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Awareness of a mental health diagnosis and its correlation with an individual's self-esteem, self-efficacy, and subjective social status

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AWARENESS OF A MENTAL HEALTH DIAGNOSIS AND ITS CORRELATION

WITH AN INDIVIDUAL'S SELF-ESTEEM, SELF-EFFICACY, AND SUBJECTIVE

SOCIAL STATUS

BY

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THESIS

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Kierkegaard explains that, "to venture causes anxiety, but not to venture is to lose one's self . . . and to venture in the highest sense is precisely to become conscious of one's self." In thinking about my experience within this graduate program, the need to continuously venture regardless of discomfort, comes into focus as a crucial lesson. In the pursuit of my degree and in this research study, I am hugely grateful to my professors, especially Dr. Loan Phan (Chairperson), Dr. Vincent Connelly, and Dr. Elizabeth Falvey, for their facilitation in the completion of this thesis study.

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ABSTRACT

AWARENESS OF A MENTAL HEALTH DIAGNOSIS AND ITS CORRELATION WITH AN INDIVIDUAL'S SELF-ESTEEM, SELF-EFFICACY, AND SUBJECTIVE SOCIAL STATUS

by

Marisa A. Mattei

University of New Hampshire, May 2007

The need for further investigation into the influence of a mental health diagnosis on a client's self-perception is grounded in ethical, clinical, and financial concerns. This study examines the correlation between self-knowledge of a mental health diagnosis and length of time since being diagnosed, with various aspects of self-concept measured by: the *Rosenberg Self-Esteem Scale* (SES), the *General Self-Efficacy Scale* (GSE), and the *MacArthur Subjective Status Scale* (SSS). The sample in this study, drawn from a northeast land grant university student body, was controlled for the presence of physical health diagnoses and resulted in a total of 70 females (68%), 31 males (30.1%), and two who did not respond (1.9%). Spearman Rho correlation was used to determine the degree of relationship between self-knowledge of a mental health diagnosis and variables of self-esteem, self-efficacy, and subjective social status. In a sample of 103 participants, results of two research questions, (1) presence of a mental health diagnosis and (2) time since being diagnosed with a mental health disorder, indicated no significant relationship with the constructs of self-esteem, self-efficacy and subjective social status.

CHAPTER I

INTRODUCTION

How does it feel to be diagnosed with a mental health disorder? Are clients able

to recognize, understand, and articulate how being labeled with a diagnosis may change

the way they feel or think about themselves? Are the problematic symptoms they

experience possibly compounded by a sense of being separate or different from others or

are they ameliorated by the reassurance that they now understand the cause of the issue at

hand? Most clinicians would have a difficult time quantifying the extent to which clients

are affected by having knowledge of a diagnosis. However, according to the ACA ethical

standards, it is the job of the clinician to "do no harm . . . even inadvertently" (Herlihy &

Corey, 2006, p. 9). It is imperative for clinicians to understand the potentially harmful

result of communicating to a client that they have been diagnosed with a mental health

disorder.

A major goal in diagnosing individuals with a mental health disorder is to provide

clinicians with a standard and comprehensive understanding of typical thoughts,

emotions, and behaviors that may be inhibiting client functioning. The diagnosis also

provides the clinician access to a body of research that indicates "best practices" for

working with individuals who have a specific diagnosis and, although each client is

different, the research allows for a general baseline in treatment planning. However, with

a categorized way of describing and understanding their way of being, clients may begin

to think of themselves in a new light. How is it that they see themselves differently? And

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to what degree is this change? Therein lies the clinician's dilemma. How do the costs and benefits of assigning a client a clinical diagnosis weigh out? This study investigates this very question.

Rationale

Therapy involving the diagnosis of a mental health disorder is a reality of the counseling field. In a discipline herded by managed care, clinicians are required to justify treatment through the assignment of a diagnosis. Proving "medical necessity" is an essential component to receiving reimbursement for mental health services rendered. Clinicians may deal with this constraint by finding comfort in the fact that the diagnosis is simply a prerequisite to the more meaningful part of the therapeutic journey. However, in viewing the role of a diagnosis as being less important, the clinician may miss or misinterpret the true effects that diagnostic labels can have on the client's self-perception.

It is estimated that in the United States, one in ten children and adolescents suffers from mental illness severe enough to cause some level of impairment (Burns, Costello, Angold, Tweed, Stangl, Farmer, & Erkanli, 1995; Shaffer, Fisher, Dulcan, Davies, Piacentini, Schwab-Stone, Lahey, Bourdon, Jensen, Bird, Canino, & Regier, 1996). In addition, the National Institute of Mental Health estimates that about one in four adults in America suffers from a diagnosable mental health disorder in a given year (Kessler, Chui, Demler, & Walters, 2005).

Taking these statistics and applying them to a university student population of about 14,000, would indicate that between approximately 1,400 and 3,500 students on campus are diagnosable with a mental health disorder. Taking these numbers into consideration, it is evident that although the effects of a mental health diagnosis may vary

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from person to person, the presence is widespread. If it is true that we are looking at a possible phenomenon that affects about 10-25% of the population, attention to this matter is worthy of attention.

From the clinician's perspective, it is alarming to think that within the process of attempting to treat a client in a beneficial way, harm may be inherent. The question arises: what are the thoughts that may be internalized by the client in learning about a diagnosis, and what areas of self-concept tend to be influenced? In understanding the dynamic that may occur when a diagnosis is assigned, clinicians may be better prepared to work with any adverse effects at play.

If we were to look at this dilemma from managed care's point of view, we would want to know how the negative effects of diagnosis may be affecting our company's bottom line. According to the U.S. Public Health Services Surgeon General (1999), in 1996 managed care paid out over $32 billion for the diagnosis and treatment of mental health illnesses. How much clinical time (and therefore managed care money) is spent on treating issues related to social stigma or low self-concept as possible causes of a diagnosis? Does requiring clinicians to diagnose clients in reality cost managed care more money? Ethical, financial, and clinical reasons provide viable grounds for exploring this topic more in depth. The researcher has chosen three main areas of self-concept to investigate.

Statement of the Problem

This study investigates the relationship between various self-perceptions of individuals who have been diagnosed with a mental health disorder. The specific self-perceptions in focus for this study include self-esteem, self-efficacy, and subjective social

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status. In looking at these self-perceptions, it is hypothesized that being diagnosed with a mental health disorder will correlate with an individual's sense of self-esteem, sense of self-efficacy, and subjective social status. In targeting these constructs, this study will help to shed light on how a diagnosis may change the way clients feel about themselves, their ability to change what they see as problematic, and their sense of how they fit within society.

Research Questions

For the purpose of this study, the following specific research questions were investigated:

(1)   Does knowledge of a mental health diagnosis correlate with an individual's self-report of self-esteem, self-efficacy, and subjective social status?

(2)   Does length of time since becoming aware of a mental health diagnosis correlate with an individual's self-report of self-esteem, self-efficacy, and subjective social status?

Definition of Terms

Self-Esteem - Rosenberg (1989) points out that the popularity of self-esteem in psychology often causes the definition of self-esteem to be distorted or misused. In an effort to be consistent with Rosenberg's *Self-Esteem Scale*, this study will define self-esteem in terms of Rosenberg's construction of the term. "Self-esteem is a positive or negative orientation toward oneself, an overall evaluation of one's worth or value" (Rosenberg, 1989, p. 2).

Self-Efficacy – Bandura (1977) coined the term self-efficacy and defines it as "a person's conviction that one can successfully execute the behavior required to produce

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the outcomes" (p. 79). He explains that there is a difference between the idea of an outcome and one's belief in the ability to successfully obtain that outcome. As it is applied to clinical practice and behavior change, Schwarzer (1992) applies Bandura's term to include self-efficacy as facilitating goal setting, effort investment, persistence in the face of barriers, and recovery from setbacks.

Subjective Status – Social class and stratification can be defined in several ways. A construct that is determined to be significantly related to one's health is subjective status. Adler and Psychosocial Working Group (2000) explain that subjective status is a construct which captures an "individual's sense of place on the social ladder" (p. 1). Data collected on this construct conveys that individuals' perceptions of their place in the hierarchy of society and community are significantly related to both their physical and mental health (Adler, Epel, Castellazzo, & Ickovics, 2000).

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CHAPTER II

REVIEW OF THE LITERATURE

What is the history behind how and why a classification system for mental health disorders was generated in the first place, and how has that influenced the way we treat mental health clients today? This review of the literature begins with a general history of the need and early use of a classification system to diagnose individuals with a mental health disorder in the United States. It then discusses common results that have emerged due to individuals becoming aware of their diagnoses.

Due to the possibility of harm resulting from a client's knowledge of a diagnosis, research is vast in the area of labeling, and is therefore presented herein. On the other hand, research has also concluded that being diagnosed with a mental health disorder can provide a client with a greater level of needed comfort, knowledge, and support. This is often the result of increased understanding about what is causing impairment in their lives, or by providing greater access to resources that help to improve daily functioning. These competing results of the costs/benefits of a mental health classification system are therefore presented.

Self-esteem, self-efficacy, and subjective social status are the chosen constructs measured and compared in this study. Thus, relevant research from these areas of concern will be provided in order to afford the reader a greater understanding of important considerations when thinking about these specific constructs.

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The Birth of Diagnosis

The physical world is understood through the creation of intellectual constructs. It is through defining the phenomena we perceive in life that we are able to venture successfully through time, space, and interactions. "The processes of identification and classification are fundamental to the need to order the world about us. This activity of ordering, while of special importance to science, is ubiquitous" (Szasz, 1964, p. 38). Whether socially or individually created, these constructs help to give birth to rules and order in an otherwise meaningless world. Relationships, behaviors, emotions, and achievement: these are all things that need to be constructed in order to explain a mortal life.

In some cases the incongruity between a socially created construct and an individually created construct of the same phenomena can cause conflict. "Science must begin with myths, and with the criticism of myths" (Popper, 1957, p.177). When this occurs, people or institutions with greater levels of influence and persistence force a compromise.

> The game must go on: that is Nature's command. But it is up to man to determine the ground rules and the teams. The determination of the rules is principally the responsibility of the specialist in ethics. The delineation of the teams – well, that is a task for which many disciplines are needed (Hardin, 1959, p. 318).

For example, in the mental health field, mental health counselors, social workers, psychologists, and psychiatrists are given the authority to decide what is "normal" and what is "not normal." The subjectivity involved in diagnosis can cause great debate. Wakefield (1992) explains that in mental health, we look to exercise the ability to differentiate disorder from normal functioning. The mental health field attempts to define normality through creating a conceptual framework to judge it.

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Disorder lies on the boundary between the given natural world and the constructed social world; a disorder exists when the failure of a person's internal mechanisms to perform their functions as designed by nature impinges harmfully on the person's well-being as defined by social values and meanings (Wakefield, 1992, p. 373).

In the above-described situation, not only is the boundary between the natural world and the constructed world defined by clinicians, but a person's well-being is also predetermined. The way that society defines a person's well-being is therefore an established construct as well. Because the rules valued by society change over time, the perceptions of relationships, behaviors, emotions, and achievement will also change.

Consider the following case in point. Until nearly three-quarters of the twentieth century had passed in America, homosexuality was seen as a mental disorder, according to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952). However, in 1973 American psychiatrists came to the conclusion that homosexuality should no longer be regarded as a psychiatric disorder (King, 2003). As society's attitude toward homosexuals has shifted over time, so has our treatment of them in the mental health field.

Perceptions of normality not only shift over time, but they also shift across cultures. Previously labeled as a disorder, homosexuality was deleted from a list of mental illnesses in China's psychiatric association's diagnostic manual as recently as 2001 (The Associated Press, 2001). Therefore, from 1973 to 2001, if you were a homosexual in China, you would have been entitled to or required psychiatric attention, whereas if you were a homosexual in America during that time, a psychiatrist would not view your homosexuality as abnormal. Society's influence appears to be vital in this instance.

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In addition to spanning time and place, constructs differ across specific individuals. One African-American woman in the 1980s might disagree with the normalcy of homosexuality because of her religious beliefs, while another African-American woman from the 1980s marches in a gay pride parade because she believes that sexual orientation is a private matter. Each individual within a specific time and culture may have varying views on what is acceptable and what is not acceptable in his or her mind.

Values of disorder shift with time, place, and person. Is it fair to be defined by the era in which you live, the country in which you reside, or another person? Because our physical reality confines us to a certain time, place and person, we are restricted to the values that surround us.

> Neurotic phenomena are by no means the products exclusively of disease. They are in fact no more than pathological exaggerations of normal occurrences; it is only because they are exaggerations that they are more obvious than their normal counterparts...At bottom we discover nothing new and unknown in the mentally ill; rather we encounter the substratum of our own natures (Jung, 1961/1965, p. 127).

As a governing entity, the United States is slowly recognizing and implementing rules that respect variations in values according to time, place and person. As a source of social welfare and organization, the mental health field in the U.S. has historically presented its set of governing guidelines or constructs that determine normalcy, through the publication of the *Diagnostic and Statistical Manual of Mental Disorders*.

History of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

The Need for a Classification System

In the United States, the primary reason for developing a classification system for mental health disorders was to collect statistical information in the 1840 national census,

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which gathered various information regarding the citizens within the country (American Psychiatry Association, 2000). Later, the United States Army looked to formulate a broader classification system in order to better incorporate the outpatient data of World War I and II servicemen and veterans (American Psychiatry Association, 2000). For over the past fifty years, the American Psychiatric Association (APA) has worked to better serve the population by updating and revising the DSM as needed.

Classifications within the DSM become more abundant and specific with time. The numerous and varying symptoms reported by clinicians across the country cause the American Psychiatric Association to continually revise its publications to fit the social attitudes of the time and based on the most up-to-date, empirically-based evidence. The APA boasts about obtaining the input of more than 1,000 professionals from various fields in order to address the breadth of evidence and opinions that go into deciding upon a valid classification system (APA, 2000). This process involves the creation of *Work Groups* that are responsible for investigating a specific section of the DSM. These Work Groups, using a pre-established formal evidence-based process, were asked to "participate as consensus scholars and not as advocates of previously held views" (APA, 2000). Once there was an agreement about their findings, these work groups report to a DSM *Task Force* which in turn further reviews and researches the data. In addition, before the publication of the most recent version of the DSM, the Task Force publishes and widely distributes the *DSM Options Book*, which details the proposed alternatives to the new edition of DSM, in order to get feedback from interested individuals. After these concerns are evaluated and addressed, the Task Force publishes the new edition of the

DSM. It is therefore obvious that the DSM presents a classification system that is widely researched and based on empirical evidence.

Behaviorally, the DSM classification system affords a more "universal" understanding of various mental illnesses, perhaps allowing for access to more synchronized communication amongst professionals. Socially, a classification system can cause problems. When individuals are classified into certain categories, the issues of self-fulfilling prophecy, social rejection, and lowered self-concept arise. With the benefits of a classification system also come such social issues. When a person is labeled with a mental health disorder, it is understood that this label originates from both a behavioral and a social component; without either part it would not be sufficient to justify the label of a disorder (Wakefield, 1992).

A Shift in Focus

Although widely used, it is important to understand that the various versions of the DSM have received criticism by questioning its usefulness in terms of theoretical, philosophical, political, and clinical foundations (Breggin, 1994; Caplan, 1995; Faidley & Leitner, 1993; Hillman & Ventura, 1992; Kutchins & Kirk, 1997; Levy, 1992; Raskin & Epting, 1993; Sanua, 1994). Criticisms like these were what motivated the mental health field to investigate the framework beyond the DSM.

Early studies and classifications of mental disorders were often presented in the form of the medical model, in which disease "portrays neurotic behavior as unfolding relentlessly out of a defective psychological system that is entirely contained within the body" (Scheff, 1966, p. 14). The medical model gave the observer the idea that what was "abnormal" about the individual had to do with something physically based. Little

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thought was given to the possibility of impinging external factors. In general, this early

model placed the responsibility for the client's behaviors, emotions, and cognitions solely

on the client. In thinking that the medical model was most likely derived from an

analysis of the border between the natural world and socially constructed values, it is

obvious that this perspective was lacking in societal factors.

In looking at cultural factors that may play into the variation of what is

determined to be psychopathology, it becomes obvious that the dominant group's idea of

"normal" may not necessarily be appropriate when applied to individuals of a minority

group.

> There are many appalling historic examples of the misapplication of Western
> psychological theory and technique to non-White and non-male populations. In
> the worst scenarios, White, upper-class males made sweeping statements about
> what was good or bad for individuals from other cultures. Further, they made
> sweeping statements about the so-called abnormal functioning or limited
> intellectual and functional potentials of persons of color, as well as women.
> When viewed from a multicultural perspective, these judgements are clearly and
> remarkably racist (Flanagan & Flanagan, 2004, p. 403).

Before the 20th century, it was thought that the community needed to be protected

from seriously deviant people. However, by the early 20th century, attitudes regarding

mental illness began to shift. A major contributing factor to this was watching as soldiers

coming home from World War I were left with serious psychological problems.

Matthews (2006) explains that over time, it became more accepted that just about anyone

could develop mental health problems just like any other health problems. Thus

presenting impetus for the creation of the medical model.

Fast-forwarding a few decades brings us to the 1970s, which marked a time in

which the limitations of the medical model began to shine through. It became obvious

that the medical model approach was too narrow in scope to help all those who needed it.

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During this shift, the power that once lay in the hands of the hospital-based psychiatrists began to be distributed to more community-based organizations in which clients could attain help from local social service departments (Matthews, 2006). Thus, the birth of the social care model.

Just as the medical model has been criticized for its inability to address the needs of different people, so has the social care model been criticized for its focus solely on the social intervention. Looking at clients solely through a socially-focused lens provides a skewed view based primarily on the views of society. This realization spurred a flurry in the mental health field to examine yet other ways of perceiving and assisting individuals with mental health disorders.

Between the 1970s and today, the number of approaches to viewing and treating clients has been vast. However, in order to provide a taste of the more current trend, a few approaches are presented. Matthews (2006) presents the idea of a more holistic approach, taking into account aspects of several models that have come and gone over time. Matthews suggests a four-part *Holistic Care Model* that includes physical health, intellectual health, emotional health, and social health. Some researchers also suggest the importance of integrating aspects of sexual health and spiritual health. This is a stance that many theorists have adopted over time. It is evident that by looking at several different areas of the client's life a counselor may be provided with a more complete and thus accurate indication of appropriate treatment goals.

Another area of research in the mental health field has concentrated on investigating ways other than focusing on a client's perceived negative symptoms in order to facilitate health and happiness. Foltz reports that using a *Strength-Based*

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Approach with pathologized youth rather than a medical model can facilitate more rapid and long-term change.

> Indeed, for decades, millions of dollars have been spent on researching the complexities of the brain and mental illness. Even if these troubling symptoms can be eliminated or suppressed, it is incorrect to conclude that an absence of symptoms is equivalent to mental health....if troubled youth can be embraced by positive, productive relationships, they can indeed become more resilient to future success (Foltz, 2006, p. 92).

In addition, *Recovery* is a concept that has recently been adopted by much of the mental health field as an effective focus of therapy for clients with chronic mental illness. Swarbrick (2006) describes recovery in her *Wellness Approach* as,

> . . . a deeply personal, unique process of (re)gaining physical, spiritual, mental, and emotional balance when one encounters illness, crisis, or trauma. As a process, the individual learns to accept the illness, crisis, or trauma and its associated challenges while adjusting attitudes, beliefs, and sometimes both life roles and goals (p. 311).

Therefore, the emphasis of this approach is on the individual's unique experience. Recovery means different things for different people. A small step for one person could be seen as a major goal by another. The *Wellness Approach* promotes balance as being a key ingredient to holistic health. Swarbrick (2006) reports that a balanced lifestyle includes the following dimensions: physical, emotional, intellectual, social, environmental, and spiritual. The idea here is that we are able to conceptualize not only one's "deficits," but we are also able to understand the positive things that keep the individual living and moving ahead.

Presented above are a few approaches that have been created in response to finding the diagnosis process, using the DSM and the medical model, insufficient. Although each of these approaches provides valid arguments for doing so, it is important

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to recognize ways in which the American Psychiatric Association has attempted to address these concerns.

The most recent version of the DSM, the DSM-IV-TR, uses a five-axis approach which looks at: Axis I – Clinical Disorders, Axis II – Personality Disorder/Mental Retardation, Axis III – General Medical Conditions, Axis IV – Psychosocial and Environmental Problems, and Axis V – Global Assessment of Functioning. In comparing some of the previously described alternative approaches to looking at mental illness to the DSM, similarities and differences arise.

Similarities between the DSM and the more holistic or strength-based models seem to lie in Axis III and Axis IV. The DSM Axis III provides a space for considering medical conditions that may contribute to the understanding or management of the client's mental illness which is similar to Matthews' idea of integrating and understanding the client's "physical health" as an aspect of the holistic pattern of care. Similarly, the DSM Axis IV looks at social and environmental concerns with factors that seem to resemble the "social health" aspect of the holistic pattern of care.

It is important to see, however, that in addition to similarities, a large gap between the DSM model and the holistic or strength-based model remains. This break seems to span the difference between the medical model's focus on an individual's deficits and symptoms compared to strength-based, holistic, or wellness approaches which emphasize an individual's strengths or individualized goals. It is in this division wherein lies the clinician's dilemma.

Ethically, it is important to use the DSM because it is grounded in a highly empirically-based bed of research and provides a baseline for communication between

professionals and managed care. However, from some points of view there seems to be concern in the DSM's ability to conceptualize the entire individual, including the positive aspects of him/her. How do these varying points of view play out in the clinical arena?

Real-Life Stories

In order to provide a closer and more intimate look at how self-knowledge of a mental health diagnosis may influence a client, the following excerpts from client stories were gathered and are presented below.

The Self

According to Jung (1961), the self is the place that exists between one's consciousness and unconsciousness and its emergence is signaled by the archetypal symbols that indicate wholeness, and completeness. The following brief excerpts provided by individuals who were diagnosed with a mental health disorder indicate a common theme of having a changed concept of self.

> At least initially, however, a diagnosis of mental illness may seem to encompass all aspects of one's self. Indeed, receiving such a diagnosis in a transformational event – one of those rare pivotal experiences that seem to demarcate life into 'before' and 'after.' The seismic plates have shifted irrevocably, defining a new internal and external landscape (Marsh, 2000, p. 1448).

> Once hospitalized, you are marked with a diagnosis and that label becomes an indelible tattoo burned into your sense of self. You may successfully hide your experiences from others, but you will always have to deal with that shadow (Bassman, 2000, p. 1449).

> We struggle constantly with our raging fears and the brutality of our thoughts, and then we are subjected as well to the misunderstanding, distrust, and ongoing stigma we experience from the community (Leete, 1997, p. 1449).

Developmental Disruptions

Another area of concern reported by individuals diagnosed with a mental health disorder is the influence on one's development. Lefrancois (1996) reports that most areas

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of development are related to each other, including social development, motor

development, emotional development, and intellectual development. Disruptions in this

development, depending upon the level of intensity of the disruption, can cause delays in

one's development.

> The tasks of adolescence and early adulthood include forging a sense of personal
> identity; achieving separation and independence from one's family of origin;
> coming to terms with sexuality, intimacy, long-term commitment, and perhaps
> parenthood; and developing and implementing educational and career plans.
> When mental illness erupts, all of these tasks may be disrupted – sometimes
> permanently (Marsh, 2000, p. 1450).

Recovery

The ability to comprehend the diagnosis of a mental health diagnosis, internalize

the implications of it, and come to an understanding of how to cope with it a way that

facilitates a meaningful way of life for the individual are essential components of one's

recovery from a mental health disorder (Swarbrick, 2006). The process of recovery is

described by diagnosed individuals in the following quotes.

> One's sense of self becomes altered, damaged, or even destroyed as a result of
> mental illness. Therefore, an important aspect of recovery is the quest for the
> newly defined, coherent, and stable sense of self (Young & Ensing, 1999, p. 220).

> Recovery is a deeply personal and unique process of changing one's attitudes,
> values, self-concept, and goals. It is finding ways to live a hopeful, satisfying,
> active, and contributing life (Walsh, 1999, p. 58).

Locus of Control

Locus of control refers to one's belief regarding the degree of influence one has

on his/her experience, where an individual with an internal locus of control believes that

achieving goals and/or avoiding punishment is within his/her control, whereas an

individual with an external locus of control expects his/her experience to be out of the

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realm of influence (Ewen, 2003). In exploring the relationship between locus of control and the presence of a mental health diagnosis, the following quotes are expressed by individuals at the juncture of these variables. "My recovery process began two years ago when I took responsibility for me" (Young & Ensing, 1999, p. 225). "I learned that both the power and the possibility of change reside within me" (Walsh, 1999, p. 57). "I don't let my illness control me – I control my illness" (Young & Ensing, 1999, p. 224).

> Ineffably, psychotherapy heals. It makes some sense of the confusion, reins in the terrifying thoughts and feelings, returns some control and hope and possibility of learning from it all...Psychotherapy is a sanctuary; it is a battleground; it is a place I have been psychotic, neurotic, elated, confused, and despairing beyond belief. But always, it is where I have believed – or have learned to believe – that I might someday be able to contend with all of this (Jamison, 1995, p. 89).

Research on the Effects of a Mental Health Diagnosis

In addition to the personal accounts presented above, it is important to take a look at the research results that have been found regarding the influence of a diagnosis. As seen in the above examples, knowledge of a mental health diagnosis can compound the mental state of the individual to now include added issues related to stigma, disruptions in development, and locus of control. Starting in the 1960s some individuals began to conceptualize the negative effects of a mental health diagnosis. One of those individuals is Thomas Scheff, known for the presentation of *Labeling Theory* in 1966.

In Labeling Theory, Scheff looks to validate the external factors involved in one's struggle. He explains the importance of looking at two basic roles in the theory: one, that identifies the social role of mental illness, and two, that society's reaction to the mentally ill is the most important determinant of that role (Scheff, 1966).

In conducting his research, Scheff found common trends among individuals with long-term mental disorders. For example, he found that individuals who are diagnosed

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with a mental disorder tend to internalize the cultural stereotypes of mental illness, which in turn causes internalized stress. The way in which individuals react to this internalized stress is often seen as deviant.

> . . . When the deviance of an individual becomes a public issue, the traditional stereotype of insanity becomes the guiding imagery for action, both for those reacting to the deviant and, at times, for the deviant himself. When societal agents and persons around the deviant react uniformly in terms of traditional stereotypes of insanity, his amorphous and unstructured rule-breaking tends to crystallize in conformity to these expectations, thus becoming similar to the behavior of other deviants classified as mentally ill, and stable over time (Scheff, 1966, p. 82).

In more recent years, labeling theory has been criticized for directly linking the emergence of mental disorders to societal reaction (e.g., Gove, 1970, 1980, 1982; Lehman, Joy, & Simmens, 1976; Weinstein, 1983). In addition, critics minimize the value of the social factors Scheff proposes, such as stereotyping and stigma (Gove, 1982). However, Link, Struening, Cullen, Shrout, and Dohrenwend (1989) present a *Modified Labeling Theory* that looks to address the issues criticized in Scheff's original labeling theory (see Figures 1 and 2).

Link et al. (1989) explain that in the typical process of development, individuals are often socialized to attach negative conceptions of what it means to have a mental health diagnosis and therefore develop beliefs about how others will view and then regard someone in that status. Consequently, when individuals are labeled with a mental health disorder, they are likely to confront the socialized negative view and then utilize coping orientations such as secrecy or withdrawal in order to deal with the internalized conceptions.

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Figure 1A

Scheff's Labeling Approach

Societal conceptions of the mentally ill		Labeled		Response based on society constrain labeled person to adopt role of "mentally ill person"

Fig. 1A: Diagramatic Representation of Scheff's Labeling Model and the Modified Labeling Approach (Link, Cullen, Struening, Shrout, Dohrenwend, 1989, p. 402)

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Figure 1B

Modified Labeling Approach

| *Step 1* | *Step 2* | *Step 3* | *Step 4* | *Step 5* |

Societal conceptions of a mental patient; perceptions of devaluation-discrimination

Labeled: Societal conceptions relevant to self.

Not Labeled: Societal conceptions irrelevant to self.

Labeled individual's response – (eg., secrecy).

No consequences. Labeling – Negative effects attributable to psycho-pathological factors unrelated to labeling.

Negative consequences for self-esteem, earning power or social network ties.

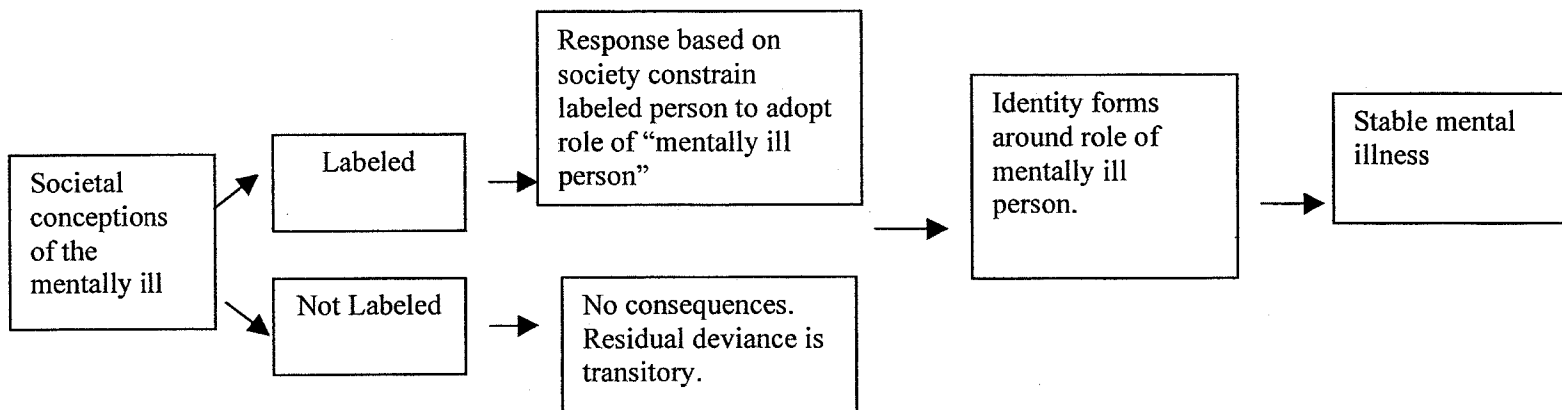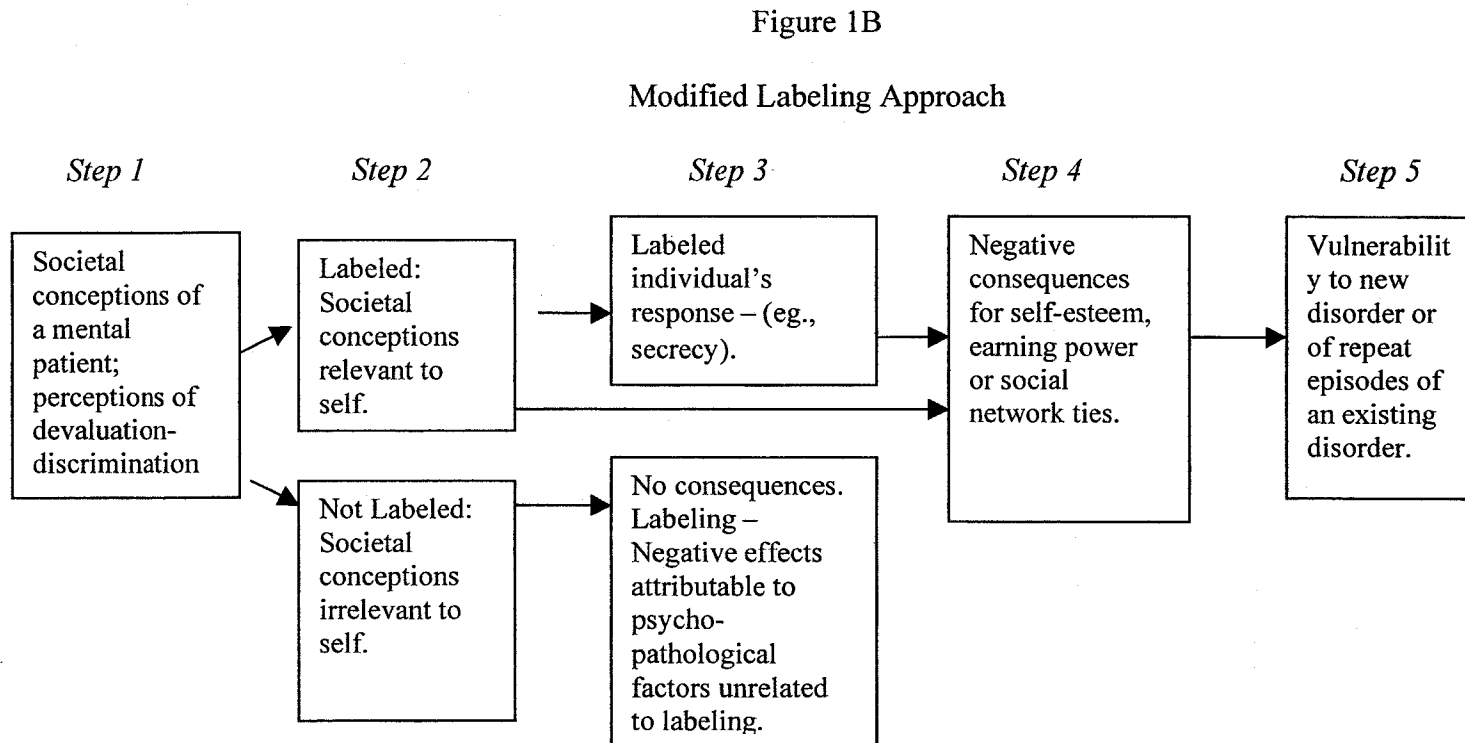Vulnerability to new disorder or of repeat episodes of an existing disorder.

Fig. 1B: Diagramatic Representation of Scheff's Labeling Model and the Modified Labeling Approach (Link, Cullen, Struening, Shrout, Dohrenwend, 1989, p. 402)

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In addition to the impact on a client's social connectedness, Link et al. also expand on Scheff's original labeling theory by suggesting that they had "identified a set of theoretically relevant attitudes—beliefs about how most people will treat mental patients—that turned out to be consistently but not uniformly negative" (1989, p. 420). In general, modified labeling theory sets out to deepen the understanding of mental disorders within the social context.

Benefits/Harm of Labeling

Due to the fact that diagnosing a disorder can be seen as somewhat of a subjective process, it is important, therefore, to look at its effects. By looking at the benefits and shortcomings of diagnosing a mental health disorder, we are better able to care for the clients who go to professionals for help. Additionally, when professionals are well informed about a certain course of action, they are then able to make better decisions about how to further research in the field.

Rosenfield (1997) attempts to link the labeling of a mental disorder with the benefits of increased ability to attain services. This study indicates that there is a significant positive relationship between received services and quality of life.

Angermeyer and Matschinger (2005) found that when the diagnosis of a mental disorder became known, "labeling had a positive effect on public attitudes insofar as it was associated with a decrease of the tendency to attribute the responsibility for the occurrence of the disorder to the afflicted person" (p. 391). Therefore, it has been found that individuals tend to remove the blame from the client for having socially unacceptable behaviors once they become aware that the client is diagnosed with a mental disorder. The diagnosis seems to give reason for acceptability of the behavior.

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Although becoming aware of a client's diagnosis may allow for a buffer of leniency with the established social norms, it has also been seen as a cause for social distance between society and mental health clients (Angermeyer & Matschinger, 2005). Though it is merely speculation, Angermeyer and Matschinger suggest that this finding may have to do with "the expectation that people with mental illness will be constantly in need for help and may sooner or later become a burden that is hard to deal with . . ." (2005, p. 394).

Link (1987) suggests that assigning a label to individuals may cause demoralizing effects and thus promote the very behavior for which a person is then discarded. It is found to be a continuing cycle in which the client exhibits behaviors for a given reason (psychological, biological, or social) and is then perceived and treated in a way that tends to promote the primary behavior.

Adams, Robertson, Gray-Ray, and Ray (2003) present the idea of *deviant self-concept* in their study of labeling and delinquency. The study indicates that educators and peers are frequent sources of negative labels which often lead to an individual taking on a deviant self-concept. In general, it is thought that ". . . during real or imagined interactions, individuals project themselves into the role of significant others and make assessments or self-appraisals" (Cooley, 1902; Shibutani, 1961; Bem, 1972, cited in Adams, Robertson, Gray-Ray, & Ray, 2003, p. 173). Adams et al. (2003) looked at this idea and found that the individual's self becomes an object for which he/she attaches labels, positive or negative, and is guided by the idea that humans have the ability to choose among competing labels for their self-conceptions. Furthermore, research indicates that labels inferring an emotional disturbance in the client tend to connote a

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more negative perception of him/her, than a label that does not infer emotional

disturbance (Stinnett, Bull, Koonce, & Aldridge, 1999).

<u>Influence on Self-Esteem</u>

Rosenberg (1989) defines self-esteem as "a positive or negative orientation

toward oneself, an overall evaluation of one's worth or value" (p. 2). Historically, self-

esteem has been seen as a relatively constant trait throughout one's lifespan. However, as

researchers report, an individual's sense of self-esteem appears to fluctuate considerably

in certain situations, and even in general (Greenier, Kernis & Waschull, 1995).

In looking at the purpose of an individual's self-esteem, Mruk (2006) explains

that individuals are thought to need self-esteem because it upholds the self and a sense of

self-sameness over time. In looking at the function of self-esteem, two separate studies

one initiated by Coopersmith (1967) and the other by Newman and Newman (1987),

indicated that self-esteem acts as a protector that defends the self against abuse from the

environment and safeguarding the integrity of the self during stressful times. In addition

to this idea of maintaining the self, others suggest that self-esteem is a motivating force

that encourages us to expand the self (Deci & Ryan, 1995; Kernis, 1995; Rogers, 1961;

Ryan & Deci, 2003, 2004). Mruk (2006) further explains that this type of motivation,

". . . Pushes the individual to face challenges rather than avoid them, keeps the person

plugging away at an obstacle instead of giving up, and encourages them to take risks to

'be all one can be' rather than to shy from such possibilities in life (pp. 34-35).

In addition to the idea that self-esteem can be a motivating force, it can also be

seen both as a dependent and an independent variable. Those who have found self-esteem

to be a dependent variable report that when variables such as academic achievement

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increase, self-esteem increases as well (Baumeister, Campbell, Krueger, & Vohs, 2003). Whereas those who see self-esteem as playing a causal role report that when increasing self-esteem, other variables such as academic achievement will increase as a result. The interesting aspect is that it seems as though self-esteem can work in both ways, dependent and independent (Harter, 1999). It is a quintessential example of "the chicken or the egg" contemplation. In addition to presenting the relevancy of the self-esteem research, a review of the research looking at how self-esteem and the diagnosis of a mental health disorder are linked in necessary.

Thompson and McKenzie (2005) examined the effects of diagnosis of a learning disability. Results show that when comparing learning disabled individuals who had been diagnosed with a learning disability and those who had not, self-esteem scores of individuals who had been diagnosed with a learning disability were likely to be lower.

Researchers suggest that possessing a sense of mastery and self-esteem are fundamental goals that seem to protect and enhance the self, and contribute to a feeling of overall well-being (Pearlin, Lieberman, Menaghan, & Mullen, 1981).

Hoza, Dobbs, Owens, Pelham, and Pillow (2002) conducted a study in which the presence of false-positives was a relevant topic. The study contained two groups of school-age boys: those who had been diagnosed with ADHD and those who had not. The purpose of the study was aimed at comparing group differences in self-concept. Findings of this study showed that the boys with ADHD presented positive illusory self-concept. Interestingly enough, the researchers found that it was in the areas that the boys were most deficient that the scores were most inflated. Another study with school-aged boys and girls, conducted two years later by Hoza and colleagues expanded on the

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aforementioned research (2004). Results of this study replicated the previous findings by showing inflated self-perceptions of competence in areas rated much lower by teachers, parents, or friends (Hoza et al., 2004). In looking at these findings, it is proposed that inflated self-perceptions may serve as a self-protective role for individuals with ADHD (Diener & Milich, 1997), allowing them to cope on a daily basis despite their disruptive behaviors.

Influence on Self-Efficacy

As explained previously, self-efficacy is defined as, "a person's conviction that one can successfully execute the behavior required to produce the outcomes" (Bandura, 1977, p. 79). The concept of self-efficacy as it relates to an individual who has been diagnosed with a mental health disorder is important to investigate, because in order for clients to work successfully with their deemed diagnosis, a certain level of belief in their ability to change must exist.

In looking at one's level of self-efficacy, it may first be important to look at how human beings respond to negative stimuli in general. At the most basic level, this brings us to the "fight or flight" response in humans when confronted with an observed threat. Beginning in the mid-1960s, researchers began to identify two distinct reactions to negative stimuli. These were termed *helpless* and *mastery-oriented* patterns (Diener & Dweck, 1978, 1980; Dweck, 1975; Dweck & Reppucci, 1973). When observing individuals who display the helpless pattern, a few commonalties surfaced (Dweck, 2000). First, within the helpless pattern of response, individuals quickly doubted their intelligence and began to lose confidence in their ability to perform. Secondly, any success that was achieved prior to the negative event was disregarded and seems to have

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little bearing on one's ability to complete the task in the future. Thirdly, individuals in this pattern of response tend to exaggerate the negative aspects involved and minimize the positives. In essence, failure is a more salient feature for them. Fourthly, individuals in this pattern tend to disengage from the current activity, often expressing boredom or discontent. Lastly, there are large drops in performance following a negative episode.

The other side of the dichotomy contains the mastery-oriented pattern. This pattern is characterized by several common traits as well (Dweck, 2000). First, when faced with a negative stimuli, individuals in this pattern tend to recognize the difficulty as simply a problem to be addressed and the focus turns to how they can improve their performance in the future. Secondly, most individuals using this pattern engage in some form of self-instruction or self-monitoring in order to aid their performance. Thirdly, these individuals remain confident that they will succeed, often giving optimistic predictions. Fourthly, these individuals seem to embrace the challenge involved in overcoming the negative stimuli. And lastly, individuals using this pattern or response either maintain or improve their performance through applying adjusted strategies for approaching the problem.

The identification and investigation of these differing ways of responding are helpful when looking at the level of one's self-efficacy. Bandura (1977) defined self-efficacy as, "the conviction that one can successfully execute the behavior required to produce the outcomes" (p. 79). In his quest to provide greater understanding of the behavioral aspects of therapy, Bandura (1997) was an advocate *of corrective learning experiences*. As Bandura explains,

> The strength of people's convictions in their own effectiveness determines whether they will even try to cope with difficult situations. People fear and avoid threatening situations they believe themselves unable to handle, whereas they behave affirmatively when they judge themselves capable of handling successfully situations that would otherwise intimidate them (p. 80).

Influence on Subjective Social Status

As explained previously, subjective social status is defined as a construct which quantifies an "individual's sense of place on the social ladder" (Adler & Psychosocial Working Group, 2000, p. 1). In other words, subjective social status is aimed at capturing the "common sense of social status across the SES indicators" (Adler & Psychosocial Working Group, 2000, p. 1). Therefore, it is thought that one's place in society is not solely determined by indicators such as income or education, but it is also influenced by individuals' perceptions of where they fit into society. It is thought that this influence, one's subjective social status, is strongly correlated with one's physical and mental health (Adler, Epel, Castellazzo, & Ickavics, 2000; Jackman & Jackman, 1973; Goodman, Adler, Kawachi, Frazier, Huang, & Colditz, 2001; Ostrove, Adler, Kuppermann, & Washington, 2000; Singh-Manoux, Adler, & Marmot, 2003).

Because that subjective status has been linked to one's physical or mental health, it is hypothesized that when an individual is informed that he/she has a mental health disorder, this causes a shift in subjective social status. In order to examine clients' perceptions of subjective social status, this study will investigate the possible correlation between being diagnosed with a mental health disorder and one's view of his/her place in society.

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Summary

A review of the literature indicates a mixed review of the costs/benefits of a mental health diagnosis. It is evident that both sides of the issue provide strong arguments indicating how assigning a diagnosis or conversely not assigning a diagnosis can be most helpful to the client.

In addition to the arguments for and against labeling, it is evident that there is little data in the field that actually quantify the influence of diagnosis on the constructs of self-esteem, self-efficacy, and subjective social status. These three constructs are crucial aspects of self-concept that help individuals navigate through adversity, and are often explored in therapy as means to improving one's resiliency. It is, therefore, the focus of this current study to quantify the relationship between knowledge of a mental health diagnosis and one's self-report of self-esteem, self-efficacy, and subjective social status.

CHAPTER III

METHODS

This chapter will provide information regarding this study's research design,

subjects surveyed, assessments used, and procedures followed. These methods are used

to examine the following research questions:

(1)   Does knowledge of a mental health diagnosis correlate with an individual's self-

report of self-esteem, self-efficacy, and subjective social status?

(1=2) Does length of time since becoming aware of a mental health diagnosis correlate

with an individual's self-report of self-esteem, self-efficacy, and subjective social

status?

Research Design

The quantitative design used correlational statistics to investigate whether or not

knowledge of a mental health diagnosis is associated with an individual's sense of self-

esteem, self-efficacy, and subjective social status.

Participants

In acquiring participants for the study, a sample of college students was surveyed.

The researcher set up a designated table within a busy building on a participating college

campus from which voluntary participants were recruited. Confidentiality and the

recruitment of subjects were carried out in compliance with the guidelines of the

University's Institutional Review Board for the Protection of Human Subjects in

Research (IRB). Approval of this study was determined by the IRB through communication of the approval letter (see Appendix A).

Assessments

Data collected for use in this study was derived from students at a northeast land grant university. Demographic information, including age, gender, and race, was collected. In addition, participants were asked if they had been formally diagnosed with a mental or physical health disorder, which disorder, and how long it had been since they were diagnosed.

In looking at the correlations related to knowledge of one's diagnosis, this study used three instruments to quantify the relationships.

Rosenberg's Self-Esteem Scale (SES) (1989)

The first instrument used measures the participant's level of self-esteem. *Rosenberg's Self-Esteem Scale (SES)* (1989) is a 10-item self-report survey in which participants rate their perception of themselves on a Likert scale that ranges from "strongly agree" to "strongly disagree." In scoring this instrument, values were assigned to each question's response, according to the instrument's instructions, and a sum score was obtained. Possible scores from this instrument range from 0-30, with 30 indicating the highest possible score. There are no established score cut-offs to indicate high and low self-esteem.

The original sample for which Rosenberg's scale was created in the 1960s consisted of 5,024 high school juniors and seniors from ten randomly selected schools in the state of New York (Rosenberg, 1965, 1989). The instrument demonstrates generally high reliability with test-retest correlations typically in the range of .82 to .88, and

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Cronbach's alpha for various samples in the range of .77 to .88 (Blascovich & Tomaka, 1993; Rosenberg, 1986).

<u>Generalized Self-Efficacy Scale (GSE) (1995)</u>

The second instrument in this study looks at the participants' level of self-efficacy. Schwarzer and Jerusalem's *Generalized Self-Efficacy Scale (GSE)* (1995) is a ten-item self-report survey in which participants rate their beliefs of their abilities on a Likert scale that ranges from "Not At All True" to "Exactly True." In scoring this instrument, values were assigned to each question's response, according to the instrument's instructions, and a sum score were obtained.

Schwarzer and Jerusalem (1995) reported samples from 23 nations and over 1,000 different studies providing reliability with Cronbach's alphas ranging from .76 to .90 and a majority in the high 0.80s (Jerusalem & Schwarzer, 1992; Schwarzer, 1992; Schwarzer & Jerusalem, 1995; Zhang & Schwarzer, 1995; Babler & Schwarzer, 1996; Schwarzer & Fuchs, 1996; Schwarzer, Jerusalem, Romek, 1996; Schwarzer, Babler, Kwiatek, Schroeder, & Zhang, 1997; Schwarzer, Born, Iwawaki, Lee, Saito, & Yue, 1997; Schwarzer, Mueller, & Greenglass, 1999; Rimm & Jerusalem, 1999; Schwarzer & Scholz, 2000; Scholz, Gutierrez-Dona, Sud, & Schwarzer, 2001; Scholz, Gutierrez-Dona, Sud, & Schwarzer, 2002; Luszczynska, Gutierrez-Dona, & Schwarzer, 2004). The authors report that the original sample for which the scale was created includes the general adult population and adolescents. In addition, the authors reported that criterion-related validity is documented in numerous correlation studies where positive coefficients were found with favorable emotions, dispositional optimism and work satisfaction.

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Negative coefficients were found with depression, anxiety, stress, burnout, and health complaints (Scholtz, Guttierrez-Dona, Sud, & Schwarzer, 2002).

Jerusalem and Schwarzer (1995) indicated that there is no established cut-off to determine a high or low score on this instrument. However, they suggest that researchers could use a median split in order to dichotomize the sample results.

MacArthur Subjective Status Scale (SSS) (2000)

The third and final instrument used in this study measures a participant's subjective social status. In this study, the researcher has adapted the *MacArthur Subjective Status Scale (SSS)* into a three-part instrument. In general, the three segments ask participants to: (1) rate their *current* subjective social status, (2) rate their *anticipated* subjective social status ten years from now, and lastly to (3) rate the *degree* to which they believe their mental health diagnosis will impact their ability to meet their *anticipated* subjective social status.

Subjective social status is visually represented by way of a 10-rung ladder. Each of the two ladders, pertaining to the first and second questions identified above are scored 1-10, with "1" being the lowest rung or the lowest social status, and "10" being the highest rung or the highest social status. The author reports there being no cut-offs for high or low scores. However, analyses were done in this study to compare groups based on demographic information. The third segment of the measure, which was created by the researcher in order to quantify the extent to which a mental health diagnosis might influence individuals' ability to achieve their anticipated status, asks participants to rate their answer on a Likert scale of "Not At All," to "Significantly."

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Studies using the SSS report correlation coefficients of .73 and .79 with a sample of 10,843 adolescents (Goodman, Adler, Kawachi, Frazier, Huang, & Colditz, 2001), and Cronbach's alpha of .70 to .93 with a sample of 157 healthy white adult women (Adler, Epel, Castallazzo, & Ickovics, 2000).

Procedure

In order to administer the above-described instruments, the investigator was stationed at a designated table in a busy building on the participating college campus with the intent to solicit subjects for participation. Subjects interested in participating were instructed to read, sign, and pass in the consent form (see Appendix B). Willing subjects were then provided with a brief instruction sheet (see Appendix C) and directed to a quiet place to complete the survey (see Appendix D). Upon completion of the survey, subjects were provided with a debriefing sheet (see Appendix E) that offered additional information regarding the study as well as indicating investigator contact information. In addition, participants were asked to fill out a separate ticket indicating contact information in order to be entered into a raffle for a $50 gift certificate. The drawing for this gift certificate occurred on February 15, 2007. The winning participant was notified and mailed the $50 gift certificate.

Assumptions

Self-Reporting Validity

The survey data collated and used in this study was constructed on the assumption that the people participating in the study are doing so under their own will. It is further assumed that they provided honest and accurate reflections of their experience and views.

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<u>Knowledge of Diagnosis</u>

In order to report having a mental health diagnosis or not, it is assumed that individuals had knowledge of their diagnosis and reported accordingly on the survey used in this study. If they have been diagnosed with a mental health disorder but are unaware of the diagnosis, it would be difficult to determine how they are resultingly influenced by it.

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CHAPTER IV

ANALYSIS OF THE DATA

This chapter presents a description of the data and findings produced from

statistical analysis that examined two research questions:

(1)   Does knowledge of a mental health diagnosis correlate with an individual's self-

report of self-esteem, self-efficacy, and subjective social status?

(2)   Does length of time since becoming aware of a mental health diagnosis correlate

with an individual's self-report of self-esteem, self-efficacy, and subjective social

status?

Findings

Rosenberg's Self-Esteem Scale (SES) (Rosenberg, 1989), the *Generalized Self-*

Efficacy Scale (GSE) (Schwarzer & Jerusalem, 1995), and the *MacArthur Subjective*

Status Scale (SSS) (Adler & Working Group, 2000) were administered to 123

participants—78 females (63.4%), 41 males (33.3%), and 4 who did not respond (3.3%).

After being controlled for individuals who indicated having a physical health diagnosis,

results included a smaller sample of 103 participants, 70 females (68.0%), 31 males

(30.1%), and 2 who did not respond (1.9%). One-hundred-twenty-two out of 123

participants completed all three instruments, while one participant failed to complete one

of the instruments and therefore was dropped from the final analysis of that particular

instrument. Demographic information, including gender, age, and race, were examined

before analyzing the final data for correct data entry and missing observations.

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Both correlations in this study were analyzed by Spearman rho correlation for the interval data within the *Rosenberg's Self-Esteem Scale (SES)* (Rosenberg, 1989), the *Generalized Self-Efficacy Scale (GSE)* (Schwarzer & Jerusalem, 1995), and the *MacArthur Subjective Status Scale (SSS)* (Adler & Working Group, 2000). The Statistical Program for the Social Sciences (SPSS) was used to conduct all statistical analyses (SPSS, 2002).

Descriptive Statistics

Thirty-three participants reported having knowledge of being diagnosed with a mental health disorder (26.8%), while ninety participants reported no knowledge of being diagnosed with a mental health disorder (73.2%). Twenty participants reported having knowledge of being diagnosed with a physical health disorder (16.3%), while one hundred three participants report no knowledge of being diagnosed with a physical health disorder (83.7%). Table 1 presents a crosstabulation of the interplay between mental health diagnosis and physical health diagnosis.

Table 1

Crosstabulation - Mental and Physical Health Diagnosis

| | | Physical Health Diagnosis | | |
		Yes	No	Total
Mental Health Diagnosis	Yes	6	27	33
	No	14	73	90
	Total	20	103	123

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In order to control for the presence of a physical health diagnosis, the twenty participants who indicated having a physical health diagnosis were eliminated from the analysis of the data, resulting in a final total of 103 participants. Consequently, all data presented in proposed findings, unless otherwise indicated, are representative of a sample that has been controlled for the presence of a physical health diagnosis.

In regard to demographic variables, Tables 2, 3, and 4 present frequencies of age groupings, gender groupings, and race groupings.

Table 2

Frequencies of Age Groupings

Age Grouping	Frequency	Percent
18-25	87	84.5
26-35	9	8.7
36-45	5	4.9
46-55	1	1.0
56+	1	1.0
Total	103	100.0

With respect to the variable of age, 84.5% of participants reported being within the 18-25 age grouping, 8.7% were within the 26-35 age grouping, 4.9% within the 36-45 age grouping, 1.0% within the 46-55 age grouping, and lastly, 1% within the 56+ age grouping.

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Table 3

Frequencies of Gender Groupings

Gender	Frequency	Percent
Female	70	68.0
Male	31	30.1
Did Not Respond	2	1.9
Total	103	100.0

In looking at the variable of gender, 68.0% of participants reported being female, 30.1% of participants reported being male, and 1.9% of participants did not respond.

Table 4

Frequencies of Race Groupings

Race	Frequency	Percent
Euro-American/Caucasian	96	93.2
Asian American or Pacific Islander	4	3.9
Biracial or Multiracial	3	2.9
African American or Black	0	0.0
Native American/American Indian	0	0.0
Latino or Hispanic	0	0.0
Total	103	100.0

With respect to the variable of race groupings, 93.2% of participants reported being Euro-American/Caucasian, 3.9% of participants reported being Asian American or Pacific Islander, and 2.9% of participants reported being biracial or multiracial.

In addition to demographic information, participants were polled on their self-knowledge of a mental health diagnosis. Twenty-seven participants (26.2%) reported having been diagnosed with a mental health disorder in their lives, while 76 participants (73.8%) reported no awareness of being diagnosed with a mental health disorder. Tables 5, 6, and 7 present a crosstabulation of results when looking at the presence of a mental health diagnosis in conjunction with the demographic variables of age grouping, gender, and race grouping.

Table 5

Crosstabulation – Age Groupings and Mental Health Diagnosis

		Age Grouping					
		18-25	26-35	36-45	46-55	56+	Total
Mental Health Diagnosis	**Yes**	23	2	1	1	0	27
	No	64	7	4	0	1	76
	Total	87	9	5	1	1	103

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Table 6

Crosstabulation – Gender Groupings and Mental Health Diagnosis

| | | Gender | | | |
		Female	Male	Did Not Respond	Total
Mental Health Diagnosis	**Yes**	18	8	1	27
	No	52	23	1	76
	Total	70	31	2	103

Table 7

Crosstabulation – Race Groupings and Mental Health Diagnosis

| | | Race | | | |
		Euro-American/ Caucasian	Asian American or Pacific Islander	Biracial or Multiracial	Total
Mental Health Diagnosis	**Yes**	26	1	0	27
	No	70	3	3	76
	Total	96	4	3	103

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Statistical Analyses

<u>Spearman Rho Correlation</u>

Spearman rho correlation was chosen to investigate both research questions. As a nonparametric test, the Spearman rho "does not make any assumptions regarding the parameters of the population" (Sprinthall, 1982, p. 417). Since the sample was small and did not meet the "assumptions underlying parametric tests" (Salkind, 2004, p. 269), the Spearman rho was selected as the statistical analysis of choice for this study.

<u>Results of Research Questions</u>

Research Question One - Does knowledge of a mental health diagnosis correlate with an individual's self-report of self-esteem, self-efficacy, and subjective social status?

To investigate the relationship between knowledge of a mental health diagnosis and self-esteem, self-efficacy, and subjective social status, a Spearman rho correlation was conducted. The research hypothesis stated that there would be a significant relationship between knowledge of a mental health diagnosis and an individual's self-report of self-esteem, self-efficacy, and subjective social status. For the sample (N = 103) in this study, the Spearman rho statistical analysis revealed no significant relationship (see Table 8).

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Table 8

Spearman Rho Correlation for Research Question One

	MH Diag.	SES Score	GSE Score	Current SSS	Ant. SSS	Diag. Impact on Ant. SSS
MH Diag.	1.000					
SES Score	.139	1.000				
GSE Score	.174	.139	1.000			
Current SSS	.131	.069	.487**	1.000		
Ant. SSS	.014	.071	.366**	.508**	1.000	
Diag. Impact on Ant. SSS	.	.009	-.519**	-.182	-.076	1.000

** Correlation is significant at the 0.01 level (2-tailed).

Research Question Two - Does length of time since becoming aware of a mental health diagnosis correlate with an individual's self-report of self-esteem, self-efficacy, and subjective social status?

To investigate the relationship between length of time since becoming aware of a mental health diagnosis and an individual's self-report of their sense of self-esteem, self-efficacy, and subjective social status, a Spearman rho correlation was conducted. The research hypothesis stated that there would be a significant relationship between length of time since becoming aware of a mental health diagnosis and an individual's self-report of self-esteem, self-efficacy, and subjective social status. For this sample (N = 27), the Spearman rho statistical analysis revealed no significant relationship (see Table 9).

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Table 9

Spearman Rho Correlation for Research Question Two

	Time Elapse of MH Diag.	SES Score	GSE Score	Current SSS	Ant. SSS	Diag. Impact on Ant. SSS
Time Elapse of MH Diag.	1.000					
SES Score	243	1.000				
GSE Score	.212	.186	1.000			
Current SSS	-.054	.069	487**	1.000		
Ant. SSS	-.061	.071	.366**	508**	1.000	
Diag. Impact on Ant. SSS	.048	.009	-.519**	-.182	-.076	1.000

** Correlation is significant at the 0.01 level (2-tailed).

Additional Findings

Further examination of the intercorrelations among the three instruments used to measure self-esteem, self-efficacy, and subjective social status, shed some light on several significant relationships. For this sample, a significant relationship was found between self-efficacy and current subjective social status, $r(103) = .487, p < .01$, self-efficacy and anticipated subjective social status, $r(103) = .366, p < .01$, self-efficacy and impact of diagnosis on anticipated subjective social status, $r(27) = -.519, p < .01$, and current subjective social status and anticipated subjective social status $r(103) = .508, p < .01$ (see Tables 8-10).

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In addition, further investigation was made into the demographic variable of gender. For this sample, a significant relationship was found between gender and current subjective social status, $r(103) = .225$, $p < .05$, and gender and self-efficacy, $r(103) = .226$, $p < .05$ (see Table 10).

Table 10

Spearman Rho Correlation for Additional Findings

	Gender.	SES Score	GSE Score	Current SSS	Ant. SSS	Diag. Impact on Ant. SSS
Gender	1.000					
SES Score	-.071	1.000				
GSE Score	.266*	.186	1.000			
Current SSS	.225*	.069	487**	1.000		
Ant. SSS	-.021	.071	.366**	508**	1.000	
Diag. Impact on Ant. SSS	-.084	.009	-.519**	-.182	-.076	1.000

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

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CHAPTER IV

DISCUSSION

Summary and Conclusions

Sampling

In polling participants for self-knowledge of a mental health diagnosis, the study provides data regarding the prevalence of a mental health diagnosis of those surveyed for this study. In this study, 26.2% of the 103 participants surveyed indicated that they had been diagnosed with a mental health disorder. This statistic is very close to the prevalence reported by the National Institute of Mental Health, which estimates about one in four adults in America as suffering from a diagnosable mental health disorder in a given year (Kessler, Chui, Demler, & Walters, 2005).

Summary Findings for Research Question One

Research Question One - Does knowledge of a mental health diagnosis correlate with an individual's self-report of self-esteem, self-efficacy, and subjective social status?

The first research question explored the degree to which knowledge of a mental health diagnosis correlates with an individual's self-report of self-esteem, self-efficacy, and subjective social status. Based upon the results, the correlation of these identified variables indicated no significant relationships.

There are several possible explanations for this finding. Firstly, the sample was severated from a population of college students. This being said, it is generally thought that individuals who have been accepted into college have a sufficient level of self-

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esteem, self-efficacy, and subjective social status to persevere through the challenges presented by college admission standards. This, in turn, may indicate that those who have been accepted into college may have adapted or been taught methods of managing the symptoms that go along with a mental health disorder prior to entering college. If this is the case, it may also be possible that these individuals consequently see themselves as functioning well and therefore have a more elevated level of self-esteem, self-efficacy, and/or subjective social status than an individual who has not been accepted in to college.

Secondly, the results may be an indication of a similar finding to that of a study conducted by Hoza et al. (2004) that showed inflated self-perceptions of competence in children diagnosed with ADHD in areas rated much lower by teachers, parents, or friends (2004). Diener and Milich (1997), propose that these inflated self-perceptions may serve as a self-protective role for individuals with ADHD, allowing them to cope on a daily basis despite their disruptive behaviors. In applying this same logic to the current study, one might find that individuals diagnosed with a mental health disorder may, in some way, inflate their level of self-esteem, self-efficacy, or subjective social status as a means of protecting the self.

Thirdly, because the current study did not survey participants to describe their level of exposure to counseling services, it is unknown whether these individuals found aid in sharing their experience of being diagnosed and processing that with a professional. If it is the case that many of these college students have already gone through therapy in order to work on negative repercussions of being diagnosed with a mental health disorder, the results would therefore be skewed.

Lastly, the lack of significance in the results to this research question may be a result of a small sample size of individuals diagnosed with a mental health disorder (N = 27). It is thought that by gathering a larger number of participants, the significance of the relationship may become apparent.

<u>Summary Findings for Research Question Two</u>

Research Question Two – Does length of time since becoming aware of a mental health diagnosis correlate with an individual's self-report of self-esteem, self-efficacy, and subjective social status?

The second research question explored the degree to which length of time since being diagnosed with a mental health diagnosis correlates with an individual's self-report of self-esteem, self-efficacy, and subjective social status. Based upon the results, the correlation of these identified variables indicated no significant relationships. A possible reason for the lack of relationships among these variables may be due to the small sample size. This question was pertinent only to 27 participants and therefore the statistical significance of the relationship was not present in this study.

Limitations

Limitations to the study include threats to both internal and external validity. First, a threat to external validity involves the fact that this study was executed utilizing students from one specific Northeast land grant university student body. This calls into question whether the study would be generalizable to other populations. Geographic location or specificity of school setting may in some way limit the diversity of the population of students who have been diagnosed with a mental health disorder.

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The second limitation of this study deals with threats to internal validity. Demographic information indicates a much larger number of female participants than male participants, as well as a primarily homogeneous, Euro-American/Caucasian racial make-up of the sample. In addition, the sample size hindered the ability to find significant association between variables within the two research questions proposed.

Another threat to internal validity has to do with the presence of extraneous influencing factors. It is understood that there may be factors other than one's self-esteem, self-efficacy, and/or subjective social status that influence the answers participants provided regarding perceptions of themselves. Factors may include issues such as recent or past trauma, recent or past accomplishments, and/or recent or past counseling services rendered. This study focused on investigating the general differences in self-esteem, self-efficacy, and subjective social status and therefore was not able to take into account these extraneous influencing factors.

Implications

Based upon the results of the study, coupled with the information provided by research in the field, it is deduced that being able to quantify the degree of influence that a mental health diagnosis has on an individual's self-concept is difficult. The sole presence of a mental health diagnosis may not be strong enough to indicate a significant influence on one's self-esteem, self-efficacy, and/or subjective social status. The likely presence of other compounding variables make these constructs difficult to assess.

Recommendations for Further Study

The lack of ability to quantify the degree of influence that a mental health diagnosis has on an individual's self-concept remains an issue. To assess the influence of

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a mental health diagnosis on an individual's self-concept, a future study could look more in depth at other variables involved in mediating the experience and conception of a mental health diagnosis, such as access to resources, level of support by family and friends, and/or level of education concerning one's mental health disorder. Investigation of variables such as these may provide an indication of what is most salient in helping or hindering an individual's self-concept when being diagnosed with a mental health disorder.

In another study of this same nature, an increase in sample size with a more representative population may improve the power to find significant relationships with the variables being studied and the ability to address issues with external validity. Another direction for future research could be to assess an individual's self-esteem, self-efficacy, and/or subjective social status as a pre-test to being diagnosed with a mental health disorder and then conducting a post-test to compare scores and thus measure the difference. Finally, an area that may provide interesting information for the field would be to look at how gender, age, and race of an individual diagnosed with a mental health disorder might influence his/her sense of self-concept. In essence, this direction may illuminate the possible differences among gender, age or race in dealing with a mental health diagnosis and consequently provide the field with a better understanding of the client's experience.

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APPENDICES

University of New Hampshire

Research Conduct and Compliance Services, Office of Sponsored Research
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28-Nov-2006

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Farmington, NH 03835

IRB #: 3845
Study: Self-awareness of a Mental Health Diagnosis and its correlation with an individual's
self-report of self-esteem, self-efficacy and subjective social status
Approval Date: 27-Nov-2006

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has reviewed and approved the protocol for your study as Exempt as described in Title 45, Code of Federal Regulations (CFR), Part 46, Subsection 101(b). Approval is granted to conduct your study as described in your protocol.

Researchers who conduct studies involving human subjects have responsibilities as outlined in the attached document, *Responsibilities of Directors of Research Studies Involving Human Subjects.* (This document is also available at http://www.unh.edu/osr/compliance/irb.html.) Please read this document carefully before commencing your work involving human subjects.

Upon completion of your study, please complete the enclosed pink Exempt Study Final Report form and return it to this office along with a report of your findings.

If you have questions or concerns about your study or this approval, please feel free to contact me at 603-862-2003 or Julie.simpson@unh.edu. Please refer to the IRB # above in all correspondence related to this study. The IRB wishes you success with your research.

For the IRB,

Julie F. Simpson
Manager

cc: File
    Phan, Loan ✓

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Consent Form for Participation in the Study

Researcher: The investigator for this study is Marisa Mattei, a graduate student in the Graduate Program in Counseling at the University of New Hampshire. This study is the focus of the investigator's master's thesis.

Purpose: The purpose of this research is to gain a better understanding of how awareness of a mental health diagnosis is related to self-esteem, self-efficacy, and subjective social status.

Description:

- You will be asked to participate in a 10-15 minute survey. As a form of compensation for this, you will be entered into a raffle for a $50 gift certificate. The investigator is anticipating about 100 participants.
- No identifying information will be gathered in this study and therefore your responses to this survey will be kept completely confidential.
- Participation in this study is voluntary. You have the right to refuse participation in this study without penalty or loss of benefits to which you are otherwise entitled or discontinue participation at any time before the completion of the survey. You will receive a debriefing form at the end of the study that will discuss the study and will offer contact information in the event that you would like to contact the researcher regarding results of the study.
- We foresee no risks to participation in this study.
- The use of human subjects in this project has been approved by the University of New Hampshire Institutional Review Board for the protection of Human Subjects in Research.
- If you have questions concerning this study, you should direct your questions to the investigator, Marisa Mattei at marisamattei@yahoo.com, or Julie Simpson at the Office of Sponsored Research at (603) 862-2003.

PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW:

I have read and understand the above information and agree to participate in this research study.

Signature: _____ Date: _____

APPENDIX C: Diagnosis Survey

Diagnosis Survey

→ **Please mark an "X" in the box with the appropriate answer:**

1. What is your age?
   ☐ 18 to 25   ☐ 26 to 35   ☐36 to 45   ☐46 to 55   ☐56+

2. What is your gender?
   ☐Female   ☐Male

3. What is your race?
   ☐ Asian American or Pacific Islander
   ☐Euro-American/Caucasian
   ☐Latino or Hispanic
   ☐African American or Black
   ☐Native American/American Indian
   ☐Biracial or Multiracial (please indicate races/ethnicities): _____

4. Have you been diagnosed as having any *mental health disorder*?
   ☐ YES   ☐NO → If "NO", skip to question #5.
   ↓
   If "YES", please indicate the diagnosis:_____
   ↓
   If "YES", please indicate when:
        ☐0-1 year ago   ☐2-4 years ago   ☐5-8 years ago   ☐9+ years ago

5. Have you been diagnosed as having any *physical health disorder*?
   ☐YES   ☐NO → If "NO", skip to question #6.
   ↓
   If "YES", please indicate the diagnosis:_____
   ↓
   If "YES", please indicate when:
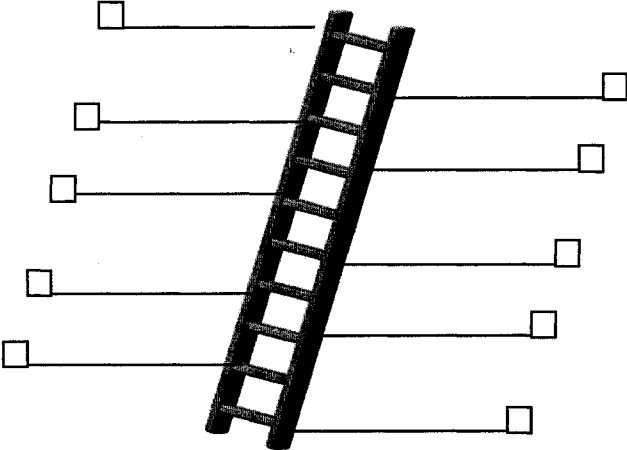   ☐0-1 year ago   ☐2-4 years ago   ☐5-8 years ago   ☐9+ years ago

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With the following statements, if you <u>STRONGLY AGREE</u>, circle <u>SA</u>. If you <u>AGREE</u>, circle <u>A</u>. If you <u>DISAGREE</u>, circle <u>D</u>. If you <u>STRONGLY DISAGREE</u>, circle <u>SD</u>.

|	Strongly Agree	Agree	Disagree	Strongly Disagree
6. I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
7. I feel that I have a number of good qualities.	SA	A	D	SD
8. All in all, I am inclined to feel I am a failure.	SA	A	D	SD
9. I am able to do things as well as most other people.	SA	A	D	SD
10. I feel I do not have much to be proud of.	SA	A	D	SD
11. I take a positive attitude toward myself.	SA	A	D	SD
12. On the whole, I am satisfied with myself.	SA	A	D	SD
13. I wish I could have more respect for myself.	SA	A	D	SD
14. I certainly feel useless at times.	SA	A	D	SD
15. At times I think I am no good at all.	SA	A	D	SD

16. Adler (2000) explains that subjective social status is "**an individual's sense of place on the social ladder**" (p. 1).

Where would you <u>currently</u> place yourself on this ladder? Please place an "X" in the box that correlates with the rung where you think you stand at this time in your life.

17. Adler (2000) explains that subjective social status is "**an individual's sense of place on the social ladder**" (p. 1).

Where would you <u>anticipate</u> placing yourself on this ladder <u>10 years from now</u>? Please place an "X" in the box that correlates with the rung where you think you will be 10 years from now?
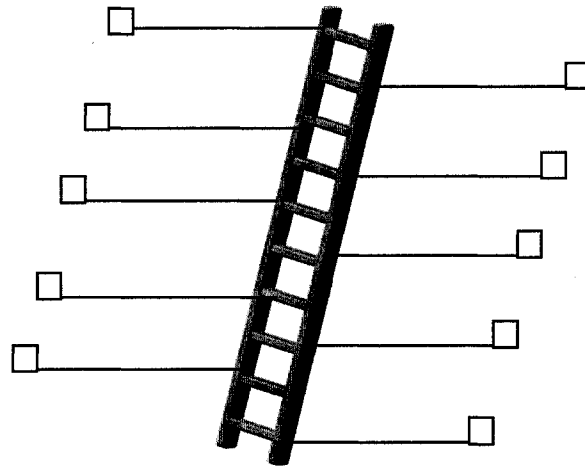
→ **STOP**! If you answered "<u>YES</u>" to question #4, #5, **OR** both, <u>**GO TO QUESTION #18**</u>, below. <u>**OTHERWISE**</u>, skip #18 and <u>**GO TO QUESTION #19**</u>.

18. Keeping in mind Adler's definition of subjective social status, how will the diagnosis impact your ability to obtain your anticipated subjective social status?

    ☐ Not at all   ☐Minimally   ☐Moderately   ☐Significantly

➡ **With the following statements, if it is NOT AT ALL TRUE, circle 1. If it is HARDLY TRUE, circle 2. If it is MODERATELY TRUE, circle 3. If it is EXACTLY TRUE, circle 4.**

	Not At All True	Hardly True	Moderately True	Exactly True
19. I can always manage to solve difficult problems if I try hard enough.	1	2	3	4
20. If someone opposes me, I can find the means and ways to get what I want.	1	2	3	4
21. It is easy for me to stick to my aims and accomplish my goals.	1	2	3	4
22. I am confident that I could deal efficiently with unexpected events.	1	2	3	4
23. Thanks to my resourcefulness, I know how to handle unforeseen situations.	1	2	3	4
24. I can solve most problems if I invest the necessary effort.	1	2	3	4
25. I can remain calm when facing difficulties because I can rely on my coping abilities.	1	2	3	4
26. When I am confronted with a problem, I can usually find several solutions.	1	2	3	4
27. If I am in trouble, I can usually think of a solution	1	2	3	4
28. I can usually handle whatever comes my way.	1	2	3	4

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY!

Instruction Sheet:

1. Please read instructions within the survey fully and complete front and back of each page.

2. If you have questions while taking the survey, please stand up from your seat and quietly ask the administrator at the designated table.

3. When finished with the survey, please turn all materials in to the administrator.

4. Once you have done so, you will receive a debriefing sheet and an opportunity to enter your name into a raffle for a $50 gift certificate.

THANK YOU FOR PARTICIPATING!!!

Debriefing Sheet:

For more information regarding the results or purpose of this study, please contact Marisa Mattei at <u>marisamattei@yahoo.com</u>. If you have concerns or complaints about this study please contact Julie Simpson at the Office of Sponsored Research at (603) 862-2003.

MORE INFORMATION ABOUT THE STUDY:

The investigator of this study is a second year Master of Arts student in the Graduate Program in Counseling at the University of New Hampshire. The purpose of this study is to investigate the relationship between having self-awareness of a mental health diagnosis and an individual's self-report of self-esteem, self-efficacy, and subjective social status.

The drawing for the raffle will take place by February 15th, 2006.

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