice, within a theoretical framework of relational cultural theory (RCT). By framing this study with the tenets of RCT, the focus remains centered on the therapeutic human relationships that form the foundation of mental health counseling, moving mental illness stigma from a broad social issue to a very personal one, for both the counselor and the client.

Researchers in the fields of counseling, psychology, sociology, and neuroscience have studied the nature of human relationship and how it may impact the therapeutic relationship. Although attitudes that form the foundation of stigma and bias have been acknowledged in the literature as detrimental to the therapeutic relationship, findings regarding the means by which they may support mental health care providers' potential stigma and bias toward their clients remain inconclusive. The following review of the

literature represents literature pertinent to the research of stigma and bias among graduate counseling trainees, and is organized into the following sections: stigma, mental health literacy, multicultural counseling self-efficacy, multicultural training and the training environment, empathy, and RCT.

The awareness that the stigma of mental illness exists is not new to either academic researchers or to individuals with mental illnesses. What has occurred over time, however, is the development of stigma as an area of mental health research that continues to find itself overlapping with other areas of research, such as mental health care disparities in access to care, diagnosis, and use of treatment or services. These disparities tend to fall along racial, ethnic, and socioeconomic lines, indicating that the stigma of mental illness may not be a discrete variable in the lives of people with mental illnesses that can be addressed and presumably eradicated with one-dimensional or unilateral efforts. As this more complex understanding of the stigma of mental illness continues to develop, those individuals who work in the field of mental health care have become a part of the research discussion, with findings indicating that the stigma of mental illness may be alive and well not only “out there” among the general public, but among both medical and nonmedical mental health care providers, including mental health counselors.

Stigma

For centuries stigma was discussed quietly, understood as a “deep mark of shame and degradation carried by a person as function of being a member of a devalued social group” (Hinshaw, 2007, p. 26). Sociologists studying racial stereotyping in the first half of the 20th century laid an important foundation for the study of stigma (Pescosolido,

2013), and in 1963, Erving Goffman helped move the discussion of stigma from the realm of the secret to a more public domain with the publication of his *Stigma: Notes on the Management of Spoiled Identity*.

Although Goffman's (1963) essay is based on the concept of stigma familiar to ancient Greek culture, as a bodily mark placed on a person to mark him or her as tainted by virtue of undesirable attributes, he clarified that only those undesirable attributes that differ from the stereotype of what we consider "normal" become stigmatized (pp. 3-4). In so doing, he described a theoretical relationship between attributes and stereotypes that is the source of stigma, applicable to any number of perceived differences among an equally large number of human social groups. By broadening the concept of stigma, his work became the foundation for an expanding research literature that spans five decades and includes work from a variety of academic disciplines and human service fields (Bos, Pryor, Reeder, & Sutterheim, 2013; Cahnman, 1968; Grasmick & Appleton, 1977; Link & Phelan, 2001; Weidner & Griffitt, 1983).

Stigma and Mental Illness

Academic interest in stigma has increased dramatically since Goffman's seminal essay, with a growing number of researchers and theorists investigating stigma at the individual, local, and global levels (Seeman, Tang, Brown, & Ing, 2015; Stuart et al., 2012; Wahl & Aroesty-Cohen, 2010). As a result, this growing awareness that the impact of stigma, specifically stigma of mental illnesses, is far-reaching has garnered attention from academics and practitioners in fields outside sociology and psychology, including medicine (Welch, Litman, Borba, Vincenzi & Henderson, 2015), criminal justice (Wright, Twardzicki, Gomez, & Henderson, 2014), education (Leahy, 2015;

Moses, 2010), and the United States military (Ben-Zeev, Corrigan, Britt, & Langsford, 2012).

Alongside the awareness that the stigma of mental illness is pertinent across fields of study and practice is the reality that, as such, its impact affects the individuals who form the groups studied and served by those fields. As members of a group, individuals form social identities specific to that social group (Tajfel, 1979). It follows that membership in a group that is stigmatized may lead to the development of a stigmatized identity, an outcome that has negative effects on quality of life, impacting self-esteem, academic achievement, and health, each of which affects other factors that also determine quality of life (Major & O'Brien, 2005). Importantly, the effects of managing a mental illness and managing the stigmatized identity that accompanies the illness are synergistic and the outcomes are cumulative. If individuals with mental illnesses are to receive effective treatment, that treatment and the professionals providing it must not only acknowledge that stigma of mental illness exists, but that it can have lasting deleterious effects equal to those of the mental illness itself.

Definitions for the stigma of mental illness vary, depending on a number of variables, including theoretical orientation and the field of study supporting a given definition (Overton, 2008). Arboleda-Florez (2002) built upon Goffman's (1963) definition of stigma by describing mental illness stigma as "a social construction whereby a distinguishing mark of social disgrace is attached to others in order to identify and devalue them" (p. 25). Other theorists have contributed to the theoretical move of mental illness stigma toward a human rights model that conceptualizes mental illness stigma as an exemplary of social separation and bias, adding to its components power and a power

differential to support social oppression (Arboleda-Florez & Stuart, 2012; Link & Phelan, 2001).

Corrigan (2004) framed the stigma of mental illness as a four-step social-cognitive process model comprised of (a) cues, (b) stereotypes, (c) prejudice, and (d) discrimination. *Cues* are those attributes of an individual that become known to others, such as social deficits, appearance, symptoms, or labels. When a cue elicits a *stereotype*, the individual is categorized. Once the stereotyped category is endorsed, *prejudice* occurs. The last step of the process is operationalized as *discrimination*: action taken (or not taken) in response to awareness that an individual has a mental illness. The cognitive response to a cue elicits a cognitive-affective response, which becomes a behavioral response (Corrigan & Watson, 2007).

Stigma is not a product solely of or within an individual, but a social construct that “originates from the social devaluation attached to a particular identity within the society” (Quinn & Chaudoir, 2009, p. 647). As such, the stigma of mental illness may help explain, and perhaps contribute to, the disparities long evidenced in mental health care, particularly in areas of access to mental health care, mental health services utilization, and diagnosis. More specifically, the critical need for examining the stigma of mental illness and its effects can be seen in individuals’ treatment seeking attitudes and behaviors, differential outcomes related to diagnoses, and utilization of mental health care services. In addition, when racial and cultural identities are considered in conjunction with these clinical areas, the significance and implications of the stigma of mental illness become more obvious.

Stigma of Mental Illness and Mental Health Disparities

Disparities in mental health care among individuals who identify as racial or ethnic minorities are well documented (U.S. Department of Health and Human Services, 2001). Research has indicated reduced treatment seeking by members of a racial or ethnic minorities (Nadeem et al., 2007), as well as lower rates of service receipt (Dobalian & Rivers, 2008), diagnostic disparities, and poorer quality of mental health care when it is accessed (Kee & Overstreet, 2007; Samnaliev, McGovern, & Clark, 2009; Snowden, Catalano, & Shumway 2009).

The disparities that emerge along racial and ethnic lines point to the likelihood that the impact of one's being stigmatized because of a mental illness may be determined by the degree to which their mental illness is considered in concert with their other identities or affiliations (Thompson, Noel, & Campbell, 2004). Studies of the impact of experiencing multiple stigmas and discrimination toward individuals with mental illnesses have indicated that the negative effects of the stigma of mental illness may be exacerbated for individuals who have multiple bases of stigmatization, such as membership in more than one marginalized or disenfranchised social group (Gabbidon et al., 2014).

The term *intersectionality* was coined in 1989 by Crenshaw, in her discussion of the subordination of Black women, as she clarified that the experience of being Black and being a woman was greater than the simple sum of racism and sexism. Among psychologists, intersectionality asks that researchers “examine categories of identity, difference, and disadvantage with a new lens” (Cole, 2009, p. 170). In similar fashion, the study of the impact felt by individuals who experience stigma of mental illness in

addition to stigma or discrimination of their other identities has begun to move from an additive conceptualization to a more intersectional one (Zerger et al., 2014).

Identities and social memberships related to race and ethnicity have been found to be highly pertinent in the study of the stigma of mental illness and its role in mental health care disparities (Gary, 2005; Conner et al., 2009; Knifton, 2012; Stickney et al., 2012). This line of inquiry has led to increased discussion of how intersectionality with regard to the stigma of mental illness has differentiated the experience of this type of stigma for those who are also members of racial or ethnic minorities. Gary (2005) focused on what she called the “double stigma” of having a mental illness and being a member of a minority group, such as a racial minority. Knifton (2012) echoed this in a study of the severely socioeconomically disadvantaged, where he found that socially constructed differences such as stigma had increased negative effects on those groups with multiple disadvantages.

In discussion of health care disparities among racial and ethnic minority groups in general, and of mental health care disparities in particular, the issue of structural support of such disparities inevitably surfaces. Corrigan, Markowitz, and Watson (2004) aligned structural stigma of mental illness with structural discrimination, outlining the differences between intentional and unintentional forms of structural discrimination, and how both have supported the continued stigmatization of people with mental illnesses and multiple disadvantages. Hatzenbuehler, Phelan, & Link (2013) concluded that the structural support of stigma in multiple domains creates an environment for individuals with multiple stigmatized identities that is inherently intersectional in nature. The authors point out that to consider the impact of stigma for only one circumstance, such as having

a mental illness, is “misguided” (p. 814), since each stigmatized circumstance will deplete an individual’s resources, independent of the others. As a result, addressing only the stigma of mental illness with respect to an individual who may be a member of multiple stigmatized groups does little to ameliorate the status loss that is endemic to all forms of stigma (Link & Phelan, 2001). By addressing the intersectionality as discrete contributors, “the production of intervening mechanisms that perpetuate health inequities among the stigmatized often go undetected” (Hatzenbuehler et al., 2013, p. 819).

Mental Illness Stigma and Attitudes Toward Treatment Seeking

Attitudes toward people with mental illnesses and toward mental health treatment may be related to racial disparities in treatment seeking. Black American college students, for example, have been found to hold more negative views than White American college students toward people with mental illnesses, whereas Latino college students were found to hold fewer negative views than White American college students (Rao, Feinglass, & Corrigan, 2007). Similarly, older Black Americans have reported having more negative views toward mental health treatment and also report experiencing higher levels of mental illness stigma than older White Americans (Conner et al., 2009).

Negative views with respect to seeking treatment were also found among a sample of 15,383 low-income immigrant and U.S.-born racial and ethnic minority women who were screened for symptoms of depression (Nadeem et al., 2007). Among the women with depression, findings indicated significantly more Black women, particularly Black immigrant women, reported mental illness-related stigma concerns. Compared to U.S.-born White women in the study, immigrant women from Africa had over three times higher odds of reporting stigma concerns and immigrant women from the Caribbean had

over six times higher odds of reporting these stigma concerns. A similar pattern concerning the odds of reporting mental illness-related stigma concerns was found among the women in the study without depression, when compared to U.S.-born White women without depression, with immigrant women from Africa having 39% higher odds and immigrant Caribbean women having 45% higher odds of reporting mental illness stigma concerns. With regard to the women's interest in seeking mental health care, immigrant women and U.S.-born racial or ethnic minority women in the study were less likely than U.S.-born White women to want treatment. The exception was immigrant Latina women, who were more likely to want treatment than were the U.S.-born White women. The authors concluded that mental illness-related stigma concerns were significantly related to immigrant women's desire to seek treatment, particularly among immigrant women with depression.

Mental Illness Stigma and Disparities in Diagnosis

Since the mid-1970s, diagnostic differences based on race have been noted in the literature (Choi et al., 2012; Sclar et al., 2012), with Black Americans diagnosed more often with schizophrenia and less often with affective disorders, such as depression, than were White Americans. Recent research by Coleman et al. (2016) found in their investigation of insurance data from 2011 obtained from the Mental Health Research Network (MHRN) that involved a review of 7,523,956 patients' records, that non-Hispanic Black patients were nearly twice as likely as non-Hispanic White patients to have received a diagnosis of schizophrenia. Additionally, although overall no significant differences were found across race and ethnic groups in the use of psychotropic medication to treat schizophrenia, the exception to this was non-Hispanic Black patients.

Despite findings that members of this group were twice as likely to have received a diagnosis of schizophrenia when compared to White patients, they were also less likely than White patients to have received medication for their schizophrenia.

International research indicates that the pattern is not exclusive to the United States and may not have changed with time. Tsakanikos, McCarthy, Kravariti, Fearon, and Bouras (2010) found in Great Britain that, among adults with intellectual disabilities who were newly referred to specialist mental health services, significantly more individuals from ethnic minority groups were diagnosed with either schizophrenia spectrum disorders or autistic spectrum disorders than were diagnosed with affective disorders.

The majority of studies investigating racial and ethnic disparity at the point of diagnosis tend to include mental health professionals who identify as psychiatrists or psychologists, and such studies with professional counselors are limited. When professional counselors have been included, the pattern has been found to be consistent, with significantly more Black Americans diagnosed with a psychotic disorder than were White Americans (Schwartz & Feisthamel, 2009). Similarly, Schwartz and Feisthamel (2009) found that racial disparities at the point of diagnosis were present in the diagnosis of childhood mental health disorders as well, with significantly more Black American children than White American children diagnosed with conduct disorder, oppositional defiant disorder (ODD) and attention deficit hyperactivity disorder (ADHD).

Related to diagnostic disparities is the phenomenon of statistical discrimination, the idea behind which is that medical personnel in the position of assigning diagnoses, presumably “unencumbered by prejudice of stereotypic beliefs, and in the presence of

uncertainty about patients' underlying condition, may use race in making a diagnosis of a patient" (Balsa, McGuire, & Meredith, 2005, p. 250). Grounded in clinical uncertainty, this type of discrimination results from the application of clinical rules and protocols that appear neutral, but may have varying effects by race (McGuire & Miranda, 2008).

Although clinical uncertainty is not inherently negative, treatment decisions informed by negative stereotypes associated with racial and ethnic minority groups may be influenced by those stereotypes. In addition, any extant clinical uncertainty might be exacerbated by language barriers, if the individual being diagnosed has limited language proficiency.

Within the context of statistical discrimination, race can play a role in one of two ways. One way is by using race as a statistical indicator of the likelihood that a patient has a given condition, such as a medical provider who believes that the prevalence of schizophrenia, for example, differs by race. Statistical prevalence, however, is the same, whether it is being used to support a diagnostic assumption or for researching diagnostic disparities (e.g., Coleman et al., 2016). A second means by which race may be considered is when patient symptomatology is perceived with more 'noise' from members of racial or ethnic minority groups, such as a medical or mental health professional who does not understand a client's language, culture, or communication patterns.

An example of statistical discrimination can be seen in McGuire and Miranda's (2008) description of disease prevalence among minority groups and majority groups. The authors report that, because the prevalence of mental health disorders among minority groups is statistically lower than among majority population groups, a relatively minor symptomatology report of psychological distress by a member of minority group

may not receive a referral for treatment. The impact of this type of statistical discrimination for racial and ethnic minorities is that, because a referral for mental health treatment might require a report of more severe symptoms by members of minority groups, only those individuals with the most serious mental health problem receive any type of treatment. The numbers analyzed, therefore, are lower, and the symptomatology more severe.

It is feasible that such diagnostic and referral disparities on the front end of the mental health treatment continuum may be related to other disparities in mental health care among members of racial and ethnic minority groups, such as those found by Delphin-Rittmon et al. (2015) in their study of African Americans ($n = 494$), Hispanic Americans ($n = 411$), and non-Hispanic White Americans ($n = 478$) who received mental health treatment at public sector inpatient mental health units in Connecticut between 2002 and 2005. Findings indicated that Hispanic Americans in the study were more likely than African Americans or White Americans to enter inpatient treatment through crisis and emergency sources, but also had a shorter length of stay in inpatient treatment than did the White Americans. African Americans were more likely than Hispanic Americans to have entered inpatient treatment as a self-referral, but less likely than White Americans to have done so. This is notable, given that the same study indicated that African Americans were more likely than Hispanic Americans or White Americans to have been diagnosed with schizophrenia and drug-related disorder and less likely to have been diagnosed with mood disorders or other Axis I diagnoses, such as anxiety disorders and cognitive disorders. Furthermore, African Americans in the study were more likely to be diagnosed with mental retardation or borderline intellectual functioning than were

White Americans.

Mental Illness Stigma and Disparities in Utilization of Mental Health Care Services

Disparities in the use of mental health care services also tend to align with race and ethnicity. Black Americans and Latino Americans have been found to be less likely than White Americans to have visited a mental health professional (Dobalian & Rivers, 2008), although later research indicated that, among males ages 18-44, health insurance coverage appeared to reduce observed racial and ethnic differences in mental health service use (Blumberg, Clarke, & Blackwell, 2015). This pattern of disparity may persist despite need, as Broman (2012) found among a sample of White American adults, Black American adults, and Latino adults. Although levels of depression were highest among Latino adults, followed by Black American adults, the latter group was significantly less likely to have received mental health treatment, with the White American and Latino adults showing similar high levels of service receipt. Additionally, higher education levels among Black American adults were associated with less mental health services use, whereas for White American adults, higher education levels were associated with increased service use. Of those individuals who reported prior use of mental health services, only the Black American participants had lower current mental health care services use.

A thorough discussion of disparities in mental health care cannot be complete without considering those disparities through the new lens suggested by Cole (2009). Although these disparities may begin before the point that an individual is diagnosed with a mental illness, evidence clearly indicates that those differences occur at the point of

initial assessment and diagnosis in significant numbers. Since ongoing treatment for mental health is planned, accessed, and utilized based on those diagnoses, inaccuracy that is the result of disparities at that initial point of contact, whether grounded in racism, mental illness stigma, or intersectionality, have the capacity to impact future treatment seeking and utilization of mental health care services.

Types of Mental Illness Stigma

Having reviewed the history of mental illness stigma and its persistence, even among mental health care providers, it is clear that its impact may affect the lives of individuals who have a mental illness on multiple levels, often simultaneously. The nature of stigma is not one dimensional, and researchers have described several types of mental illness stigma, each with unique outcomes for individuals, their friends and families, and even mental health care providers.

Described as a process, stigma, even when associated with mental illness, sounds simple. It is not. Grounded in individual differences, it is “a powerful phenomenon, inextricably linked to the value placed on varying social identities” (Heatherton, Kleck, Hebl, & Hull, 2003, p. 3). In addition to the effects of group membership on identity development and the complexities of managing a concealed identity, an individual who identifies as a person with a mental illness often must manage stigma that comes to them from others. Embedded in the interconnected processes that move stigma from cues to discrimination are several types of stigma, each of which has its own effect and consequence.

Public Stigma

Public stigma is defined as the public endorsement of stereotypes, or negative

beliefs, about mental illness that lead to the public's fear, rejection, avoidance, and discrimination against people who have a mental illness (Corrigan, 2016; Parcesepe & Cabassa, 2013). Similar to other forms of bias and prejudice, such as racism and sexism, the public stigma of mental illness matters because it "sets the context in which individuals in the community respond to the onset of mental health problems, clinicians respond to individuals who come for treatment, and public policy is crafted" (Pescosolido et al., 2010, p. 1324).

In addition to the role public stigma may have in setting the context in which it occurs, the nature of public stigma is made more complex by the fact that it is situationally influenced by the context and culture in which it occurs (Broman, 2012; Knifton, 2012; Pescosolido, 2013; Yang et al., 2007). Historical beliefs and current value systems of cultures, whether defined by race and ethnicity, geographical location (countries, townships, neighborhoods, or households), religious beliefs, or any number of possible cultural variants, form the framework in which mental illness stigma is understood and expressed.

Theorists have suggested that stigmatized differences, such as mental illnesses, are considered by a given cultural public in light of the extent to which the difference disrupts *what matters most* to that culture (Kleinman & Benson, 2006; Yang, Chen, et al., 2014). For example, Yang, Chen et al. (2014) found among a sample of Chinese immigrant men ($n = 31$) and women ($n = 19$) being treated for psychiatric disorders in a New York hospital that the most damaging consequences of stigma were reported to be those related to the ability to work. For these individuals and their community, the ability to work was what mattered most. Among the participant interviews that were included in

the study, impaired ability to work because of a mental health diagnosis was related to intensified experiences of stigma, while a continued capacity to work, despite a mental health diagnosis, appeared to protect against the effects of stigma.

In addition to the myriad contexts in which the stigma of mental illness may occur, its nature is made more complex by the fact that it may be expressed at both the explicit and the implicit levels, with explicit stigma being accessible at the conscious level, and implicit stigma operating at a more subconscious level. With the development of means to identify and measure these dimensions of mental illness stigma separately (Teachman, Wilson, & Komarovskaya, 2006), evidence has emerged indicating that they are, in fact, separate constructs (Stier & Hinshaw, 2007).

Explicit stigma is the cognitive and behavioral responses by an individual or group to cues indicating the presence of a mental illness. These explicit responses are observable or reportable, and are typically measured using self-report instrumentation. This has been found to be problematic in the study of attitudes associated with prejudice and bias, as measures of explicit attitudes tend to neglect underlying biases and more subtle forms of expression (Dovidio, Kawakami, Johnson, Johnson, & Howard, 1997). Society's tolerance for overt prejudice and bias has declined, and the effects of social desirability have likely influenced the explicit expression of negative attitudes. Unconscious negative attitudes, however, are more difficult to manage, especially when alternative and more subtle forms of expression, such as micro-aggressions and world views such as belief in meritocracy or a just world (Rüsch, Todd, Bodenhausen, & Corrigan, 2010) are employed. Although terminology associated with mental illnesses and the individuals who have them (e.g., "crazy," "loony," "nuts") are generally used

more freely than derogatory terms associated with racial bias, it is likely that similar underreporting of mental illness stigma occurs on instruments that measure explicit attitudes (Stier & Hinshaw, 2007).

Although many researchers and theorists in the field of social psychology believe that stigma, including mental illness stigma, is largely influenced and supported by explicit attitudes resulting in conscious responses such as anxiety, others consider those motivations that are outside of conscious awareness to have a primary role (Pescosolido, Martin, Lang, & Olafsdottir, 2008). Implicit stigma is comprised of those attitudes that are outside of conscious awareness or control and are more automatic (Peris, Teachman, & Nosek, 2008). Research of these more automatic stigma processes, or implicit stigma, has indicated that the components of stigma that are activated in an implicit manner may not necessarily be identifiable through explicit and observable expression (Wang, Huang, Jackson, & Chen, 2012).

Awareness of implicit stigma of mental illness is of interest to stigma researchers in general, but it may be of particular concern for those who work in the fields of mental health care. Peris et al. (2008) investigated implicit and explicit mental illness stigma links between bias and clinical decision-making among a sample of 1,429 individuals with different levels of mental health training. Participants groups were (a) Mental Health, comprised of clinical psychology graduate students, professional psychologists, social workers, counselors, and psychiatrists; (b) Undergraduate students with an expressed interest or some experience with the general health care field; (c) General Public, comprised of individuals who reported no experience or training in the field of mental health; and (d) Other Health/Social Services, a group whose members indicated

that they worked in a health or social service field, but had no training in the treatment of mental illnesses. Women comprised 72% of the overall study sample, and the racial and ethnic makeup of the sample was reported by the study's authors as Caucasian (75.3%), African American (6.7%), Asian (5.9%), Hispanic (4.1%), multiracial (4.8%), and identification with another race or ethnic group (3.2%).

Findings indicated what Peris et al. (2008) considered to be low levels of both explicit and implicit bias toward individuals with mental illness, a result the authors reported could have been affected by another stigmatized group, welfare recipients, used in the study as a comparison category. Differences were found among participant groups, with those participants who had training and experience in mental health care viewing individuals with mental illnesses more favorably in terms of explicit and implicit bias, compared to the participants with less mental health care experience or training. Additionally, although results indicated that mental health service providers showed less explicit and less implicit bias toward individuals with mental illnesses, findings suggested that the two types of mental illness stigma played unique roles with respect to clinical decision making. Explicit bias among those with mental health training and experience was more predictive of prognosis (less or more negative), whereas implicit bias among the same group of participants was more predictive of a tendency to over diagnose (over pathologize). This illuminates the roles that the stigma of mental illness, both explicit and implicit, can play in the areas of diagnosis and prognosis, on which ongoing treatment planning and therapeutic interventions are based.

Subsequent research that investigated similar questions yielded findings with less positive implications for mental health care service providers. A study by Kopera et al.

(2015) among a sample of Polish mental health professionals ($n = 29$) and nonmental health professionals ($n = 28$) found that both the mental health provider group and the nonprovider group self-reported positive attitudes toward individuals with mental illnesses. In contrast to Peris et al. (2008), however, findings of the Kopera et al. (2015) study suggested that both groups were more likely to associate mental illness with negative rather than positive attributes, with no significant differences between those participants with mental health care experience or training and those without experience or training. The study's authors suggested that this effect, even among mental health professionals, was indicative of the persistence of implicit attitudes, and that mental health professionals need not assume that conscious awareness of potential bias and mental illness stigma is necessarily enough.

In response to the increased awareness and study of mental illness stigma, researchers have investigated changes in mental illness stigma over time. Pescosolido et al. (2010), for example, compared data from the 1996 and 2006 General Social Survey (GSS), a biennial stratified probability sample national survey that has been administered since 1972, designed to monitor changes in social characteristics, intergroup relations, and attitudes in American society. GSS surveys for 1996 and 2006 included a response module to assess the stigma of mental illness. Results of the comparison study indicated that, while Americans in 2006 were generally more accepting of receiving treatment for mental illnesses than they were in 1996, views that individuals with mental illnesses are dangerous increased over time, as did the desire for social distance, with fewer Americans in 2006 being willing to be neighbors to an individual with schizophrenia, compared to 1996 responses.

Both the endorsement of treatment for mental health problems and increased public stigma were associated in the Pescosolido et al. (2010) study with a significant increase in the public's attribution of mental illness to neurobiological, or biogenetic, causes. In both years and across conditions (schizophrenia and major depression), biogenetic attribution had no effect on stigma levels or increased the odds of stigmatization. Clearly, the public education that accompanied advances in neuroscience, while apparently received as intended, was not associated with decreased levels of mental illness stigma. Similar findings were reported by Parcesepe and Cabassa (2013), whose systematic review of literature addressing the public stigma of mental illness from 1988 to 2013 indicated that perceptions that people with mental illnesses are dangerous were widespread, and that perceptions were closely associated with biogenetic attributions of causality. Even children viewed their peers with depression or ADHD as being more violent than peers with an illness not considered being a mental illness, such as asthma. Children also considered depression to be a more shameful condition than ADHD, and any mental illness to be more shameful than asthma. Interestingly, the most stigmatized groups found in the analysis were children with depression and adults with drug dependence (Parcesepe & Cabassa, 2013).

Although public stigma toward mental illnesses may be assessed by large scale survey instruments, the consequences of public stigma to individuals with a mental illness are much more personalized. Some resist the stigma successfully (Thoits, 2011). Others, perhaps due to the symptomatology of their mental illness itself, internalize the negativity ascribed by society and engage in self-derogation that can present additional barriers to treatment and recovery. Professionals in the field of mental health care must

be aware that individuals who approach them seeking treatment may have come to believe that there is little hope for their condition, or that they are simply not worth the effort. Treating the diagnosed mental illness may occur in concert with or even take secondary role to addressing the internalized mental illness stigma that the individual had accepted as inevitable.

Self-Stigma or Internalized Stigma

Where public stigma has the potential to affect an individual's quality of life through the discriminatory actions of others, such as reluctance to hire a person with a mental illness, self-stigma, also referred to as internalized stigma, is a separate but related process that involves awareness of the stereotype, agreement with the stereotype, and internalization of that stereotype (Corrigan, Larson, & Rüsch, 2009; Thornicroft, 2007). Although most stigma researchers and authors use the terms *internalized stigma* and *self-stigma* interchangeably, Livingston and Boyd (2010), conceptualized self-stigma as one of two types of internalized stigma, the other being *felt stigma*. Where felt stigma is defined by Livingston and Boyd (2010) as the negative impact of one's awareness of how society perceives and may act toward the group to which he or she belongs, self-stigma is "the process of an individual accepting society's negative evaluation and incorporating it into his or her own personal value system and sense of self" (p. 2151).

The detrimental effects of internalized stigma include low self-esteem, reduced sense of empowerment (self-efficacy) and goal attainment, reduced levels of hope, and reluctance to seek treatment (Corrigan et al., 2009; Lannin, Vogel, Brenner, Abraham, & Heath, 2016). The effect of reduced self-esteem has been studied among diverse populations and among those with a variety of mental illness diagnoses. Livingston and

Boyd (2010), in their meta-analysis of mental illness stigma-related research that investigated the negative effects of internalized stigma for people with mental illnesses, identified self-esteem as the only variable that demonstrated a robust relationship with internalized stigma among the 127 studies reviewed and the 45 studies used in the meta-analysis.

Subsequent research by Krajewski, Burazeri, and Brand (2013), however, found among a sample of 796 European adults from Israel, Lithuania, Malta, Romania, and Sweden that the assumption that low self-esteem or self-efficacy is a direct effect of self-stigma was not supported. Although their findings indicated a minimal association between self-stigma scores and scores of self-esteem and self-efficacy, variance of self-stigma scores was found to be more closely related to cultural- and context-specific differences than to levels of self-stigma or self-efficacy among study participants. The study authors concluded that the effects of self-stigma on self-esteem and self-efficacy are influenced by the cultural context in which the stigma and self-stigma occur, and may include variables such as a country's acceptance of hierarchical relationships, societal views concerning egalitarian values, and levels of personal empowerment.

Self-stigma also appears to be related to treatment seeking among individuals with mental health problems. Among 583 college students, most of whom identified as European-American (86%), Vogel, Wade, and Haake (2006) found levels of self-stigma associated with seeking mental health care predicted less intention to seek treatment, beyond the effects of public stigma and anticipated risks and benefits. Similar results were reported in more recent research (Lannin et al., 2016) that indicated that even the decision to seek information about counseling, such as that available online, was

associated with levels of self-stigma. Lannin et al. (2016) found among a sample of undergraduate college students at a large Midwestern university ($N = 370$) that self-stigma of mental illness was significantly associated with decreased probability of seeking counseling information and online mental health information. In addition, findings indicated that self-stigma was a significant predictor of negative attitudes toward counseling. Although those participants in the study who reported high levels of distress were more likely to seek information about mental health and counseling, the results suggest even among those individuals, self-stigma was associated with reluctance to access such information.

Attempts by individuals to avoid being labeled as having a mental illness, or *label avoidance*, has also been linked to reduced treatment seeking (Corrigan, 2004), even among populations with well-reported need for mental health services. Investigation of this phenomenon among military service persons in the United States has indicated that soldiers chose to not seek treatment for their mental health concerns due to fear that they would be identified as having a mental illness (Ben-Zeev et al., 2012). Label avoidance may also affect large scale data reporting, as there is evidence that suicides may be underreported or reclassified at the point of documentation as accidental or undetermined (Pritchard & Hansen, 2015). Furthermore, Cummings, Lucas, and Druss (2013) concluded from their review of three U.S. federal antidiscrimination laws that expanded protection to individuals with mental illnesses, that the stigma of mental illness, specifically label avoidance, limited the effectiveness of the laws. The individuals who would have benefited from the expanded laws did not seek protection because of fear of being publicly identified as having a mental illness.

Similar to findings that indicated that the reduced self-esteem and self-efficacy associated with self-stigma may be influenced by cultural context, mental health treatment seeking and attitudes toward help-seeking have been found to vary with sociodemographic differences. Researchers have suggested that counseling may be viewed as a threat to men and their sense of masculinity (Schaub & Williams, 2007) and that men who seek counseling may self-stigmatize more than women (Judd et al., 2006). In a study of conformity to masculine norms and self-stigma of mental illness among men from diverse backgrounds, Vogel, Heimerdinger-Edwards, Hammer, and Hubbard (2011) found that, although the African American men in the study endorsed some dominant masculine norms to a greater degree than the European American men in the study, the relationship between conformity to masculine norms and self-stigma was weaker for the African American men, suggesting less internalization of stigma by those men. The same pattern emerged for the Asian American men in the study.

In a study of mental illness stigma among a racially balanced sample ($N = 449$) of White Americans ($n = 229$) and African American ($n = 220$), Brown et al. (2010) found that, overall, internalized stigma mediated the relationship between public stigma and attitudes toward mental health treatment. Within-group analyses, however, indicated similarities and differences. Although there was no significant difference between African American and White Americans in their current use of mental health treatment or in their intention to seek mental health treatment, the African Americans in the study reported more negative attitudes toward mental health treatment. Findings also indicated a direct relationship between internalized stigma and attitudes toward treatment among African-American participants in the study. This differed from the relationship between

stigma and attitudes toward treatment of White Americans in the study, for whom the relationship was mediated by internalized stigma. The authors concluded that for attitudes toward treatment among African Americans in the study, the influence of stigma was directly determined by the degree to which African Americans held negative attitudes about themselves because they had depression, rather than by how they predicted others might judge them.

Although the negative outcomes of internalized stigma may affect quality of life and attitudes toward treatment seeking, it is notable that self-stigma is not universal, and evidence exists that some individuals develop a “righteous anger,” seemingly energized by the awareness of the public stigma they see around them (Watson & River, 2005).

The study of identity management strategies applied to people with mental illnesses indicated that the manner in which an individual chooses to manage their stigmatized identity can determine the extent to which having a mental illness negatively affects outcomes such as life satisfaction, self-esteem, and stigma resilience (Ilic et al., 2014). As professionals working in the field of mental health care seek to help the client who has sought treatment, it is equally important that those professionals remain cognizant that their client’s response to the stigma of mental illness may be influenced not only by the larger social environment in which they live their lives, but also by its impact on those much closer to them. The stigma of mental illness rarely affects only the person who has been diagnosed, but may also impact the everyday lives of their families and friends.

Courtesy Stigma or Associative Stigma

Goffman (1963) referred to an additional type of stigma as courtesy stigma, also known as stigma by association, in which people who are associated with a stigmatized

individual are devalued because of their connection to that stigmatized individual (Bos et al., 2013; Hinshaw, 2007; Thornicroft, 2007). For family members, this type of stigma may take the form of blaming parents or upbringing for a child's mental illness, a phenomenon that has been reported by some to be more burdensome than caring for the individual with the mental illness (Tessler & Gamache, 2000). Because courtesy stigma may also be cast upon friends or coworkers of those with a mental illness, it has the power to alienate not only those individuals who have a meaningful connection with a stigmatized individual, but also those who have a purely arbitrary or distant connectedness (Bos et al., 2013).

Professionals in the field of mental health care also experience courtesy stigma, at best being blamed for having nebulous interpersonal boundaries or offering ineffective treatment and, at worst, being depicted by the media as subjecting clients to invasive or cruel treatment (Hinshaw, 2007; Sadow et al., 2002; Schulze, 2007). As the impact of courtesy stigma on the professionals who treat individuals with mental illnesses becomes more directly the focus of study, researchers have referred to courtesy stigma in the context of the practice of mental health care as *associative stigma* (Kennedy, Abell, & Mennicke, 2014; Verhaeghe & Bracke, 2012).

Of the small number of studies of associative stigma targeting mental health professionals, the majority of studies have been undertaken with mental health nurses, with most of those in Europe (Halter, 2008). Halter (2008), however, studied associative stigma among a sample of 122 registered nurses (RN) or licensed practical nurses (LPN) in northeast Ohio, and found, of 10 nursing specialty areas included, that psychiatric nursing was ranked lowest (least desirable as a work environment) from both personal

and societal perspectives by the participants. The author found that the consistently low preference for psychiatric nursing as a specialty may have been related to the characteristics associated with it and the other specialties ranked. For example, intensive care and emergency department nurses were rated by study participants as being skilled, logical, respected, and autonomous, and oncology and pediatric nurses were considered to be accepting and caring, respectively. Psychiatric nurses, in contrast, were generally described by the nurses in the study as unskilled, illogical, idle, and disrespected more often than any other nursing specialty.

The findings by Halter (2008) that nurses viewed members of their own profession differentially based on their professional specialty area offered additional evidence that the stigma of mental illness resides not only in the person who has a mental illness, or in his or her family, but that it is clearly associated with those who choose to work in professional fields serving those individuals. Similar attitudes toward mental health and psychiatric specialty areas were found in earlier research among medical students (Malhi et al., 2003) and in later research among medical and nonmedical mental health care providers (Gras et al., 2015). In both studies, participants indicated concern related to having chosen to work in what they perceived to be a highly stigmatized professional field.

In response to the awareness that the literature on the stigma of mental illness has generally not included studies that focus on mental health professionals and associative stigma, Verhaeghe and Bracke (2012) analyzed data from a larger stigma study in Belgium that included mental health professionals ($n = 543$) and mental health service users ($n = 707$) from 46 mental health agencies and hospitals. The mental health

professionals represented a variety of mental health job roles, including psychiatrists, nurses, psychologists, vocational trainers, social workers, and pedagogues (clinical instructors). The purpose of the study was to investigate the impact of associative stigma on the well-being of both mental health providers and service users, and findings indicated that the associative stigma of mental illness experienced by providers was associated with levels of their emotional exhaustion and job satisfaction. Furthermore, the associative stigma experienced by the providers was also related to self-stigma among mental health service users, with higher levels of associative stigma among service providers linked to lower levels of satisfaction with mental health services among users. The authors concluded that the associative stigma experienced by mental health professionals appeared to enhance self-stigma among service users, and self-stigma was found to be the single most important determinant of service user satisfaction, an emotional response that has been linked to poor interpersonal relationships between mental health provider and their clients (Schulze, 2007).

Structural Stigma

An additional type of stigma reported in the literature is structural stigma, grounded in a phenomenon that exemplifies how having a devalued status as the member of a stigmatized group can, once it extends to the larger society, lead to measurable inequity that is then supported by the structure of society itself. Once this occurs, the person who develops a mental illness is affected by stigma insofar as the structure around him or her has been affected (Link & Phelan, 2001). Because structural stigma is not *in* an individual, but is rather imposed upon an individual, its nature is interactional and malleable. An understanding of structural stigma cannot be realized without knowledge

of the context in which it occurs and the cultural knowledge systems that have allowed it to form (Bos et al., 2013; Pescosolido et al., 2008).

This context has been conceptualized by stigma researchers and theorists as a structure that defines moral experience, a phrase used by Kleinman and Benson (2006) to denote that which *matters* to individuals, that which is fundamental to one's moral core. This moral experience varies not only among ethnic, racial, or cultural groups, but also among the individuals within those groups. It is that which "matters most" (Kleinman & Benson, 2006, p. 836). This experience that matters most is formed and re-formed by larger forces that affect cultural meanings, social experience, and a sense of self among individuals in a given culture. In regard to the stigma of mental illness, what matters most is determined by the perceived impact a mental illness has on the group's and the individuals' sense of self, which then dictates the intensity of the stigma (Yang, Thornicroft, et al., 2014).

Empirical study of cross-cultural structural stigma remains limited despite evidence that culture-specific constructs play a primary role in determining the effects of stigma related to mental illness (Yang, Thornicroft, et al., 2014). In a two-year study of the largest Black and Minority Ethnic (BME) communities in Scotland, Knifton (2012) worked with focus groups comprised of individuals of Pakistani, Chinese, and Indian heritage who represented a variety of cultures and religious belief systems. Consistent beliefs among groups included views that people with mental health problems were dangerous, not intelligent, not employable, and undesirable as a marriage partner. Additionally, the view that mental illness is incurable emerged, as did shame as the most frequent response to mental health issues.

Differences among the groups in the Knifton (2012) study were generally aligned with groups' prevailing religious beliefs. For example, where some of the groups explained mental illness as a punishment from God for sinful behavior, Chinese and Hindu groups attributed karma. Other areas of difference emerged with regard to the impact of stigma. Although the majority of groups identified mental illness as being inheritable, this was most strongly expressed by individuals from Hindu, Sikh, and Muslim communities, who described their extended family structures and marriage traditions as being most seriously threatened by mental illness in the family lineage. The authors concluded that it cannot be assumed that all communities share the view that mental illness is a medical illness, or that being part of a close community or family is protective against the stigma of mental illness.

The impact of structural stigma is found among other cultural groups, including Black Americans and Latino immigrants. Ward, Wiltshire, Detry, and Brown (2013) found among a sample of 272 African American men ($n = 158$) and women ($n = 114$) between the ages of 25 and 72, that participants were reluctant to disclose psychological problems and were very concerned about the stigma associated with a mental illness, but were somewhat open to seeking mental health services. This finding is in contrast with previous literature that suggested that African Americans tend to have negative views toward mental health treatment-seeking (Gary, 2005). Such variation in research with African Americans may be indicative of the large variety of cultural differences within any group that may be identified in the research literature as African American, Black, or Black American. As Abdullah and Brown (2011) clarified, Africa itself has 54 countries with varying colonial histories and customs, and Americans of African descent may

differ widely from each other given historical differences and degree of identification with their African heritage.

In a qualitative study that employed a series of focus groups and interviews, Hansen and Cabassa (2012) found among Spanish-speaking immigrant Latino individuals ($n = 19$) who had lived an average of 25 years in the United States, that structural barriers may have played a role in treatment seeking and adherence to treatment for depression. Participants in the study were selected from a larger randomized clinical trial investigating comorbid depression and diabetes among Latino individuals, and the qualitative study with the smaller purposive sample was intended to look more closely at cultural and structural factors associated with the individuals' mental health diagnosis.

The most pervasive structural barriers to mental health treatment that emerged from the Hansen and Cabassa (2012) study centered on initiation of treatment and treatment adherence. Initiation of treatment was affected primarily by language barriers, as the participants all had limited English proficiency but were often screened for mental health treatment by medical providers whose knowledge of Spanish was limited to the point that some participants reported that they left the screening not knowing whether or when they were to return for treatment. The reported effect of this on study participants were feelings that their concerns had not been fully understood, and that any type of personal relationship with the provider was impossible. The study's authors point out that this perceived absence of a trusting interpersonal relationship is particularly salient for Latino individuals, as interpersonal relationships form an important cultural norm in Latino communities.

In addition to difficulties forming an interpersonal relationship being associated

with initiation of treatment issues, Hansen and Cabassa (2012) also found lack of an interpersonal relationship to be associated with adherence to treatment, as participants reported making decisions to rely on family rather than continue with recommended treatment. Treatment adherence, specifically adherence to antidepressant medication, was also affected by pervasive beliefs not only that antidepressant medication is addictive and harmful, but that being prescribed such medication labels one as ‘loco’ (‘crazy’). One participant noted that, although her antidepressant medication helped calm her, she often skipped doses or took half doses when her symptoms became overwhelming. This participant explained to the study investigators that she believed that taking antidepressant medication would make her condition worse, since antidepressants were only used for those people who were truly ‘loco.’ Her efforts to manage the stigma associated with taking psychotropic medication and avoid the label of being ‘crazy’ created a barrier to the treatment she was otherwise willing to accept. Professionals who work in the field of mental health, particularly those who work with clients who identify with racial, ethnic, and cultural groups that are different from their own, must remain aware that the treatment they offer may unintentionally interact with their clients’ own stigmatizing attitudes toward having a mental illness. Again, it may be necessary to address the stigma of mental illness and the context in which that stigma is grounded in order to effectively treat the person and the mental illness.

Socioeconomic status is a context within which structural stigma of mental illness may be identified. However, results from a study by Hansen, Bourgois, and Drucker (2014) identify mental illness as playing a unique and somewhat unexpected role. Through a series of case studies, the authors investigated the subjective experience of

structural stigma from the perspective of individuals who were receiving public assistance due to a mental disability. Findings indicated that, in an era of what the authors refer to as ‘medicalized poverty,’ the stigma associated with mental illness is tempered by the perceived respect that comes with having stable housing and a means by which individuals may reintegrate into functional communities. Hansen et al. (2014) concluded:

In the context of poverty, using disability and illness to gain benefits can be interpreted at the street and family level as a marker of competence and social responsibility, or at least a viable harm-reduction strategy in a post-welfare state that offers few alternative solutions to unemployment. (p. 81)

Power and the structural support of stigma. Link and Phelan’s (2001)

conceptualization of the stigma of mental illness builds on that of others by incorporating more directly the structural element of power, that it occurs “when elements of labeling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold” (p. 367). Since this addition of power, a number of authors have included access to power in theoretical analyses of structural stigma (e.g., Metzl & Hansen, 2014; Pescosolido et al., 2008; Richman & Lattanner, 2014), referencing Link and Phelan’s prioritization of power as an integral and necessary part of the stigma process.

That the role of power is necessary for the structural support of stigma, including the stigma of mental illness, is theoretically grounded by Hatzenbuehler et al. (2013), who posited that stigma meets the criteria of a fundamental cause of population health inequity. As such, stigma (a) influences multiple disease outcomes through a variety of risk factors among a large number of people; (b) stigma affects access to financial and education resources, as well as power, prestige, and social connection, that could be used

as protective factors; and (c) stigma is related to health inequities across time and place. These criteria form the concept of social status, the loss of which was previously identified by Link and Phelan (2001) as essential to the experience of being stigmatized.

In a study of status and stigma process, Lucas and Phelan (2012) measured the effects of personal characteristics such as educational attainment, mental illness, and physical disability on dependent variables of influence (status) and social distance (stigma) among a sample of 323 college students at a large university. Study participants engaged over a computer network in an experimental condition with fictitious partners presented as real. The authors hypothesized that educational attainment, mental illness, and physical disability would produce status effects, but that only mental illness and physical disability would produce stigma effects. The authors also predicted that the fictitious partners would benefit from added information given to study participants that the partners possessed high task ability related to the tasks being performed.

Results of the study (Lucas & Phelan, 2012) indicated that mental illness had a strong effect on influence and social distance, whereas physical disability had no significant effect on influence, but did have an effect on social distance. The addition of high task ability also was associated with higher influence by all of the fictitious partners, regardless of condition. The authors concluded from their study that participants, when assessing their partners without the information about their high task ability, considered themselves to be status advantaged or status equals, relative to their fictitious partners, allowing them the power necessary for stigmatization as described by Link and Phelan (2001). Once the high task ability information was added and considered, participants became more status disadvantaged, eliminating the power required for social rejection.

Stigma resistance has also been found to be associated with empowerment of individuals with mental illness. Thoits (2011), who discussed stigma specifically in terms of mental illness, acknowledged that her conceptualization of stigma resistance can be applied to any stigma, and describes the resistance as being of two types: *challenging*, or the confronting and fighting of stigma as a harmful force, and *deflecting*, or the refusal to yield to a perceived harmful force. Thoits (2011) proposes that both forms of stigma resistance “serve to protect the self against devaluation, but challenging opens possibilities for victory in changing others’ negative views or actions, while deflecting does not” (p. 11). In short, stigma and stigma resistance appear to be related to power.

Research by Campellone, Caponigro, and Kring (2014) included the resistance to stigma of mental illness as described by Thoits (2011) in their study of 51 men ($n = 27$) and women ($n = 24$) between the ages of 18 and 60 who had been diagnosed with either schizophrenia ($n = 34$) or schizoaffective disorder ($n = 17$). In the study, links between social power, internalized stigma (self-stigma), stigma resistance, and negative symptoms associated with schizophrenia were investigated. Findings indicated that greater social power was associated with greater stigma resistance, lower internalized stigma, and fewer negative symptoms. Additionally, stigma resistance, but not internalized stigma, was related to fewer negative symptoms. Because this study indicated neither a significant relationship between internalized stigma and negative symptoms in people with schizophrenia nor a significant relationship between internalized stigma and stigma resistance, the authors concluded that stigma resistance may be separate and distinct from internalized stigma. They contend, however, that “both are linked with power, specifically in the context of social relationships” (Campellone et al., 2014, p. 283).

The idea that power and power differentials are inherent in counseling relationships is not new. Rogers (1946) preferred to refer to the individuals who came to him for therapy as clients rather than patients, which he believed allowed them to engage with him in the context of relationships that were democratic and empowering (Zucconi, 2011). Such a democratic relationship relies on much more than a mere change in terminology, and more recent authors have continued to suggest means by which counselors and therapists can connect with their clients in meaningful and egalitarian ways (e.g., Kidd, Miller, Boyd, & Cardeña, 2009; Patrick & Connolly, 2009). For professionals in the field of mental health care, an awareness of the power differential that accompanies any counseling relationship is critical to understanding the pervasive nature of stigma, even among those who seek to help individuals who have mental illnesses. It is within the context of power that the stigma of mental illness and its negative consequences occur (Yang, Link, & Phelan, 2008).

Power and emotional response in stigma. In addition to power, Link and Phelan's (2001) expanded conceptualization of stigma includes emotional, or affective, responses related to stigma of mental illness. These emotional responses are present to varying degrees in both the individual who stigmatizes others and those who are stigmatized. While an individual who stigmatizes others may experience emotions such as disgust, anxiety, or empathy in response to an individual with a mental illness, the person who is stigmatized may experience shame, embarrassment, alienation, or anger (Yang et al., 2008).

Among a sample of 85 individuals with diagnoses of schizophrenia, schizoaffective, or affective disorders, Rüsç et al. (2009) investigated the emotional

consequences of and cognitive coping responses to stigma induced stress, and found that involuntary emotional responses, such as those associated with shame and social anxiety, linked the stress associated with being a member of a stigmatized group to an emotional response. In addition, results indicated that emotional stress responses, particularly social anxiety, predicted high levels of hopelessness and low self-esteem, controlling for diagnosis and symptoms of depression. Findings reported by Livingston and Boyd (2010) in their meta-analysis of empirical literature investigating the effects of internalized stigma of mental illness support findings of Rüsç et al. (2009) and others, namely that there are strong relationships between internalized stigma and a range of psychosocial variables, including hope, empowerment, self-esteem, and emotional discomfort.

Emotional response from the perspective of others, or those who may potentially stigmatize individuals with mental illnesses, has also been studied, though not extensively. In their review of literature focused on emotional response of the general population to people with mental illnesses, Angermeyer, Holzinger, and Matschinger (2010) found a dearth of studies that included measures of emotional response, indicating that the public's emotional response to people with mental illnesses may be an area that needs increased attention by researchers. Their findings, based on the approximately 47 studies that included measures of emotional response, indicated that, overall, the public most frequently reports positive feelings toward individuals with mental illnesses, followed by fear and anger, and that there were significant differences in this pattern depending on the specific mental illness diagnosis being considered. For example, the study by Angermeyer et al. (2010) indicated that the public had a particularly unfavorable

social distance response to individuals with a diagnosis of alcohol dependence, but a fear response was more closely associated with individuals with a diagnosis of schizophrenia. Individuals with a diagnosis of depression evoked the least negative response.

Although the association of emotional response and stigma was underrepresented in the literature prior to Link & Phelan (2001), it has since taken on a more central role in research on the stigma of mental illness, with emotional response referred to in the recent literature as “the lynchpin connecting stereotypes to action” (Sadler, Kaye, & Vaughn, 2015). The addition of the emotional responses of the individual who is stigmatized and the person who stigmatizes and the role of power to the conceptualization of mental illness stigma broadens the locus from which mental illness stigma operates. No longer is it an occurrence of one individual being stigmatized by another individual because of a label of mental illness. With Link & Phelan’s (2001) expanded conceptualization and ongoing research of emotional response, the associated stigma is a social issue embedded with power differentials. Those groups of individuals who are not labeled as mentally ill, who have power and status, opt at the very least to maintain social distance or, depending upon the diagnosis being considered, are “disgusted” by or “afraid” of the individuals that comprise other groups that are labeled as mentally ill. As a result, individuals known to have a mental illness are afforded lower status, less power, and limited access to resources that support quality of life.

Stigma of Mental Illness Among Mental Health Care Providers

Authors of studies investigating mental illness stigma among mental health care providers have found that it not only exists, but may be more pronounced than in the general public (Lauber et al., 2006; Schulze, 2007). Other researchers have found that

the stigma of mental illness among mental health care providers may have a role in reduced treatment seeking and service receipt among those with mental illness diagnoses (Horsfall et al., 2010; Stuart et al., 2012).

Mental healthcare providers, however, generally consider themselves to be “entirely blameless” with regard to the stigma of mental illness (Stuart et al., 2012, p. 58), not realizing that they may engage in microaggressive behavior, exhibiting subtle or dismissive messages discounting the individuals they treat (Nemec, Swarbrick, & Legere, 2015). Indicators of mental illness stigma among mental health care providers may be similar to those of the general public, such as the belief that an individual may be more dangerous than a an individual without a mental illness or that recovery from a mental illness is unlikely. It follows that these types of underlying stigmatizing views, however, take on a more significant role in the lives of individuals when the mental health care professional providing services believes, for example, that their client has little hope of recovery.

The attitudes of mental health care providers toward their clients has been referred to as *iatrogenic stigma* by Sartorius (2002). Although iatrogenic stigma may be operationalized in any number of ways by healthcare and mental health care providers, the most pervasive, according to Sartorius is the careless use of diagnostic labels. The purported efficiency of applying diagnostic labels and categorizing individuals by disorder loses its efficiency when the labels are used as identifiers of negative characteristics by nonmental health care professionals. With this type of labeling, which often occurs early in an individual’s engagement with mental health care services during the process of diagnosis, negative and pejorative associations are applied to that person.

Having entered the emergency room or the counseling office as a person seeking treatment, an individual may leave as a ‘depressive,’ or a ‘SCUT’ (schizophrenia, chronic undifferentiated type). With the label, this individual has been given a new identity, and the subsequent responses of family, friends, coworkers, and professionals in the medical and mental health care fields will contribute to how he or she engages or resists the new identity.

Diagnostic labeling developed as a means of categorizing people who exhibit specific symptomatology, and allows clinicians to describe their patients or clients efficiently. This convention, however, has been found to support the stigma of mental illness by way of three processes, described by Ben-Zeev, Young, and Corrigan (2010) as groupness, homogeneity, and stability. Groupness refers to a common sense among members of a group of differentness from the larger population. Although a group does not necessarily engender prejudice, a group to whom a negative label has been applied links individuals in that group to the negative associations, even in the absence of outward signs on the part of the individual. Those who are associated with the group experience stigma not because of their individual behavior, but because of the label identifying them as members of that group. This process works alongside homogeneity, which leads to the overgeneralization that all individuals identified as a member of a diagnostic group will exhibit the behaviors attributed to the group and, by extension, have similar responses to treatment and similar outcomes. Pertinent to clinical outcomes is stability, which is the assumption that the diagnosis or categorization is static and permanent. This sense of permanence can affect not only the attitudes and actions of mental health care providers, but can also impact clients’ levels of hope, found to be

central to the process of recovery (Mashiach-Eizenberg, Hasson-Ohayon, Yano, Lysaker, & Roe, 2013).

The presentation of the label itself may also have an impact on the extent to which an individual is associated with the stigmatized characteristics of a diagnostic category. In the United States, person-first language has been proposed as a means of separating the individual from the condition, following the awareness that the use of labels, particularly those associated with mental health conditions, led to increased stigma (Granello & Gibbs, 2014) and dehumanization of those with mental illnesses (Angell, Cooke, & Kovac, 2005). Granello and Gibbs (2014) investigated the effect of labels among samples of undergraduate students ($N = 221$), adults ($N = 211$), and counselors-in-training ($N = 269$), with the purpose of identifying differences elicited by the use of person-first language, namely postmodified nouns such as *people with mental illnesses* or *person with depression*, compared to the use of premodified nouns, such as *the schizophrenic* or *the mentally ill*.

The study by Granello and Gibbs (2014) used two versions of the Community Attitudes toward the Mentally Ill (CAMI; Dear & Taylor, 1979), one with postmodified language (people with mental illnesses) and one with premodified language (the mentally ill). The CAMI is a self-report survey instrument comprised of four subscales: (a) Authoritarianism (the view that individuals with mental illness require coercive control); (b) Benevolence (the view that society should assume some degree of responsibility for kindness toward and care of individuals with mental illnesses); (c) Social restrictiveness (reflects the idea of dangerousness associated with mental illnesses, and the view that distance should be maintained from people with mental

illnesses); and (d) Community mental health ideology (the view that there is therapeutic value in community and the community-based care for people with mental illnesses is preferable to institution-based care).

The sample of professional counselors and counselors-in-training in the study by Granello and Gibbs (2014) was recruited at the 2013 American Counseling Association (ACA) Conference & Expo in Cincinnati, Ohio, and was predominantly female (77%, $n = 209$) and European American (84.8%, $n = 228$). Other participants identified as African American (8.6%, $n = 23$), Asian American (3.3%, $n = 9$), other (1.1%, $n = 3$), Hispanic (0.7%, $n = 2$), Native American (0.7%, $n = 2$), and mixed race (0.7%, $n = 2$). Findings indicated that professional counselors and counselors-in-training who completed the premodified version (the mentally ill) of the CAMI (Dear & Taylor, 1979) scored significantly higher on the Authoritarian and Social Restrictiveness subscales than those professional counselors and counselors-in-training who completed the postmodified version (people with a mental illnesses). There were no significant differences between the same groups in the scores on the Benevolence and Community Mental Health Ideology subscales. Furthermore, this pattern persisted when the professional counselors' scores were examined separately from the scores of the counselors-in-training. The authors noted that the difference in the professional counselors' scores between the premodified and the postmodified versions of the Authoritarianism subscale of the CAMI (Dear & Taylor, 1979) was greater than that of the counselors-in-training, with an effect size ($d = 0.67$) greater than that of any other group on any other subscale.

The findings of this study (Granello & Gibbs, 2014) are a sober reminder that language and labels matter, and that those who work as mental health care providers may,

in fact, be particularly susceptible to the effects of person-first identifiers when discussing and describing their clients. Given the dehumanizing effects of mental illness stigma, often by way of careless use of labels (Sartorius, 2002), and the call for counselors to adopt a more active advocacy role, it seems that counselors may be called upon to engage the humanistic approach that “thoroughly animates professional counseling” (Hansen, Speciale, & Lemberger, 2014, p. 173) and become more aware of how behavior and language may be perceived by both professional peers and clients.

Research indicating that the stigma of mental illness has an effect on mental health outcomes has led to increased study of stigmatizing attitudes among mental health providers, both of individuals providing service (Hansson et al., 2011; Woollaston, & Hixenbaugh, 2008) and of mental health care program settings (Flanagan, Miller, & Davidson, 2009; Holley, Tavassoli, & Stromwall, 2016). Researchers have already called upon medical professionals, such as physicians and nurses, to become more aware of the stigmatizing attitudes that have negatively impacted the medical care of their patients with mental illnesses (Clarke et al., 2007; Freidrich et al., 2013; Sadow et al., 2002). Additional recent literature suggests that such awareness will become expected of a wide range of mental healthcare providers, including non-medical mental health care providers, such as professional counselors (Holley et al., 2016; Kennedy et al., 2014; Nemecek et al., 2015; Stuber, Rocha, Christian, & Link, 2014).

The awareness by mental health providers that they may, in fact, hold stigmatizing attitudes toward the clients with whom they work has led to what Schulze (2007) referred to as an “intricate relationship” (p. 137). The intricacy, explains Schulze, arises from the multiplicity of roles a mental health care provider may play with a client

and within their professional field. A mental health care provider may simultaneously be stigmatized, stigmatize others, and advocate for antistigma campaigns in the community. Based on Schulze's review, a mental health care provider may hold negative attitudes towards a client's recovery by offering a poor prognosis for a diagnosis such as schizophrenia. This same provider may, due to a presumed high level of education and social awareness, be asked to assist with antistigma efforts in the community. At the same time, the mental health care field in which the provider works is stigmatized by the media and poor public support for mental health care funding.

Despite the intricate nature of the relationship counselors or therapists may have with the stigma of mental illness (Schulze, 2007), they nonetheless have a primary relationship with their clients. In consideration of the therapist's role in the maintenance of social structures that provide the structural support of stigma, Rogers may have been ahead of his time when he stated, "I object to the process of depersonalization and dehumanization of the individual which I see in our culture. I regret that the behavioral sciences seem to me to be promoting and reinforcing this trend" (Rogers, as cited in Zucconi, 2011, p. 4).

Mental Health Literacy

Mental health literacy is integral to the study of the stigma of mental illness, as researchers have found that increased knowledge of mental health and mental disorders and a broadened awareness of how to seek treatment are factors in improved mental health outcomes (Evans-Lacko, Henderson, & Thornicroft, 2013). As a construct, however, mental health literacy has evolved over time, a phenomenon perhaps bolstered by research indicating that knowledge itself is not closely related to the stigma of mental

illness (Nordt et al., 2006) and does not protect against stigma (Schulze, 2007).

Originally defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997, p. 182), literacy of mental health and mental illness has become a more complex and multidimensional process that addresses the interrelated concepts of knowledge, attitudes, and help-seeking efficacy (Wei et al., 2015). The concept of mental illness stigma, once considered to be separate from knowledge of mental illness, is now included in the more integral and comprehensive term mental health literacy. An additional layer, help-seeking self-efficacy, builds upon Jorm’s (2011) self-help strategies, forming a tripartite construct that is conceptually applicable and meaningful to mental health care providers and mental health care consumers. According to Corrigan, Druss, and Perlick (2014),

Mental health literacy exceeds knowledge per se and includes the extent to which information mastery and parallel skills lead to actual care seeking and participation. In this light, mental health literacy includes knowledge about preventing disorders, recognizing them when they develop, pursuing help when disorders become distressing, and using mental health first aid skills to support others in distress. (p. 45)

These interrelated parts of the evolved conceptualization of mental health literacy means that knowledge, attitudes (stigma), and help-seeking awareness are outcomes that play separate roles, but fit together in a way that, if effective, is context specific, developmentally appropriate, and effectively integrated into existing social structures (Kutcher, Wei, & Coniglio, 2016).

In a systematic review of research studies ($N = 401$) investigating mental health literacy, most of which were published after 2000 ($n = 337$), Wei et al. (2015) included studies that used mental health knowledge measures, mental illness stigma measures, and mental health help-seeking measures. The majority of the studies were conducted in the

United States (42%) and included participants who were postsecondary students enrolled in mental health-related programs such as psychology. Results of the study indicated that the majority of the studies reviewed by Wei et al. (2015) evaluated mental illness stigma, followed by mental health knowledge, with a much smaller number evaluating help-seeking. Only a few of the measures used in the studies had been validated, and of those that were, Wei et al. (2015) reported that there was no additional research identified that supported the quality of the psychometric properties. Notably, none of the studies reviewed considered knowledge of good mental health or well-being, an element the authors of the review consider to be important to mental health literacy.

Knowledge measures included in the review by Wei et al. (2015) used the vignette approach, a method of determining knowledge that depends upon the participant being able to recognize symptomatology and name the disorder being described. This method of measuring mental health knowledge, popularized by Jorm, is considered by some researchers to inadequately measure a participant's knowledge of mental illnesses (Kutcher et al., 2016). Although there were a large number of studies that included mental illness stigma measures, only eight assessed participants' emotional responses to mental illness, an aspect of any kind of stigmatization that taps into discomfort and other unpleasant feelings, and has been found to be associated with how people respond to people with mental illnesses (e.g., Thornicroft, 2007). Measures addressing help-seeking were least in number, and most of those addressed attitudes toward help-seeking and intentions to seek help, with only four studies measuring actual help-seeking behavior, and none of those included psychometric information. The authors concluded that there was a distinct imbalance among the three components of mental health literacy with the

focus on negative attitudes and stigma far outweighing a focus on knowledge or help-seeking.

The gaps found in the Wei et al. (2015) review may indicate potential sources of findings by other researchers that increased knowledge, and even literacy, of mental health and mental illness are not necessarily associated with lower levels of mental illness stigma among the public (Andrade et al., 2014; Angermeyer, Holzinger, & Matschinger, 2009), and may be associated with increased levels of mental illness stigma (Schomerus et al., 2012). While it seems counterintuitive, this pattern has also been found among mental health professionals, who, despite presumed higher levels of mental health literacy, have been found in some studies to have stigma levels similar to those of the general public (Nordt et al., 2006; Panayiotopoulos et al., 2012).

Reviews of research on negative and stigmatizing attitudes of mental health professionals have concluded that findings are mixed and that this area of study has been neglected in the literature (Crowe & Averett, 2015; Wahl & Aroesty-Cohen, 2010). Recent research of the relationship between mental health literacy and stigmatizing attitudes continues to indicate that the former does not necessarily temper the latter. Svensson and Hansson (2016), for example, found that even when study participants' increased mental health literacy was associated with decreased stigma as evidenced by social distance preference toward individuals with depression, social distance preferences with regard to individuals with 'psychosis' remained high.

Social Distance Preference

Defined as the "willingness to engage with a target person in relationships that vary in closeness" (Yang et al., 2008, p. 179), social distance preference is often used by

researchers as a behavioral proxy for the stigma of mental illness (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Penn et al., 1994). Comparisons of stigma-related constructs such as social distance and mental health literacy among mental health care providers and the general public support Schulze's (2007) intricate relationship (e.g., Nordt et al., 2006; Panayiotopoulos et al., 2012), as outcomes have remained inconsistent.

Nordt et al. (2006), for example, found in a sample of medical and nonmedical mental health care providers that, when compared to a general public sample, the mental health care providers had more knowledge of schizophrenia and depression. The same respondents' preferences for social distance, however, did not differ significantly from those of the general public. Their results supported earlier findings that knowledge of mental illnesses is not closely related to stigmatizing attitudes (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Similarly, Stuber et al. (2014) reported that, although a sample of mental health professionals generally held more positive attitudes toward individual with mental illnesses than did the sample of individuals from the general public in their study, the mental health professionals were vulnerable to endorsement of negative social messages about mental illnesses.

In a review of 19 studies from 13 countries between 2004 and 2009, Wahl and Aroesty-Cohen (2010) found that the majority of studies offered evidence of more positive attitudes, overall, among mental health professionals than among the general public. The authors note also, however, that many mental health professionals doubted the possibility of recovery from mental illnesses and maintained negative attitudes with regard to social distance, evidenced by a reluctance to accept individuals with mental

illnesses into their own occupational or social circles. Although the studies reviewed by Wahl and Aroesty-Cohen (2010) were limited to those including practicing psychiatrists, psychologists, and psychiatric nurses, the authors posited that their review provides evidence of a continuation of a pattern of attitudinal inconsistency among mental health care providers presented by Schulze (2007), and that it supports the need for mental health providers to be acutely aware of their attitudes and behaviors toward the people they serve.

Familiarity with Mental Illness

Studies have shown that familiarity with mental illness and contact with individuals who have a mental illness are associated with reduced stigma of mental illness (Penn et al., 1994), as is the presence of an equitable relationship, such as a friendship, between an individual with a mental illness and an individual who may stigmatize (Bell, Johns, & Chen, 2006; Corrigan & Penn, 2015; Couture & Penn, 2003). In a study of 151 students from 24 Illinois community colleges, Corrigan et al. (2001) found that those individuals who were more familiar with mental illness or had family experience with mental illness were less likely to endorse negative attitudes toward individuals with a mental illness. Contradictory results were reported by Crisp et al. (2000), who, in a general population sample of adults ($N = 1737$) stratified by region in Great Britain, found that those individuals who reported knowing someone with a mental illness did not differ significantly from the attitudes of those individuals who reported having had no contact, a finding attributed by the authors to increased media reports of violence at the time of data collection.

Couture and Penn (2003) suggested in their review of literature not only that

familiarity of mental illness by way of contact with individuals who had a mental illness may help reduce stigmatizing attitudes, but specifically that the nature and quality of contact with an individual who has a mental illness may determine the effect on stigmatizing attitudes. The authors posited that, while familiarity of mental illness by way of contact is important for stigma reduction, factors such as the setting in which the contact occurs and the level of intimacy of the contact directly impact attitudes. This supported Sadow et al. (2002), who found in a sample of 97 nursing students enrolled in a two-year nursing program in Boston, that the only variable associated with decreased stigma of mental illness was whether a participant reported having a friend who had a mental illness.

The idea that contact and personal familiarity with mental illness may impact the stigma of mental illness was taken by Mann and Himelein (2008) to the postsecondary classroom environment, where they studied a sample ($N=53$) of introductory psychology students in a small liberal arts university in the southeast United States. For this study, one-half of the students (diagnostic group) learned about mental illnesses from a diagnostic manual, using excerpts written by clinicians, whereas the other half (humanizing group) learned about mental illnesses from a series of first-person narratives authored by individuals diagnosed with depression, schizophrenia, and bipolar disorder. The students in the latter group also were asked to complete an assignment that required them to write a poem from the perspective of someone diagnosed with either schizophrenia or bipolar disorder. Results of pretests and posttests from both groups indicated no improvement in students' reported stigma of mental illness in the diagnostic group, whereas students in the humanizing group reported significantly lower posttest

levels of stigmatizing attitudes toward individuals who had a mental illness.

Research that has supported contact and familiarity with mental illness as a means of reducing the stigma of mental illness might lead to the conclusion that mental health service providers, who have regular and often long-term relationships with individuals who have mental illnesses, have lower levels of stigmatizing attitudes as a result of that increased familiarity with mental illness. This has not been the case, as studies have shown that mental health service providers often report levels of stigmatizing attitudes that do not differ from those of the general public or are higher (Hansson et al., 2011). As with the general public, the nature and quality of the contact around which familiarity with mental illness is gained from one's professional experiences may have a bearing on its association with stigma levels, and may support the apparent contradiction (Mårtensson, Jacobsson, & Engström, 2014).

In a sample of 140 mental health care providers working in outpatient and inpatient mental health services, Hansson et al. (2011) found that those staff members working in an inpatient setting held significantly more negative attitudes toward individuals with mental illnesses than did the staff members from outpatient units. Stuber et al. (2014) found, among a sample of 731 mental health service providers from 25 community mental health agencies, that having personal experience with mental illness, being a program manager (as opposed to front-line staff), and having more years of experience were predictors of more positive attitudes toward individuals with mental illnesses. This finding supports the suggestion that mental health service providers, depending on their job title, may spend a disproportionate amount of time in the company of individuals with mental illnesses when they are most unwell (Henderson et al., 2014)

and when their engagement represents a hierarchical, rather than equal status, relationship (Bell et al., 2006).

Mental health care professionals, particularly counselors and therapists who work in hospitals or other inpatient mental health care settings, are likely to spend a great deal of time with clients when those clients are experiencing high levels of distress and reduced levels of social functioning. Although this is unquestionably a time of greatest need, heightened awareness by clinical supervisors of the impact that the quality of contact experienced by counselors and therapists may have on the therapeutic relationships is important. Given the relationship found between work environment (inpatient, outpatient) and stigmatizing attitudes toward people with mental illnesses (Hansson et al., 2011) it may be that clinical staffing models that allow for rotating schedules or balanced caseloads with both inpatient and outpatient clients would vary the quality of contact experienced by counselors and therapists. This would allow counselors and therapists increased opportunities to engage in equitable relationships with people with mental illnesses, potentially reducing the risk of mental illness stigma among the providers who work most closely with individuals who have mental illnesses.

Multicultural Counseling Self-Efficacy

Multicultural counseling self-efficacy is based in Bandura's (1997) expanded self-efficacy theory, which clarified that self-efficacy may vary for individuals depending on the context in which they are functioning. With this expansion of self-efficacy theory to include the myriad contexts in which human beings may perform, self-efficacy researchers began to investigate the nature of counselor self-efficacy, defined as "one's beliefs or judgments about her or his capabilities to effectively counsel a client in the near

future (Larson & Daniels, 1998, p. 180).

Neville and Mobley (2001) subsequently proposed an ecological model of multicultural counseling psychology processes (EMMCP), which highlighted multicultural counseling self-efficacy as a critical element of multicultural counselor training and practice. In the model, multicultural counseling self-efficacy was defined as that which “reflects culturally based cognitive schema processes in which counselors-in-training construct beliefs about their ability to perform culturally appropriate tasks and behaviors at a given level during interactions with clients as well as with their peers and faculty” (Neville & Mobley, 2001, p. 483). As such, multicultural counseling self-efficacy maintains its tie to the theoretical roots as posited by Bandura (1997) and is positioned as a construct related to but different from multicultural counseling competence as conceptualized by Sue et al. (1992).

If self-efficacy, as theorized by Bandura (1997), influences whether an individual feels as though he or she can execute a given behavior in given circumstances, then it would be expected that changes in those given circumstances could be accompanied by a change in self-perceived ability, and multicultural counseling would seem to be fertile ground from which to cull examples of varying interpersonal multicultural encounters. Although research that investigates multicultural counseling self-efficacy has emerged since Neville and Mobley’s (2001) proposal of multicultural counseling psychology processes, findings remain mixed regarding factors that influence multicultural counseling self-efficacy (Barden & Greene, 2015). Among the factors investigated as being related to multicultural counseling self-efficacy are length of time in graduate school (Sheu & Lent, 2007), amount of multicultural training (Holcomb-McCoy et al.,

2008), and number of experiential training opportunities (Barden, Mobley, & Shannonhouse, 2014; Sheu et al., 2012).

Findings have also indicated that race and ethnicity, as well as racial identity may play a role in multicultural counseling self-efficacy (Sohelian & Inman 2015).

Investigation of gender as a variable has led to mixed findings, with some researchers reporting significant differences in multicultural counseling self-efficacy by gender (Sheu & Lent, 2007) and others finding no differences based on gender (Barden & Greene, 2015; Holcomb-McCoy et al., 2008; Wei, Chao, Tsai, & Botello-Zamarron, 2012).

Given the relative recency with which multicultural counseling self-efficacy has emerged as a construct pertinent to multicultural counseling, efforts to develop instruments to measure counselors' multicultural counseling self-efficacy have, thus far, centered on differences related to race and ethnicity. Sheu and Lent's (2007)

Multicultural Counseling Self-Efficacy Scale–Racial Diversity Form (MCSE-RD) was developed to examine counseling trainees' perceived capabilities within the context of cross-racial therapeutic relationships. A subsequent validation study (Sheu et al., 2012) supported the instrument's psychometric properties, and suggested that trainees' perceived capabilities to perform multicultural-specific skills in cross-racial counseling sessions is intertwined with their confidence in performing more general and basic counseling skills, such as listening, reflecting, and asking open questions. This finding seems to begin to explain how a counselor's self-efficacy or confidence with clients who are racially or ethnically different may affect that counselor's ability to access and use more general counseling skills in the context of counseling sessions with specific clients.

In an effort to further investigate counselors' comfort levels with individual client

differences, Wei et al. (2012) developed the Concerns about Counseling Racial Minority Clients Scale (CCRMC). Similar to the MCSE-RD (Sheu & Lent, 2007), the CCRMC also limited the scope of individual differences to that of racial difference, and the instrument was designed to assess not only levels of self-efficacy and the use of counseling skills in cross-racial counseling settings, but also to determine the role of counselors' anxiety and fear associated with counseling a client who was racially different. Although no subsequent validity studies of the CCRMC have been performed, the inclusion of counselor attitudes and beliefs into multicultural counseling research and instrument development points to the persistent awareness that counselor response to their clients with differences plays a defined role in the counseling relationship. As the study of multicultural counseling self-efficacy and its potential role in multicultural counseling competence continues, researchers suggest that thorough assessment of multicultural counseling competence should include acknowledgment of contextual features of individual clinical cases and counselor multicultural self-efficacy (Katz & Hoyt, 2014).

Given the documented mental health care disparities among racial and ethnic minorities (U.S. Department of Health and Human Services, 2001), a discussion of multicultural counseling self-efficacy would seem incomplete without acknowledging the potential role of intersectionality (Crenshaw, 1989). Although researchers have begun to investigate the impact of intersectionality from the perspective of the individual seeking mental health treatment, there appears to be little, if any, mention of how intersectionality may operate from the perspective of the counselor or therapist. It seems reasonable to conclude that, if a client is experiencing "double stigma" (Gary, 2005), the counselor is

also engaged with it. The question then becomes whether a counselor's self-efficacy with regard to a client's racial or ethnic difference is sufficient when that same client is experiencing the effects of mental illness stigma. For example, a Black American female client who has recently been diagnosed with bipolar depression and experienced a job loss has been referred to a White American male counselor at a community mental health center. Although the counselor may be confident working with a client who is culturally different from him, without understanding the role of mental illness stigma in his client's current situation and the intersectional effects of race, gender, and mental illness, the counselor's multicultural counseling self-efficacy may be less than adequate for the needs of this new client.

Multicultural Counseling Self-Efficacy and Multicultural Counseling Competence

Studies have suggested that multicultural counseling self-efficacy is a related but separate construct from multicultural counseling competence, that it depends upon interpersonal and intrapersonal mechanisms that differ from those of multicultural counseling competence (Holcomb-McCoy et al., 2008), and that it may be an important piece of multicultural training that cannot be thoroughly measured with existing assessments of multicultural counseling competence (Barden & Greene, 2015; Sheu & Lent, 2007).

That multicultural counseling self-efficacy might be a different and separate from multicultural counseling competence was discovered early, as research began to show that measurement studies yielded mixed findings that indicated a nonsignificant relationship between multicultural counseling competence and multicultural counseling

skills. In a study that included an investigation of the relationship between four self-report multicultural counseling competence measures and multicultural case conceptualization (a multicultural counseling skill), Constantine and Ladany (2000) analyzed data from 135 (female $n = 101$; male $n = 34$) doctoral-level counselors and counseling psychologists, master's-level counselors, and bachelor's-level counselors. The racial and ethnic makeup of the sample was reported as: 77% White American, 8% African American, 7% Latino, 5% Asian American, 1% Native American, and 2% Biracial. Findings indicated that, controlling for social desirability, there was no significant relationship between each of the four self-report multicultural counseling competence instruments and multicultural case conceptualization ability, supporting previous similar findings by Ladany, Inman, Constantine, and Hofheinz (1997). The authors suggested that these findings reflected the likelihood that instruments intended to measure multicultural counseling competence may have measured anticipated rather than actual attitudes or beliefs, knowledge, and skills, or that they, in fact, were measuring multicultural counseling self-efficacy rather than multicultural counseling competence.

Similar findings were reported by Holcomb-McCoy et al. (2008) in their study of 181 members of the American School Counselor Association, the majority of which were practicing professional school counselors ($n = 157$) and female ($n = 127$). The study sample self-identified as White/European American ($n = 134$), Black/African American ($n = 29$), Hispanic/Latino ($n = 10$), Asian/Pacific Islander ($n = 3$), and the remainder as American Indian, multiracial, or other. Participants were recruited for an exploratory study of the psychometric properties of the School Counselor Multicultural Self-Efficacy Scale (SCMES; Holcomb-McCoy et al., 2008), designed to measure school counselors'

multicultural counseling self-efficacy, specifically counselors' comfort with people of other groups and ability to develop relationships with people with individual differences.

Although the study Holcomb-McCoy et al. (2008) did not statistically examine differences between general school counseling self-efficacy and multicultural school counseling self-efficacy, the authors concluded that there may not have been a significant relationship between the two constructs, and that "a school counselor's ability to perform typical school counseling tasks and functions might not be indicative of his or her ability to perform tasks and functions related to equity and diverse student populations" (Holcomb-McCoy et al., 2008, p. 174). In other words, a White American school counselor may have a higher level of self-efficacy working with a White American client as compared to performing similar counseling work with a Black American client or a recent immigrant from Syria. This conclusion was based largely on the nonsignificant results for gender, which differs from previous research in which gender was found to be significantly related to *general* school counseling self-efficacy (Bodenhorn & Skaggs, 2005). The findings by Holcomb-McCoy et al. (2008) of nonsignificant results for gender with respect to multicultural counseling self-efficacy indicated the possibility of a difference between the constructs of general school counseling self-efficacy and multicultural school counseling self-efficacy.

The question of what is and is not being measured by existing multicultural counseling competence instruments was addressed by Sheu and Lent (2007), who proposed not only that there were differences between multicultural counseling competence and multicultural counseling self-efficacy, but that the existing instruments designed to measure three areas of multicultural functioning, namely multicultural

knowledge, awareness, and skills, measured skills less adequately than knowledge and awareness. Additionally, Sheu and Lent (2007) suggested that the underlying problem may rest in the generality of multicultural counseling competence skill measures, exemplified by an item from the Skills subscale of the Multicultural Counseling Inventory (MCI; Sadowsky, Taffe, Gutkin, & Wise, 1994) that reads “I use varied counseling techniques and skills” (as cited in Sheu & Lent, 2007, p. 31). Neither the item nor the instrument’s general instructions indicate a specific type of “multicultural” client or setting, leaving respondents to potentially consider whether they would generally use varied counseling techniques and skills, rather than whether they do so with an individual from a group with whom they may be personally and professionally unfamiliar.

Contributing to both conceptual and measurement challenges related to multicultural counseling competence and multicultural counseling self-efficacy is the issue of scope. Where multiculturalism may refer to any number of individual differences, such as age, race, ethnicity, education level, socioeconomic status, language, among others (Sue & Sue, 2003), a counselor’s self-efficacy related to counseling an individual with specific differences could vary widely. This awareness that multicultural knowledge and awareness may not translate directly to skill or confidence in practice has led to investigations targeting counselor self-efficacy with specific individual differences.

Research has indicated that mental health counselors’ multicultural counseling self-efficacy may have an influence not only on a counselor’s confidence when working with clients from different racial or ethnic groups, but may impact counselors’ interest in working with clients who have individual differences (Sheu et al., 2012) or their willingness to do so (Kugelmass, 2016) once outside the oversight of their training

programs. Disparities in mental health care among racial and ethnic minorities have been well-documented in the domains of diagnosis (Choi et al., 2012; Sclar et al., 2012), treatment seeking (Nadeem et al., 2007), and treatment use and adherence (Blumberg et al., 2015; Dobalian & Rivers, 2008). With differences having been cited in both the multicultural counseling and psychotherapy literature (Kirmayer, 2012) and in the mental illness stigma literature (Corrigan, Bink, Fokuo, & Schmidt, 2015), it is conceivable that the mechanisms that support racism and the stigma of mental illness may be associated, even among mental health service providers, such as counselors.

Multicultural Training and the Training Environment

Although self-efficacy in general and multicultural counseling self-efficacy in particular may be considered to be counselor traits, there is evidence that a counselor's multicultural training and length of time in a graduate counseling program may be related to multicultural counseling self-efficacy levels. In the development of the MCSE-RD, Sheu and Lent (2007) found that master level trainees scored significantly higher than bachelor level counseling trainees, and doctoral level trainees scored higher than master level trainees. Additionally, counseling trainees' tenure in their programs was significantly associated with MCSE-RD scores, with those trainees in their third or higher year consistently scoring higher than second-year students. Differences between first- and second-year students were nonsignificant. In the study, MCSE-RD scores were also significantly positively associated with multicultural training experiences, including multicultural courses taken and direct clinical contact hours with racially different clients. Results of a hierarchical regression indicated that participants' degree level (bachelor, master, doctoral) explained 15% of the variance in MCSE-RD scores, with number of

multicultural courses and workshops taken accounting for an additional 6%, and participants' direct contact with racially different clients explaining another 8% of the variance in the MCSE-RD total scores ($R = .54, p < .01$).

Subsequent to other research that indicated similar support of a relationship between multicultural counseling self-efficacy and multicultural training (e.g., Holcomb-McCoy et al., 2008), Barden and Greene (2015) suggested that the relationship may be more complex when other variables, such as counselor gender, race or ethnicity, and multicultural counseling competence are considered. In their study of the relationship between multicultural counseling competence and multicultural counseling self-efficacy, Barden and Greene (2015) found that, while neither counselors' gender, ethnicity, nor time in graduate school predicted overall multicultural counseling self-efficacy, time in graduate school was significantly related to overall multicultural counseling competence scores, with those trainees enrolled in their graduate programs for more than one year having higher scores than students enrolled for less than one year. Furthermore, when the differences in the subscale scores of the multicultural counseling competence instrument used in the study, the MCCTS-R (Holcomb-McCoy & Day-Vines, 2004), were investigated, only the Multicultural Knowledge subscale indicated a significant difference based on amount of time in graduate school. The authors concluded from their findings that, in general and aside from the area of multicultural knowledge, masters and doctoral students in counselor training programs did not consider themselves to be multiculturally competent or confident to work with clients from diverse backgrounds.

Barden and Greene (2015) concluded that multicultural courses may not be supportive of multicultural skill acquisition that would influence trainees' multicultural

counseling self-efficacy, and that this “gap in pedagogical practices” (Barden & Greene, 2015, p. 10) aligns closely with critiques of multicultural counseling competence that have pointed to the inadequacy of competency-focused counselor training that is more heavily weighted in the areas of multicultural knowledge and awareness than in the area of multicultural skill development. What appears to have remained uncontested in studies of multicultural training for counselors, however, is the need for training programs to provide more opportunities for trainees to engage with multicultural populations through direct experience and exposure. These opportunities may include opportunities or activities such as multicultural practicum courses that emphasize multicultural skills (Cates, Schaeffle, Smaby, Maddux, & LeBeauf, 2007), immersion experiences (Barden et al., 2014; Barden & Greene, 2015), forums in which trainees may develop or strengthen interpersonal relationships with individuals from whom they differ (Coleman, 2006), and opportunities for trainees to express and process their concerns related to counseling clients from diverse backgrounds (Wei et al, 2012).

Barden et al. (2014) investigated the effects of immersion training among a sample of 37 students enrolled in a counselor preparation program in a midsized university in the southeast United States. The students comprised two experimental groups ($n = 19$), who engaged in a three-week cultural immersion program in Costa Rica, one group in the summer of 2011 and the other in the summer of 2012. Two comparison groups ($n = 18$) did not travel to Costa Rica, and engaged in traditional counselor preparation coursework (classes, practica, internships). All participants completed the MCCTS-R (Holcomb-McCoy & Day-Vines, 2004) as a measure of multicultural counseling competence and the MCSE-RD (Sheu & Lent, 2007) to measure multicultural

counseling self-efficacy. The experimental and comparison groups were found to be statistically equivalent on pretest measure, but posttest results indicated significant differences in MCSE-RD scores with medium effect sizes for those students who participated in the immersion experience compared to students who participated in traditional coursework. There were, however, no significant differences found between the groups for scores on the MCCTS-R. Findings also indicated that this effect with regard to the multicultural counseling self-efficacy associated with immersion experiences may not be generalizable from one context to another, as the students who engaged in the immersion experience did not score similarly on the same measures six months after their return from Costa Rica. The authors concluded that counselor educators need to consider experiential opportunities that focus on cultural differences that contribute to both short-term and long-term outcomes.

Findings by Barden et al. (2014) that a cultural immersion training experience was related to multicultural counseling self-efficacy scores points to the importance for graduate counseling trainees of contact with clients who have individual differences. Although studies of a direct relation between the mechanisms of multicultural counseling self-efficacy and those of mental illness stigma have not been undertaken, the concept of contact is present in studies independently investigating the two constructs. Depth of contact appears to be related to multicultural counseling self-efficacy, in that scores were higher among graduate counseling trainees after their participation in a three-week cultural immersion program than among graduate counseling trainees who participated in tradition coursework (Barden et al., 2014). Similarly, quality of contact has been found to be related to mental illness stigma levels among mental health care providers (Couture

& Penn, 2003; Hansson et al., 2011). It is feasible that multicultural counseling self-efficacy and the stigma of mental illness may, at least conceptually, share the common element of meaningful human contact. If so, counselor preparation programs that provide opportunities for cultural immersion programs may also, perhaps unknowingly, be addressing at least one factor that supports the stigma of mental illness.

In their validation study of the MCSE-RD, which included analysis with the Multicultural Environment Inventory–Revised (MEI-R; Pope-Davis et al., 2000), Sheu et al. (2012) found not only that prior cross-racial client contact during training significantly predicted MCSE-RD scores, supporting previous research (Sheu & Lent, 2007), but that it also produced a significant path to trainee interest in multicultural counseling. The authors concluded that this may point to an area of development for training programs that would increase not only trainees’ self-efficacy with clients who are racially and ethnically diverse, but also counselors’ interest in working with diverse clients.

There is evidence that trainees’ interest in multicultural counseling developed during graduate training programs may carry over into trainees’ postgraduate professional practice. In a recent audit study of autonomously practicing licensed psychotherapists ($N = 320$) in New York City, Kugelmass (2016) studied the response of these psychotherapists to phone inquiries made by actors posing as help-seekers requesting mental health care. A total of 640 calls were made (two per therapist), with the actors identifying themselves, either by declaration or by implication, as being middle class or working class, male or female, and White or Black. Calls were intentionally made after standard office hours to increase the likelihood that the help-seeker would be able to leave a message on the voice-mail system. The main dependent variable of the study was

therapist accessibility, operationalized through an appointment offer rate. Each return call received from a therapist in response to the voice-mail message was categorized as one of five types, ranging from a clear statement of no available appointments to clear offer of an appointment at the help-seekers preferred time. Results showed that, of the 287 returned messages received, 34% ($n = 97$) included an appointment offer.

Kugelmass (2016) found therapist accessibility by class and race of the help-seeker to be striking, in that 28% of calls made by White middle class help-seekers resulted in an appointment offer, whereas only 17% of call made by Black middle class help-seekers elicited an appointment offer. Importantly, the study's design was such that the actors playing the part of White and Black middle class help-seekers called the same individual therapists. Help-seeker race, however, significantly influenced therapist access for middle class help-seekers only, and the racial disparity was more pronounced for middle class men than for middle class women. Working class callers, regardless of race, experienced only an 8% rate of receiving an appointment offer. This pattern held when appointment offers made for the help-seekers' stated preferred times were considered, with therapists indicating a clear preference for middle class help-seekers over working class help-seekers.

Although Kugelmass (2016) did not investigate the multicultural training history of the licensed therapists contacted by actors posing as help-seekers in her study, she suggests that the autonomy afforded licensed therapists in private practice allows for decisions about access to be made under circumstances that "may be particularly conducive to the emergence of non-conscious biases that lead to their discriminatory accessibility" (p. 10). It is conceivable that these biases, perhaps grounded in low self-

efficacy when counseling clients with individual differences and operationalized by a reluctance to provide services, illustrate the predictable outcomes of counselor preparation programs that limit multicultural training to coursework focusing on knowledge and awareness of multicultural issues at the expense of multicultural skill development that leads to multicultural counseling self-efficacy and potentially lasting interest in serving diverse client groups. It is also conceivable that, if quality of contact has effects on levels of mental illness stigma similar to the effects on multicultural counseling self-efficacy, the same autonomy that allows for racial, ethnic, or cultural discrimination may also allow for the stigma of mental illness, particularly by independently practicing counselors and therapists.

The Multidimensional Nature of Empathy

Nearly three decades after empathy was named by Rogers (1957) as one of the therapeutic conditions that, collectively, he considered necessary and sufficient for change in a person, he indicated in a presentation to the University of California, Irvine, that the nature of empathy was more complex than previously considered (Rogers, 1987). He clarified that the act of empathy was not passive, but “one of the most active experiences I know” (Rogers, 1987, p. 45), and reasoned that, because there are a limited number of human emotions, if a therapist connected with a client on the level of an emotion, such as fear, then that therapist would be more inclined to understand the client’s fear “as if” (p. 46) he or she was also frightened. This would, in effect, make empathy possible.

Although Rogers’ (1987) revisiting of empathy expanded it conceptually from an act of listening to more active emotional engagement with a client, it remained two-

dimensional. The 30 years between the introduction of empathy's role as one of the necessary and sufficient conditions for change (Rogers, 1957) and his later statements initially produced a great deal of academic interest in empathy, a trend that declined sharply in the mid-1970s. The research that was undertaken during those years began to indicate that empathy was not only more complex, but was multidimensional in its structure as a construct.

By the mid-1970s, empathy had been identified by various theorists as being a purely affective phenomenon that allowed for direct engagement with the emotions of another person, a purely cognitive phenomenon that supported an intellectual understanding of another person's experience, and a combination of both cognitive and affective components (Duan & Hill, 1996). With each of the aforementioned views accompanied by related measures and research findings, usually supporting one or the other type of empathy as primary, it is not surprising that research literature related to therapeutic empathy fell into a state of relative neglect due to what would later be referred to as "epistemological confusion" (Gibbons, 2011, p. 243).

Davis (1983) was among those who viewed empathy as being multidimensional, and proposed that empathy was a set of four discriminate constructs that were related by virtue of their relationship to responsiveness to others. These individual constructs formed the foundation of the four subscales of Davis and the American Psychological Association's (1980) Interpersonal Reactivity Index (IRI), each designed to tap into an aspect of the more global concept of empathy. Two subscales, Perspective-taking (PT) and Fantasy (FS), were intended to assess the cognitive aspects of empathy, with the remaining two subscales, Empathic Concern (EC) and Personal Distress (PD), associated

with affective responses. The overall instrument was developed in such a way as to assess both the cognitive and affective components of empathy as active in an individual, presumably at the same time.

In a study of the IRI (Davis & American Psychological Association, 1980) with 677 men and 667 women enrolled in introductory psychology courses at the University of Texas at Austin, Davis (1983) investigated the intercorrelations between the instrument's subscale scores and the relationships of each subscale to five potentially related psychological constructs (social competence/interpersonal functioning, self-esteem, emotionality, sensitivity to others, and intelligence). Findings indicated strong support for the multidimensionality of empathy in the alignment of each subscale with individual psychological constructs. The strongest of these relationships was that of the Personal Distress scale with lower self-esteem, poor interpersonal functioning, and a threefold emotional grouping of vulnerability, uncertainty, and fearfulness. Not only did the study offer evidence of empathy as multidimensional, but it also pointed to the likelihood that therapist emotions and affective responses, such as fear, and therapist levels of self-esteem relate to the quality of his or her ability to engage empathically with others.

The idea that fear, in particular, may affect a counselor's or therapist's ability to engage empathically with their clients is salient on its own, but may also tap into the constructs of multicultural counseling self-efficacy and the stigma of mental illness. Wei et al. (2012) specifically considered the effects of fear associated with counseling a client who was racially different on a counselor's multicultural counseling self-efficacy. A number of researchers have documented the association of fear and public stigma of mental illness (e.g., Angermeyer et al., 2010; Corrigan, 2016; Parcesepe & Cabassa,

2013). Although Rogers (1987) suggested that counselors identify with a client's fear as a means of developing empathy, it could be that a counselor's own, perhaps unidentified, fear is the greater barrier to empathic response.

The multidimensionality of empathy conceptualized and measured by Davis (1983) may have served as a catalyst from which additional efforts at defining the construct followed. Barrett-Lennard (1981), for example, defined empathy as arising from three perspectives: that of the therapist (empathic resonance), that of the observer (expressed empathy) and that of the client (received empathy). Duan and Hill (1996) considered use of the terms *cognitive* and *affective* to describe empathy to be imprecise and confusing, and proposed that researchers use instead *intellectual empathy* to refer to the cognitive aspects of empathy and *empathic emotions* to refer to the affective aspects of empathy. Bohart and Greenberg (1997) suggested three stages of empathic expression: empathic rapport, communicative attunement, and experiencing near understanding of the client's world. Although each of these definitions and models can be associated with the sub-constructs of empathy as defined by Davis (1983), the variations add both increased conceptual understanding and quantitative ambiguity.

Despite the increased attention in the literature to therapist empathy as a multidimensional construct, uncertainty as to the nature of empathy seems to have lingered, with conceptual articles and reviews of empathy literature calling for the development of additional valid measures (Duan & Hill, 1996). The answers to this call, bolstered by myriad definitions and reconceptualizations of empathy, yielded as many ways to observe, perceive, and measure the construct. Elliott et al. (2011), in their investigation of the efficacy of empathy, categorized measures of therapist empathy into

four categories: (a) observer (third-party nonparticipant rated empathy), (b) client ratings, (c) therapist self-rating scales, and (d) empathic accuracy (therapists rating clients as they think the client might rate themselves). Clearly, despite fluctuations in academic interest of empathy since the suggestion by Rogers (1957) that it was critical to helping clients enact change, the construct has remained an important force in research and in practice. Even without agreement as to its precise nature, it continues to be considered one of the most important qualities of a therapist and a cornerstone of humanistic counseling practice (Coll, Dumas, Trotter, & Freeman, 2013).

Empathy and the Counseling Relationship

In spite of the uncertainty and confusion that has surrounded the construct of empathy, it has remained important enough to be considered “the single most important human and technical tool at the therapist’s disposal” (Strupp, 1996, p. 137) and “the trait most essential to the human situation” (Dyche & Zayas, 2001, p. 257). In 1966, with the nature of empathy not yet defined as multidimensional, researchers were debating the source of empathy in psychotherapy, namely whether empathy and the other two core conditions of the counseling relationship, warmth and genuineness, were the responsibility of the therapist or the client. In some of this early research, Truax and his colleagues (1966) found among a sample of 40 outpatient clients randomly assigned to four different therapists, that empathy and genuineness were controlled by the therapist, rather than the client. Warmth, they found, develops over time, but is initially influenced by the nature of the client.

The role of empathy, warmth, and genuineness in the counseling relationship became the focus of extensive study, with findings that credit the core conditions with

both successful and failed client outcomes. In a review of studies investigating the core conditions of the counseling relationship, Patterson (1984) pointed out that many of the reviews since the early 1960s were flawed, either because the studies reviewed were methodologically flawed or because of reviewer bias regarding the selection of studies to be reviewed. He concluded that reviewer bias led to conclusions regarding the effectiveness of specific elements of the therapeutic relationship that discounted documented improvement by clients in individual studies because the technique or construct being studied did not directly lead to that improvement. Patterson (1984) posited that the effectiveness of the therapeutic relationship itself, over a wide range of client conditions and therapist techniques, speaks to the value of including the relational aspect of counseling as a means by which client improvement may occur.

The debate as to whether therapeutic effectiveness is better secured through honing counseling technique or developing interpersonal and relational skills predictably produced integrated models, which combined therapist qualities such as empathy with technical skill (Clark, 2010; Pearson, 1999). Although integrative approaches did little to lessen the confusion as to the precise nature of empathy, they served to support the construct as an important part of the therapeutic relationship. Feller and Cottone (2003) concluded that empathy, although it may not be a central component of every counseling theory, can be found in many theoretical orientations, including psychoanalytic, existential, psychodynamic, cognitive-behavioral, and rational emotive behavioral approaches.

There is continued research evidence that the ambiguity surrounding the construct of empathy has not kept it from being considered an important part of the counseling

relationship. The review and analysis by Elliott et al. (2011) included 57 empathy studies of 59 different clients' samples encompassing 3,599 clients. Findings of this study, while acknowledging sources of confusion regarding empathy, also indicated that empathy, across measures and across theoretical orientations, accounted for 9% of the variance in therapy outcomes, with a medium effect size at the study level ($r = .31, p < .001$, 95% confidence interval: $r = .28-.34$). This study also indicated that client measures predicted outcome better than observer rated measures, and client-perceived empathy predicted outcome significantly better than therapist-rated empathic accuracy measures. This finding is consistent with other research indicating that therapists' ratings of their own empathy do not accurately predict client outcome (Barrett-Lennard, 1981; Sommers-Flanagan, 2015).

Mental Illness Stigma, Counselor Attitudes, and Counselor Anxiety

The effects of attitudes and biases potentially held by counselors and psychotherapists have been topics of discussion since Rogers (1961) identified the need for counselors to “keep a relationship free of judgment and evaluation” (p. 55), later suggesting that, in an effort to become aware of their own biases, counselors videotape or transcribe their sessions for review (Rogers, 1975). In the years since attitude and bias became a creditable focus of attention, research interest in the effects of counselor attitudes has expanded to include multicultural counseling, and to a lesser degree, stigmatized groups. This dichotomy can be seen perhaps most clearly in counselor preparation programs, where an emphasis on multiculturalism is secured by accrediting bodies such as CACREP (2015) and the recent publication of the MSJCC (Ratts et al.,

2016). No such means of comprehensively addressing stigma of mental illness at the counselor preparation level, perhaps due to an assumption that counselor trainees and counselor educators are tacitly considered to be immune to the stigma of mental illness. This blind spot has been noticed by researchers and as the literature of the stigma of mental illness expands, it increasingly includes mental health care professionals, such as counselors (e.g., Lauber et al., 2006; Smith & Cashwell, 2011).

Counselor attitudes. A counselor's treatment decisions and clinical impressions may be affected by knowledge of a client's previous diagnoses (Morrow & Deidan, 1992), a phenomenon grounded in the theory that once preconceptions or attitudes are formed, it is difficult to change them, even in the face of new and contradictory information (Lichtenberg, 1984). Strupp (1996) posited that therapists develop an initial attitude, positive or negative, toward a client very early in the relationship. These attitudes can have a "profound influence on the therapist's diagnostic and prognostic judgments about the patient, treatment plans, and . . . the empathic quality of the therapist's hypothetical communications to the patient" (Strupp, 1996, p. 135). The effects of counselor attitude and bias on diagnostic impression has also surfaced in the counselor education literature, as detailed by McLaughlin (2002) in a description of various types of counselor bias, including diagnostic sampling bias, diagnostic assessment bias, and diagnostic criterion bias.

A counselor attitude that may result in bias has been linked with counselors' and psychotherapists' beliefs concerning whether they consider the source of a client's symptoms to be biological or psychosocial. The underlying theoretical assumption is that a biological or biogenetic explanation tends to be associated with less blame on the part

of the client, compared to a psychosocial explanation, which often include lifestyle choices made by the client (Deacon, 2013; Kvaale, Haslam, & Gottdiener, 2013). In a series of three studies investigating the effect of this information on the attitudes of mental health providers, Lebowitz and Ahn (2014) provided a series of vignettes to a national sample of mental health clinicians practicing in the United States ($n = 132$ in study 1; $n = 105$ in study 2; $n = 106$ in study 3), which included both medically trained mental health care providers (psychiatrists) and nonmedically trained mental health care providers (psychologists and social workers). Participants were presented with vignettes describing fictional clients with diagnoses of schizophrenia, social phobia, major depression, and obsessive-compulsive disorder. Each disorder was accompanied by an explanation that was purely biological (genetic and neurobiological), purely psychosocial (included aspects of the client's life history), or both, with the last category varying as to which explanation predominated. The study was designed to assess the extent to which participants believed the client's symptoms could improve by either medication or psychotherapy, as well as participants' feelings toward the client, including empathy and personal distress.

Findings of the Lebowitz and Ahn study (2014) indicated that, across all disorders, the explanations led to differences in perceived effectiveness of treatment methods, with psychotherapy being considered significantly less effective for those fictional clients whose symptoms were explained biologically. Additionally, biological explanations indicated significantly less empathy than did the psychosocial explanations, and medically trained mental health care providers reported significantly less empathy than the nonmedically trained providers. Except for the diagnosis of schizophrenia, the

biological explanations were not associated with higher levels of personal distress. In analyses of the explanations that included both biological and psychosocial elements, those explanations that were predominantly biological were associated with lower empathy and lower ratings of psychotherapy effectiveness than were those that were predominantly psychosocial. The authors concluded not only that endorsement of biogenetic models of mental illness among mental health care providers may serve to reduce empathy levels, but also may lead clinicians to believe less strongly in the therapeutic potential of psychotherapy, as compared to that of medication, an attitude that could affect client outcomes.

Causal explanations for mental illnesses were also investigated by Magliano et al. (2016) among a sample of undergraduate psychology students ($n = 566$) enrolled at the Second University of Naples, Italy. The students were surveyed between March 2012 and March 2013, using the Opinions on Mental Illness Questionnaire (QO; Magliano et al., 2004), a self-report instrument designed to explore respondents' beliefs about the causes of schizophrenia, the effectiveness of available treatments, the rights of individuals with schizophrenia, and the psychosocial consequences of the condition. Results of the study indicated that a number of the psychologists-in-training were not fully aware of effective treatment alternatives to medication. Only 60% of the students reported being convinced that psychological interventions were effective with clients who were diagnosed with schizophrenia. In addition, only 32.6% of participants agreed completely that persons with schizophrenia could, in fact, recover. Although an additional 62.9% of the sample partially agreed that persons with schizophrenia could recover, the authors note their concern that this type of skepticism may reduce students'

interest in working with individuals who have a diagnosis of schizophrenia, and may also limit clients' belief in their ability to recover.

An example of an attitude that has been associated with anxiety and reduced empathy among counselors and therapists is color-blindness, or the "belief that race should not and does not matter" (Neville, Lilly, Duran, Lee, & Browne, 2000, p. 60). By negating that race and ethnicity matters, a counselor or therapist who holds such an attitude and refrains from addressing race-related issues with clients would be engaged in what amounts to avoidant behavior. Among a sample of psychologists ($N = 247$), the majority of whom identified as either clinical psychologists ($n = 176$) or counseling psychologists ($n = 36$), Burkard and Knox (2004) investigated therapists' color-blind attitudes, empathy, and attributions of client responsibility for both the cause of and solution to a problem. The study sample of psychotherapists included women ($n = 114$) and men ($n = 133$) who identified as African American ($n = 4$), Asian American ($n = 2$), European American ($n = 234$), Latina or Latino ($n = 4$), Native American ($n = 1$), and biracial ($n = 2$). Each participant was given a packet that included measures of the constructs being studied, one of four randomly assigned vignettes of a fictional client identified as either an African American or European American who identified the source of their difficulty as depression or racial discrimination, and a measure of social desirability responding.

After controlling for social desirability, Burkard and Knox (2004) found that color-blind attitudes among therapists were related to empathy levels, with those therapists who had high color-blindness scores having significantly less empathy than those therapists whose color-blindness scores were lower. This effect persisted even

when race of the fictional client was considered, such that the less color-blind therapists were more empathic with all clients. The authors suggest that this may be an indication that therapists' increased sensitivity to racial issues may also serve to increase their overall empathy in therapy relationships. Although the authors anticipated an interactive effect of client race, therapist color-blindness, and client attribution as to the source of the problem, this was not supported, as findings indicated a direct relationship between therapist color-blind attitudes and therapist empathy. Client race, however, did interact with therapist attributions of client responsibility to solve their problem, with those therapists who had high color-blindness scores rating African American clients as more responsible for solving their problem than did the therapists whose color-blindness scores were lower. Therapist levels of color-blindness did not have a significant effect on therapists' views of European American clients' responsibility to solve their problems.

The finding by Burkard and Knox (2004) of a discrepancy in attributions of responsibility for solving problems by therapists with high color-blindness highlights the potential impact of a new kind of racism. This new racism, while more subtle in its presentation than earlier conceptualizations of racism defined by overt behaviors that limited the rights of individuals of nondominant races (McConahay, 1986), denies that racism exists by claiming to be evidence of society's postracial status. In so doing, the structure of racism is maintained in more hidden places, such as a therapy session, where "raceless explanations for all sort of race-related affairs" (Bonilla-Silva, 2015) have the potential to misidentify sources of and solutions to problems for clients whose lives may, in fact, be deeply affected by their race or ethnicity.

Perhaps rooted in data that show that a large majority of licensed nonmedical

professionals practicing in behavioral health fields in the United States identify as White (63.2% for counselors, 84.7% for psychologists, and 63% for social workers; U.S. Department of Health and Human Services, 2013), study samples appear to be consistently unequal with regard to race and ethnicity of the participants. Because similar percentages exist among school counselors (75%; College Board National Office for School Counselor Advocacy, 2011), as well as in CACREP-accredited counselor preparation programs (White students: 60.22%, White full-time faculty: 74.33%; CACREP, 2015), it is not surprising that research appears to increasingly include studies that focus on the racial responses of White mental health service providers.

Additionally, studies of race and ethnicity and counselor behavior have yielded mixed findings with regard to multicultural counseling competence, with studies indicating that counselors who identify as members of ethnic or racial minorities report higher levels multicultural counseling competence than do White American counselors (e.g. Constantine, 2001b; Holcomb-McCoy & Myers, 1999), and other researchers finding no significant differences in multicultural counseling competence scores of minority counselors when compared to multicultural counseling competence scores of White American counselors (Manese, Wu, & Nepomuceno, 2001). The relationship of multicultural counseling competence to other factors, such as multicultural training, has also been studied, also with mixed results. Smith, Constantine, Dunn, Dinehart, and Montoya (2006), for example, found in two meta-analyses of quantitative studies of multicultural education in the mental health professions (Study 1, Survey studies: $n = 45$, Study 2, Outcome studies: $n = 37$), that, although both studies supported the hypothesis that multicultural education would be associated with positive outcomes, the race and

ethnicity of the participants did not moderate results in either study.

In addition to investigations of factors that may contribute to counselor bias, research of counselor attitudes surrounding race has led to the study of the role of counselors' affective responses specifically to race and racism. Spanierman et al. (2008) investigated the relationship between multicultural counseling competence (demonstrated and observed) and affective responses of guilt, empathy, and fear by White counselors, measured by their Psychosocial Costs of Racism to Whites Scale (PCRW). This instrument was designed to measure the consequences of societal racism experienced by White individuals, and includes three subscales: (a) White Empathic Reactions toward racism, (b) White Guilt, and (c) White Fear of People of Other Races.

Spanierman et al. (2008) administered the PCRW to measure the psychological and social costs of racism, an unpublished short form of the Color-blind Racial Attitudes Scale (COBRAS; Neville et al., 2000), and the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002) to a sample of 311 White trainees enrolled in clinical psychology programs (54.3%), counseling psychology programs (40.8%), and counselor education, health psychology, or other programs (4.8%). In a second related study, 59 White students seeing clients as part of a practicum or internship were given the same survey instruments as in Study 1, and also completed a measure of social desirability and a multicultural case conceptualization task. Supervisors ($n = 49$) were included in the second study, and completed a measure designed to assess trainees' observed multicultural counseling competence. Findings of the two studies indicated that, among the White trainees participating in the studies, those with lower levels of color-blind attitudes experienced

higher levels of compassionate costs (empathy and guilt) and lower levels of fear, which predicted higher levels of multicultural counseling knowledge. In addition to multicultural training being directly associated with multicultural knowledge, the two were also associated indirectly, mediated by trainees' fear of people of other races.

Affective responses of guilt and empathy were also found to have significant effects in the Spanierman et al. (2008) studies. As the level of guilt felt by White trainees about their dominant status increased, the trainees became more inclined to consider racial and cultural factors into their case conceptualizations, an effect greater than that of multicultural knowledge on case conceptualization. This aligns with previous research indicating a positive relationship between White guilt and acknowledgement of White privilege (Iyer, Leach, & Crosby, 2003). Empathy among the White trainees was found to predict supervisor ratings of observed multicultural counseling competence over amount of practicum training and self-reported multicultural counseling competence. The authors conclude that the findings of this study supported the inclusion of student affective and emotional responses, including fear, guilt, and empathy, in multicultural training programming for counseling and psychotherapy trainees.

Counselor anxiety. Counselor anxiety has been found to have an adverse effect on a counselor's capacity to express empathy (Hiebert, Uhlemann, Marshall, & Lee, 1998), and to reduce levels of empathy-related distress (Negd, Mallan, & Lipp, 2011). Although counselor anxiety may arise from a number of sources, including dispositional issues and concerns related to appraisal by a supervisor (Daniels & Larson, 2001), it also has been found to arise in the course of counseling clients who have individual differences. This anxiety about differences is, according to Dyche and Zayas (2001)

“native to the human condition” (p. 250), but also is particularly salient for counselors and psychotherapists, as they work to experience the feelings of another person in circumstances such as cross-cultural work, when a counselor’s own experience and values may be very different from those of a client.

According to Bandura (1997), however, the effect of anxiety on behavior can only be considered in the context of self-efficacy beliefs. Anxiety is often and generally associated with avoidant behaviors, although, as Bandura (1997) points out, the relationship between anxiety and avoidant behavior disappears when the effects of self-efficacy are controlled. Given the findings regarding the relationship between anxiety and empathy among counselors and psychotherapists (Heibert et al., 1998; Negd, et al., 2011), and the positive contribution of empathy to multicultural counseling competence (Constantine, 2001b; Fuertes & Brobst, 2002), it is conceivable that counselors’ affective responses to racial or ethnic differences may play a role in counselors’ multicultural counseling self-efficacy.

In studies that use only measures of multicultural counseling competence, and in which multicultural counseling self-efficacy-specific scores are not considered, the overlap of the components of the two constructs may contribute to ambiguity surrounding the precise natures of empathy, anxiety, multicultural counseling self-efficacy, and their respective roles in counseling relationships and client outcomes. In one of the very few studies that has investigated relationships between measures of empathy, multicultural counseling competence, and multicultural counseling self-efficacy, Sohelian and Inman (2015) found among a sample of counselor trainees ($N = 256$), each of whom responded to one of three vignettes with varying descriptions of characteristics indicating that the

fictional clients were of Middle Eastern American descent, that multicultural counseling competence was significantly correlated with multicultural counseling self-efficacy ($r = .62, p < .001$), as well as with affective empathy ($r = .15, p = .014$) and cognitive empathy ($r = .28, p < .001$). Additionally, cognitive empathy was significantly correlated with multicultural counseling self-efficacy ($r = .28, p < .001$), and cognitive empathy and affective empathy were significantly correlated ($r = .21, p < .001$). The primary goal of the Sohelian and Inman (2015) study was an investigation of the effect of counselor race on levels of multicultural counseling competence, multicultural counseling self-efficacy, and empathy in work with clients of Middle Eastern descent, of which no effect was found. Still, the results regarding the correlations between the measures lent support to the potential role of empathy in multicultural counseling competence and multicultural counseling self-efficacy.

The study of empathy and the human tendency to have biases toward those who are similar, or are part of one's ingroup, indicates that this tendency leaves socially excluded those who are not recognized as similar. Research has often used race or ethnicity as a group identifier, but prejudice and stigma occur for a wide range of human differences, and any means by which individuals or groups are rejected or excluded is grounded in the same dehumanization that Goffman (1963) referred to when he wrote that "we believe the person with a stigma is not quite human" (p. 5). The effects of this dehumanization interrupt social connectedness, interpersonal relationship, and chips away at the very essence of what it means to be part of the human community (Bastian & Haslam, 2010).

In a study of the effects of ascribing humanity to people with mental illness and

its effects on treatment seeking for mental health care, Martinez (2014) tested a model in which ascribing humanity to the category of mental illness predicted compassion toward that group, which then influenced perceivers' motivation to seek treatment. In a series of three studies with three samples (Study 1: $n = 320$ recruited online; Study 2: $n = 84$, students at a large public university; Study 3: $n = 230$, recruited online), participants completed survey instruments to measure ascribed humanity, compassion, perceived dangerousness, and willingness to seek treatment if it were to become necessary. Findings suggested that ascribing humanity was associated with a more inclusive self-concept (humanizing implicates the self and people with mental illness in the same group), which influenced compassion toward others and subsequent willingness to seek treatment. Martinez (2014) posited that this ascription of humanity to individuals with mental illnesses extends the effects from an intergroup, or even interpersonal, phenomenon to a model that may serve to increase treatment seeking among individuals who may be reluctant to seek treatment because of perceived stigma of mental illness.

This review has presented research literature that supports the study of mental illness stigma and bias among graduate counseling trainees by examining not only the role that stigma plays in mental health disparities, but by exploring the impact of these negative attitudes on the counseling relationship and counselor qualities, such as multicultural counseling self-efficacy. Given that a counselor's ability to engage empathically with clients contributes to the development of therapeutic relationships and outcomes, it seems reasonable to expect negative attitudes and reduced empathy to detrimentally affect the human relationship that is the foundation of counseling. As researchers continue to study counselors and outcomes of their clients, the nature of the

therapeutic relationship continues to be central. By framing the current study with the tenets of RCT, the focus remains on that relationship and its capacity to offer human connectedness to individuals who have mental illnesses.

Relational Cultural Theory (RCT)

As a framework for the study of mental illness stigma and multicultural counseling self-efficacy, empathy, and other factors such as mental health literacy and multicultural training, RCT serves as a means of identifying the role of human relationship in the association of these constructs among counselors and therapists, and the potential effect of those associations on clients. Where traditional psychology has focused on healthy development as a process of individuation and independence, RCT holds that healthy development is more closely associated with connection and context (Jordan, 2000). Context is particularly salient to the diagnosis and treatment of mental health issues, since the cognitions and behaviors that may have led to a diagnosis of pathology may be considered, from an RCT perspective, to be entirely consistent with that client's history and experience (Duffey & Somody, 2011).

Research of RCT applied to therapeutic intervention has indicated that the focus on connectedness and relationship may be conducive to positive counseling outcomes. In a longitudinal qualitative study of 177 women ($n = 93$) and men ($n = 85$) with mood disorders and schizophrenia spectrum disorders who were receiving psychotherapy in the Pacific Northwest at Kaiser Permanente Northwest, Green et al. (2008) investigated clients' views regarding their relationships with their counselors over time. Analyses suggested eight primary themes: (1) "fit" and comfort with the counselor, which was associated by the participants with treatment adherence; (2) a caring compassionate

approach by the counselor, including listening, understanding, and believing the client; (3) friendship and mutuality in the relationship; (4) mutual trust; (5) collaboration in the therapeutic relationship; (6) continuity with the same counselor; (7) counselor competence, flexibility, and creativity; and (8) providing a sense of hope, associated by participants with their counselor's positive attitude and confidence about recovery.

The study (Green et al., 2008) also included a statistical analysis based on a hypothesized model of how continuity of care would interact with counselor-client relationship factors. Quantitative analysis of questionnaire responses indicated that recovery-oriented and patient-directed care was associated with greater adherence to medication treatment, which resulted in fewer mental health symptoms. A recovery-oriented approach, in the context of a strong relationship with the counselors, was also associated with improved recovery outcomes. The authors concluded from their study that counselors who are interested in their clients as *persons*, and who facilitate and encourage strong and trusting relationships, provide a foundation for long-term clinical relationships that are particularly important when clients encounter periods of increased distress. Also noted, however, is that in many community mental health centers, staff turnover, which was low at the center where the Green et al. (2008) study took place, may preclude the development of such long-term client-counselor relationships.

More recent research has yielded similar findings. In their study of the effects of brief relational-cultural therapy (BRCT; Oakley & Addison, 2003) among a diverse group of women ($N = 91$) receiving mental health care at an urban teaching college clinic in Canada, Oakley et al. (2013) investigated outcomes of a therapy model that focused on the client-counselor relationship. The women who were participants in the study ranged

in age from 17-66 years, self-identified as 40 different ethnicities, and spoke 19 languages. Participants were evaluated three times (beginning, middle, and end) during the course of a 16-week program of individual therapy sessions as to clinical progress and the quality of the client-counselor relationship. Upon finishing their counseling, participants completed 3-month and 6-month follow-up evaluations. Findings of the study indicated significant changes on measures of depression, anxiety, self-esteem, self-acceptance, autonomy, and alexithymia (emotion identification and interpersonal relating). The quality of the therapeutic relationship, central to BRCT (Oakley & Addison, 2003), was identified by the authors as facilitating progress among study participants in the area of empowerment, as many participants reported enhanced self-esteem (88%) and well-being (96%), increased sense of personal effectiveness (93%), and improved relationships (89%).

Relationships are fundamental to the human condition, and social exclusion can have devastating effects (Bastian & Haslam, 2010). Furthermore, research in the field of neurobiology has suggested that the experience of social rejection engages the same part of the brain that mediates the physiological response to pain (Decety, Norman, Bernston, & Cacioppo, 2012). Eisenberger and Lieberman (2004) suggested that these shared neural processes have evolved over time as a means of ensuring continued nurturance among humans, at the same time creating a “lifelong need for social connection and a corresponding sense of distress when social connections are broken” (p. 298). There seems to be little question that human behavior that excludes individuals or groups, such as prejudice, discrimination, and stigma, negatively impacts the quality of life for those who are rejected. With evidence indicating that such exclusionary behaviors may be

grounded in conscious, unconscious, and even physiological mechanisms, it seems that those whose professions center on helping other humans should pay heed, seeking means of identifying and eliminating attitudes that serve to create distance between people.

Connection to other human beings is central to RCT, both theory and practice (Jordan, 2001). Alongside the importance of connectedness are the detrimental effects of disconnection, which results from “nonresponsive or aggressive, hostile responses from the more powerful person in a relationship” (Jordan, 2000, p. 1009). This has the effect placing a person “outside the human community” (Jordan, 2006, p. 4), echoing the dehumanization associated with the stigma of mental illness (Angell et al., 2005; Goffman, 1963) and racial or ethnic differences (e.g., Haslam, 2006). The disconnection from others that epitomizes the experience of an individual with a mental illness, or a racial or ethnic difference, or both is classified in RCT as chronic disconnection, and shares outcomes similar to those of mental illness stigma and racism, such as isolation, shame, self-blame, a sense of otherness, and helplessness (Duffey & Somody, 2011).

RCT places isolation and disconnectedness as the primary sources of human suffering, the same suffering that counselors, psychotherapists, and other mental health care providers presumably seek to ease for their clients. Failure of mental health care providers to understand or acknowledge disconnections such as those experienced by minority groups that are marginalized or discounted only reinforces the sense of disconnection (Duffey & Somody, 2011). As awareness of the detrimental effects of disconnecting and isolating social phenomena such as the stigma of mental illness continues to grow, mental health care providers are uniquely positioned to examine their own attitudes and capacities to understand, to ensure that their clients have the

opportunity to experience supportive and empowering human relationships.

Summary

For the current study, RCT serves as a framework within which attitudes that are known to effect human social relationships, namely those associated with race, ethnicity, and mental illness, are investigated from the perspective of graduate counseling trainees. Although a direct relationship among the variables of mental illness stigma, multicultural counseling self-efficacy, mental health literacy, multicultural training environment, and empathy has not been empirically investigated, each of these constructs has been found, independently, to be significant when associated with counselor effectiveness, the quality of the therapeutic relationship, and client outcomes.

The disparities in mental health care, from access to outcomes, remain a dire concern and an indicator that more research is necessary. Theorists have described the clinical effects of nonspecific relational factors on the therapeutic relationship (e.g., Freedberg, 2007). Researchers also have determined that “something else” about individual counselors (Okiishi et al., 2003, p. 370) may be a source of variance in client outcomes. It seems appropriate, therefore, to investigate the nature of the relationships that may exist among constructs that are already known to impact the therapeutic relationship. RCT, as a theory and as a mode of therapy, focuses on the human relationship and human connectedness as the means to mental health and wellness. As counselor preparation programs continue to seek means of preparing graduate counseling trainees not only to be effective counselors, but to be active participants in the elimination of barriers to mental health treatment, it may be that developing meaningful human relationships, replete with the vast array of individual human differences, is an

appropriate starting point.

CHAPTER III

METHODOLOGY

The purpose of the current study is to examine the extent to which mental illness stigma scores and multicultural counseling self-efficacy scores are related, as well as the moderating effects of empathy and the multicultural training environment on this relationship. A secondary purpose is to determine differences in mental illness stigma scores and multicultural counseling self-efficacy scores, as well as differences associated with demographic factors, among students in selected counselor training programs, including mental health counseling, school counseling, college student and personnel, art therapy, counseling psychology, and counselor education and supervision. Group differences associated with demographic factors and levels of familiarity with mental illness are assessed. This chapter describes the study design, instrumentation, data collection procedures, and statistical analysis used to examine the study's research questions.

Research Questions

The study's six research questions address the relation between mental illness stigma and multicultural counseling self-efficacy among graduate counseling trainees¹, as

¹ In the current study, the term *graduate counseling trainees* refers to those students enrolled in a master's or doctoral level nonmedical human-helping program of a regionally accredited college or university.

well as any impact on that relationship of empathy, multicultural training environment, and mental health literacy. The following research questions are addressed:

1. To what extent is there a significant relation among mental illness stigma, multicultural counseling self-efficacy, multicultural training environment, mental health literacy, and empathy among graduate counseling trainees?

2. Does mental illness stigma predict multicultural counseling self-efficacy among graduate counseling trainees?

3. To what extent is the relation between mental illness stigma and multicultural counseling self-efficacy moderated by empathy among graduate counseling trainees?

4. To what extent is the relation between mental illness stigma and multicultural counseling self-efficacy moderated by the multicultural training environment among graduate counseling trainees?

5. Are there differences in mental illness stigma scores and multicultural counseling self-efficacy scores based on select demographic factors and program affiliation among graduate counseling trainees?

6. Are there differences in mental illness stigma scores and multicultural counseling self-efficacy scores based on individuals' reported level of familiarity with mental illnesses among graduate counseling trainees?

Research Design

The researcher employed a cross-sectional survey design to examine the research questions of the current study. A sample of graduate counseling trainees were surveyed as to their current attitudes and characteristics.

Participants

The study gathered data from graduate-level counseling trainees in select academic counselor preparation programs at regionally accredited Midwestern colleges and universities. To ensure racial diversity among the study sample, at least one university was a designated Historically Black College or University (HBCU).

Sampling

This study used a convenience sampling method. The target population included graduate counseling trainees in approximately five regionally accredited Midwestern universities (see Appendix A), with the study sample a subgroup drawn from the population (Creswell, 2012).

The convenience sampling method has limitations, including results that limit generalization to the population (Cohen, Manion, & Morrison, 2011). The study attempted to minimize this limitation by including participants enrolled in a counselor preparation programs at a Historically Black College or University, as research with graduate counseling trainees has reported on findings using samples composed primarily of White Americans (e.g., Greason & Cashwell, 2009; Liu, Sheu, & Williams, 2004; Sheu et al., 2012).

Based on the combined enrollment of approximately 684 students at select graduate-level counselor preparation programs, Dillman, Smyth, and Christian (2009) estimate a minimum sample size of 240 to attain a 95% confidence level and 5% margin of error. The study sought to collect completed and usable surveys from a minimum of 280 graduate level counseling trainees. The estimated sample would be large enough to achieve statistical power.

Procedures

The data collected in this study was considered primary data, and data collection began once approval for the study was granted by the university institutional review board (IRB). Data collection occurred in the fall semester 2016 and spring semester 2017.

The chairs of the academic departments that house counselor preparation programs at select regionally accredited colleges or universities were contacted by email to determine their interest in participating in the study. The email introducing the study was the same for each department chair associated with the selected counselor preparation programs (see Appendix B), and included information as to the purpose and scope of the study, IRB approval, script to be presented by the researcher to participants, and a request to schedule the survey administration. Upon receipt of approval from the department chair, course instructors were contacted by email to introduce the study and schedule dates and times for the survey administration (see Appendix C).

Once the dates for the survey administration at each academic department were finalized, the researcher administered the survey packets to the participating departments. Each packet contained a cover letter informing students about the study, an informed consent form that was signed and returned to the researcher (see Appendix D), and the survey questions (see Appendix E), which were administered to student groups by the researcher. Respondents were assured that neither their personal identity nor the identity of their school will be disclosed in the dissertation.

The completed surveys were collected by the researcher at the conclusion of each group administration. No incentive was offered for the completion of the survey packet.

Course instructors may have offered points of extra credit for survey completion.

The lab-based paper and pencil condition of administration was selected over an internet-based administration method, in an effort to receive the most complete data. Although response rates for internet surveys have been found to be roughly equivalent to that of paper and pencil surveys (Lewis, Watson, & White, 2009), the latter method has yielded less missing data (Weigold, 2013).

Instrumentation

A researcher-designed demographic questionnaire and five self-report instruments were used to gather the study data. Data on mental illness stigma among graduate counseling trainees were collected with the Mental Illness: Clinician's Attitude Scale v.4 (MICA v.4; Gabbidon et al., 2013). The Multicultural Counseling Self-Efficacy Scale–Racial Diversity Form (MCSE-RD; Sheu & Lent, 2007) was used to collect data on participants' perceived capability to counsel racially diverse clients. Data on multidimensional empathy were gathered with the Interpersonal Reactivity Index (IRI; Davis, 1980), and data on the perceived presence and effectiveness of specific multicultural elements of the counseling training environment by participants were collected using the Multicultural Environmental Inventory–Revised (MEI-R; Pope-Davis et al., 2000). Mental health literacy was assessed with the Mental Health Knowledge Schedule (MAKS; Evans-Lacko et al., 2010). The Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) was used to determine the impact, if any, of social desirability bias on the validity of the scores.

Demographic questionnaire. The researcher-designed demographic questionnaire was used to collect self-reported information on participants' backgrounds.

The questions were based on the nine cultural influences that Hays (1996; 2009) posits must be considered by counselors and other human helpers in their work with clients, and comprise what Hays termed the ADDRESSING Model. The nine influences are Age/generational, Developmental disability/Disability acquired later in life, Religion and spiritual orientation, Ethnic and racial identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender. In keeping with more recent best practices related to gender identity and status, two items, one that asked for assigned sex at birth, and one that asked for current gender identity, replaced a single gender item on the demographic questionnaire (The GenIUSS Group, 2014).

Familiarity with mental illness. Three items were used to gather information on participants' level of familiarity with mental illness. Wolff, Pathare, Craig, and Leff (1996) found that personal familiarity with mental illness in the form of having experienced a mental illness was associated with having more positive attitudes toward people with mental illness. Familiarity with mental illness gained through education has been related to stigmatizing attitudes toward mental illness (Corrigan & Watson, 2007), as has familiarity with mental illness gained through professional contact (Crowe & Averett, 2015). Participants were asked to indicate if they have a friend with a mental health diagnosis, if they have a family member with a mental health diagnosis, and if they currently have or have had a history of a mental health diagnosis.

Mental Illness: Clinicians' Attitude Scale v. 4. The Mental Illness: Clinicians Attitude Scale v.4 (MICA v.4; Gabbidon et al., 2013) is a 16-item scale developed to measure attitudes toward the field of mental health care and people with mental illness among students and professionals in a variety of healthcare disciplines. This instrument

is an extension of the work by Kassam, Glozier, Leese, Henderson, and Thornicroft (2010) that produced the MICA 1.0 (28-items) and 2.0 (16 items; medical student version), validated with a sample of third-year medical students ($n = 77$).

Each item of the MICA v.4 (Gabbidon et al., 2013) uses a 6-point Likert-type scale ranging from 1 = strongly agree to 6 = strongly disagree, with scores ranging from 16 to 96. Higher scores indicate more negative stigmatizing attitudes. Sample items include, “people with a severe mental illness can never recover enough to have a good quality of life,” “working in the mental health field is just as respectable as other fields of health and social care,” and “people with a severe mental illness are dangerous more often than not.”

Reliability. The MICA v.4 has been found to have acceptable internal consistency, with Gabbidon et al. (2013) reporting a Cronbach’s alpha of $\alpha = 0.72$. Internal consistencies ranging from 0.72 to 0.73 were also reported for the Chinese version (Li, Li, Thornicroft, & Huang, 2014) and the Dutch version (Gras et al., 2015) of the MICA v.4, with a test-retest reliability of $r = 0.76$ reported by Gras et al. (2015) for the Chinese version. According to DeVellis (2012), Cronbach’s alphas may be considered minimally acceptable if they are between 0.65 and 0.70, with those between 0.80 and 0.90 being very good.

Validity. Convergent validity of the MICA v.4 was estimated by Gabbidon et al. (2013) as adequate when correlated with the Reported and Intended Behavior Scale (RIBS; Evans-Lacko et al., 2011). The correlation of $r = 0.49$, $p < 0.01$, $n = 182$ reported by Gabbidon et al. (2013) is within Cohen’s (1992) threshold of 0.3–0.5 for adequate convergent validity. These authors also reported good face validity of the MICA v.4, as

did Gras et al. (2015) of the Dutch version of the MICA.

In their study with 191 nursing students with intended specialty areas of adult, child, or mental health nursing, the instrument's authors reported a five-factor structure: (1) views of health/social care field and mental illness, (2) knowledge of mental illness, (3) disclosure, (4) distinguishing mental and physical health care, and (5) patient care for people with mental illness. The instrument's authors concluded that the five-factor structure of the MICA v.4 needs further study, and the scoring guide that accompanies the instrument includes a total score only.

Multicultural Counseling Self-Efficacy Scale–Racial Diversity Form.

Developed by Sheu and Lent (2007), the 37-item Multicultural Counseling Self-Efficacy Scale–Racial Diversity Form (MCSE-RD) was designed to assess perceived confidence by trainees and therapists of their ability to counsel racially diverse clients. The scale's authors state that the MCSE-RD (Sheu & Lent, 2007) reflects self-efficacy regarding specific behaviors that therapist or counseling trainees perform when working with racially diverse clients, rather than reflecting a counseling trainee's description of effective multicultural counseling.

The MCSE-RD comprises three subscales: Multicultural Intervention (MCSE-RD, MI; 24 items), Multicultural Assessment (MCSE-RD, MA; 6 items) and Multicultural Counseling Session Management (MCSE-RD, MCSM; 7 items). Items are rated on a 10-point Likert-type scale from 0 (no confidence at all) to 9 (complete confidence). A sample item from the MCSE-RD, MI subscale is “remain flexible and accepting in resolving cross cultural strains or impasses.” A sample item from the MCSE-RD, MA subscale is “select culturally appropriate assessment tools according to

the client's cultural background." A sample item from the MCSE-RD, MCSM subscale is "keep sessions on track and focused with a client who is not familiar with the counseling process." The MSCE-RD (Sheu & Lent, 2007) is scored by calculating mean scores and mean subscale scores. Higher scores indicate higher levels of multicultural self-efficacy.

Reliability. The MCSE-RD (Sheu & Lent, 2007) subscales are reported to have high levels of internal consistency, as does the full scale (Barden & Greene, 2015). Sheu and Lent (2007) found subscale Cronbach's alpha ranging from 0.92 and 0.98, with a total score reliability of 0.98. In a subsequent study, Sheu et al. (2012) reported internal consistency estimates of the subscale scores ranged from 0.87 to 0.97, with a total score reliability of 0.97. Barden and Greene (2015) reported similar internal reliability of the instrument's subscale scores (0.87 to 0.95) and total scores (0.94). Across these studies, MSCE-RD (Sheu & Lent, 2007) subscale scores intercorrelations ranged from $r = 0.52$ to 0.85, and total score correlations with the subscale scores from $r = 0.78$ to 0.98. According to Sheu and Lent (2007), test-retest reliability scores for subscales ranged from 0.69 to 0.88 and total scale scores had correlation coefficient of $r = 0.77$.

Validity. Sheu and Lent (2007) demonstrated convergent validity of the MSCE-RD using correlations between the MCSE-RD (Sheu & Lent, 2007) subscale scores and total scores with scores of the Counselor Activity Self-Efficacy Scales (CASES; Lent, Hill, & Hoffman, 2003), designed to assess general counseling self-efficacy, and the Multicultural Counseling Inventory (MCI; Sadowsky et al., 1994), developed to measure multicultural counseling competence. Subscale scores of the MCSE-RD (Sheu & Lent, 2007) were found to correlate highly with both the subscales of the CASES (Lent et al.,

2003) and the MCI (Sodowsky et al., 1994), and MCSE-RD (Sheu & Lent, 2007) total scores correlations were reported as $r = 0.79$ for the CASES (Lent et al., 2003) total score and $r = 0.58$ for the MCI (Sodowsky et al., 1994) total score (Sheu & Lent, 2007). These authors supported discriminant validity of the MCSE-RD (Sheu & Lent, 2007) by correlating the scale with the Marlowe Crowne Social Desirability Scale (Crowne & Marlowe, 1960), a measure of social desirability response bias. This correlation indicated a weak relationship (.09) between MCSE-RD (Sheu & Lent, 2007) scores and social desirability scores.

Multicultural Environmental Inventory–Revised. Pope-Davis et al. (2000) developed the Multicultural Environmental Inventory–Revised (MEI-R) in response to their identification of a need for an instrument that could assess attitudinal and holistic cultural aspects of graduate-level counseling and psychology training environments for research and program development purposes. During the initial validation study with 208 student and faculty participants from a pool of 68 APA-accredited graduate counseling psychology programs, Pope-Davis et al. (2000) reduced the original Multicultural Environment Inventory (MEI) from 53 items to 27 items. The resulting 27-item MEI-R (Pope-Davis et al., 2000) consists of four subscales: Curriculum and Supervision (11 items), Climate and Comfort (11 items), Honesty in Recruitment (11 items), and Multicultural Research (2 items). A sample item for the Curriculum and Supervision subscale is “the course syllabi reflect an infusion of multiculturalism.” A sample item from the Climate and Comfort subscale is “I feel comfortable with the cultural environment in class.” A sample item from the Honesty in Recruitment subscale is “when recruiting new faculty, I am completely honest about the climate.” A sample item

from the Multicultural Research subscale is “There is at least one person whose primary research interest is in multicultural issues.” The items are rated on a 5-point Likert-type scale from 1 (not at all) to 5 (a lot). Higher scores indicate student perception of a greater degree of focus on multicultural issues within a graduate-level counseling or psychology training program.

Reliability. The scale’s authors reported initial Cronbach’s alpha reliability estimates for the overall MEI-R scores to be 0.94, with the 4 subscales ranging from 0.83 to 0.94 (Pope-Davis et al., 2000). Subsequent studies yielded Cronbach’s alphas of the total scores to be 0.94, with subscale score reliability estimates ranging from 0.73 to 0.92 (Coleman, 2006; Toporek, Liu, & Pope-Davis, 2003).

Validity. Liu et al. (2004) subsequently reported a significant correlation between MEI-R total scores and therapist trainees’ knowledge about multicultural counseling, an indicator of convergent validity. Divergent validity of the MEI-R was also supported by Liu et al. in their finding of a weak relationship (0.04) between the MEI-R and the Multicultural Social Desirability Scale (MCSD; Sadowsky, O’Dell, Hagemoser, Kwan, & Tonemah, 1993).

Mental Health Knowledge Schedule. The Mental Health Knowledge Schedule (MAKS; Evans-Lacko et al., 2010) is a 12-item instrument developed to assess stigma-related mental health knowledge at the population level. It comprises 6 knowledge areas with 1 item each: help-seeking, recognition, support, employment, treatment, recovery. Sample items include, “most people with a mental illness want to have paid employment,” “If a friend had a mental health problem, I know what advice to give them to get professional help,” and “people with severe mental health problems can fully

recover.” Items 7-12 address knowledge of mental illness conditions, including depression, stress, schizophrenia, bipolar disorder, drug addiction, and grief, and are intended to assist interpretation. Only items 1 – 6 are used for scoring, and scores range from 0–30, with higher scores indicating more knowledge.

Reliability. Evans-Lacko et al. (2010) reported moderate internal consistency of 0.65, overall test-retest reliability of 0.71, and item retest reliability that ranged from 0.57–0.87, with a sample of 495 adult members of the general population across England.

Validity. In a study with a sample of mental health care providers in China, Li et al. (2014) found a significant negative correlation of the MAKS (Evans-Lacko et al., 2010) and the MICA (Kassam et al., 2010), indicating that increased mental health knowledge was associated with lower mental illness stigma scores.

Interpersonal Reactivity Index. The Interpersonal Reactivity Index (Davis, 1980) was developed to measure cognitive and affective aspects of empathy. The instrument’s 28 items are rated on a 5-point Likert-type scale, with responses ranging from 1 (does not describe me very well) to 5 (describes me very well). It contains four seven-item subscales: Perspective Taking (IRI-PT; the tendency to adopt the psychological viewpoint of another; cognitive empathy), Fantasy Scale (IRI-FS; measures the tendency to take on the feelings and actions of fictional characters), Empathic Concern (IRI-EC; measures the extent to which one sympathizes or feels concern for those encountering misfortune; affective empathy), and Personal Distress (IRI-PD; assesses the extent to which one feels anxious or uncomfortable during difficult or challenging interpersonal interactions). Sample items of the Perspective Taking (IRI-PT) subscale include, “I sometimes find it difficult to see things from the ‘other guy’s’

point of view,” and “I try to look at everybody’s side of a disagreement before I make a decision.” Sample items from the Fantasy Scale (IRI-FS) subscale include, “I really get involved with the feelings of the characters in a novel” and “after seeing a play or movie, I have felt as though I were one of the characters.” Sample items from the Empathetic Concern (IRI-EC) subscale include, “I often have tender, concerned feelings for people less fortunate than me,” and “other people’s misfortunes usually do not disturb me a great deal.” Sample items from the Personal Distress (IRI-PD) subscale include, “I sometimes feel helpless when I am in the middle of a very emotional situation,” and “being in a tense emotional situation scares me.” Davis (1980) suggested that the IRI-PT and IRI-EC subscales reflect the most advanced levels of empathy, while the IRI-PD subscale, which correlates negatively to the other IRI subscales, indicates potential anxiety in highly emotional situations and overidentification with the issues of others.

Reliability. Cronbach’s alpha internal reliability estimates of the four subscales of the IRI were reported by Davis (1980) as ranging from 0.70 to 0.72, and other researchers have reported ranges from 0.79 to 0.72 (Pulos, Elison, & Lennon, 2004) and 0.77 to 0.81 (Love, Smith, Lyall, Mullins, & Cohn, 2014). Greason and Cashwell (2009) reported an overall composite reliability estimate for the IRI of 0.96. Over a two-month testing period, test-retest reliabilities ranged from 0.62 to 0.71 (Davis, 1980).

Validity. Davis (1983) and Davis and Franzoi (1991) demonstrated concurrent validity in their finding that the IRI-PT subscale of the IRI (Davis, 1980) correlated positively with the Hogan Empathy Scale (Hogan, 1969), a measure of cognitive empathy. Davis (1983) additionally reported that the affective IRI-EC subscale of the IRI was positively associated with the Questionnaire Measure of Emotional Empathy

(QMEE; Mehrabian & Epstein, 1972) at $r = .63$ for males and $r = .56$ for females. The IRI-PD subscale of the IRI (Davis, 1980) was significantly and negatively associated with the instrument's IRI-FS, IRI-EC, and IRI-PT subscales, and was consistently correlated with a strong tendency toward emotionality characterized by fearfulness and uncertainty.

Marlowe-Crowne Social Desirability Scale. The 33-item Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) was developed to collect social desirability data and examine the presence of a respondent's bias toward socially acceptable views and attitudes. Scores range from 0 – 33, with higher scores indicating a greater need for social approval (Crowne & Marlowe, 1960). Responses to all items are True or False, and sample items include, “I am always careful about my manner of dress,” “there have been occasions when I took advantage of someone,” and “I am sometimes irritated by people who ask favors of me.” Although a number of shorter versions of the scale have been developed and tested, Barger (2002) posited that improved model fit found in studies of shorter versions of the MCSDS (Crowne & Marlowe) could be a function of the reduced number of items, and that the shorter forms of the scale are inadequate as proxies for the full 33-item version.

In the years since the initial development of the MCSDS (Crowne & Marlowe, 1960), questions as to the nature and dimensionality of the social desirability construct itself have arisen, resulting in admonitions that any social desirability scale be used with caution (Johnson, Fendrich, & Mackesy-Amiti, 2012; Leite & Beretvas, 2005). Despite the cautionary warnings and continued attempts to define the construct of social desirability response bias, van de Mortel (2008) recommended that researchers use a

measure of social desirability alongside the primary instrument(s), especially when the construct of interest is of high social value.

Reliability. Crowne and Marlowe (1960) reported an internal consistency of 0.88, using Kuder-Richardson formula 20 (Richardson & Kuder, 1939), and a test-retest reliability of 0.89 after a one-month interval. Fisher (1967) subsequently reported a test-retest reliability of 0.84, with a one-week interval. Reynolds (1982) found a Kuder-Richardson formula 20 reliability estimate of 0.82 for the MCSDS (Crowne & Marlowe, 1960), and Paulhus (1991) later reported internal consistency coefficients from 0.73–0.88. Similar internal consistency coefficients have been reported by Barger (2002), Norman, Sorrentino, Windell, and Manchanda (2008) and Sârbescu, Costea, and Rusu (2012), 0.74, 0.89, and 0.78, respectively.

Validity. Crowne and Marlowe (1960) offered evidence of validity in their initial validation study of the MCSDS, and reported significant correlations with the Edwards Social Desirability Scale (Edwards, 1957) and 17 of the validity, clinical, and derived scales of the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1943). Additional evidence of construct validity was offered by Crowne and Marlowe (1964) in their review of studies in which numerous correlates were reported, showing that individuals who scored high on the MCSDS responded more to social influence, were more affected by social influence, and avoided the evaluations of others when possible. Although there have been few additional direct attempts to validate the MCSDS (Johnson et al., 2012), it is a commonly used means of detecting and controlling for social desirability bias in self-report survey research (Leite & Beretvas, 2005).

Data Analysis

All statistical tests were performed using The IBM program SPSS (Version 21), using the appropriate tests to address each research question. Before proceeding with data analysis, the data were cleaned. Tests for assumptions were conducted prior to data analysis.

Research question 1: Correlation analysis was selected to determine the presence of a relationship among the study's constructs: a) mental illness stigma, as measured by the MICA v.4 (Gabbidon et al., 2014); b) multicultural counseling self-efficacy, measured by the MCSE-RD Total Score (Sheu & Lent, 2007); c) multicultural intervention, measured by the MCSE-RD, MI subscale; d) multicultural assessment, measured by the MCSE-RD, MA subscale; e) multicultural counseling session management, measured by the MCSE-RD, MCSM subscale; f) perspective taking empathy, measured by the IRI-PT subscale of the IRI (Davis, 1980); g) fantasy scale empathy, measured by the IRI-FS subscale of the IRI; h) empathetic concern empathy, measured by the IRI-EC subscale of the IRI; i) personal distress empathy, measured by the IRI-PD subscale of the IRI; j) mental health literacy, measured by the MAKS (Evans-Lacko et al., 2010); k) the multicultural training environment, measured by the MEI-R (Pope-Davis et al., 2000); l) Curriculum and Supervision subscale of the MEI-R; m) Climate and Comfort subscale of the MEI-R; n) Honesty in Recruitment subscale of the MEI-R; and o) Multicultural Research subscale of the MEI-R. According to Cohen et al. (2011), correlation is intended to determine the presence of a relationship between variables, the direction of the relationship, and the magnitude of the relationship.

Research question 2: Linear regression analysis was selected to determine the

predictive ability of mental illness stigma, as measured by the MICA v.4 (Gabbidon et al., 2014) on multicultural counseling self-efficacy, measured by the MCSE-RD (Sheu & Lent, 2007) Total Score and three subscales (MCSE-RD, MI; MCSE-RD, MA; MCSE-RD, MCSM).

Research question 3: Multiple regression analysis was selected to determine the moderating effect, if any, of empathy, measured by the four subscales of Davis' (1980) IRI (IRI-PT, IRI-FS, IRI-EC, and IRI-PD) on the relationship between mental illness stigma, measured by the MICA v.4 (Gabbidon et al., 2014) and multicultural counseling self-efficacy, measured by the MCSE-RD (Sheu & Lent, 2007) Total Score and three subscales (MCSE-RD, MI; MCSE-RD, MA; MCSE-RD, MCSM) among graduate counseling trainees.

Research question 4: Multiple regression analysis was selected to determine the moderating effect, if any, of the multicultural training environment, measured by the Total Score of the MEI-R (Pope-Davis et al., 2000) and four subscales (Curriculum and Supervision; Climate and Comfort; Honesty in Recruitment; Multicultural Research) on the relationship between mental illness stigma, measured by the MICA v.4 (Gabbidon et al., 2014) and multicultural counseling self-efficacy, measured by the MCSE-RD (Sheu & Lent, 2007) Total Score and three subscales (MCSE-RD, MI; MCSE-RD, MA; MCSE-RD, MCSM) among graduate counseling trainees.

Research question 5: Analysis of variance (ANOVA) was selected to investigate differences in mental illness stigma, measured by the MICA v.4 (Gabbidon et al., 2014) and multicultural counseling self-efficacy, measured by the MCSE-RD (Sheu & Lent, 2007) Total Score and three subscales (MCSE-RD, MI; MCSE-RD, MA; MCSE-RD,

MCSM), based on demographic factors and counseling program affiliation.

Research question 6: ANOVA was selected to investigate differences in mental illness stigma, measured by the MICA v.4 (Gabbidon et al., 2014) and multicultural counseling self-efficacy, measured by the MCSE-RD (Sheu & Lent, 2007) Total Score and three subscales (MCSE-RD, MI; MCSE-RD, MA; MCSE-RD, MCSM), based on self-reported levels of familiarity with mental illnesses. Where indicated, appropriate post hoc tests were performed.

Summary

This chapter reviewed the purpose of the research study and presented six research questions that address the relation between mental illness stigma and multicultural counseling, as well as the moderating effects, if any, of empathy and the multicultural training environment on those relations. Study participants were recruited from select graduate-level counselor preparation programs through the appropriate contact person at the respective college or university. The required sample size and data collection procedures were described, as were the psychometric properties of each instrument included in the survey. Finally, the methods of data analysis for each of the research questions were presented.

CHAPTER IV

RESULTS

The purpose of the current study was to examine the extent to which mental illness stigma scores and multicultural counseling self-efficacy scores are related, as well as the moderating effects of empathy and the multicultural training environment on this relationship. A secondary purpose was to determine differences in mental illness stigma scores and multicultural counseling self-efficacy scores based on selected demographic variables and counseling program affiliation. This chapter will present descriptive statistics, organized in terms of demographic data and the study's variables of interest. This will be followed by the results of the study organized by the six research questions presented in Chapters I and III.

Participants

A total of 245 individuals from four regional Midwest universities were invited to participate in the study. Of the 245 individuals invited to be in the study, all agreed, although three participants returned survey packets with fully missing data and were not included, yielding a 99% response rate. In addition, 10 participants were excluded from the study due to missing responses or extreme scores. Thus, the final sample size was $N = 232$. The demographic data show that 80.2% ($n = 186$) of participants identified as female at birth. Those who identified as male at birth comprised 19.8% ($n = 46$) of the sample, and .4% ($n = 1$) identified as currently neither male nor female. With respect to

age, 48.3% ($n = 112$) of participants were between the ages of 25 and 34, 34.9% ($n = 81$) were between 18 and 24, 12.5% ($n = 29$) were between 35 and 44, 3.9% ($n = 9$) were between the ages of 45 and 54, and one (.4%) participant was between the ages of 55 and 64. Complete demographic data for study participants are presented in Table 1.

The racial makeup of the sample indicated that 72.8% ($n = 169$) of the sample self-identified as White, 21.1% ($n = 49$) reported their race as Black or African American, and 2.6% ($n = 6$) reported their race as being not listed as an option. The percentage of participants who reported their race as Asian was 1.3% ($n = 3$), with .9% ($n = 2$) reporting their race as American Indian or Alaskan Native, and .4% ($n = 1$) as Native Hawaiian and Other Pacific Islander. One participant (.4%) indicated identification with multiple races by marking more than one race option. With regard to ethnicity, 3% ($n = 7$) of participants identified as Hispanic, Latino, or Spanish.

In response to the items regarding faith tradition, 25% ($n = 58$) of participants reported that they identified with no specific faith tradition, and 75% ($n = 174$) reported that they identified with a specific faith tradition. A large majority of participants reported growing up in the Southeast United States (54.7%, $n = 127$) or the Midwest United States (31.9%, $n = 74$).

The data collected on participants' graduate counseling preparation program affiliation indicated that 40.5% ($n = 94$) reported being enrolled in a School Counseling program, 24.6% ($n = 57$) in a Counseling Psychology program, 14.2% ($n = 33$) in a College Counseling or College Student Personnel program, 11.2% ($n = 26$) in an Art Therapy program, 7.8% ($n = 18$) in Mental Health Counseling or Clinical Mental Health programs, and 1.3% ($n = 3$) in Counselor Education and Supervision programs. One

participant did not respond to the program affiliation item.

The majority of study participants were in the early stages of their graduate programs, with 58.2% ($n = 135$) having completed 1-18 total credit hours, followed by another 25.4% ($n = 59$), who had completed 19 - 36 credit hours in their respective programs. A majority of participants (75%, $n = 171$) also reported having completed one or fewer practicum or internship courses, and a similar percentage of participants reported having completed one or fewer multicultural courses in the past five years. A small minority of study participants (3%, $n = 7$) reported being certified or licensed in a mental health field. The study's complete sample demographic data are presented in Table 1.

Table 1

Study Sample Demographic Data

Characteristic	<i>N</i>	<i>n</i>	%
Sex assigned at birth	232		
Female		186	80.2
Male		46	19.8
Gender identity	232		
Female		186	80.2
Male		45	19.4
Transgender		0	0.0
Do not identify		1	.4
Age	232		
18-24		81	34.9
25-24		112	48.3
35-44		29	12.5
45-54		9	3.9
55-64		1	.4

Table 1 continued

Characteristic	<i>N</i>	<i>n</i>	%
Race	231		
American Indian or Alaskan Native		2	.9
Asian		3	1.3
Black or African American		49	21.1
Native Hawaiian and Other Pacific Islander		1	.4
White		169	72.8
Other Race		6	2.6
Multiple Responses		1	.4
Hispanic, Latino, or Spanish Origin	232		
Yes		7	3.0
No		225	97.0
Belong to a Faith Tradition	232		
Yes		174	75.0
No		58	25.0
Specific Faith Tradition	232		
Christian		64	27.6
Christian, non-denominational		51	22.0
Protestant		3	1.3
Pentecostal/Charismatic		1	.4
Mormon/Latter Day Saints		1	.4
Roman Catholic		30	12.9
Jewish, Orthodox		0	0.0
Jewish, Reform		0	0.0
Muslim/Islam		2	.9
Eastern Religions		1	.4
Spiritual		7	3.0
Agnostic		8	3.4
Atheist		4	1.7
Other Faith Tradition		1	1.7
Geographic location of childhood	232		
Midwest		74	31.9
Northeast		13	5.6

Table 1 continued

Characteristic	<i>N</i>	<i>n</i>	%
Southeast		127	54.7
Southwest		7	3.0
West		10	4.3
Outside the United States		1	.4
Counselor Preparation Program Affiliation	231		
Art Therapy		26	11.2
College Counseling/College Student Personnel		33	14.2
Counselor Education and Supervision		3	1.3
Counseling Psychology		57	24.6
Mental Health Counseling/Clinical Mental Health		18	7.8
School Counseling		94	40.5
Credit Hours Completed	232		
1-18		135	58.2
19-36		59	25.4
37-54		27	11.6
More than 54		11	4.7
Practicum/Internship Courses	232		
None		139	59.9
One		32	13.8
Two		33	14.2
More than two		28	12.1
Multicultural Courses in Past 5 Years	232		
None		74	31.9
One		100	43.1
Two		40	17.2
More than two		18	7.8
Certified/Licensed	232		
Yes		7	3.0
No		225	97.0
Level	232		
Master's		199	85.8
Doctoral		33	14.2

Descriptive Statistics

This section will describe the descriptive statistics for each of the current study's constructs of interest, a) *mental illness stigma*, as measured by the MICA v.4 (Gabbidon et al., 2014); b) *multicultural counseling self-efficacy*, measured by the MCSE-RD Total Score (Sheu & Lent, 2007); c) *multicultural intervention*, measured by the MCSE-RD, MI subscale; d) *multicultural assessment*, measured by the MCSE-RD, MA subscale; e) *multicultural counseling session management*, measured by the MCSE-RD, MCSM subscale; f) *perspective taking empathy*, measured by the IRI-PT subscale of the IRI (Davis, 1980); g) *fantasy scale empathy*, measured by the IRI-FS subscale of the IRI; h) *empathetic concern empathy*, measured by the IRI-EC subscale of the IRI; h) *personal distress empathy*, measured by the IRI-PD subscale of the IRI; i) *mental health literacy*, measured by the MAKS (Evans-Lacko et al., 2010). This discussion will focus on the demographic data related to each construct, namely participants who were identified as having the lowest and highest scores for the constructs of interest. The measures of central tendency for all measures are presented in Table 2.

Table 2
Descriptive Statistics by Variable

Study variable	<i>N</i>	<i>M</i>	<i>SD</i>	Range	Median
MICA	230	59.17	4.67	46.0-72.0	59.00
MCSE-RD Total Score	222	6.44	1.51	1.57-9.00	6.64
MCSE-RD, MI	226	6.61	1.48	1.33-9.00	6.83
MCSE-RD, MA	225	5.18	2.19	.00-9.00	5.17
MCSE-RD, MCSM	227	6.98	1.44	1.14-9.00	6.14
IRI-PT	231	20.47	4.05	9.00-28.00	21.00
IRI-FS	231	17.63	5.80	.00-28.00	18.00

Table 2 continued

Study variable	<i>N</i>	<i>M</i>	<i>SD</i>	Range	Median
IRI-EC	231	21.94	3.99	4.0-28.00	22.00
IRI-PD	232	9.94	4.69	.00-22.00	10.00
MAKS	227	16.51	1.46	13.00-20.00	16.00

Note. MICA = Mental Illness: Clinicians' Attitudes Scale v.4, measure of mental illness stigma; MCSE-RD, Total Score = Multicultural Counseling Self-Efficacy–Racial Diversity Form, Total Score; MCSE-RD, MI = Multicultural Counseling Self-Efficacy–Racial Diversity Form, Multicultural Intervention subscale; MCSE-RD, MA = Multicultural Counseling Self-Efficacy–Racial Diversity Form, Multicultural Assessment subscale; MCSE-RD, MCSM = Multicultural Counseling Self-Efficacy–Racial Diversity Form, Multicultural Counseling Session Management subscale; IRI-PT = Interpersonal Reactivity Index Perspective Taking empathy subscale; IRI-FS = Interpersonal Reactivity Index Fantasy Scale empathy; IRI EC = Interpersonal Reactivity Index Empathetic Concern empathy subscale; IRI-PD = Interpersonal Reactivity Index Personal Distress empathy subscale; MAKS = Mental Health Knowledge Schedule.

Mental illness stigma. Mental illness stigma was assessed with the MICA v.4 (Gabbidon et al., 2013). Scores on the MICA v.4 range from 16 - 96, with higher scores indicating higher levels of mental illness stigma. Sample items from the MICA v.4 include, “people with a severe mental illness can never recover enough to have a good quality of life,” “working in the mental health field is just as respectable as other fields of health and social care,” and “people with a severe mental illness are dangerous more often than not.” The overall mean score for the MICA v.4 in the current study was $M = 59.17$ ($SD = 4.67$), with scores ranging from 46 - 72. The lowest stigma score belonged to the one participant who reported being between the ages of 55 – 64, and scored 57.00, with those in the 18 - 24 age group scoring slightly higher ($M = 58.78$, $SD = 4.37$). The highest mean scores were found among those 35 - 44 years ($M = 59.48$, $SD = 5.24$).

With regard to race, the lowest mental illness stigma score was that of the participant who identified as being a member of multiple races (50.00) and the highest scores were among those who identified as belonging to a race other than those listed (n

= 6, $M = 61.67$, $SD = 5.61$). With regard to program affiliation, scores of those in School Counseling programs indicated the lowest levels of mental illness stigma ($M = 58.46$, $SD = 5.00$), with the highest scores among participants in Counselor Education and Supervision and Counseling Psychology programs, $M = 63.00$ ($SD = 5.57$) and $M = 60.02$ ($SD = 4.18$), respectively.

Multicultural counseling self-efficacy. Multicultural counseling self-efficacy was assessed with the MCSE-RD (Sheu & Lent, 2007). Sample items from the MCSE-RD include, “remain flexible and accepting in resolving cross cultural strains or impasses,” “select culturally appropriate assessment tools according to the client’s cultural background,” and “keep sessions on track and focused with a client who is not familiar with the counseling process.” Scores on the MCSE-RD range from 0-9, with higher scores indicating higher levels of multicultural counseling self-efficacy. The overall mean score for the MCSE-RD Total Score in the current study was $M = 6.44$ ($SD = 1.51$), with scores ranging from 1.57 - 9.0.

The participant who identified as being over the age of 55 had the lowest score (5.16), followed by those in the 18 - 24 age group, with a mean total score of $M = 6.26$ ($SD = 1.40$). The age group with the highest multicultural counseling self-efficacy scores was the 25 - 34 group, with a mean score of $M = 6.57$ ($SD = 1.51$). Among racial groups, the lowest multicultural counseling self-efficacy scores were among those who identified as White ($M = 6.24$, $SD = 1.57$), with the exception of the one student who reported being Native Hawaiian or Other Pacific Islander (2.97). The highest score was that of the one participant who identified as belonging to multiple races, who scored 9.0.

With regard to program affiliation, the lowest multicultural counseling self-

efficacy scores were among those in College Student Personnel programs ($M = 5.39$, $SD = 1.63$), with the highest scores for multicultural counseling self-efficacy among those in Counselor Education and Supervision programs ($M = 7.72$, $SD = .96$). Doctoral students and those who reported completing more than 54 credit hours scored higher than master's level students and those with 54 or fewer credit hours.

Empathy. Empathy was assessed with the IRI (Davis, 1980). This instrument consists of four subscales (Perspective Taking, Fantasy Scale, Empathetic Concern, and Personal Distress), each considered to be a factor of empathy. Perspective Taking (IRI-PT), measures the extent to which an individual has the capacity to adopt the viewpoint of another person (sample items: "I sometimes find it difficult to see things from the 'other guy's' point of view," and "I try to look at everybody's side of a disagreement before I make a decision"). The Fantasy Scale (IRI-FS) assesses the tendency to identify with the feelings and actions of fictitious characters, such as in a book or movie (sample items: "I really get involved with the feelings of the characters in a novel" and "after seeing a play or movie, I have felt as though I were one of the characters"). Empathetic Concern (IRI-EC) measures the feeling of emotional concern for another person (sample items: "I often have tender, concerned feelings for people less fortunate than me," and "other people's misfortunes usually do not disturb me a great deal"). Personal Distress (IRI-PD) measures the extent to which negative feelings or anxiety arises in response to the discomfort of others (sample items: "I sometimes feel helpless when I am in the middle of a very emotional situation," and "being in a tense emotional situation scares me"). Scores for each of the IRI subscales range from 0-28, with higher scores on each scale indicating higher levels of that empathy factor. The mean scores in the current

study were $M = 20.47$ ($SD = 4.05$) for Perspective Taking (IRI-PT), $M = 17.63$ ($SD = 5.80$) for Fantasy Scale (IRI-FS), $M = 21.94$ ($SD = 3.99$) for Empathetic Concern (IRI-EC), and $M = 9.94$ ($SD = 4.69$) for Personal Distress (IRI-PD).

Among age categories of participants in the current study, the mean score for the IRI-PT subscale was lowest for those 18-24 ($M = 20.01$, $SD = 4.07$) and highest for those 35 - 44 ($M = 20.86$, $SD = 4.32$), with the exception of one participant who reported being over the age of 55 and scored 21. For the IRI-FS, the lowest scores were among those in the 45-54 age group ($M = 16.11$, $SD = 3.95$), with the scores of the age group 18-24 being the highest ($M = 18.39$, $SD = 5.69$). On the IRI-EC subscale, the lowest scoring group was the 25 - 34 age group ($M = 21.79$, $SD = 4.01$) and the highest score belonged to the participant who was over the age of 55 and scored 28.00, followed by the 35 - 44 age group with a mean score of 22.31 ($SD = 3.33$). The mean scores of the IRI-PD subscale indicated that those in the 25 - 34 age group had the lowest levels of personal distress ($M = 9.03$, $SD = 4.31$). The age group 18 - 24 had the highest levels of personal distress with a mean score of 11.41 ($SD = 4.70$), again with the exception of the participant over the age of 55, who scored 14.00 on the IRI-PD subscale.

Mental health literacy. Mental health literacy was assessed in the current study with the Mental Health Knowledge Schedule, or MAKS (Evans-Lacko et al., 2010). MAKS scores can range from 5 - 30, with higher scores indicating higher levels of stigma-related mental health knowledge or literacy. The overall mean score in the current study was $M = 16.51$ ($SD = 1.46$), with scores that ranged from 13 - 20.

Among the age groups, the lowest scores were found among those in the 18 - 24 group ($M = 16.43$, $SD = 1.28$), with the one individual over the age of 55 scoring lower,

at 16.00. The highest scores were among those age 45 - 54 ($M = 17.11$, $SD = 1.76$).

Mean mental health literacy scores among the counseling program affiliation groups varied only slightly, ranging from $M = 16.00$ ($SD = 1.73$) to $M = 16.93$ ($SD = 1.49$), with those in Counselor Education and Supervision programs having the lowest scores and those in Counseling Psychology having the highest.

It must be noted that the version of the MAKS used in the current study was inadvertently modified by the current researcher. More specifically, the wording of the response options was inadvertently changed from those developed by the original authors of the MAKS (Evans-Lacko et al., 2010). In response to this error, an exploratory factor analysis with varimax rotation was conducted using SPSS (Version 21) to determine the factor structure of the original six items. The results of the Bartlett's test of sphericity (Bartlett, 1954) indicated that the data were factorable, and the Kaiser-Meyer-Olkin measure of sampling adequacy was mediocre at .686 (Kaiser, 1974). Exploratory factor analysis was selected since the version of the psychometric properties of the MAKS with the changed response options had not been previously examined. Principal component analysis was selected as the extraction method in order to identify the extent to which the change in response options affected the factor structure, compared to the original MAKS instrument.

The result of the factor analysis indicated that items 1-5 loaded on a single factor, with item 6 loading on the second factor. This item was excluded, as retention of factors with fewer than three items is not recommended (Tabachnik & Fidell, 2001). Review of a scree plot also suggested the presence of a single factor. A subsequent factor analysis with varimax rotation was conducted with the remaining five items, a solution that

explained 40.87% of the variance. Factor loadings for this solution are presented in Table 3. After the removal of item 6, (*Most people with mental health problems go to a healthcare professional to get help*), Cronbach alpha internal consistency of the 5-item MAKS instrument was $\alpha = .64$, consistent with the internal consistency values found by the original authors (Evans-Lacko et al., 2010), which ranged from $\alpha = .54$ to $\alpha = .69$.

Table 3

Component Matrix for the 5-item MAKS Instrument

MAKS Item Number	MAKS Item	Component 1
3	Medication can be an effective treatment for people with mental health problems.	.737
4	Psychotherapy (e.g., counseling or talking therapy) can be an effective treatment for people with mental health problems.	.700
1	Most people with mental health problems want to have paid employment.	.618
2	If a friend had a mental health problem, I know what advice to give them to get professional help.	.582
5	People with severe mental health problems can fully recover.	.537

Note. Extraction method: Principal component analysis.

Multicultural training environment. This variable was excluded from the current study, as the data collected from the instrument chosen to measure this construct, the MEI-R (Pope-Davis et al., 2000), included 42% missing data for the Total Score, and missing data among the 4 subscales that ranged from 9.1% to 37.9%. Although Shafer (1999) determined that a missing rate of 5% is likely inconsequential, Bennett (2001) held that rates of missing data that exceed 10% are likely to bias analysis.

Major Analyses

Research Question 1: Bivariate Correlations

The study's first research question asked, *To what extent is there a significant relation among mental illness stigma, multicultural counseling self-efficacy, multicultural training environment, mental health literacy, and empathy among graduate counseling trainees?* In order to answer this research question, correlation analysis was used to determine the presence of significant relations among the study variables. Although correlation analysis cannot offer causal conclusions as to the relation among variables, it can provide increased insight into the direction of additional study (Cohen, 2008).

The scores associated with each variable were entered in a correlation analysis using SPSS (Version 21). The variables and their associated instruments included: a) *mental illness stigma*, as measured by the MICA v.4 (Gabbidon et al., 2014); b) *multicultural counseling self-efficacy*, measured by the MCSE-RD Total Score (Sheu & Lent, 2007); c) *multicultural intervention*, measured by the MCSE-RD, MI subscale; d) *multicultural assessment*, measured by the MCSE-RD, MA subscale; e) *multicultural counseling session management*, measured by the MCSE-RD, MCSM subscale; f) *perspective taking empathy*, measured by the IRI –PT subscale of the IRI (Davis, 1980); g) *fantasy scale empathy*, measured by the IRI-FS subscale of the IRI; h) *empathetic concern empathy*, measured by the IRI-EC subscale of the IRI; h) *personal distress empathy*, measured by the IRI-PD subscale of the IRI; i) *mental health literacy*, measured by the MAKS (Evans-Lacko et al., 2010). Social desirability was included in this analysis, and was measured with the Marlowe Crowne Social Desirability Scale (Crowne & Marlowe, 1960). The MEI-R (Pope-Davis et al., 2000) was not included in this

analysis due to its exclusion as a result of a large amount of missing data. The intercorrelations of the study's primary variables and Cronbach alpha internal consistency reliability scores for each scale are presented in Table 4.

Overall, intercorrelations of the study variables ranged from $r = -.219$ to $r = .985$. Examination of the intercorrelations among study variables indicated statistically significant positive correlations between the IRI-PT subscale and the MCSE-RD Total Score ($r = .212, p < .01$) and with the three subscales of the MCSE-RD, with correlations ranging from $r = .152$ to $r = .236$. Significant negative correlations were found between the IRI-PD subscale and the MICA ($r = -.150, p < .05$). The IRI-PD subscale also negatively correlated with the MCSE-RD Total Score ($r = -.219, p < .01$), as well as with the three subscales of the MCSE-RD, with correlations that ranged from $r = -.219$ to $r = -.150$, all at the $p < .01$ level.

The MAKS correlated with the MCSE-RD Total Scale ($r = .149, p < .05$), as well as with the MCSE-RD Multicultural Session Management scale ($r = .194, p < .05$). Of the four IRI scales, the MAKS correlated only with the IRI-EC subscale ($r = .139, p < .05$). The 33-item Marlowe-Crowne Social Desirability Scale was included to determine the association, if any, of social desirability and the scores of the instruments associated with the constructs of interest. Scores of the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) correlated significantly and positively with the IRI-PT subscale ($r = .276, p < .01$) and the IRI-EC subscale ($r = .166, p < .05$), and negatively with the IRI-PD subscale ($r = -.152, p < .05$) and the MAKS ($r = -.191, p < .01$).

The correlation analysis indicated that mental illness stigma scores, measured by the MICA v.4, and multicultural counseling self-efficacy scores, measured by the MCSE-

Table 4

Intercorrelations Among Study Variables

	M	SD	α	1	2	3	4	5	6	7	8	9	10	11
1 MICA	59.17	4.67	.69	--										
2 MCSE-RD, MI	6.61	1.48	.97	.001	--									
3 MCSE-RD, MA	5.18	2.19	.92	.069	.849**	--								
4 MCSE-RD, MCSM	6.98	1.44	.92	-.036	.815**	.737**	--							
5 MCSE-RD, Total Score	6.45	1.51	.98	.013	.985**	.910**	.872**	--						
6 IRI-PT	20.47	4.05	.78	.160*	.211**	.152*	.236**	.212**	--					
7 IRI-FS	17.63	5.80	.85	.017	.017	-.031	.022	.008	.240**	--				
8 IRI-EC	21.93	3.99	.80	.129	.118	.074	.143*	.115	.528**	.404**	--			
9 IRI-PD	9.94	4.69	.81	-.150*	-.192**	-.186**	-.206**	-.219**	-.164*	.138*	.105	--		
10 MAKS	16.52	1.46	.64	.028	.127	.131	.194**	.149*	.083	.106	.139*	.011	--	
11 MCSDC	5.74	5.56	.82	.054	.053	.083	.089	.066	.276**	-.090	.166*	-.152*	-.191**	--

Note. $N = 232$. MICA = Mental Illness: Clinicians' Attitudes Scale v.4, measure of mental illness stigma; MCSE-RD, MI = Multicultural Counseling Self-Efficacy-Racial Diversity Form, Multicultural Intervention subscale; MCSE-RD, MA = Multicultural Counseling Self-Efficacy-Racial Diversity Form, Multicultural Assessment subscale; MCSE-RD, MCSM = Multicultural Counseling Self-Efficacy-Racial Diversity Form, Multicultural Counseling Session Management subscale; MCSE-RD, Total Score = Multicultural Counseling Self-Efficacy-Racial Diversity Form, Total Score; IRI-PT = Interpersonal Reactivity Index Perspective Taking empathy subscale; IRI-FS = Interpersonal Reactivity Index Fantasy Scale empathy subscale; IRI-EC = Interpersonal Reactivity Index Empathetic Concern empathy subscale; IRI-PD = Interpersonal Reactivity Index Personal Distress empathy subscale; MAKS = Mental Health Knowledge Schedule; MCSDC = Marlowe-Crowne Social Desirability Scale.

* $p < .05$, ** $p < .01$

RD, were not significantly correlated. This analysis also indicated that the perspective taking factor of empathy, measured by the IRI-PT subscale, correlated significantly and positively with mental illness stigma and multicultural counseling self-efficacy. The personal distress factor of empathy, measured by the IRI-PD subscale correlated significantly and negatively with mental illness stigma and multicultural counseling self-efficacy.

Research Question 2: Prediction of Multicultural Counseling Self-efficacy by Mental Illness Stigma

The second research question asked, *Does mental illness stigma predict multicultural counseling self-efficacy among graduate counseling trainees?* A linear regression analysis was conducted to determine the nature of mental illness stigma as a predictor of multicultural counseling self-efficacy among graduate counseling trainees (Stevens, 2009). Therefore, mental illness stigma was entered into SPSS (Version 21) as the predictor variable and multicultural counseling self-efficacy as the outcome variable. These results are displayed in Table 5.

Table 5

Summary of Simple Regression Analysis for Mental Illness Stigma Predicting Multicultural Counseling Self-Efficacy

Source	<i>R</i>	<i>R</i> ²	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>
Mental Illness Stigma	.013	.000	.004	.022	.013	.192	.848

Visual inspection of a scatter plot revealed a linear relationship between the variables. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.716, and homoscedasticity, as assessed by a visual inspection of a plot of standardized

residuals versus predicted values. Residuals were approximately normally distributed as assessed by visual inspection of a normal probability plot. Results indicated that mental illness stigma did not significantly predict multicultural counseling self-efficacy in the study sample.

Research Question 3: Empathy as a Moderator

The study's third research question asked, *To what extent is the relation between mental illness stigma and multicultural counseling self-efficacy moderated by empathy among graduate counseling trainees?* Multiple regression analysis was used to answer this research question (Frazier, Tix, & Barron, 2004). Since the IRI yields no total score for empathy, four analyses were conducted. Each model contained a dependent variable (MCSE-RD scores), an independent variable (centered MICA v.4 scores), and a moderator variable (IRI-PT, IRI-FS, IRI-EC, or IRI-PD). As recommended for moderated analyses (Aiken & West, 1991), the independent variables were centered to zero to address any multicollinearity. An interaction term was computed between mental illness stigma and each of the empathy scales (IRI-PT, IRI-FS, IRI-EC, or IRI-PD). The results of these analyses as presented in Table 6.

Perspective taking (IRI-PT). Step 1 of this analysis tested the prediction of mental illness stigma. The overall model (Model 1) indicated that there was not a significant relation between the predictor variable (mental illness stigma) and the criterion variable (multicultural counseling self-efficacy), $F(1, 217) = .009, p = .924$. The R value ($r = .006$) for this model indicated no effect size (Cohen, 2008), and the R^2 value indicated that none of the variance in multicultural counseling self-efficacy was explained by the model.

Step 2 (Model 2) tested the prediction of the two predictor variables, mental illness stigma and IRI-PT. The overall model (Model 2) indicated a significant relationship between the predictor variables and the criterion variable, $F(2,216) = 5.175$, $p = .006$. The R value ($r = .214$) for this model met the criterion for a small effect size (Cohen, 2008), and the R^2 value indicated that 4.6% of the variance in multicultural counseling self-efficacy was explained by the model. The beta weights showed that IRI-PT made a significant contribution ($\beta = .217$, $p = .002$), but mental illness stigma did not ($\beta = -.031$, $p = .643$).

Table 6

Summary of Multiple Regression Analyses with IRI Empathy Scales as Moderator Variables

Step and Model	R	R^2	B	$SE B$	B
IRI Perspective Taking (IRI-PT)					
Step 1 (Model 1)	.006	.000	.002	.022	.006
Step 2 (Model 2)	.214	.046			
MICA			-.010	.022	-.031
IRI-PT			.081	.025	.217
Step 3 (Model 3)	.239	.057			
MICA			-.005	.022	-.015
IRI-PT			.076	.025	.204
MICA x IRI-PT			.008	.005	.108
IRI Fantasy Scale (IRI-FS)					
Step 1 (Model 1)	.013	.000	.004	.022	.013
Step 2 (Model 2)	.015	.000			
MICA			.004	.022	.013
IRI-FS			.002	.018	.007
Step 3 (Model 3)	.048	.002			
MICA			.006	.022	.017
IRI-FS			.002	.018	.007
MICA x IRI-FS			.003	.004	.046

Table 6 continued

Step and Model	<i>R</i>	<i>R</i> ²	<i>B</i>	<i>SE B</i>	<i>B</i>
IRI Empathetic Concern (IRI-EC)					
Step 1 (Model 1)	.013	.000	.004	.022	.013
Step 2 (Model 2)					
MICA	.115	.013	-.001	.022	-.003
IRI-EC			.044	.026	.115
Step 3 (Model 3)					
MICA	.152	.023	.005	.022	.014
IRI-EC			.042	.026	.112
MICA x IRI-EC			.007	.005	.101
IRI Personal Distress (IRI-PD)					
Step 1 (Model 1)	.013	.000	.004	.022	.013
Step 2 (Model 2)					
MICA	.221	.049	-.007	.022	-.021
IRI-PD			-.073	.022	-.223
Step 3 (Model 3)					
MICA	.223	.050	-.007	.022	-.021
IRI-PD			-.073	.022	-.223
MICA x IRI-PD			-.002	.005	.030

Note. MICA = Mental Illness: Clinician's Attitude Scale; IRI-PT = Interpersonal Reactivity Index Perspective Taking scale; IRI-FS = Interpersonal Reactivity Index Fantasy Scale; IRI-EC = Interpersonal Reactivity Index Empathetic Concern scale; IRI-PD = Interpersonal Reactivity Index Personal Distress scale.

Step 3 (Model 3) tested whether IRI-PT moderated the relationship between mental illness stigma and multicultural counseling self-efficacy. An interaction term was created between the predictor variables mental illness stigma and IRI-PT. A significant relationship was found between the predictor variables (mental illness stigma and IRI-PT) and the moderator variable (mental illness stigma x IRI-PT), $F(3,215) = 4.334$, $p = .005$, and the R value ($r = .239$) met the criterion for a small effect size (Cohen, 2008). The R^2 value indicated that 5.7% of the variance in multicultural counseling self-efficacy was explained by this model, an increase of 1.1% ($\Delta R^2 = .011$) over the second model. The interaction term, however, did not offer a statistically significant contribution ($\beta =$

.108, $p = .110$), indicating that a moderating effect was not observed.

Fantasy scale (IRI-FS). As in the previous analysis, Step 1 (Model 1) tested the prediction of mental illness stigma, and found no significant relation between the predictor variable (mental illness stigma) and the criterion variable (multicultural counseling self-efficacy), $F(1,218) = .037, p = .848$. The R value ($r = .013$) for the model indicated no effect (Cohen, 2008), and the R^2 value indicated that none of the variance was explained by the model.

Step 2 (Model 2) tested the prediction of the two predictor variables, mental illness stigma and IRI-FS. Model 2 indicated that there was not a significant relationship between the predictor variables and the criterion variable, $F(2,217) = .023, p = .977$. The R value ($r = .015$) for this model indicated no effect (Cohen, 2008), and the R^2 showed that none of the variance in multicultural counseling self-efficacy was explained by Model 2. The beta weights indicated that neither predictor variable made a significant contribution.

Step 3 (Model 3) tested whether IRI-FS moderated the relationship between mental illness stigma and multicultural counseling self-efficacy. An interaction term was created between mental illness stigma and IRI-FS. A non-significant relationship was found between the predictor variables (mental illness stigma and IRI-FS) and the moderator variable (mental illness stigma x IRI-FS), $F(3,216) = .166, p = .919$. The R value ($r = .048$) indicated no effect (Cohen, 2008), and the R^2 value indicated that .2% of the variance in multicultural counseling self-efficacy was explained by the model. The beta weights for this model revealed that the interaction term did not offer a statistically significant contribution ($\beta = .046, p = .502$), indicating that a moderating effect was not

observed.

Empathetic concern (IRI-EC). Step 1 (Model 1) of this analysis again tested the prediction of mental illness stigma. The overall model indicated that there was not a significant relation between the predictor variable (mental illness stigma) and the criterion variable (multicultural counseling self-efficacy), $F(1,218) = .037, p = .848$. The R value ($r = .013$) indicated no effect (Cohen, 2008), and the R^2 value showed that none of the variance in multicultural counseling self-efficacy was explained by the model.

Step 2 (Model 2) tested the prediction of two predictor variables, mental illness stigma and IRI-EC. The overall model indicated a non-significant relationship between the predictor variables and the criterion variable, $F(2,217) = 1.452, p = .236$. The R value ($r = .115$) for this model met the criterion for a small effect size (Cohen, 2008), and the R^2 value indicated that 1.3% of the variance in multicultural counseling self-efficacy was explained by the model. The beta weights indicated that neither of the predictor variables made a significant contribution.

Step 3 (Model 3) of this analysis tested whether IRI-EC moderated the relationship between mental illness stigma and multicultural counseling self-efficacy. An interaction term was created between the predictor variables mental illness stigma and IRI-EC. A non-significant relationship was found between the predictor variables (mental illness stigma and IRI-EC) and the moderator variable (mental illness stigma x IRI-EC), $F(3,216) = 1.707, p = .166$. The R value ($r = .152$) met the criterion for a small effect size (Cohen, 2008), and the R^2 value showed that 2.3% of the variance in multicultural counseling self-efficacy was explained by this model. The beta weights for the model showed that none of the predictor variables made a significant contribution to

the variance explained, indicating that a moderating effect was not observed.

Personal distress (IRI-PD). Step 1 (Model 1) tested the prediction of mental illness stigma, and the overall model indicated that there was not a significant relation between the predictor variable (mental illness stigma) and the criterion variable (multicultural counseling self-efficacy), $F(1,218) = .037, p = .848$. The R value ($r = .013$) indicated no effect, and the R^2 value indicated that none of the variance in multicultural counseling self-efficacy was explained by Model 1.

Step 2 (Model 2) tested the prediction of two predictor variables, mental illness stigma and IRI-PD. The overall model (Model 2) revealed a significant relationship between the predictor variables and the criterion variable, $F(2,217) = 5.569, p = .004$. The R value ($r = .221$) for this model met the criterion for a small effect size, and the R^2 value indicated that 4.9% of the variance in multicultural counseling self-efficacy was explained by the model. The beta weights showed that IRI-PD made a significant contribution to the variance explained ($\beta = -.223, p = .001$), but mental illness stigma did not ($\beta = -.021, p = .750$).

Step 3 (Model 3) of this analysis tested whether IRI-PD moderated the relationship between mental illness stigma and multicultural counseling self-efficacy. An interaction term was created between the predictor variables mental illness stigma and IRI-PD. A significant relationship was found between the predictor variables (mental illness stigma and IRI-PD) and the moderator variable (mental illness stigma x IRI-PD), $F(2,216) = 3.768, p = .011$. The R value ($r = .223$) met the criterion for a small effect size, and the R^2 value showed that 5% of the variance in multicultural counseling self-efficacy was explained by the model, an increase of .1% ($\Delta R^2 = .001$) over the second

model. The interaction term, however, did not offer a statistically significant contribution ($\beta = .030, p = .650$), indicating that a moderating effect was not observed.

Results of the four moderated regression analyses indicated that none of the four IRI scales acted as a moderator by significantly amplifying or weakening the relation between mental illness stigma and multicultural counseling self-efficacy. Since a moderating variable indicates when or under what circumstances an association can be expected, the results of the moderated regression analyses indicated that empathy cannot be expected to significantly impact a relation between mental illness stigma and multicultural counseling self-efficacy in the current study sample. These results are displayed in Table 6.

Research Question 4: Multicultural Training Environment as Moderator

The fourth research question asked, *To what extent is the relation between mental illness stigma and multicultural counseling self-efficacy moderated by the multicultural training environment among graduate counseling trainees?* This research question was not examined, given that the MEI-R yielded a large amount of missing data, ranging from 9.1% to 37.9% among the four subscales and 42% missing data for the MEI-R Total Score.

Research Question 5: Group Differences Based on Demographic Factors and Program Affiliation

The fifth research question asked, *Are there differences in mental illness stigma scores and multicultural counseling self-efficacy scores based on select demographic factors and program affiliation among graduate counseling trainees?* The demographic variables investigated included age, sex assigned at birth, current gender

identification, ethnicity, identification with a faith tradition, specific faith tradition, and geographic region of childhood. Included in the study's demographic information were items intended to determine participants' counseling program affiliation, degree level (master's or doctoral), credit hours completed, number of practicum or internship courses completed, number of multicultural counseling courses completed in the past five years, and whether participants were certified or licensed in a mental health-related field.

Analysis of variance (ANOVA) was selected to examine this research question (Norman, 2010). An ANOVA was conducted with each of the demographic factors included in the study survey instrument to determine if mental illness stigma scores, measured with the MICA v. 4, differed significantly based on those demographic factors. Visual inspection of histograms indicated that the data were approximately normally distributed. In each case, there was homogeneity of variances, as assessed by Levene's test of homogeneity of variances. Results of the ANOVA for each demographic factor indicated that differences in mental illness stigma scores based on demographic factors in this study were not significant. The results of ANOVA for mental illness stigma are presented in Table 7.

Table 7

Analysis of Variance for Mental Illness Stigma by Demographic Variable

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Age					
Between groups	4	27.038	6.760	.306	.874
Within groups	225	4964.005	22.062		
Sex at birth					
Between groups	1	.938	.938	.043	.836
Within groups	228	4990.106	21.886		

Table 7 continued

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Current gender identity					
Between groups	2	17.667	8.834	.403	.669
Within groups	227	4973.376	21.909		
Ethnicity					
Between groups	1	20.455	20.455	.983	.334
Within groups	228	4970.588	21.801		
Race					
Between groups	6	190.712	31.785	1.473	.188
Within groups	222	4790.213	21.578		
Faith Tradition Y/N					
Between groups	1	11.071	11.071	.507	.477
Within groups	228	4979.973	21.842		
Specific faith tradition					
Between groups	12	108.604	9.050	.402	.962
Within groups	217	4882.439	22.500		
Geographic location of childhood					
Between groups	5	19.541	3.908	.176	.971
Within groups	224	4971.502	22.194		
Program affiliation					
Between groups	5	133.263	26.653	1.224	.299
Within groups	223	875.095	21.781		
Master's/Doctoral					
Between groups	1	2.007	2.007	.092	.762
Within groups	228	4989.037	21.882		
Credit hours completed					
Between groups	3	35.657	11.886	.542	.654
Within groups	226	4955.386	21.926		
Practicum/Internship courses					
Between groups	3	19.034	6.345	.288	.834
Within groups	226	4972.009	22.000		
Multicultural courses last 5 years					
Between groups	3	58.239	19.413	.889	.447
Within groups	226	4932.805	21.892		

Table 7 continued

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Licensed or certified					
Between groups	1	20.455	20.455	.938	.334
Within groups	228	4970.588	21.801		

* $p < .05$ ** $p < .01$

Analysis of variance was also performed with each of the demographic factors included in the survey instrument to determine if multicultural counseling self-efficacy scores, measured with the MCSE-RD, differed significantly based on those demographic factors. Visual inspection of histograms indicated that the data were approximately normally distributed. There was heterogeneity of variances, as assessed by Levene's test of homogeneity of variances for Race ($p = .049$), Masters or Doctoral level ($p = .001$), Credit hours completed ($p = .002$), and Number of multicultural courses completed in the past 5 years ($p = .002$). Results indicated that MCSE-RD total scores differed significantly based on the demographic factors of Race, Program Affiliation, and Masters or Doctoral level. Results for the analyses of variance performed with multicultural counseling self-efficacy as the dependent variable are presented in Table 8.

Due to the large discrepancy of the Race subgroup sizes, the researcher chose to analyze differences between the groups who identified as Black or African American ($n = 49$, 21.1%) and White ($n = 169$, 72.8%). This decision was based on the guidelines offered by the United States Department of Education (2007), which specify that in the collection and reporting of racial data, groups cannot be aggregated into fewer than 6 racial groups. Instead of aggregating groups for purposes of analysis, groups with very small numbers may be excluded (VanEenwyk, 2010). MCSE-RD total scores were lower

Table 8

Analysis of Variance for Multicultural Counseling Self-Efficacy by Demographic Variable

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Age					
Between groups	4	6.355	1.589	.697	.595
Within groups	217	494.958	2.281		
Sex at birth					
Between groups	1	3.167	3.167	1.399	.238
Within groups	220	498.146	2.264		
Current gender identity					
Between groups	2	4.787	2.393	1.056	.350
Within groups	219	496.526	2.267		
Ethnicity					
Between groups	1	2.184	2.184	.963	.328
Within groups	220	499.129	2.269		
Race					
Between groups	6	49.423	8.237	3.902	.001**
Within groups	214	451.775	2.111		
Faith Tradition Y/N					
Between groups	1	.740	.740	.325	.569
Within groups	220	500.573	2.275		
Specific faith tradition					
Between groups	12	28.986	2.415	1.069	.388
Within groups	209	472.327	2.260		
Geographic location of childhood					
Between groups	5	6.345	1.269	.554	.735
Within groups	216	494.968	2.292		
Program affiliation					
Between groups	5	52.048	10.410	5.010	.000**
Within groups	215	446.752	2.078		
Master's/Doctoral					
Between groups	1	10.667	10.667	4.783	.030*
Within groups	220	490.645	2.230		

Table 8 continued

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Credit hours completed					
Between groups	3	11.849	3.950	1.759	.156
Within groups	218	489.464	2.245		
Practicum/Internship courses					
Between groups	3	13.734	4.578	2.047	.108
Within groups	218	487.579	2.237		
Multicultural courses last 5 years					
Between groups	3	15.314	5.105	2.290	.079
Within groups	218	485.999	2.229		
Licensed or certified					
Between groups	1	4.457	4.457	1.973	.162
Within groups	220	496.856	2.258		

* $p < .05$ ** $p < .01$

for the group that identified as White ($M = 6.24$, $SD = 1.54$) than for the group that identified as Black or African American ($M = 7.03$, $SD = 1.09$). An ANOVA conducted on the scores yielded a significant difference among these two groups $F(6, 214) = 3.902$, $p = .001$.

MCSE-RD total scores also differed significantly based on Program Affiliation. Analysis of variance conducted on the scores showed a significant difference among counseling program groups, $F(5, 215) = 5.01$, $p < .005$. The results of a Tukey's post hoc test indicated that the scores of the College Student Personnel group differed significantly from the School Counseling group at a significance level of $p = .002$, and from the Counseling Psychology group at a significance level of $p < .001$. Scores for the Art Therapy, Counselor Education and Supervision, and Mental Health Counseling/Clinical Mental Health groups did not differ significantly from other groups. Degree level, or whether a participant was studying at the master's or the doctoral level, also resulted in

significant differences in multicultural counseling self-efficacy scores, $F(1,220) = 4.78$, $p = .030$, with doctoral students scoring higher than master's level students.

Research Question 6: Group Differences Based on Familiarity with Mental Illness

The final research question asked, *Are there differences in mental illness stigma scores and multicultural counseling self-efficacy scores based on individuals' reported level of familiarity with mental illnesses among graduate counseling trainees?*

Familiarity with mental illness was assessed by the analysis of "Yes" or "No" responses to three questions on the demographic questionnaire that asked participants to indicate if they have a friend who has been diagnosed with or treated for a mental illness, have a family member who has been diagnosed with or treated for a mental illness, or if they themselves have been diagnosed with or treated for a mental illness.

An ANOVA was conducted with each level of familiarity with mental illness to determine if there were differences in mental illness stigma scores, measured with the MICA v. 4, and multicultural counseling self-efficacy scores, measured with the MCSE-RD. For each analysis, data were approximately normally distributed, as evidenced by visual inspection of histograms. For each analysis, there was homogeneity of variances, as assessed by Levene's statistic. Results of the current study indicated that neither having a family member with a diagnosis of a mental illness nor having a diagnosis oneself resulted in a significant difference in scores on the MICA v.4. The results of ANOVA, however, indicated a significant difference in MICA v. 4 scores between those who reported having a friend who had been diagnosed or treated for a mental illness and those who reported not having a friend who had been diagnosed or treated $F(1,228) = 5.88$, $p = .016$. In the current study, those who reported having a friend with a mental

illness had higher scores ($M = 59.57, SD = 4.44$) than those who reported not having a friend with a mental illness ($M = 57.81, SD = 57.81$). Results of the analyses conducted with the MCSE-RD total scores, however, indicated no significant differences in multicultural counseling self-efficacy based on having a friend or family member who had been diagnosed, or with having been diagnosed oneself. The results of these analyses are presented in Table 9.

Table 9

Analysis of Variance for Mental Illness Stigma and Multicultural Counseling Self-Efficacy by Level of Familiarity with Mental Illness

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Mental Illness Stigma					
Friend with diagnosis					
Between groups	1	125.416	125.416	5.877	.016*
Within groups	228	4865.627	21.340		
Family member with diagnosis					
Between groups	1	9.151	9.151	.419	.518
Within groups	228	4981.893	21.850		
Self with diagnosis					
Between groups	1	8.319	8.319	.381	.538
Within groups	228	4982.725	21.854		
Multicultural Counseling Self-Efficacy					
Friend with diagnosis					
Between groups	1	.791	.791	.348	.556
Within groups	220	500.522	2.275		
Family member with diagnosis					
Between groups	1	2.210	2.210	.974	.325
Within groups	220	499.103	2.269		
Self with diagnosis					
Between groups	1	2.526	2.526	1.114	.292
Within groups	220	498.787	2.267		

* $p < .05$ ** $p < .01$

Summary

An unplanned factor analysis was conducted as a result of a change that occurred to the response options of the MAKS instrument, and results were reported based on the revised version of the instrument. Correlation analysis was used to examine the relationship among the study's primary variables of mental illness stigma, multicultural counseling self-efficacy, empathy, and mental health literacy. Regression analysis was used to determine the nature of the relationship between mental illness stigma and multicultural counseling self-efficacy. Multiple regression analysis was then used to investigate the effect, if any, of empathy on the relation between mental illness stigma and multicultural counseling self-efficacy. Results indicated that mental illness did not significantly predict multicultural counseling self-efficacy, and that empathy could not be expected to change the relation between the two variables. The fourth research question was not examined due to the large amount of missing data for the MEI-R instrument, and therefore the planned moderated regression associated with the research question was not conducted.

With respect to multicultural counseling self-efficacy, analyses of group differences indicated that the demographic variables of Race, Program Affiliation, and the level at which participants were studying (master's or doctoral) were associated with significant differences in multicultural counseling self-efficacy scores. Analyses of group differences indicated that the only study variable that resulted in a significant difference in mental illness stigma scores was whether participants reported having a friend who had been diagnosed with or treated for a mental illness.

Conclusion

This chapter reviewed the purpose of the study, and presented the descriptive statistics related to the participants and the instruments used in the study. In addition, the analyses used to investigate each research question were described, as were the results of those analyses. The following chapter will discuss these results within the context of the extant literature on mental illness stigma, multicultural counseling self-efficacy, mental health literacy, and empathy, and recommendations will be made regarding counseling research, training, and practice.

CHAPTER V

DISCUSSION

The purpose of the current study was to examine the extent to which mental illness stigma scores and multicultural counseling self-efficacy scores were related, and to investigate the moderating effects, if any, of empathy and the multicultural training environment on this relationship. An additional purpose was to determine differences in mental illness stigma scores and multicultural counseling self-efficacy scores, as well as differences associated with demographic factors, among trainees enrolled in selected counselor preparation programs.

Participants were recruited from four regionally accredited universities, one of which was designated as an HBCU, within a 200-mile radius of Louisville, Kentucky. The study sample included 232 master's level and doctoral level participants, who were affiliated with one of six counselor preparation programs, including Art Therapy, College Student Personnel, Counselor Education and Supervision, Counseling Psychology, Mental Health Counseling, and School Counseling. Findings of the current study will be discussed in the context of the research literature in the sections that follow, organized by the study's research questions.

Summary of Major Findings

The study's first research question asked: to what extent is there a significant relation among mental illness stigma, multicultural counseling self-efficacy, multicultural

training environment, mental health literacy, and empathy among graduate counseling trainees? The current study sought to address two primary constructs, mental illness stigma and multicultural counseling self-efficacy. These two constructs have not previously been studied jointly, although the negative expression of each has the capacity to detrimentally affect the therapeutic relationship. The investigation of the relation among the two constructs, as well as their relation to other study variables, was intended as a starting point in determining the nature of any relationship among the two primary constructs of interest. Although findings indicated a number of significant correlations, those with the highest magnitude were among the different subscales of the MCSE-RD, which corresponds to findings by the instrument's authors (Sheu & Lent, 2007). The magnitude of the relation among other study variables was small, and statistical significance could have been due to the relatively large sample size.

Mental Illness Stigma

In the current study, a relationship was not found between mental illness stigma and multicultural counseling self-efficacy. This finding also suggests that stigmatizing attitudes of graduate counseling trainees cannot be linked to levels of multicultural counseling self-efficacy in the study sample. The investigational nature of the current study raised the question of a relationship among constructs based on the theoretical foundation of RCT (Miller, 1976), namely that the human tendencies that create disconnections based on responses to otherness (e.g., mental illness, race) may act similarly in mental illness stigma and in multicultural counseling self-efficacy among graduate counseling trainees. This otherness can be seen in a sample item of the instrument used to measure mental illness stigma, the MICA v.4 (Gabbidon et al., 2014),

“people with severe mental illnesses are dangerous more often than not,” and also in an MCSE-RD (Sheu & Lent, 2007) sample item, “openly discuss cultural differences and similarities between the client and yourself.” Findings of this study indicated that, with regard to these two constructs of mental illness stigma and multicultural counseling self-efficacy, determining the nature of a relationship may depend on additional research.

This finding that mental illness stigma and mental health literacy were not related supports previous research. Nordt et al. (2006) reported similar findings, and Schulze (2007) held that mental health knowledge, including that which may be gained through counselor preparation programs, did not protect against mental illness stigma. Research has offered evidence that mental health care providers, such as counselors, while they have more positive attitudes overall toward mental illness than does the general public, tend to have stigmatizing views that center on clinical outcome expectations, such as beliefs surrounding whether an individual can and will recover (Mittal et al., 2016).

Despite presumed high levels of knowledge of mental health and illness, mental health providers are vulnerable to stigmatizing messages and to the endorsement of those messages (Stuber et al., 2014). This has implications for those who develop counselor preparation program curricula and who may expect that the increased mental health literacy that accompanies progress through a counseling preparation program will also, by default, address issues of mental illness stigma. Research continues to indicate that mental illness stigma may need to be not only the focus of more attention among counselors and counselor preparation programs, but may need to be addressed separately from mental health literacy. Given that mental illness stigma is known to be present among mental health care providers (e.g., Nemec et al., 2015) the findings of the current

study may point again to the need to assess mental illness stigma among counselors and counseling trainees separate from the assessment of mental health literacy and general counseling knowledge.

The findings of the current study indicated that mental illness stigma was related to two factors of empathy, the perspective taking factor and the personal distress factor. A sample item from the Perspective Taking (IRI-PT) subscale included, “Is sometimes find it difficult to see things from the ‘other guy’s’ point of view,” and a sample item from the Personal Distress (IRI-PD) subscale included, “I sometimes feel helpless when I am in the middle of a very emotional situation.” The IRI (Davis, 1980) does not produce a total empathy score, but rather assesses specific factors of empathy (perspective taking, fantasy, empathetic concern, and personal distress) that can be assessed and considered separately. The current study offers evidence of how Davis’ (1980) four factors of empathy may relate to study constructs differently.

In the current study’s sample of graduate counseling trainees, the perspective taking factor of empathy was found to be associated with mental illness stigma, indicating that greater perspective taking was associated with higher levels of mental illness stigma. Although this seems counterintuitive, given the emotion control associated with higher levels of perspective taking (Pulos, 2004), an explanation may lie in participants’ underlying views regarding explanations for mental illnesses, which were not directly elicited in the current study. Lebowitz and Ahn (2014) suggested in their study of clinicians’ responses to biogenic explanations for causality of mental illness that, while these explanations may increase empathic response by limiting the blame placed on an individual for their own mental illness, a corresponding reduction in mental illness

stigma was not found. Despite the reduction in blame, the categorical otherness created by biogenic explanations for mental illnesses ultimately resulted in an essentialism that led to increases in mental illness stigma (Deacon, 2013).

Findings regarding mental illness stigma and the personal distress factor of empathy are equally as counterintuitive. The literature centered on mental illness stigma has found fairly consistently that increased fear or anxiety is closely related to increases in mental illness stigma (Angermeyer et al., 2010; Corrigan, 2016; Parcesepe & Cabassa, 2013). In the current study, however, increases in personal distress, the factor of empathy associated with anxiety and emotional discomfort, were associated with lower levels of mental illness stigma.

Although the research of mental illness stigma has found that elevated anxiety and fear are associated with increased levels of mental illness stigma (e.g., Angermeyer et al., 2010; Corrigan, 2016), research of other types of stigma offers results similar to those of the current study. For example, in his study of empathy and personal distress in the context of HIV/AIDS related stigma, Olapegba (2010) found that higher levels of personal distress led to higher levels of emotional concern, which then led to lower levels of stigma. The author concluded that this association may have been due to the effects of compassion and altruism, constructs that are similar to empathy but also include an active desire to help, as detailed in the work of Batson (1991). Research of stigma of HIV/AIDS indicates that the inverse relationship found in the current study between mental illness stigma and the personal distress factor of empathy is not without precedent, and may be an area of further investigation for researchers focusing on mental illness stigma.

Findings of the current study indicated that two empathy factors, perspective taking and personal distress, were related to mental illness stigma, both in ways that seemed counterintuitive. Two other factors of empathy, fantasy and empathetic concern, were not found to be associated with mental illness stigma. While these findings leave unclear the precise nature of a generalized construct of empathy among the study variables, it does speak to the multidimensional, and perhaps unpredictable, nature of empathy that has been the source of discussion and debate throughout the 20th century and into 21st century (Duan & Hill, 1996; Elliott et al., 2011).

Overall, the findings of the current study indicated that there was some relation among empathy and mental illness stigma, although the unpredictable nature of empathy and its measurement may have had some bearing on the findings. The association of the factor of empathy associated with fear and anxiety with mental illness stigma may indicate the need for additional research into how counseling trainees' experience of fear affects their views of the clients with whom they will work. Pescosolido noted that this matters because it "sets the context in which individuals in the community respond to the onset of mental health problems, clinicians respond to individuals who come for treatment, and public policy is crafted" (Pescosolido et al., 2010, p. 1324). Given research that has indicated that mental health providers consider themselves blameless with regard to mental illness stigma (Stuart, 2012), additional research may clarify clinicians' affective responses mentioned by Pescosolido et al., (2010) that may be doing more harm than good.

Multicultural Counseling Self-Efficacy

As previously mentioned, a relationship between the study's primary constructs of

multicultural counseling self-efficacy and mental illness stigma was not found.

Multicultural counseling self-efficacy, however, was found to be related to mental health literacy. This supports previous literature (Reich, Bickman, & Heflinger, 2004) that has tested and confirmed Bandura's (1977) maxim that self-efficacy is developed through one's "knowledge and skills in dealing with the environment" (p. 203). The findings in the current study may also support the influence of a general helping skills factor, posited by the authors of the MCSE-RD, as the means by which increased practical experience with basic counseling skills, such as listening and reflected feeling, result in higher levels of self-efficacy in the multicultural counseling environment (Sheu et al., 2012).

The association of multicultural counseling self-efficacy and mental health literacy may also be the product of the awareness in counseling programs of the importance of multicultural competence, as compared to mental illness stigma, for example. Multiculturalism in counseling program curricula is ubiquitous, and culturally competent counselors are clearly the expectation of the field (CACREP, 2015; Celinska & Swazo, 2015). Awareness of the stigma of mental illness, particularly among counselors, is less visible, if present at all, a blind spot that has been recognized in the literature (Lauber et al., 2006; Smith & Cashwell, 2011). Clearly, the literature, including the current study, confirms that both constructs exist among graduate counseling trainees. How the two constructs will be addressed in counselor preparation programming will certainly depend on additional study.

Multicultural counseling self-efficacy was also found in the current study to be related to two of the four factors of empathy measured by the IRI (Davis, 1980).

Increased levels of the perspective taking factor of empathy were associated with higher

levels of multicultural counseling self-efficacy, supporting previous research that found that higher levels of perspective taking were associated with higher levels of counseling self-efficacy (Greason & Cashwell, 2009). In addition, multiculturalism has been associated with increased levels of perspective taking by Todd and Galinsky (2012), who found that exposure to multiculturalism strengthened perspective taking propensity among a sample of undergraduate college students.

The perspective taking factor of empathy, according to Davis (1983), can be described as the ability to cognitively take the perspective of another individual or group. Although multicultural counseling self-efficacy, as a construct, has not been studied exhaustively, the findings of the current study and those of others (Greason & Cashwell, 2009; Todd & Galinsky, 2012) provide initial evidence that multicultural counseling self-efficacy and the perspective taking factor of empathy may be related in a manner which, if supported by counselor preparation programs, serves to increase both.

Lower levels of multicultural counseling self-efficacy were also found in the current study to be related to higher levels of the personal distress factor of empathy. This affective quality of empathy has been associated with anxiety and discomfort in emotional social settings (Davis, 1983). More recent research has suggested that counselor anxiety, including that arising from attitudes toward racially different clients, may lead to avoidant behavior on the part of the counselor and is related to empathy levels (Burkhard & Knox, 2004). The findings of the current study may indicate that anxiety, or fear, associated with counseling racially different clients has a negative impact on multicultural counseling self-efficacy, supporting previous research by Wei et al. (2012) in their study of counselor anxiety associated with client race.

The findings of this study regarding the perspective taking and personal distress factors of empathy yielded information that has the potential to be used by counselor preparation programs in very specific ways if they were to consider a developmental order of courses. Although counselor preparation programs generally require that introductory courses be completed prior to more advanced coursework, the remediation of anxiety related to human difference, including racial differences, is not typically a clearly articulated program goal.

When Davis (1980) developed the IRI to measure the four factors of empathy, his conceptualization included a developmental element, namely that the perspective taking factor was considered to be the most highly developed empathy factor, and reflective of cognitive empathy. The personal distress factor, however, was considered by Davis to be the most primal level of empathic response to the pain of another, an affective response akin to anxiety and fear. In the current study, both factors were related to multicultural counseling self-efficacy such that higher perspective taking was associated with higher multicultural counseling self-efficacy, and higher personal distress was related to lower levels of multicultural counseling self-efficacy.

Given that the current study supported Davis' findings (1980, 1983) with results indicating higher levels of the perspective taking factor of empathy were related to lower levels the personal distress factor, it appears that a developmental approach to course presentation may be worthy of consideration. Spanierman et al. (2008) determined in their study of White counseling trainees that affective responses by trainees to clients who identified as members of racial or ethnic minorities moderated the relationship between multicultural training and multicultural knowledge. Building on Spanierman's

(2008) recommendation of integrating affective material into the curriculum, assessment of counselor trainees may need to include not only the summative assessment of student knowledge and skill development, but methods of formative assessment that would include affective responses.

The second research question asked: does mental illness stigma predict multicultural counseling self-efficacy among graduate counseling trainees? Findings indicated that mental illness stigma did not predict multicultural counseling self-efficacy in the current study, in keeping with the earlier finding that the two constructs were not significantly related. These two constructs have not been studied jointly in previous research, so understanding the nature of the relationship between the constructs will clearly depend on additional study. The current study indicates that these constructs may require separate and intentional efforts on the parts of counselor preparation programs and of counselors themselves, if both are to be addressed adequately.

Contributing to these findings may be the choice of instrumentation used to answer the research questions. Multicultural counseling self-efficacy was chosen as a construct of interest for the current study in an effort to differentiate the construct from multicultural counseling competence, a related but separate construct (Holcomb-McCoy et al., 2008). Although research of the factors that are directly related to multicultural counseling self-efficacy is limited (Barden & Greene, 2015), it has come to be considered an important piece of multicultural training that cannot be adequately or accurately measured with instruments developed to measure multicultural counseling competence (Hill, Vereen, McNeal, & Stotesbury, 2013).

The researcher's decision to assess multicultural counseling self-efficacy in the

current study was also influenced by recent research by Kugelmass (2016), who suggested that a practicing counselor's willingness to work with clients who have differences may become more exclusive once they are outside the oversight of their training programs. Given that measures of multicultural counseling competence have not been found to detect multicultural counseling self-efficacy (Barden & Greene, 2015), it would be feasible for a trainee to successfully master the knowledge and skills associated with multicultural competency, while remaining uncomfortable or unsure of their ability to work with clients who were racially different.

The study's third research question asked: to what extent is the relation between mental illness stigma and multicultural counseling self-efficacy moderated by empathy (Perspective Taking, Fantasy Scale, Empathetic Concern, and Personal Distress) among graduate counseling trainees? The study's theoretical framework of RCT (Miller, 1976) suggested that empathy could provide the means by which the relationship between mental illness stigma and multicultural counseling self-efficacy would be moderated. Findings indicated, however, that the relationship between the mental illness stigma and multicultural counseling self-efficacy was not moderated by any of the four empathy factors. These findings may indicate the need for an approach in counselor preparation programs that supports different and separate means of reducing mental illness stigma and increasing multicultural counseling self-efficacy. Although different factors of empathy were found to be related to mental illness stigma and multicultural counseling self-efficacy, this study did not provide evidence that a more general conceptualization of empathy would necessarily have a similar relationship to the constructs.

The theoretical underpinnings of RCT (Miller, 1976), however, do not exclude

other types of empathic response not directly investigated in the current study. Greene et al. (2008) found that a caring, compassionate approach by a counselor was valued by clients. In the same study, findings also indicated that continuity with the same counselor was highly valued, meaning that empathy may not independently allow for the connectedness that is at the core of RCT. Other researchers, including Batson (2007), have researched antecedents of empathy, including perceiving the other as in need, valuing the other's welfare, and compassion, all of which may exist alongside the factors of empathy described by Davis (1980). Therefore, it is feasible that affective responses that are similar to empathy may relate to mental illness stigma and multicultural counseling self-efficacy in ways different from Davis' (1980) four-factor structure of empathy.

The fourth research question asked: to what extent is the relation between mental illness stigma and multicultural counseling self-efficacy moderated by the multicultural training environment among graduate counseling trainees? This research question could not be addressed, due to the significant amount of missing data associated with the MEI-R (Pope-Davis et al., 2000). An investigation of response patterns indicated that the demographic makeup of the sample in the current study may have played a role, as many of the missing responses centered on items related to recruitment of students, faculty, and staff or clinical supervision.

The majority of the sample of graduate counseling trainees in the current study were master's level students, most of whom had completed between 1 and 18 credit hours in their counselor preparation programs. Not only might these students not have had experience in their respective departments of assisting with recruitment efforts, they also

may not have completed coursework that included supervision, such as practicum or internship courses. Research by Celinska and Swazo (2015) found that the effect of a counseling program's multicultural focus was best seen when a single multicultural counseling course was required, rather than the intentional infusion of multicultural concepts into other counseling courses. Furthermore, they determined that the single course be required of students in the initial stages of their programs, early enough to "set the diversity/multicultural compass that will shape the academic lenses from which the students see the content areas taught in other courses throughout the program" (Celinska & Swazo, 2015, p. 18).

Although the missing data may have been the result of the MEI-R (Pope-Davis et al., 2000) being a poor fit for the study's sample, it raises concern that goes beyond the impact on the methodology of the current study to that of whether it points to a blind spot with regard to the multicultural training environment. If counseling trainees in the early stages of their programs are unaware of multiculturalism in their departments to the extent that they cannot offer responses to questions about their multicultural training environment, or are not comfortable doing so, then it may be a signal that should not be cast aside or attributed to not being far enough in their programs.

Demographic group differences were addressed by the fifth research question, which asked: are there differences in mental illness stigma scores and multicultural counseling self-efficacy scores based on select demographic factors and program affiliation among graduate counseling trainees? The current study sought to determine where differences in mental illness stigma and multicultural counseling self-efficacy could be associated with select demographic factors. Although there were no significant

differences in mental illness stigma found in the current study associated with demographic differences, the study's findings indicated significant differences in multicultural counseling self-efficacy levels based on race, whether participants were studying at the master's or the doctoral level, and participants' program affiliation. This may be an indication that multicultural counseling self-efficacy is responsive to programmatic elements and to trainees' counseling knowledge base, differentiating it from mental illness stigma, which has been found to be not closely related to an individual's knowledge of mental illness or level of mental health literacy (Schulze, 2007; Stuber et al., 2014).

Findings of the current study indicated that counseling trainees who identified as Black or African American had higher multicultural counseling self-efficacy scores than those who identified as White. These findings support previous literature by Sheu and Lent (2007), who found that graduate counseling students who identified as members of a racial or ethnic minority group had higher multicultural counseling self-efficacy scores than their peers who identified as White. These findings also support research by Holcomb-McCoy et al. (2008) who found that school counseling trainees who identified as members of a racial minority group had higher levels of multicultural counseling self-efficacy than nonminority students (Holcomb-McCoy et al., 2008). Similarly, Hill et al. (2013), in their study of self-perceived multicultural competence among counseling trainees, found that race/ethnicity was the only salient factor in the study, with those trainees who identified as African American or Hispanic scoring higher than those trainees who identified as White or Asian.

Although the study's findings support previous findings related to differences in

multicultural counseling self-efficacy based on racial and ethnic minority status, this cannot be viewed as a positive with respect to the presumed efforts of counselor preparation programs to increase multiculturalism in their programs. Pope-Davis et al. (1995) suggested two decades ago that the lived experience of counselors who identify as members of a racial minority group may contribute to their higher levels of multicultural awareness and skills. Still, in the United States, counselor preparation programs continue to train a majority of students who identify as White (CACREP, 2015). Given this, if counselor preparation programs continue to maintain the gap in multicultural counseling self-efficacy that has apparently existed for some time between those who identify as members of a racial minority and those who do not, then it would seem that the effectiveness of multicultural counseling programming efforts may need to be reassessed.

In the current study, those participants who were studying at the doctoral level had higher multicultural counseling self-efficacy scores than those studying at the master's level. This finding also supports previous research by Sheu and Lent (2007), which found that doctoral level trainees had higher scores than master's level trainees. Similar findings were reported by Singh (2010), who found that hours of clinical experience completed in training programs were positively associated with higher levels of multicultural counseling self-efficacy.

Program affiliation was an additional source of significant differences in multicultural counseling self-efficacy scores found in the current study, with counseling trainees in Counselor Education and Supervision programs having the highest scores. These trainees were also doctoral-level trainees, as the Counselor Education and Supervision programs from which students were recruited enrolled only at the doctoral

level. With those students removed from consideration, the group with the highest levels of multicultural counseling self-efficacy was the group of Counseling Psychology trainees, a group also found to have the highest scores among the groups studied by Sheu and Lent (2007).

The program affiliation group with the lowest multicultural counseling self-efficacy scores in the current study was the College Student Personnel group. The placement of the Counseling Psychology and College Student Personnel groups as the program affiliation groups with the highest and lowest multicultural counseling self-efficacy scores may be a product of differential programming and curriculum, factors not specifically included in the current study. Given that a large majority of participants in the current study reported having completed 18 or fewer credit hours in their programs, differences in the chronological order of initial required courses in the various programs may have impacted multicultural counseling self-efficacy scores of the sample.

The sixth and final research question asked: are there differences in mental illness stigma scores and multicultural counseling self-efficacy scores based on individuals' reported level of familiarity with mental illnesses among graduate counseling trainees? Investigation of differences in mental illness stigma scores yielded one source of significant differences in the current study, that of whether participants reported having a friend who had been diagnosed with or treated for a mental illness. Prior research has found that the nature of an individual's relationship with an individual who has a mental illness was a significant factor determining mental illness stigma levels (Couture & Penn, 2003).

In the current study, however, those counseling trainees who reported having a

friend with a mental illness had significantly higher levels of mental illness stigma than did their peers who did not have a friend with a mental illness. This finding appears to contradict research by Bell et al. (2006) and Corrigan and Penn (2015), who found that familiarity with someone who has a mental illness, particularly familiarity in the context of an equitable relationship, such as a friendship, was associated with lower levels of mental illness stigma.

Research of the effects of varying levels of familiarity with mental illness on mental illness stigma have yielded mixed findings (e.g., Crisp et al., 2000), and more recent research with family members (van der Sanden, Bos, Stutterheim, Pryor, & Kok, 2015) suggested that the effects of relationships on mental illness stigma levels may be more complex than previously considered. Their research indicated that, although the voluntary nature of the relationship is salient to what Couture and Penn (2003) referred to as the quality of the relationship, the anticipation of being stigmatized as a family member may negatively affect the relationship with the individual who has a mental illness. For example, van der Sanden et al. (2015) found that living with a family member increases the effects of courtesy stigma, negatively impacting not only the relationship, but the psychological distress of the family member. It is conceivable that this effect may also impact relationships at the friendship level.

For counselors and counselor preparation programs that recognize the importance of assessing and reducing mental illness stigma, development of equitable relationships may present challenges. Even careful vetting of practicum and placement sites is not likely to provide trainees with the equivalent of a friendship with someone who has a mental illness, and if it did, the associated ethical dilemmas would be burdensome.

Given mental health professionals' relative lack of awareness of mental illness stigma in themselves (Stuart et al., 2012), the logical starting point would be a change in counseling program departmental culture that would allow not only the acknowledgment that mental illness and mental illness stigma exist among counselors, but also open discussion about the effects of both.

Limitations of the Study

Although the study's purposes were addressed, several limitations must be noted. Convenience sampling, used in the study, has inherent limitations, including results that limit generalization to the larger population (Cohen, Manion, & Morrison, 2011). The cross-sectional design of the study was also limiting, as this design allows a snapshot of a moment in time and cannot be used to determine causality among the study variables. Additionally, the self-report methodology used in the current study, while widely used in research of attitudes, carries with it limitations of potential bias caused by social desirability, attempts at self-preservation, and individual constraints on self-knowledge (Paulhus & Vazire, 2007).

The Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) was administered to study participants to determine if scores were influenced by social desirability. It should be noted that the Marlowe Crowne Social Desirability Scale correlated significantly with the perspective taking empathy factor, the empathetic concern factor of empathy, the personal distress factor of empathy, and the MAKS instrument (Evans-Lacko et al., 2010). This is an indication that social desirability may have influenced the scores of the affected scales, limiting validity.

In addition to limitations related to the research design, data limitations were also

present. The study sample was overwhelmingly identified as female ($n = 186$, 80.2%) and as White ($n = 169$, 72.8%), despite efforts to increase the racial diversity of the sample by recruiting participants from an HBCU. Master's-level students, comprising 85.8% ($n = 199$) of the sample, greatly outnumbered doctoral-level students, and majority of students reported being in the very early stages of their counselor preparation programs, reporting completion of 1-18 credit hours. Therefore, the findings of the current study cannot be generalized to other groups of graduate counseling trainees. Results of the analyses of group differences should be interpreted with caution, given the violations of the homogeneity of variance assumptions and the unequal sample sizes of the groups included in the analyses.

The study also had limitations with respect to instrumentation. One instrument, the MEI-R (Pope-Davis et al., 2000), yielded a large amount of missing data, which led to the decision to exclude the instrument and the associated construct of the multicultural training environment from the study's statistical analyses. The elimination of this instrument led to the exclusion of the construct multicultural training environment from the correlation analysis. Therefore the nature of the relationship of this study variable to the remaining study variables was unknown. Because of the exclusion of the MEI-R instrument and the planned analysis of its potential moderating effects on the relationship between mental illness stigma and multicultural counseling self-efficacy, the study was unable to answer research question 4, *To what extent is the relation between mental illness stigma and multicultural counseling self-efficacy moderated by the multicultural training environment among graduate counseling trainees?*

An additional limitation arose as the result of an inadvertent transcription error by

the researcher that led to the response options of the MAKS instrument being changed from those developed by the instrument's authors (Evans-Lacko et al., 2010). Although the adjusted version of the instrument yielded internal consistency value of $\alpha = .64$, which corresponds to the values reported by the instrument's authors, it is considered a low value for internal consistency, generally considered to be acceptable in the range of .70 or higher (DeVellis, 2012). In the current study the MICA v.4 also yielded an internal consistency value considered to be low at $\alpha = .69$. Consequently, findings of the current study associated with the MAKS and the MICA v.4 instruments must be interpreted with caution.

Recommendations

Although the results of the current study did not find a direct relation between mental illness stigma and multicultural counseling self-efficacy, it indicated that both of these primary constructs appeared to be separately related to different factors of empathy. The structure of the IRI (Davis, 1980), the instrument used to measure empathy, measures different factors of empathy (perspective taking, fantasy scale, empathetic concern, and personal distress) separately and does not include a total score for empathy. It is therefore feasible that the separate scales of the IRI (Davis, 1980) could be associated with separate and unrelated constructs, such as occurred in this study with this sample of graduate counseling trainees.

Recommendations for Future Research

Research on mental illness stigma among counselors remains scant. That which does exist has indicated that, among mental health care providers, the stigma associated with mental illness and the people who have those illnesses centers on very specific and

clinically-based stigmatizing attitudes or beliefs. These may include attitudes centered on recovery and outcome expectations, estimation of dangerousness, and beliefs that may be grounded in the essentialism of biogenic causes of mental illnesses (Deacon, 2013; Lebowitz & Ahn, 2014). Future study that disaggregates these clinically-based stigmatizing beliefs and addresses them in the context of the clinical environment may serve to more precisely define the sources of counselors' endorsement of stigmatizing beliefs.

Although this study found no direct relationship between mental illness stigma and multicultural counseling self-efficacy, research performed from the perspective of the person who is stigmatized indicates that those who identify as members of an ethnic or racial minority experience mental illness stigma at higher levels from mental health care providers than do their nonminority peers (Coleman et al., 2016; Lauber et al., 2006). This disparity seems reason enough to continue research into the structural and systemic frameworks that support both stigma and racism, and include, by default, the individual counselors and therapists who work in those systems. The current study offers initial evidence, however, that researchers interested in both constructs cannot assume a relationship exists between the two constructs.

With regard to empathy, future research of mental illness stigma may need to examine the role of a more general empathy factor in conjunction with or instead of the four-factor conceptualization of empathy developed by Davis (1980), which was examined in the current study. Empathy has long been considered a critical element of the therapeutic relationship, but has been difficult to precisely define and measure (Duan & Hill, 1996). Based on the findings of this study that showed an inverse relationship

between the personal distress factor of empathy and mental illness stigma, the work of researchers such as Olapegba (2010), who have investigated stigma toward those with HIV/AIDS, may hold clues as to how to proceed with the stigma of mental illness. For example, research that would include the construct of compassion or altruism, which supplements empathy with an active desire to help another person (Batson, 1991), may serve to elucidate the willingness of a counselor to actively assist clients with differences. Although research of compassion and its relation to mental illness stigma has been limited, the work of Martinez (2014) indicates that this line of inquiry has made its way into the stigma literature.

Continued research of mental illness stigma among mental health care providers such as counselors and counseling trainees may inform the development of additional instruments that measure mental stigma among these groups. Mental health care providers may express stigma in ways that vary from those of the general public, and developing additional instrumentation that targets specific stigmatizing attitudes pertinent to the clinical environment, such as recovery or outcome expectations and stability (Ahmedani, 2011; Mashiach-Eizenberg et al., 2013), may more accurately define the nature of stigma among this group. Additional to the study of mental illness stigma expressed by counselors and other mental health care providers, the study of self-stigma among mental health care providers who have been diagnosed with a mental illness is emerging in the literature (Crowe et al., 2016). Future research that continues and further develops this vein of research will undoubtedly inform not only the awareness of mental illness stigma among mental health professionals, but also the self-stigma that may keep them from seeking treatment.

Additional research is needed on some of the instruments used in the current study to provide additional estimations of reliability and validity. The MCSE-RD (Sheu & Lent, 2007), for example, has not been used extensively enough to assess its long-term usefulness as a viable alternative or addition to multicultural counseling competence measures. Similarly, the MEI-R (Pope-Davis et al., 2000), while not a new instrument, has been employed in very few studies, with the current study indicating that the measure may not be appropriate for use with graduate counseling trainees in the initial stages of their programs.

Future research also will need to consider intentional recruitment of counseling students who identify as members of racial or ethnic minorities, groups that remain underrepresented in the counseling literature. The current study sought to ameliorate this imbalance by recruiting students from counseling preparation programs at an HBCU. Continued intentional efforts by the counseling research community to include participants who identify as minorities will serve to inform not only counseling programs and their trainees, but will better prepare counselors to treat the diversity of clients who will approach them for care.

Recommendations for Counseling Programs

Graduate counselor preparation programs provide the foundational knowledge and experiences from which trainees learn skills that will allow them to engage with their clients. Among the skills encountered will be multiculturalism and the expectation that each trainee will leave their program as a multiculturally competent counselor (CACREP, 2015). The current study supported previous research indicating that studying at the doctoral level in a counselor preparation program is associated with higher levels of

multicultural counseling self-efficacy than was found in master's level trainees. The finding that those counseling trainees who identified as Black or African American had higher levels of multicultural counseling self-efficacy also supported prior research (Sheu & Lent, 2007; Singh, 2010). With a large majority of counselors in the United States identifying as White, it seems clear that counseling programs be called upon to ensure that their White American trainees not only acquire knowledge related to multiculturalism, but build the multicultural skills through experiential learning activities that will improve self-efficacy.

Examples of such activities include cultural immersion practicum or internship experiences, similar to those described by Barden et al. (2014), beginning very early in a counseling trainee's preparation program, a recommendation also put forth by Celinska and Swazo (2015). The inclusion of a mini-practicum designed specifically to address cultural difference and beginning in a trainee's initial semester of study would provide not only the expectation of cultural competence and self-efficacy from the outset, but would increase the opportunities a counseling trainee has to reflect upon and discuss issues such as intersectionality, color-blindness, and privilege. This type of experiential training would serve not only to support reduction of anxiety found to be associated with working with clients who are racially different, but would allow for the assessment of affective responses, as recommended by Spanierman et al. (2008), to be incorporated into formative assessment of trainee development.

Awareness of mental illness stigma within counselor preparation programs is not as visible as is multiculturalism, perhaps due to mental illness stigma itself. For most professors and students in a counseling department, the teaching and learning that occurs

references a target client who is “out there” at the clinic or the hospital. The personal experiences that professors and students may have with mental illness themselves or within their families remains a quiet reality, until professors such as Sawyer (2011) point out the irony. “Psychotherapy is good” she writes, “just not for us” (Sawyer, 2011, p. 776). Initial steps aimed at changing departmental culture surrounding mental illness necessarily involves open discussion. Organizations such as Active Minds (<http://www.activeminds.org>) and the National Alliance for Mental Illness (NAMI; <http://www.nami.org>) offer a number of programs that foster discussion intended to address mental illness stigma on college campuses.

Recommendations for Counseling Practice

Many practicing counselors may not have easy access to the high levels of supervision they experienced while in training. Education of other counselors, however, does not necessarily need to be a top-down only enterprise. By engaging in education efforts, such as providing workshops or seminars to a group of counselors or presenting at professional conferences, practicing counselors can increase awareness of mental illness stigma among their peers. By highlighting specifics, such as diagnostic labeling, the effects of statistical discrimination (Balsa et al., 2005), and the disparities in mental health care that align with racial and ethnic differences, counselors can educate other counselors while simultaneously advocating for marginalized clients.

World Health Organization (WHO, 2003) highlighted the criticality of mental health advocacy in its statement that the concept “was initially developed to reduce stigma and discrimination and to promote human rights of persons with mental disorders” (p. 9). For practicing counselors, however, advocating at the public or the policy level

may not come as naturally as advocating for clients at the individual level. Still, advocacy by counselors can start small. A school counselor can increase awareness of mental illness stigma and its effects in faculty meetings by inviting an individual with lived experience to share their story. A group of counselors may choose to become active in organizations such as NAMI by becoming trained presenters who visit businesses and schools specifically to discuss mental illness stigma. Counselors can also empower their clients by introducing them to the concept of advocacy as a means of helping them develop stigma resistance (Thoits, 2011).

In a community mental health clinic or private practice group, efforts that target the structural sources of disparity and stigma may begin with self-assessment, such as identifying and analyzing the population served by the clinic. Assessing demographics of race, ethnicity, insurance status, employment status, zip code of residence, and presenting symptomatology may provide valuable insight into the individuals who are being served and those who are not being served. In addition, instilling a culture of awareness with regard to how clinicians discuss their clients in formal settings, such as treatment planning meetings, and in more private and informal conversations may serve to bring increased attention to the use of person-first language, groupness, homogeneity, and overgeneralization (Ben-Zeev et al., 2010).

Mental health professionals have been found to be reluctant to seek mental health care for themselves because of mental illness stigma (Crowe et al., 2016). The normalization of help-seeking behavior among those who are recommending counseling to their clients would potentially tap into the structural sources of mental illness stigma. This normalization of help-seeking may require a culture shift among counselors, one in

which holding professional peers accountable would be viewed as a professional courtesy rather than an intrusion, and expectations of professional supervision would include recommendations to seek mental health care services if deemed necessary.

Practicing counselors are expected to be multiculturally competent (CACREP, 2015; Ratts et al., 2016), and this competence could be expanded to include the culture-bound nature of mental illness stigma. Acknowledging that internalized mental illness stigma, or self-stigma (e.g., Krajewski, 2013), for clients from different racial, ethnic, and cultural backgrounds informs how they respond to their own diagnosis has the potential to yield valuable information for counselors who seek to help individuals meet and overcome barriers to successful treatment. The possibility that a client's culture may affect their response to a mental health diagnosis may also serve to explain subsequent barriers to successful treatment, such as drop-out, reluctance to pharmacological interventions, and difficulty initiating or maintaining a therapeutic relationship.

The development of professional learning groups committed to discussing multicultural issues is one way counselors may create their own access to peer supervision. Honest self-reflection is also a critical means of identifying one's own concerns grounded in human difference. As Kugelmass (2016) found, nonconscious biases can cause or be caused by self-efficacy issues, and can lead to denial of services to individuals in need. Being able to identify one's own blind spots, and then act to correct them, serves to support not only multicultural competence, but multicultural self-efficacy, as well (Wei et al., 2012).

With regard to mental illness stigma, counseling practice offers many examples where stigmatization can and does occur. Counselors must be willing to ask themselves

and each other difficult questions about their attitudes and then monitor themselves. As counselors, we must listen to how clients talk about themselves, and ask, “Is that a reflection of *my* beliefs about this person?” In addition, and likely as a result of increased awareness of mental illness stigma, a number of professional groups, such as AMHCA (American Mental Health Counselors Association), have resources appropriate for mental health professionals, as well as for members of the general public.

Conclusion

The study presented herein sought to investigate the nature of the relation between mental health stigma and multicultural counseling self-efficacy, and their association with other constructs, including mental health literacy and empathy. Background literature and the theoretical framework afforded by RCT (Miller, 1976) provided support for the study’s research questions and the primary investigation of the presence of a relation of mental illness stigma and multicultural counseling self-efficacy among graduate counseling trainees.

Although the findings indicated a negative study, in that the constructs of mental illness stigma and multicultural counseling self-efficacy were found to be unrelated in the study sample, evidence of a relation of both of the primary constructs of interest to factors of empathy as described by Davis (1980) offered insights into the nature of mental illness stigma and multicultural counseling self-efficacy as separate constructs.

The study confirmed that mental illness stigma and multicultural counseling self-efficacy can and do exist among graduate counseling trainees as parallel constructs. With respect to the counseling field and counselor preparation programs specifically, self-reflective research has focused much more often on multiculturalism and related

constructs than on mental illness stigma. Despite literature that offers evidence of rates of mental illness stigma among mental health providers, such as counselors, that outpaces that of the general public (e.g., Lauber et al., 2006), mental illness has not yet become a primary focus of concern for counselors or for the programs that train them.

The value of the current study may not lie in the attempt to discover a previously unknown relationship among constructs, but in the investigation of constructs that occur simultaneously among mental health care providers such as counselors. Determining if and how counselor attitudes and beliefs affect the therapeutic relationship helps counselor preparation programs better prepare their trainees to be clinicians, and helps clinicians become more self-aware. The current study sought to address two primary constructs, mental illness stigma and multicultural counseling self-efficacy. Although the negative expression of both constructs has the capacity to detrimentally affect the therapeutic relationship, they have received unequal attention at the research, program, and practice levels.

Given that the two constructs appear to be unrelated among graduate counseling trainees, any likelihood that mental illness stigma may be accidentally or unintentionally addressed through programmatic efforts at increasing multicultural counseling self-efficacy among its trainees is clearly unlikely. Mental illness stigma will need to be recognized as the clinically relevant issue it is. Just as a counselor's multicultural counseling self-efficacy can strain or rupture a therapeutic relationship, so too can unacknowledged mental illness stigma on the part of a counselor. Without this attention, mental illness stigma may continue to be a blind spot for counseling trainees and practicing counselors, who tacitly consider themselves to be immune to the stigma of

mental illness.

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APPENDIX A

Appendix A

Selected Schools for Inclusion in Dissertation Study

Indiana University Southeast

School Counseling

Northern Kentucky University, Highland Heights, Kentucky

Mental Health Counseling

School Counseling

Tennessee State University (HBCU), Nashville, Tennessee

School Counseling

Counseling Psychology

University of Louisville, Louisville Kentucky

Art Therapy

College Student Personnel

Mental Health Counseling

School Counseling

Counseling Psychology

Counselor Education and Supervision

Vanderbilt University, Nashville, Tennessee

Mental Health Counseling

School Counseling

The above listed schools and programs were selected based on: (a) geographic location within 200 miles of Louisville, Kentucky, as surveys will be distributed in

person using paper-and-pencil format; (b) programs are housed at a regionally accredited college or university; (c) counselor preparation programming that includes one or more of the following: art therapy, college student personnel, counseling psychology, counselor education and supervision, mental health counseling, and school counseling.

Tennessee State University was selected due to its status as an historically Black university (HBCU) and is within the geographic target area. Research findings among counselors and counseling trainees are often limited due to the racial and ethnic makeup of samples being overwhelmingly White American. The selection of an HBCU for the current study is an attempt to remedy this limitation in the research base to the extent possible.

APPENDIX B

Appendix B

Request for Permission to Conduct Research

Department Chair
Department
University
Address

Date

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Department Chair

My name is Sarah Tucker, and I am a doctoral candidate in the Counselor Education and Supervision program at the University of Louisville. The research I wish to conduct for my doctoral dissertation will support an investigation of the relationship between the stigma of mental illness and multicultural counseling self-efficacy among graduate level counseling trainees. This project will be conducted under the supervision of Dr. Lisa Hooper, of the University of Louisville.

I am seeking your consent to contact the teaching faculty of your counseling programs to request the opportunity to administer on-site paper and pencil survey instruments to their classes. The survey administration will be a one-time event, and completion of the study protocol is expected to take no longer than 25 minutes. To reduce any burden, course instructors will not be required to assist. I will travel to each class and administer the study protocol.

I have included a copy of the student consent form and the survey instrument I will use, as well as a copy of the approval letter received by the University of Louisville's Human Subjects Protection Program (502-852-5188). If you require further information, please do not hesitate to contact me at setuck01@louisville.edu. Thank you for your time and consideration of my request.

Sincerely,

Sarah E. Tucker
Doctoral Candidate
Department of Counseling & Human Development
University of Louisville

APPENDIX C

Appendix C

Letter to Course Instructors

Course Instructor
Department
University
Address

Date

Course Instructor,

My name is Sarah Tucker, and I am a doctoral candidate in the Counselor Education and Supervision program at the University of Louisville. I have been granted permission by Dr. (appropriate program contact person) to request the opportunity to conduct survey research with your (name of class) class. The purpose of my doctoral dissertation will support an investigation of the relationship between the stigma of mental illness, multicultural counseling self-efficacy, and other related variables among graduate level counseling trainees. I hope that this research will add to the existing literature that addresses the effects of counselor attitudes on their relationships with their diverse clients. This project will be conducted under the supervision of Dr. Lisa Hooper, of the University of Louisville.

In order to gather data, I would like to visit your class one time during the 2016 fall semester to administer paper and pencil surveys to your students. Completion of the survey instrument is expected to take no longer than 25 minutes. There are no known risks to completing this survey instrument, and individual participation is voluntary. To reduce any burden to you, I will travel to each class to administer the study protocol.

If you are open to granting class time for your students to participate in this research, please respond to this email no later than (date). I have included a copy of the student consent form and the survey instrument I will use, as well as a copy of the approval letter received by the University of Louisville's Human Subjects Protection Program (502-852-5188).

Please feel free to contact me at setuck01@louisville.edu if you require further information. Thank you for your time and consideration of my request.

Sincerely,

Sarah E. Tucker
Doctoral Candidate
Department of Counseling & Human Development
University of Louisville

APPENDIX D

Appendix D

Subject Informed Consent Document

STIGMA OF MENTAL ILLNESS AND MULTICULTURAL COUNSELING SELF-EFFICACY: INVESTIGATING THE IMPLICATIONS OF THE MULTICULTURAL TRAINING ENVIRONMENT, MENTAL HEALTH LITERACY, AND EMPATHY

Investigator(s) name & address:

Sarah Tucker
200 Ridgeway Avenue
Louisville, KY 40207

Lisa Hooper, Ph.D.
Department of Counseling and Human Development
329 Woodford R. and Harriett B. Porter Building
The University of Louisville
Louisville, Kentucky 40292

Site(s) where study is to be conducted: University of Louisville and select regional colleges and universities

Phone number for subjects to call for questions: Sarah Tucker 502-836-6566

Introduction and Background Information

You are invited to participate in a research study about counselors' attitudes toward their clients. The study is being conducted by Sarah Tucker, Doctoral Candidate, and Lisa M. Hooper, Ph.D. The study is sponsored the University of Louisville, Department of Counseling and Human Development. The study will take place at selected colleges and universities. Approximately 600 subjects will be invited to participate.

Purpose

The purpose of the proposed study is to examine the extent to which different counselor attitudes are related, as well as the effects of additional select variables. A secondary purpose is to determine how these attitudes differ based on select demographic factors among students in selected counselor preparation programs, including mental health counseling, school counseling, college student and personnel, art therapy, counseling psychology, and counselor education and supervision.

Procedures

You will be asked to complete a demographic questionnaire and survey instrument related to

the study. You may skip any question you are not comfortable answering. The maximum time needed to complete the questions is estimated to be 25 minutes.

Potential Risks

There are no foreseeable risks associated with participation in this study, other than possible discomfort in answering personal questions.

Benefits

The possible benefits of this study include findings that could help develop greater understanding of how future counselors from several universities view their work and their clients. The information collected may not benefit you directly. The information learned in this study may be helpful to others.

Compensation

You will not be compensated for your time, inconvenience, or expenses while you are in this study.

Confidentiality

Total privacy cannot be guaranteed. Your privacy will be protected to the extent permitted by law. If the results from this study are published, your name will not be made public. While unlikely, the following may look at the study records:

The University of Louisville Institutional Review Board, Human Subjects Protection Program Office

Office for Human Research Protections (OHRP)

Dissertation committee members

Conflict of Interest

There are no identified conflicts of interest.

Security

Your information will be kept private by storage of the completed survey instruments in a secured area. Digital data will be kept in a password-protected computer.

Voluntary Participation

Taking part in this study is voluntary. You may choose not to take part at all. If you decide to be in this study you may stop taking part at any time. If you decide not to be in this study or if you stop taking part at any time, you will not lose any benefits for which you may qualify.

Contact Persons, Research Subject's Rights, Questions, Concerns, and Complaints

If you have any concerns or complaints about the study or the study staff, you have three options.

- You may contact the supervising investigator at lisa.hooper@louisville.edu.
- If you have any questions about your rights as a study subject, questions, concerns or complaints, you may call the Human Subjects Protection Program Office (HSPPO) (502) 852-5188. You may discuss any questions about your rights as a subject, in secret, with a member of the Institutional Review Board (IRB) or the HSPPO staff. The IRB is an independent committee composed of members of the University community, staff of the institutions, as well as lay members of the community not connected with these institutions. The IRB has reviewed this study.
- If you want to speak to a person outside the University of Louisville, you may call 1-877-852-1167. You will be given the chance to talk about any questions, concerns or complaints in secret. This is a 24-hour hot line answered by people who do not work at the University of Louisville.

Acknowledgment and Signatures

This informed consent document is not a contract. This document tells you what will happen during the study if you choose to take part. Your signature indicates that this study has been explained to you, that your questions have been answered, and that you agree to take part in the study. You are not giving up any legal rights to which you are entitled by signing this informed consent document. You will be given a copy of this consent form to keep for your records.

Subject Name (Please Print)	Signature of Participant	Date Signed
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Printed Name of Legal Representative (if applicable)	Signature of Legal Representative	Date Signed
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Relationship of Legal Representative to Subject

Printed Name of Person Explaining Consent Form	Signature of Person Explaining Consent Form (if other than the Investigator)	Date Signed
---	--	-------------

Printed Name of Investigator	Signature of Investigator	Date Signed
------------------------------	---------------------------	-------------

List of Investigators:

Contact information:

Sarah E. Tucker, M.Ed.	502-836-6566	setuck01@louisville.edu
Lisa M. Hooper, Ph.D.	502-852-5311	lisa.hooper@louisville.edu

APPENDIX E

Appendix E

List of Survey Instruments

Researcher Developed Demographic Questionnaire

Interpersonal Reactivity Index (IRI; Davis, 1980, 1996)

Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960)

Mental Health Knowledge Schedule (MAKS; Evans-Lacko et al., 2010).

Mental Illness: Clinicians' Attitudes Scale (MICA; Kassam, Glozier, Leese, Henderson,
& Thornicroft, 2010).

Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MCSE-RD; Sheu
& Lent, 2007).

Multicultural Environmental Inventory – Revised (MEI-R; Pope-Davis, Liu, Nevitt, &
Toporek, 2000).

Demographic Questionnaire

1. What is your age?

- | | |
|---|--|
| <input type="checkbox"/> 18 to 24 years | <input type="checkbox"/> 45 to 54 years |
| <input type="checkbox"/> 25 to 34 years | <input type="checkbox"/> 55 to 64 years |
| <input type="checkbox"/> 35 to 44 years | <input type="checkbox"/> Age 65 or older |

2. What sex were you assigned at birth, on your original birth certificate?

- | | |
|---------------------------------|-------------------------------|
| <input type="checkbox"/> Female | <input type="checkbox"/> Male |
|---------------------------------|-------------------------------|

3. How do you describe yourself?

- | | |
|---------------------------------|--|
| <input type="checkbox"/> Female | <input type="checkbox"/> Transgender |
| <input type="checkbox"/> Male | <input type="checkbox"/> Do not identify as female, male, or transgender |

4. Are you of Hispanic, Latino, or Spanish origin?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

5. What is your race? For purposes of this question, persons of Spanish/Hispanic/Latino origin may be of any race.

- | | |
|--|---|
| <input type="checkbox"/> American Indian and Alaska Native | <input type="checkbox"/> Native Hawaiian and Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other race |

6. Would you describe yourself as belonging to a faith tradition?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

7. If yes, please indicate your faith tradition:

- | | |
|--|--|
| <input type="checkbox"/> Christian (Baptist, Methodist, Lutheran, Presbyterian, Episcopalian, United Church of Christ) | <input type="checkbox"/> Roman Catholic |
| <input type="checkbox"/> Christian, non-denominational | <input type="checkbox"/> Jewish, Orthodox |
| <input type="checkbox"/> Protestant (Churches of Christ, Jehovah's Witness, Seventh Day Adventist) | <input type="checkbox"/> Jewish, Reform |
| <input type="checkbox"/> Pentecostal/Charismatic | <input type="checkbox"/> Muslim/Islam |
| <input type="checkbox"/> Mormon/Latter Day Saints | <input type="checkbox"/> Eastern Religions (Buddhism, Hinduism, Sikhism, Taoism) |
| | <input type="checkbox"/> Spiritual |
| | <input type="checkbox"/> Agnostic |
| | <input type="checkbox"/> Atheist |
| | <input type="checkbox"/> Other faith tradition |

8. In what region of the United States did you grow up?

- Midwest - IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI
- Northeast - CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
- Southeast - AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV
- Southwest - AZ, NM, OK, TX
- West - AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY
- If you grew up outside of the United States,
please indicate country: _____

9. In which counselor preparation program are you enrolled?

- Art Therapy
- College Counseling or College Student Personnel
- Counselor Education and Supervision
- Counseling Psychology
- Mental Health Counseling/Clinical Mental Health
- School Counseling

10. Are you currently enrolled at the master's or doctoral level?

- Master's
- Doctoral

11. How many credit hours have you completed in you current program of study?

- 1 – 18 credit hours
- 19 – 36 credit hours
- 37 – 54 credit hours
- More than 54 credit hours

12. How many practicum or internship course have you completed?

- None
- One
- Two
- More than two

13. How many graduate level multicultural courses have you completed in the last 5 years?

- None
- One
- Two
- More than two

14. Are you certified or licensed as a mental health care provider?

- Yes
- No

If yes, professional field in which you are licensed: _____.

15. Do you have any close friends who have ever received a diagnosis of a mental illness or been referred to a mental health care provider for counseling?

Yes

No

16. Has a member of your immediate family ever received a diagnosis of a mental illness or been referred to a mental health care provider for counseling?

Yes

No

17. Have you ever received a diagnosis of a mental illness or been referred to a mental health care provider for counseling?

Yes

No

Interpersonal Reactivity Index

(Davis, 1980)

1. I daydream and fantasize, with some regularity, about things that might happen to me.
2. I often have tender, concerned feelings for people less fortunate than me.
3. I sometimes find it difficult to see things from the "other guy's" point of view.
4. Sometimes I don't feel very sorry for other people when they are having problems.
5. I really get involved with the feelings of the characters in a novel.
6. In emergency situations, I feel apprehensive and ill-at-ease.
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.
8. I try to look at everybody's side of a disagreement before I make a decision.
9. When I see someone being taken advantage of I feel kind of protective towards them.
10. I sometimes feel helpless when I am in the middle of a very emotional situation.
11. I sometimes try to understand my friends better by imagining how things look from their perspective.
12. Becoming extremely involved in a good book or movie is somewhat rare for me.
13. When I see someone get hurt, I tend to remain calm.
14. Other people's misfortunes do not usually disturb me a great deal.
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.
16. After seeing a play or movie, I have felt as though I were one of the characters.

17. Being in a tense emotional situation scares me.
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.
19. I am usually pretty effective in dealing with emergencies.
20. I am often quite touched by things that I see happen.
21. I believe that there are two sides to every question and try to look at them both.
22. I would describe myself as a pretty soft-hearted person.
23. When I watch a good movie, I can very easily put myself in the place of a leading character.
24. I tend to lose control during emergencies.
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.
27. When I see someone who badly needs help in an emergency, I go to pieces.
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.

Marlowe Crowne Social Desirability Scale

(Crowne & Marlowe, 1960)

1. Before voting I thoroughly investigate the qualifications of all the candidates.
TRUE or FALSE
2. I never hesitate to go out of my way to help someone in trouble. TRUE or FALSE
3. It is sometimes hard for me to go on with my work if I am not encouraged. TRUE or FALSE
4. I have never intensely disliked anyone. TRUE or FALSE.
5. On occasion I have had doubts about my ability to succeed in life. TRUE or FALSE
6. I sometimes feel resentful when I don't get my way. TRUE or FALSE
7. I am always careful about my manner of dress. TRUE or FALSE
8. My table manners at home are as good as when I eat out at a restaurant. TRUE or FALSE
9. If I could get into a movie without paying and be sure I was not seen I would probably do it. TRUE or FALSE
10. On a few occasions I have given up doing something because I thought too little of my ability. TRUE or FALSE
11. I like to gossip at times. TRUE or FALSE
12. There have been times when I felt like rebelling against people in authority, even though I knew they were right. TRUE or FALSE
13. No matter who I'm talking to, I'm always a good listener. TRUE or FALSE
14. I can remember "playing sick" to get out of something. TRUE or FALSE
15. There have been occasions when I took advantage of someone. TRUE or FALSE

16. I am always willing to admit when I made a mistake. TRUE or FALSE
17. I always try to practice what I preach. TRUE or FALSE
18. I don't find it particularly difficult to get along with loud-mouthed, obnoxious people. TRUE or FALSE
19. I sometimes try to get even rather than forgive and forget. TRUE or FALSE
20. When I don't know something, I don't mind at all admitting it. TRUE or FALSE
21. I am always courteous, even to people who are disagreeable. TRUE or FALSE
22. At times I have really insisted on having things my own way. TRUE or FALSE
23. There have been occasions when I felt like smashing things. TRUE or FALSE
24. I would never think of letting someone else be punished for my wrongdoings
25. I never resent being asked to return a favor. TRUE or FALSE
26. I have never been irked when people expressed ideas very different from my own.
TRUE or FALSE
27. I never make a long trip without checking the safety of my car. TRUE or FALSE
28. There have been times when I was quite jealous of the good fortune of others.
TRUE or FALSE
29. I have almost never felt the urge to tell someone off. TRUE or FALSE
30. I am sometimes irritated by people who ask favors of me. TRUE or FALSE
31. I have never felt that I was punished without cause. TRUE or FALSE
32. I sometimes think when people have a misfortune they only got what they deserved.
TRUE or FALSE
33. I have never deliberately said something that hurt someone's feelings. TRUE or
FALSE

Mental Health Knowledge Schedule

(Evans-Lacko et al., 2010)

1. Most people with mental health problems want to have paid employment.
2. If a friend had a mental health problem, I know what advice to give them to get professional help.
3. Medication can be an effective treatment for people with mental health problems.
4. Psychotherapy (e.g. counseling or talking therapy) can be an effective treatment for people with mental health problems.
5. People with severe mental health problems can fully recover.
6. Most people with mental health problems go to a healthcare professional to get help.

For items 7-12, say whether you think each condition is a type of mental illness by ticking one box only.

7. Depression
8. Stress
9. Schizophrenia
10. Bipolar Disorder (Manic Depression)
11. Drug Addiction
12. Grief

Mental Illness Clinicians' Attitudes Scale V. 4

(Kassam et al., 2010)

1. I just learn about mental health when I have to, and would not bother reading additional material on it.
2. People with a severe mental illness can never recover enough to have a good quality of life.
3. Working in the mental health field is just as respectable as other fields of health and social care.
4. If I had a mental illness, I would never admit this to my friends because I would fear being treated differently.
5. People with a severe mental illness are dangerous more often than not.
6. Health/social care staff know more about the lives of people treated for a mental illness than do family members or friends.
7. If I had a mental illness, I would never admit this to my colleagues for fear of being treated differently.
8. Being a health/social care professional in the area of mental health is not like being a real health/social care professional.
9. If a senior colleague instructed me to treat people with a mental illness in a disrespectful manner, I would not follow their instructions.
10. I feel as comfortable talking to a person with a mental illness as I do talking to a person with a physical illness.
11. It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed.

12. The public does not need to be protected from people with a severe mental illness.
13. If a person with a mental illness complained of physical symptoms (such as chest pain) I would attribute it to their mental illness.
14. General practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist.
15. I would use the terms 'crazy', 'nutter', 'mad' to describe to colleagues people with a mental illness who I have seen in my work.
16. If a colleague told me they had a mental illness, I would still want to work with them.

Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form

(Sheu & Lent, 2007)

When working with a client who is racially different from yourself, how confident are you that you could do the following tasks effectively over the next week?

1. Openly discuss cultural differences and similarities between the client and yourself.
2. Address issues of cultural mistrust in ways that can improve the therapeutic relationship.
3. Help the client to articulate what she or he has learned from counseling during the termination process.
4. Where appropriate, help the client to explore racism or discrimination in relation to his or her presenting issues.
5. Keep sessions on track and focused with a client who is not familiar with the counseling process.
6. Respond effectively to the client's feelings related to termination (e.g., sadness, feeling of loss, pride, relief).
7. Encourage the client to take an active role in counseling.
8. Evaluate counseling progress in an on-going fashion.
9. Identify and integrate the client's culturally specific way of saying good-bye in the termination process.
10. Assess the client's readiness for termination.
11. Select culturally appropriate assessment tools according to the client's cultural background.
12. Interpret standardized tests (e.g., MMPI-2, Strong Interest Inventory) in ways

sensitive to cultural differences.

13. Deal with power-related disparities (i.e., counselor power versus client powerlessness) with a client who has experienced racism or discrimination.
14. Use non-standardized methods or procedures (e.g., card sort, guided fantasy) to assess the client's concerns in a culturally sensitive way.

When working with a client who is racially different from yourself, how confident are you that you could do the following tasks effectively over the next week?

15. Take into account the impact that family may have on the client in case conceptualization.
16. Assess relevant cultural factors (e.g., the client's acculturation level, racial identity, cultural values and beliefs).
17. Take into account cultural explanations of the client's presenting issues in case conceptualization.
18. Repair cross-cultural impasses that arise due to problems in the use or timing of particular skills (e.g., introduce the topic of race into therapy when the client is not ready to discuss).
19. Conduct a mental status examination in a culturally sensitive way.
20. Help the client to develop culturally appropriate ways to deal with systems (e.g., school, community) that affect him or her.
21. Manage your own anxiety due to cross-cultural impasses that arise in the session.
22. Assess culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness).
23. Help the client to set counseling goals that take into account expectations from her

or his family.

24. Help the client to identify how cultural factors (e.g., racism, acculturation, racial identity) may relate to his or her maladaptive relational patterns.
25. Manage your own racially or culturally based countertransference toward the client (e.g., over- identification with the client because of his or her race).
26. Encourage the client to express his or her negative feelings resulting from cross-cultural misunderstanding or impasses.
27. Assess the salience and meaningfulness of culture/race in the client's life.
28. Take into account multicultural constructs (e.g., acculturation, racial identity) when conceptualizing the client's presenting problems.
29. Help the client to clarify how cultural factors (e.g., racism, acculturation, racial identity) may relate to her or his maladaptive beliefs and conflicted feelings.

When working with a client who is racially different from yourself, how confident are you that you could do the following tasks effectively over the next week?

30. Respond in a therapeutic way when the client challenges your multicultural counseling competency.
31. Admit and accept responsibility when you, as the counselor, have initiated the cross-cultural impasse.
32. Help the client to develop new and more adaptive behaviors that are consistent with his or her cultural background.
33. Resolve misunderstanding with the client that stems from differences in culturally based style of communication (e.g., acquiescence versus confrontation).
34. Remain flexible and accepting in resolving cross-cultural strains or impasses.

35. Treat culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness).
36. Help the client to utilize family/community resources to reach her or his goals.
37. Deliver treatment to a client who prefers a different counseling style (i.e., directive versus non-directive).

Multicultural Environmental Inventory – Revised
(Pope-Davis et al., 2000)

1. I believe that multicultural issues are integrated into coursework.
2. The course syllabi reflect an infusion of multiculturalism.
3. There is a diversity of teaching strategies and procedures employed in the classroom (e.g. cooperative and individual achievement).
4. There are various methods used to evaluate student performance and learning (e.g., written and oral assignments).
5. Multicultural issues are considered an important component of supervision.
6. There is at least one person whose primary research interest is in multicultural issues.
7. Faculty members are doing research in multicultural issues.
8. Awareness of and responsiveness to multicultural issues is part of my overall evaluation.
9. Being multiculturally competent is valued.
10. I am encouraged to integrate multicultural issues into my courses.
11. I am encouraged to integrate multicultural issues into my work.
12. I feel comfortable with the cultural environment in class.
13. I feel my comments are valued in classes.
14. During exams, multicultural issues are reflected in the questions.
15. The environment makes me feel comfortable and valued.
16. There is a place I can go to feel safe and valued.
17. I generally feel supported.

18. When recruiting new students, I am completely honest about the climate.
19. When recruiting new faculty, I am completely honest about the climate.
20. When recruiting new staff, I am completely honest about the climate.
21. The faculty are making an effort to understand my point of view.
22. A diversity of cultural items (pictures, posters, etc.) are represented throughout my program/department.
23. All course evaluations ask how/if multicultural issues have been integrated into courses.
24. All courses and research conducted by faculty address, at least minimally, how the topic affects diverse populations.
25. I feel comfortable discussing multicultural issues in supervision.
26. There are faculty with whom I feel comfortable discussing multicultural issues and concerns.
27. There is a demonstrated commitment to recruiting minority students and faculty.

APPENDIX F

Appendix F

Permission for Instrument Use

Permission for Use: MAKS, MICA v.4

Evans-Lacko, Sara

To: sarah.tucker@louisville.edu, Thornicroft, Graham
RE: Stigma measure - student question

January 31, 2016 at 8:53 AM

Inbox - U of L

ES

Dear Sarah

Apologies for not getting back to you earlier. Many thanks for your email and for your interest in the MICA. All current details about the stigma measures and MICA (including the psychometric paper) can be found here <http://www.kcl.ac.uk/ioppn/depts/hspr/research/ciemh/cmh/CMH-Measures.aspx>.

Regarding use of the scale, we have now created an automated system for registering use of the stigma measures. This automated registration is in place of contacting us by email for permission to use the scales. If you are planning to use any of these measures in your research or anti-stigma work we would really appreciate it if you would complete the short registration questionnaire by clicking here

<https://www.surveymonkey.com/s/stigmascalesregistration> .

The registration takes about 5 minutes to complete. The data you enter will let us know how many people are using the scales we have produced, and in which contexts, as we sometimes need to report on this to our funders or as an indicator of the impact of our work. It will also enable us to contact scale users by email with updates about the scales and about possible future research. The data you enter will not be passed on to any third party. The data will be held in confidence and will be accessible only to Professor Thornicroft and his research team.

Best of luck with your research


Sara

Sara Evans-Lacko, PhD
Senior Lecturer
Health Service and Population Research Department
Institute of Psychiatry, Psychology & Neuroscience at King's College London
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De Crespigny Park
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Sara.Evans-Lacko@iop.kcl.ac.uk

<https://kclpure.kcl.ac.uk/portal/sara.evans.html>

Registration was completed online for the MAKS and the MICA v.4 using the link noted in Dr. Evans-Lacko's email.


Permission for Use: MCSE-RD

Sheu, Hung-Bin 

To: sarah.tucker@louisville.edu, Sarah E Tucker

RE: Instrument use permission request

April 11, 2016 at 12:09 AM

Inbox - U of L 

SH

Sarah,

Thanks for requesting the MCSE-RD!! Yes, you have my permission to use the MCSE-RD for your dissertation. Please see attached files and, yes, it'd be great if you can send me a copy of your findings.

Hung-Bin

Hung-Bin Sheu, Ph.D.
Assistant Professor
Department of Educational and Counseling Psychology
University at Albany, SUNY

[See More](#) from Tucker, Sarah Elizabeth



MCSE-RD-
37_Distribu...n Copy.pdf



Sheu_Lent-2007.pdf



Sheu_Rigali-Oiler_Lent-
2012.pdf

Permission for Use: MEI-R

Don Pope Davis 

To: sarah.tucker@louisville.edu Cc: Don Pope Davis
MRI-R Measure/Scoring Key

May 17, 2016 at 5:39 PM

Inbox - U of L 

DP 

Sarah.....

Please find attached to this email the MRI-R Instrument and Scoring Key. By way of this email, I am giving you permission to utilize this instrument for your research. Permission is only granted to you for your research. Please do not pass this measure on to others students/faculty/staff for their use. Please have them seek my permission.

By accepting these conditions, in the event that we update the measure, you will be required to share with me your data so that we can continue to improve the validation of the measure.

I wish you the best in your research efforts.

Don Pope-Davis, Ph.D.
Dean



MEI-R.pdf



MEI-R Scoring.pdf

CURRICULM VITA

NAME: Sarah E. Tucker

ADDRESS: 200 Ridgeway Ave.
Louisville, KY 40207

DOB: Louisville, Kentucky – February 25, 1963

EDUCATION & TRAINING:

B.A., English
Bellarmine College
1982-1986

B.S., Art
University of Louisville
1999-2003

M.Ed., Counseling and Personnel Services
University of Louisville
2009-2012

Ph.D., Counseling and Personnel Services
University of Louisville
2012-2017

AWARDS: Outstanding Research Presentation Award,
Educational and Counseling Psychology (School Counseling)
2012

Winthrop Allen Prize in Art
2003

PROFESSIONAL SOCIETIES:

American Counseling Association
American School Counselor Association
Association for Counselor Education and Supervision

PRESENTATIONS:

Cunningham, N.J., Williams, J., Williams, Y., & **Tucker, S. E.** (2012, October). *Using your power for good: Reframing bullying in middle school*. Presented at the Kentucky Counseling Association Conference, Louisville, KY.

Dewell, J., Lee, K. A., & **Tucker, S. E.** (2012, September). *Animating research in counselor education: Necessary to make the field sufficient*. Roundtable presentation at the Southern Association for Counselor Education and Supervision Conference, Savannah, GA.

Tucker, S. E., & Duncan, S. (2012, March). *The use of mindfulness in P-12 school settings*. Presented at Kentucky School Counselors Association Conference, Lexington, KY.

Tucker, S. E., & Duncan, S. (2012, October). *Mindfulness in education: Supporting change from the inside out*. Presented at the Kentucky Counseling Association Conference, Louisville, KY.