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Emergency Responders' Perceptions of Mental Health Patients While Providing Care in Rural Areas

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Abstract

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MA, Walden University, 2011

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Prior research has shown a correlation between public stigma and emergency responders' perceptions of mental health patients while providing care. However, research examining public stigma and emergency responders' perceptions of mental health patients is limited in rural areas. The purpose of this study was to explore possible relationships between the dependent variable, public stigma, and the independent variables: social distance, blameworthiness, and fear of unpredictable behavior. Link's modified labeling theory was the theoretical framework for this study. A sample of 92 emergency responders obtained from Facebook completed a questionnaire that consisted of three Likert scales. A multiple regression showed little correlation between public stigma and social distance, blameworthiness, and fear of unpredictable behavior. Only .077 of the variance in public stigma was explained by the combination of independent variables. This study has demonstrated a possible shift in societal attitudes toward mental illness. It is important to determine the cause of this change in results so that continued education regarding mental health awareness may positively affect social change.

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Dedication

To my children, I hope this accomplishment encourages you to pursue your dreams and know they are possible to achieve.

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Chapter 1: Introduction to the Study

Stigmatization of mental health patients has been a long-studied topic in research. It comes in three forms: self-stigmatization, public stigmatization, and label avoidance. All three forms have devastating effects on the lives of individuals with mental health disorders (Alexander & Link 2003; Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003; Norman, Sorrentino, Windell & Manchanda, 2007; Shrivastava, Johnston & Bureau, 2012; Thornicroft, Rose & Kassam, 2007). All three forms of stigma are experienced and felt in distinct ways by this population. Sometimes they are experienced singularly, and other times, mental health patients are faced with all three forms simultaneously. This study was conducted as a contribution to the existing literature and to fill a gap within that literature as it applies to emergency responders' perceptions of mental illness in rural areas. I focused on public stigma in this study.

In terms of public stigma, researchers have explored prevalent misconceptions that larger social groups hold concerning mental illness. Researchers have also studied differences in attitudes about stigma as it relates to rural and urban areas and why these differences exist (Corrigan & Watson, 2002; Girma et al., 2013; Hartley et al., 2007; Loganathan & Murthy, 2008). The National Institute of Mental Health has supported research regarding urban police officers' perceptions of individuals with mental illness and how crisis teams are improving law enforcement approaches toward this population (as cited in Husbands et al., 2011). However, there is no research that describes all types of emergency responders' perceptions of mental health patients when providing care in crisis situations. Moreover, the research on police officer perceptions has been conducted

solely in urban areas, and the findings might not generalize to rural populations. In this study, I measured emergency responders in rural areas.

Emergency responders are those first responders to crisis situations, which includes police officers, ambulance personnel, emergency room doctors, and nurses who provide emergency care for mental health patients whether it is in the community, jail, or emergency rooms. Emergency care is a form of triage for the mental health patient that allows them to be stabilized in order for them to be transferred to an actual mental facility if needed. Because they are frequently the point of first contact for someone with acute needs, it is important to understand the different levels of stigma they experience toward this population.

Research has indicated that public stigma is expressed through a desire for social distance, a feeling of blameworthiness toward mental health patients, and a fear of unpredictable behavior from individuals with mental illness (Alexander & Link, 2003; Corrigan et al., 2003; Link & Phelan, 2001). In this study, I sought to fill the gap about the different attitudes of public stigmatization felt by all emergency responders when in contact with this population. The results added valuable information to the existing literature on the subject for researchers, educators, and professionals in the field. The findings provided information needed to encourage additional education and training where it is lacking within the field of first responders, affecting positive social change.

In this chapter, I briefly summarize public stigma as it relates to mental illness. I discuss current research regarding stigma felt by emergency responders toward mental

health patients. Finally, I explain the intent and type of quantitative study that was conducted as well as provide the research questions and hypotheses.

Background

Public stigma is an external form of stigma directed from the larger social group toward a smaller targeted group, meaning it is a generalized form of stereotyping that is accepted by large social groups (Ben-Zeev, Young, & Corrigan, 2010). The original word *stigma* was taken from the Greeks referring to a sign that was possibly cut or burned onto an individual's body. The sign would indicate something morally unusual or bad, such as being a criminal, slave, or possibly a traitor (Goffman, 1963). Later, the term came to mean there could be some form of physical disability or abnormality affecting the targeted individual (Goffman, 1963); it was eventually generalized to include mental disabilities.

Stigma is a phenomenon that requires power for it to be exercised. It is the social group that is more powerful that labels the weaker group, and this can only be done within a power situation that allows it. Link and Phelan (2001) explained that labeling, stereotyping, separation, status loss, and discrimination must coincide together in a cultural situation that will allow it to happen. In order for stigma to be effective, the stigmatized group must accept the label that is being placed upon them as their identity. If the stigmatized group does not accept the identity that the larger group is attempting to place on them, the power of the larger social group is diminished (Link & Phelan, 2001).

Public stigma is expressed to individuals with mental illness through discrimination and stereotyping, placing them in a category that many times robs them

from leading a fulfilled life and pursuing their dreams. Prejudice and discrimination concerning mental illness impacts the ability to obtain and maintain meaningful employment and the ability and confidence to achieve personal goals (Ben-Zeev et al., 2010). People with mental illness are grouped into stereotypes that say that all people with mental illness (a) are dangerous; (b) have contributed to their own weakness or misfortune, making them blameworthy; (c) are unpredictable and exhibit inappropriate behavior, whether it is violent outbursts or behaviors that are out of context and finally, (d) are unlikely to experience improvement with care (Norman et al., 2008). These undesirable attributes associated with mental illness are the sum parts that create the phenomena that is labeled stigma.

Emergency responders as part of the larger social group are not immune to the social stereotyping and cultural perspectives of mental illness. Police officers are often the first to respond to situations in which persons with mental health issues are in crisis. Behaviors that are exhibited during periods of acute crisis may be misunderstood by police officers as hostile, unresponsive, or resistant (Kerr, Morabito & Watson, 2010; Morabito et al., 2010). Although research in urban areas (Kerr et al., 2010; Morabito et al., 2010) revealed no difference between the level of force used with individuals with mental illness and those without, Broussard et al. (2011) found that officers generally regard this population as both dangerous and unpredictable, reflecting the stigmatizing attitudes of the larger social group. The research mentioned at this point addressed feelings of stigma from emergency responders that is limited to urban areas. Interactions with this population may be particularly frustrating for police officers partially due to the

increased hours spent on a call before an individual in crisis is admitted into a hospital but also because of a lack of training and knowledge that is required to effectively diffuse a mental health patient during crisis episodes (Morabito et al., 2010).

Although police officers are generally the first to respond to crisis situations, mental health patients require several different types of emergency responders working in collaboration to meet the unique needs of this population. Emergency room personnel and crisis mental health workers are other forms of emergency responders who provide care for this population during acute crisis situations. Emergency rooms in rural areas most often provide the first form of triage care for persons with mental illness and are generally not prepared to care for this type of patient (Hartley et al., 2007). Since the physical and financial responsibilities for mental health care have been placed on local communities, emergency rooms and police departments have been on the front line of care for patients with mental illness (Clifford, 2010).

There is growing research on law enforcements' perceptions of mental illness in urban areas, but there is no research on the broader category of all emergency responders providing care in rural communities. Therefore, in this study, I focused on public stigmatization that is felt by all emergency responders in rural areas. I sought to fill a gap and add additional knowledge to the subject of emergency responders' perceptions of mental health patients when providing emergency care in crisis situations in rural communities. The sample for this study included law enforcement, emergency medical technicians, mental health crisis clinicians, and emergency room nurses and doctors.

Problem Statement

Emergency rooms are experiencing an increasing number of mental health patients. According to Kalucy, Thomas, Lia, Slattery, and Norris (2004), mental health treatment in emergency facilities has recently increased tenfold. Thornicroft, Rose, and Kassam (2007) found that mental health patients feel as though they are treated with disrespect. These patients feel discriminated against when they receive care in public settings from emergency responders that is inclusive of law enforcement, ambulance personnel, mental health crisis clinicians, emergency room doctors, and nurses. Although there is research on the subject of stigmatization of mental health patients as it is experienced by mental health workers and law enforcement in urban areas, there is limited information on the subject of public stigmatization of mental health patients that includes law enforcement, crisis clinicians, ambulance personnel, and emergency room staff that is specific to rural areas (Broussard et al., 2011; Douglas & Cuskelly, 2012; Husband et al., 2011; Morabito et al., 2010; Morabito et al., 2012).

The results from this study have added knowledge to the already existing research in this area, along with an original contribution of knowledge to the educational and professional community by explaining whether there is a gap in awareness of public stigma toward the mental health population in rural areas by emergency responders. In providing further knowledge as it relates to rural communities, this study has promoted positive social change in the quality of care provided to mental health patients by emergency responders in rural areas.

Theoretical Framework

The modified labeling theory describes how cultural perceptions of the mentally ill become personally relevant to an individual when they are diagnosed, causing self-demoralization and lowered self-esteem or value (Kroska & Harkness, 2006; Link, Cullen, Struening, Shrout & Dohrenwend, 1989). This theory states that once an individual is diagnosed and in treatment, there are negative outcomes. These outcomes may include loss of social status and possibly loss of employment partially due to public stigma expressed and because of reduced self-esteem and social withdrawal (Link et al., 1989). However, individuals who share the same mental health symptoms but remain undiagnosed do not experience the same labeling as diagnosed mental health patients and therefore do not experience negative consequences due to labeling (Kroska & Harkness, 2006; Link et al., 1989). Link (1987) indicated that patients, both active and inactive, believed that mental health patients would be devalued and discriminated against by the public. When an individual becomes labeled themselves, these feelings become personally relevant with the person fearing rejection (Link et al., 1989).

Stigmatization of mental illness among various populations has been an issue that has gained a large amount of attention and research. Corrigan et al. (2003) stated that the social hierarchy brands individuals as having a lesser social value when they are mentally ill, therefore discrediting them and reducing and labeling them to their disorder, such as schizophrenic or bipolar. Public stigma is largely affected by the following attitudes: desire for social distance, blameworthiness, and fear of unpredictable behavior exhibited by mental health patients (Kroska & Harkness, 2006).

The modified labeling approach states that once a person is labeled with a disorder of mental illness by society, negative consequences such as withdrawal, lowered self-esteem, and lower earning power may possibly result in vulnerability to repeat manic episodes and prolonged illness (Link et al., 1989). In this study, I sought to measure the major three attitudes (i.e., social distance, blameworthiness, and fear of unpredictability) that may affect levels of public stigma that are expressed by emergency responders towards mental health patients. These stigmatizing attitudes may negatively affect responses from emergency responders while they are providing care. These stigmatizing attitudes may ultimately result in poor patient outcomes providing support for the modified label theory, which is discussed in detail in Chapter 2.

Purpose of the Study

The purpose of this study was to explore the possible relationships between the dependent variable public stigma and the independent variables (need for social distance, blameworthiness, and fear of predictable behavior through a quantitative inquiry). The intent was to look for correlations between the dependent variable public stigma and the independent variables (desire for social distance, blameworthiness, and unpredictable behavior). Emergency responders as defined in this study included law enforcement, emergency medical teams, mental health crisis clinicians, and doctors and nurses in emergency rooms.

Research Questions and Hypotheses

1. What are the levels of stigmatization felt toward mental health patients by emergency responders in rural communities while providing care?

2. Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' fear of unpredictable behavior of this population?
3. Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' need for social distance from this population?
4. Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' perceptions of blameworthiness regarding the behaviors exhibited by this population?

H_0. There is no relationship between the level of stigma felt, the need for social distance, the fear of unpredictable behavior, the perception of blameworthiness, and stigmatization toward mental health patients by emergency responders in rural communities.

H_1 There is a relationship between the level of stigma felt, the need for social distance, the fear of unpredictable behavior, the perception of blameworthiness, and stigmatization toward mental health patients by emergency responders in rural communities.

Nature of Study

Quantitative research was the appropriate methodology for this study. Quantitative results can be used to generalize to the population and survey research provides numeric information regarding trends, attitudes, and opinions (Creswell, 2009).

Quantitative research tests an already established theory, in this situation the modified labeling theory, by testing each hypothesis and determining whether the results support or refute the existing theory (see Creswell, 2009). The key variables in this inquiry were stigmatization as the dependent variable and social distance, fear of unpredictable behavior, and blameworthiness as the independent variables.

Data were collected from participants through a survey and through data collected from state and federal government entities online and through peer review journals. Data from the survey were collected using surveymonkey.com and were analyzed using SPSS Statistics 21.

Definitions

Blameworthiness: The attitude that patients are responsible for causing their illness (Corrigan et al., 2003).

Emergency responders: These are first responders to emergency situations and include law enforcement, ambulance personnel, emergency room personnel, and mental health crisis clinicians (Corrigan et al., 2003).

Fear of unpredictable behavior: The attitude (or feeling of fear) that the patients' behaviors could become dangerous or out of control (Corrigan et al., 2003).

Public stigma: The attitudes and behaviors toward mental illness that negatively impact the quality of the lives of individuals with the illness (Corrigan et al., 2003).

Self stigma: Prior to the onset of mental illness, people have developed perspectives associated with mental illness. When the individual is diagnosed, these attitudes are activated inwardly, possibly diminishing worth (Corrigan et al., 2003).

Social distance: A person's desire for greater social (physical) distance, which would be considered a safe personal distance due to being uncomfortably close to individuals with mental and behavioral disorders (Broussard et al., n.d.; Sears, Pomerantz, Segrist & Rose, 2011).

Stigma: An attribute that is deeply discrediting to another person or group (Goffman, 1963). Stigma exists when the elements of labeling, stereotyping, status loss, and discrimination occur together within a social power unit that allows it to exist (Link & Phelan, 2001).

Assumptions

The following assumptions were believed to be true in this study:

1. The respondents in this study would answer the questions honestly when completing the questionnaire.
2. The results of this study would provide accurate data with the intent of generalizing from the sample surveyed to the general population of rural emergency providers.

These assumptions were necessary in the context of the study since the survey would be proved invalid unless the results from the population were answered honestly. The assumptions would affect the accuracy of the data, and therefore generalizing to the population would be inaccurate. These assumptions were vital to the integrity of the study and the results.

Scope and Delimitations

There were certain aspects of the research problem that needed to be addressed to ensure internal validity. One issue of internal validity was the sensitivity of the topic being studied and the participants' ability to answer the questions honestly. Another was their fear of confidentiality being jeopardized. These issues were addressed by conducting an anonymous survey online that protected the anonymity of individuals providing the survey responses, ensuring they understood their responses would be kept confidential. An online survey allowed confidentiality and privacy for completing the survey without outside influences. Participants were able to complete the survey without having to face an interviewer. This should have improved the accuracy of the results of the survey and the willingness of participants to complete the questionnaire.

The survey participants were limited to emergency responders working in rural areas. These included law enforcement, ambulance personnel, emergency room personnel, and mental health crisis clinicians who had contact with mental health patients through their employment. It did not include individuals who did not have contact as emergency responders with mental health patients.

Although the modified labeling theory includes the possible results of negative outcomes such as lower self-esteem and poorer recovery for mental health patients because of stigma, these were not addressed in this study. The sample population consisted of emergency responders in a rural southwest region of California and Arizona and, as a result, could be generalized to the rural populations.

Limitations

Limitations of this study included the small area in which the sample was drawn. The population of emergency responders was from very rural areas; therefore, participants may have been familiar with each other and may have shared similar attitudes about mental illness. The emergency responders shared the population of mental health patients for this area, possibly affecting their biases towards these patients. Even though a random sample was preferable, this inquiry was a convenience sample since it relied on the availability of volunteer participants. The correlational design used for this study was limited in that it allowed predictions to be made for the variables, but it did not allow inferences to be made as to the cause of the relationship between the variables.

Significance

The significance of this study was to bring understanding of public stigma that was felt by emergency responders toward mental health patients. These professionals provided emergency mental health care in crisis situations for this population. The results from this study provide an original contribution of knowledge to the educational and professional community by explaining the gap in awareness and knowledge of the mental health population by emergency responders in rural areas and the possible need for further education and training in this area. In providing further knowledge as it relates to rural communities, this study promotes positive social change among emergency responders regarding this population.

There is a wealth of literature on the subject of stigmatization, mental health stigmatization as it relates to its impact on individuals with mental illness, and mental health stigmatization as it relates to the way in which they perceive its influence. The literature revealed stigmatization felt by mental health patients from specific types of emergency responders, such as police officers and emergency room personnel, as well as stigmatizing attitudes of mental health professionals toward individuals with mental illness. There are also growing amounts of research on the subject of mental health patients and police officers' perceptions of this population (Broussard et al., 2011; Husbands et al., 2011; Morabito et al., 2010). However, emergency responders' perceptions toward mental illness that includes all types of emergency responders was not available, especially when it came to rural areas. In this study, I measured levels of stigma that were felt by all emergency responders who provided care to mental health patients in crisis situations. It contributes knowledge that could provide important information to policymakers and educators with regard to the effects of stigma on the ways emergency responders provide care and the effects of those attitudes on mental health patients.

Summary

This study was a quantitative inquiry on public stigma that is felt by emergency responders toward mental illness when providing care. There is a growing body of research on this topic that has been specific to public stigma felt by law enforcement when providing care to mental health patients. In this study, I sought to expand the sample population to include all first responders such as emergency room personnel,

mental health crisis clinicians, law enforcement, and ambulance personnel. Social distance, fear of unpredictable behavior, and blameworthiness are variables that have been attributed in current research as factors that contribute to public stigma and are prevalent within the research on law enforcement.

Chapter 2 provides details on the origin of the theory of stigma as well as current theories that evolved because of the original work of Goffman (1963). In addition, current literature regarding the increased population of mental health patients to emergency rooms and the stigma felt by of law enforcement and emergency room personnel toward this population is explained.

Chapter 2: Literature Review

Stigmatization of mental illness among various populations has been an important issue studied by clinical and social psychologists. It comes in two forms: public stigma of mental illness, which is placed on individuals by external sources, and internal stigma, which is a result of how individuals with mental illness view themselves and their illness (Corrigan et al., 2003). Emergency rooms are experiencing an increased number of mental health patients in psychiatric crisis. According to Kalucy et al. (2004), mental health treatment in emergency facilities has recently increased tenfold. Thornicroft et al. (2007) found that mental health patients feel as though they are treated with disrespect by professionals providing care. These patients feel discriminated against from emergency responders, such as law enforcement, ambulance personnel, mental health crisis clinicians, and emergency room doctors and nurses when they receive care in public settings (Corrigan, Druss, & Perlick, 2014). Although there is research on the subject of stigmatization of mental health patients within the health care industry, there is limited information on the subject of public stigmatization of mental health patients felt by emergency responders, specifically in rural areas.

Emergency responders provide care to mental health patients who are experiencing crisis. Hanafi, Bahora and Demir (2008) defined mental health patients in crisis as individuals who have momentarily lost the ability to use coping skills effectively to function successfully. The individual may be acting out in a number of ways, such as shouting, acting out physically, hallucinating, hearing voices, or threatening to commit suicide (Hanafi et al., 2008). In these situations, law enforcement personnel may be

trained as crisis intervention teams, educated about possible signs and symptoms of mental illness. The goal in training is to reduce stigma and stereotyping, while encouraging patience when dealing with this population, ultimately improving care while reducing arrests (Hanafi et al., 2008). Many emergency responders may feel the need to keep a comfortable social distance from individuals with mental illness. The reasons for this may include fear of unpredictable behavior or simply a lack of knowledge about this population (Broussard et al., 2011; Corrigan & Watson, 2002; Morabito et al., 2010). Mental health patients in crisis situations may exhibit behaviors that may be misunderstood, such as aggressiveness, combativeness, or refusal to cooperate due to a decrease in coping skills. These misunderstood behaviors combined with the negative attributes associated with mental illness may increase feelings of stigma resulting in poor outcomes for the patient. It is the fear of unpredictable behavior, blameworthiness, and the need for social distance that influence the level of stigma experienced by emergency providers that are the constructs for this study (see Morabito et al., 2010).

Care during crisis periods may require several types of emergency responders working simultaneously, while other situations may only require one type of emergency responder. A mental health crisis is determined by the individual's inability to effectively use coping mechanisms to handle everyday stress due to a variety of reasons. There may be many causes that influence the individual's inability to function, and it is during this period of crisis that emergency responders provide mental health intervention.

With the increase of emergency care for mental health patients within local communities, emergency responders' lack of knowledge of this population and feelings

of stigma toward them have led to poor outcomes in crisis situations. One example of this was the death of a mental health patient in Memphis, Tennessee by law enforcement in 1987 (Husbands et al., 2011). Relatives of the patient who was in crisis called police for help because the individual was cutting himself and threatening to cut others within reach. Upon arrival, the officers were faced with a person exhibiting manic behavior while he threatened those around him holding a knife in his hand. Husbands et al. (2011) indicated that due to the officers' lack of training and knowledge of mental health patients, they fatally shot the individual several times in the chest. Since the incident, there has been an increase in research of perceived stigma felt by police officers toward mental health patients in an effort to gain understanding of the levels of stigma and to provide education and awareness of the needs of this population (; Broussard et al., 2011; Husbands et al., 2011; Kerr et al., 2010; Morabito et al., 2012).

While research on law enforcement officers' perceptions has increased, research on law enforcement in rural areas is not as available. There are two studies that address stigma as it relates to general communities in rural areas, and both were conducted outside of the United States (Girma et al., 2013; Loganathan & Murthy, 2008). These two studies addressed stigma in rural areas from opposite perspectives, one from community members toward mental health patients and the latter study from patients who were receiving attitudes of stigma from their community members. Both studies revealed higher levels of stigma in urban compared to rural areas (Girma et al., 2013; Loganathan & Murthy, 2008). Although neither study addressed emergency responders' perceptions in rural communities, the differences in levels of stigma experienced and the reasons for

the stigma between rural and urban areas add support to the need for an inquiry of emergency responders' perceptions of mental illness in rural areas. In addition, the results of both studies highlight a need for similar research in the United States.

The focus of this study was on public stigmatization that is felt by emergency responders in rural areas. The existing literature shows stigma that is felt from community members in rural and urban areas, stigma felt by emergency responders in urban areas, as well as the effects of stigma felt by community members and expressed toward individuals with mental illness in rural and urban areas. The literature assesses levels of mental health stigma felt by emergency responders specific to rural areas. The current literature has differentiated between rural and urban communities in the levels and causes of stigma felt by community members. This demonstrates that people in rural areas experience higher levels of stigma toward mental health patients for different reasons (Girma et al., 2013; Loganathan & Murthy, 2008). The differences made it necessary to conduct an inquiry specific to emergency responders in rural areas.

The results from this study provided an original contribution of knowledge to the educational and professional community by assessing which variables influence higher levels of stigma experienced by emergency responders in rural areas toward individuals with mental illness. In providing further knowledge as it relates to rural communities, this study promotes positive social change among emergency responders regarding this population. In the remainder of this chapter, I review the literature related to the origins of the theory of stigma, the transition into modern stigma theories, and current research as it relates to emergency responders.

Literature Search Strategy

The scope of literature review spanned from 1963 to the current year. The Walden Library ProQuest database had a list of eighteen dissertations on the topic of stigma in a variety of different fields. There was limited research on the subject of stigma experienced by law enforcement toward mental health patients, but there was no research that was inclusive of other emergency responders' perceptions of mental illness in rural areas. This made the topic of emergency responders' perceptions of mental health patients an important contribution to the literature.

The library databases and search engines that were used in my search were as follows: Google Scholar, PsycInfo, National Institute of Corrections, USA.gov, and ProQuest. My search terms included *stigma, public stigma, discrimination, stigmatization, social distance, dangerousness, mental illness, rural, emergency responders, blameworthiness, stereotyping*, and *labeling*.

The Evolution of Stigma Theory

Stigma was originally discussed as a phenomenon that occurs when the larger social group expresses attitudes of discrimination, negative stereotyping, and labeling targeted at smaller groups with attributes that have been determined as less desirable (Goffman, 1963). The effect of the perceived stigma was explained as discrediting to the targeted group, crippling their ability to achieve success and fulfillment within their lives (Goffman, 1963). Although there are many weaker groups that have historically been stigmatized, in this review and study, I focused on mental illness stigma.

In the following pages, I lay the theoretical foundation of this dissertation by describing the seminal work of Goffman (1963), followed by a description of Scheff's (1989, 1999) original labeling theory. I end by detailing the modified labeling theory proposed by Link (1989, 2001), concluding with a brief review of current research that supports the modified labeling theory (Corrigan 1997, 2003; Broussard et al., 2011; Husbands et al., 2011; Morabito et al., 2012).

Original Stigma Theory

The seminal work of Goffman (1963) explained the way attitudes that have been accepted by larger, more powerful social groups are expressed behaviorally in ways that minimize the weaker group. Goffman adopted the term "stigma" from the Greeks who burned signs, or "stigmas," on an individual's body in order to reveal them as a slave, traitor or criminal. This mark would advertise them as someone to avoid in public. Later, Goffman explained that the term stigma expanded to describe bodily signs of a physical disorder. His accumulated case studies that analyzed stigmatized people's experiences trying unsuccessfully to conform to society's perception of what was considered the norm. His work defined the phenomenon of public and self-stigma, which laid the foundation for future research on the nature, sources and the consequences relating to stigma (Link & Phelan, 2001).

Goffman's theory (1963) stated that conditions such as mental illness are highly stigmatizing and deeply discrediting. His research was based on analyses of autobiographies and case studies that were accumulated over time. From his research, Goffman theorized that society categorized individuals with particular attributes they felt

were considered normal and with those attributes came expectations that were considered appropriate within the social setting. When an individual came into a setting with attributes that did not fit what had been established as normal, but rather embodied attributes that were different, the individual was perceived as less desirable, dangerous or possibly weak. This individual would be stigmatized due to the unfamiliar attributes. The unfamiliar traits would then be categorized as undesirable, ultimately leading to the individual being labeled undesirable by the larger social group.

Goffman (1963) theorized that the seemingly undesirable characteristics caused stigmatization that was manifested through labeling and stereotyping, leading to acts of discrimination. He explained that stigma was a language of relationships rather than attributes that should be examined, since an attribute that may stigmatize one group may be confirmed usual in another group (Goffman, 1963). Therefore, the undesirable characteristic was not the cause of the stigma, but the perception of what was considered desirable or normal by the larger social group instead. Consistent with this focus on relationships, stigma was explained by Goffman as a phenomenon that could only exist within a society in which the more powerful social group collectively agreed with certain labels being placed upon a weaker group who shared common characteristics that were collectively considered undesirable to the larger more powerful group (Alexander & Link, 2003; Arboleda-Florez & Stuart, 2012; Goffman, 1963). Distinguishing traits may be identified as skin color, physical abnormality, unemployment or a foreign culture. Any trait that distinguishes the individual from the normal expectations of the larger group

may cause the group in power to stigmatize and ultimately assign the individual to the weaker more vulnerable group (Goffman, 1963).

Although stigma was originally defined as an attribute that was part of the person, something about them that was different from the perceived norm, it was Link and Phelan (2001) who later proposed that stigma was not a part of the individual but a negative label that had been attached to a person by the larger societal group (Link & Phelan, 2001).

Modern Stigma Theories

Goffman developed the original theory of stigma, which covered all areas of stigma in society. He explained that stigma affects anyone who does not fit into a category that may be considered normal by the larger more powerful societal group within a particular area. Goffman's theory is the foundation for modern psychological theories on stigma. The first researcher to do this was Scheff (1989, 1999), who proposed what he called the labeling theory. Later, Link (1989) proposed a modified labeling theory. Scheff's original labeling theory proposed that stigma felt by the larger social group would lead to the labeling of an individual who would inevitably exhibit behaviors consistent with mental illness as shown in figure 1A (Link, et al., 1989; Scheff, 1989, 1999). This assumed label would eventually produce mental illness by the individual's internalizing the label being applied and then assuming the expected role (Link et al., 1989; Scheff, 1989, 1999).

Later, Link et al. (1989) proposed the modified labeling theory. His theory posited that when a person is seen exhibiting behaviors consistent with mental illness or when a person has made contact with treatment for mental illness, negative labeling from

the community is applied because of the stigma of mental illness. When labeling has been applied, the attitude of stereotyping is established which says that all mental health patients exhibit the same behavioral symptoms, such as dangerousness and unpredictable behavior which may include violence. These negative attitudes turn into the action of discrimination expressed by the individual's community through the refusal of housing, jobs, and relationships, bringing negative outcomes to the individual in the form of devalued self-esteem and community rejection as shown in figure 1B (Link et al., 1989).

Figure 1A and 1B detail the differences between the original labeling theory and the modified labeling theory.

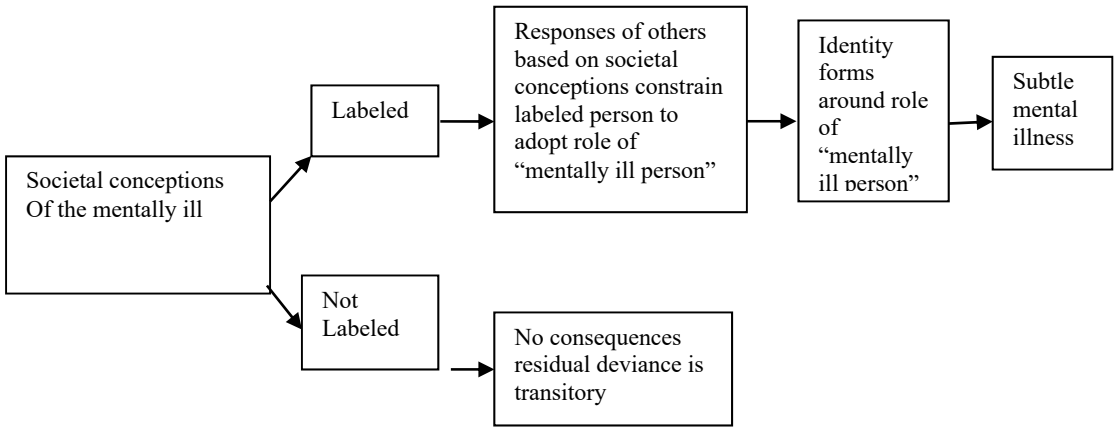

Figure 1A. Original labeling theory.

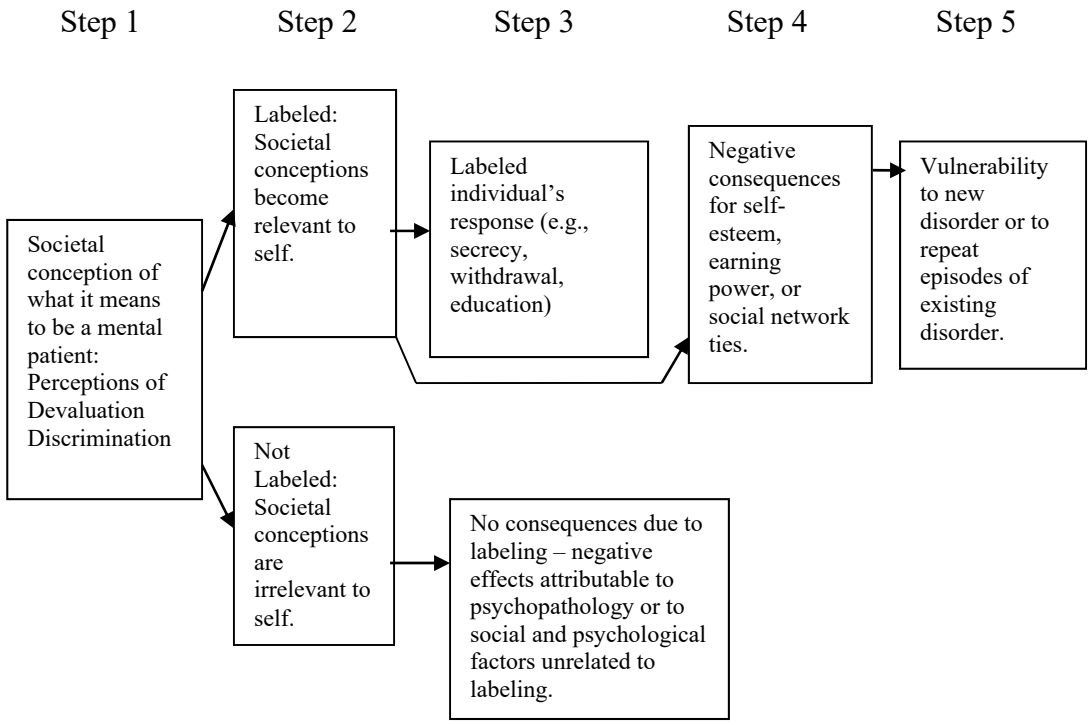

Figure 1B. Modified labeling approach. Diagrammatic representation of Scheff's labeling model and the modified labeling approach. Adapted by "A Modified Labeling Theory Approach to Mental Disorders: Am Empirical Assessment" by B. Link, E. Struening, F. Cullen, P. Shrout, and B. Dohrenwend, 1989, *American Sociological Review*, *54*, p. 402.

The difference between the original labeling theory and the modified labeling theory is Scheff's (1989, 1999) conclusion that labels that are repeatedly applied will cause the individual to accept them and these accepted labels will ultimately cause mental illness. If an individual has exhibited behaviors consistent with those seen in mental health patients and the label is applied, then the person internalizes the role and will ultimately become what the label has designated (Scheff, 1989, 1999). In contrast, Link et al. (1989) emphasized in his research that the labeling does not inflict or cause the

mental disorder in the individual as Scheff (1989) had earlier proposed. The modified labeling theory states that once an individual is labeled by diagnosis, it leads to lowered self esteem followed by negative outcomes in the form of discrimination through loss of jobs, lower income, social withdrawal and possible prolonged illness. These negative outcomes are caused by the expressed stigmatization of the larger social group (Goffman, 1963; Link et al., 1989). It is these attitudes of stigma that are central to this study, specifically feelings of blameworthiness, fear of unpredictable behavior and the need for social distance.

Current research conducted by Corrigan et al. (2003) and Corrigan, P.W., Druss, B.G., & Perlick, D.A. (2014) have supported Link's (1989) modified labeling theory and demonstrate that stigma towards mental health patients is particularly present among professionals working directly with mental health patients. Accepted stereotypes include labels such as all mental health patients are (1) dangerous; (2) have contributed to their own weakness or misfortune and are blameworthy; (3) are unpredictable and exhibiting inappropriate behavior whether it is violent outbursts or behaviors that are out of context and, finally, (4) are unlikely to experience improvement with care (Norman, Sorrentino, Windell & Manchanda, 2008). These stereotypical beliefs are the misconceptions explained within the Modified Labeling Theory and are feelings that health professionals, particularly mental health professionals express toward these patients when providing care (Ben-Zeez, Young & Corrigan, 2010; Corrigan et al., 2014; Link et al., 1989). This theory further explains that many people will discriminate against this population supporting the theory that stigma will ultimately lead to negative outcomes for mental

health patients (Alexander & Link, 2003; Link et al., 1989; Norman et al. 2008). Norman et al. (2008) indicated in his study that there is a significant relationship between the variables of desire for social distance, feelings of blameworthiness and the fear of unpredictable behavior toward individuals with mental illness. These attitudes of stigma are the key constructs of this study and will be explained in detail below.

The independent variable fear of unpredictable behavior is a false belief that an individual with mental illness may demonstrate unpredictable behavior without cause. These possible behaviors may be inappropriate or erratic, and possibly dangerous even though research has indicated that individuals with mental illness are no more violent than any other person (Corrigan, 2003).

The independent variable blameworthiness assumes that the individual can somehow control his or her own behavior and is therefore responsible for the manic episode being displayed (Corrigan, 2003). When a mental health patient arrives in an emergency room, doctors and nurses may perceive the patient as blameworthy. They perceive that the patient is purposefully creating the incident. This perception stems from the repeated attempts at seeking help from emergency responders because of recurring manic episodes (Corrigan et al., 2003). According to Thornicroft et al. (2007), people with personality disorders are particularly vulnerable to expressed public stigma by emergency room personnel, because they believe this population has more control over their suicidal tendencies. Therefore, their behaviors are seen as annoying, attention seeking, and blameworthy. Feelings of blameworthiness may create resentment from health care professionals (Corrigan et al., 2003; Corrigan et al., 2014). The community in

general labels individuals with these similar undesirable traits and then stereotypes all individuals with mental illness as having these traits in common, which then ultimately may create separation from the larger social group.

Social distance, another independent variable, occurs when the larger social group creates the separation of the "us" from "them" phenomenon (Goffman, 1963; Link & Phelan, 2001). The stereotyping of the mentally ill person happens because the larger group believes they are fundamentally different from and ultimately superior to the person (Link & Phelan, 2001). Researchers have found that the need for social distance may also be due to the fear of perceived dangerousness, which has become of research interest in the area of law enforcement (Norman et al., 2008; Brossard et al., 2011; Morabito, M., Kerr, A., Watson, A., Draine, J., Ottati, V., & Angell, B. 2012). Brossard et al. (2011) indicated that law enforcement's need for social distance was influenced by their misperceptions of dangerousness and unpredictability during previous encounters with mentally ill individuals. In particular, they found that social distance was highly correlated with stigmatizing attitudes especially in relation to mental health patients experiencing psychosis.

Emergency Responders' Perceptions of Public Stigma

Public stigma impacts social interactions for individuals with mental illness especially when confronted by trained professionals working with this population. According to current research it is professionals who work directly with this population who devalue and stereotype people with mental illnesses more than any other group (Corrigan & Watson, 2002). Additionally, research has shown that stereotypical

perceptions such as the fear of unpredictable behavior and blameworthiness may also influence police officers attitudes when responding to calls in the field (Broussard et al., 2011).

Broussard et al. (2011) conducted a study to determine the level of stigma perceived by police officers and the causes of the perceived stigma. The independent variables of social distance and perceived dangerousness in six police departments in Georgia were measured. The officers were asked to view two separate vignettes, one of an officer responding to a call about an African American male disturbing the peace exhibiting signs of psychosis, delusions, hallucinations, and agitation. The second vignette focused on an officer responding to a call of an intoxicated African American female, expressing thoughts and threats of suicide. After viewing the vignettes the officers were then asked to complete a semantic differential measure (SDM) evaluating the two subjects. The semantic differential measure (SDM) measured attitudes toward the individuals along bipolar scales that represented five dimensions: (a) predictable-unpredictable, (2) simple-complicated, (3) strong-weak, and rugged-delicate, (4) warm-cold and fast-slow, and (5) valuable-worthless, clean-dirty, sincere-insincere, safe-dangerous, wise-foolish and relaxed-tense. The results of the SDM showed that the independent variables social distance and perceived dangerousness influenced higher levels of public stigma toward mental health patients. They also found that law enforcement trained in mental health crisis intervention experienced lower levels of stigma towards this population, suggesting that knowledge and awareness of mental illness reduced stigma levels.

There are other factors that influence emergency responders' perceptions of mental health patients, such as their appearance, demeanor, and level of hostility as well as responders' fear of unpredictable behavior. These were considered factors that may influence the different levels of force used by police officers when confronted with mental health patients (Kerr et al. 2010; Morabito, et al., 2012). Stigmatizing attitudes and stereotyping of mental health patients may cause certain behaviors to be viewed as aggressive or noncompliant to direction, causing officers' to respond more aggressively. When in fact, the mental health patient does not understand the events surrounding them during moments of mental health crisis. According to Kerr et al. (2010) officers' observations and interpretations of mental health patients' behaviors were perceived as being accurate and yet, research conducted by Douglas and Cuskelly (2012) resulted in the opposite. In fact, in their study less than one quarter of individuals with mental illness encountered by law enforcement were correctly identified as being mentally ill, indicating a large discrepancy between the results of the two studies and demonstrating the need for further research (Douglas & Cuskelly, 2012).

Emergency responders, particularly police officers, have taken on the burden of being on the front line of crisis mental health treatment (Clifford, 2010; Hanafi, Bahora, Demir, & Compton, 2008; Jines, J. 2013). The majority of police officers continue to become anxious and fearful of their own safety, because of their beliefs that this population is dangerous and unpredictable (Clifford, 2010). Although the previously mentioned research conducted by Hanafi et al. (2008) and Jines, J. (2013,) showed that training was related to a decrease in stigma when providing emergency services to mental

health patients, there is no research measuring the levels of stigma experienced by other emergency responders such as ambulance, nurses, doctors, and crisis clinicians when providing care to this population in rural areas.

Corrigan et al. (2003) explained that although currently there is more research and education about mental illness, there is a proportionate increase of feelings of perceived dangerousness associated with mental illness. Due to the increase of emergency responders being the first to respond to calls of individuals with mental illness and because it is out of their area of expertise, perceived dangerousness has become an important issue (Morabito et al., 2010). Although individuals with mental illness are not normally dangerous, behaviors exhibited during times of crisis may be misinterpreted, especially when this population may not respond to directives given to them in the manner that would generally be expected (Morabito et al., 2010; Morabito et al., 2012). Researchers have begun to measure stigma levels in law enforcement because of the increase of violence during calls that involve mentally ill patients as it relates to the need for increased awareness and training of this population (Broussard et al., 2011; Husbands et al., 2011; Jines, J., 2013).

There is a growing body of literature on police officers' perceptions of mental illness and yet there is no research that is inclusive of the different categories of emergency responders in rural areas. The strength in the current research is the increase in the assessment of stigma in police officers and the measurement of the variables of fear of unpredictable behavior and desire for social distance. Kerr et al. (2010) conducted a study assessing the level of force used by police officers toward mental health patients

but the results did not show a significant difference in amount of force used between mental health patients and the general population. However, Brossard et al. (2011) indicated that the effects of excessive force used on mental health patients due to the lack of education regarding this population, was the reason for enacting additional training that would provide awareness. The discrepancy in results of the two studies would indicate the need for further inquiry to support the findings.

Even though there is increased research in the area of stigma for emergency responders, the research is not entirely consistent. The weakness in the research thus far is the exclusion of other crisis clinicians that work alongside police officers in the field, such as ambulance personnel, crisis mental health clinicians and emergency room personnel. Finally, there is a lack of research on emergency responders in rural areas and as indicated below there are differences between rural and urban areas in the way stigma is both felt and expressed making this an important area for research.

Public Stigma in Rural Areas

While research on law enforcement officers' perceptions has increased, research on law enforcement in rural areas was not as available. However, there were two studies that examined stigma as it related to general communities in rural areas. One study conducted by Girma et al. (2013) in Southwest Ethiopia randomly selected community members to assess levels of stigma in both rural and urban communities. They found the strongest predictor of stigma was whether the person lived in an urban or rural setting with higher levels of stigma in rural communities (Girma et al., 2013). Their findings indicated that when levels of understanding about mental illness increased, levels of

stigma decreased in both rural and urban areas (Girma et al., 2013). Even though levels in both groups decreased, levels of stigma in rural areas remained higher than the urban areas; however, the researchers were not able to indicate the cause of the overall higher levels of stigma within rural areas.

A study conducted at the National Institute of Mental Health and Neurosciences in India by Loganathan and Murthy (2008) gathered interviews from individuals with schizophrenia to assess stigma and experiences of discrimination because of their mental illness in both rural and urban settings. The researchers found that people with mental illness in rural areas experienced more ridicule, shame, and discrimination from their community members, which they attributed to the rural community's rigid thinking and unwillingness to change. Mental health patients in urban areas were able to work through their mental illness and maintain gainful employment. It is interesting to note that participants reported that urban areas offered more public information regarding mental illness, possibly influencing the lower level of stigma experienced, while rural areas did not. It is indicated by the two studies that there are differences in the way stigma is experienced and expressed in rural and urban areas.

Summary

The gap in the research was important for two reasons, mental health patients many times come into contact with police, ambulance, crisis mental health clinicians, and emergency room personnel simultaneously during one crisis call and present research that assesses stigma of emergency responders that was inclusive of all emergency responders was lacking. Research on this population in rural areas was also lacking and since it was

demonstrated that there were differences in the way stigma is felt and expressed between rural and urban areas this was important. Those two reasons made this research an important addition to the existing literature. The current research remained consistent regarding attitudes of stigma and the relationship between the variables of fear of unpredictable behavior, blameworthiness and social distance. Attitudes demonstrated by professionals working with mental health patients regarding these variables also showed consistent results.

It is known through current research that stigma is a phenomenon experienced by the larger social group towards mental health patients and expressed through varying attitudes of fear of unpredictable behavior, desire for social distance, and feelings of blameworthiness. Labels from these expressed attitudes are translated into stereotypes which become acts of discrimination that are generally accepted by the larger social group, leaving mental health patients feeling devalued, rejected, and ultimately experiencing lowered self-esteem. The outcomes of stigma for mental health patients have been lower paying jobs, failure to pursue dreams and reach goals, and the possibility of prolonged illness.

The present study sought to determine the levels of stigma perceived by emergency responders toward mental health patients. There was a gap in the literature with regard to factors affecting stigmatization that emergency responders experience toward mental health patients in rural communities. Specifically, there was a gap with reference to emergency responders inclusive of police, emergency medical technicians, ambulance, emergency room personnel, and crisis mental health clinicians. Although

there was extensive research on law enforcement, emergency responders that would include all other categories within rural communities was not measured.

This dissertation was important because public stigmatizing attitudes of blameworthiness, need for social distance and perceptions of dangerousness that lead to labeling, stereotyping, and ultimately acts of discrimination all result in negative outcomes for mental health patients. It was also important because it filled the gap in the literature by including all emergency responders who provide care to mental health patients in crisis situations in rural areas. Outcomes of stigma have all been proven detrimental to those with mental illness interfering with their desire to seek professional help and to pursue their dreams to live without the negative effects that stigma produces (Alexander & Link, 2003; Ben-Zeev, Young, & Corrigan, 2010; Corrigan et al. 2003; Link & Phelan, 2001; Norman, 2008; Scheff, 1966; Watson et al. 2007).

Chapter 3: Research Method

In the two previous chapters, I discussed stigma and the way in which attitudes of stigma were expressed through the larger societal group and the possible negative outcomes of those attitudes for the smaller stigmatized group of individuals. The purpose of this study was to bring understanding of public stigma as it is experienced by emergency responders toward mental health patients while providing care in rural communities. The results provided an original contribution of knowledge to the educational and professional community regarding the different levels of stigma that are felt by emergency responders toward mental health patients in rural areas. In this chapter, I outline a description of the research design and its approach, the setting, participants, instrumentation used for data collection and analysis procedures, and an explanation regarding the measures used to protect participants' privacy and rights.

Research Design and Rationale

Research Methodology

The quantitative method was chosen to be the most suitable form of research for this topic. Survey research as the method of data collection was used to better understand the relationships between the dependent variable stigma and the independent variables of social distance fear of unpredictable behavior, and blameworthiness. The purpose of this survey was to ask questions from a sample of the population of emergency responders regarding their attitudes about stigma as it related to mental health patients they provided care for in crisis situations. Findings were generalized from the sample to the population

so that inferences could be made regarding emergency responders' attitudes of stigma toward mental health patients (see Creswell, 2009).

The survey method was self-administered using Survey Monkey on Facebook. I used convenience sampling relying on the availability of volunteer participants (see Creswell, 2009). Convenience sampling allowed me to gather data over a larger area in a very short period of time. This was the preferred method since it provided a rapid turnaround with greater convenience as well as a minimum of cost and materials (see Creswell, 2009). The strength of this method was its convenience, relatively quick response, and simplicity. Using data collection through Survey Monkey on Facebook allowed me to target the desired population and make the survey available to them very quickly. Survey Monkey facilitated the recruitment of participants in an easy way. The absence of an interviewer assured a greater level of anonymity for participants, increasing the probability that they would respond to sensitive issues without fear of repercussion (Frankfort-Nachmias & Nachmias, 2008).

Method

Population

The population for this inquiry was emergency responders who provided care for individuals with mental illness during crisis situations. Therefore, the population was inclusive of law enforcement, ambulance personnel, crisis mental health technicians, emergency medical technicians, and emergency room doctors and nurses. The geographical area for this population was located on the California-Arizona border

covering the lower region of the Riverside and La Paz Counties, with approximately 300 emergency responders within the area.

Sampling

I used convenience sampling, relying on the availability of volunteer participants (see Creswell, 2009). The survey was self-administered using Survey Monkey; participants were recruited through a link on Facebook. The recruitment strategy comprised of posting public invitations multiple times until the desired sample was reached. The advertisement began by asking if the proposed participant was an emergency responder working within the targeted area of research. This approach allowed the gathering of data over a larger area in a very short period of time.

G*Power 3.1.7 was used to calculate the sample size for a multiple regression test (Faul, Erdfelder, Buchner, & Lang, 2009). Using alpha level of 0.5 and a power of .80, at least 92 participants were required for the analysis to achieve a medium effect ($f^2 = .15$) (Gravetter & Wallnau, 2007).

Data Collection Procedures

As described above, responses to the questionnaire were collected anonymously and remained confidential through the privacy settings on Survey Monkey. The consent form was built into the beginning of the survey; potential participants who did not consent were disqualified from taking the survey automatically. The survey took approximately 5 minutes to complete, and there was no incentive provided for the participants. When the participants finished, they merely closed out the web browser.

Measures

Stigma. Link (1987) developed the Devaluation Discrimination Scale to measure the level at which people devaluate and discriminate against mental health patients. The scale showed a Cronbach's alpha of .78 in Link's original study. This scale has since been widely used to measure stigma. Its reliability has remained consistent as evidenced in a recent study that concluded that the scale maintained strong psychometric properties with high reliability and validity (Boyd, Otilingam, & DeForge 2014). This scale consists of 12 items, each measured on a 6-point *strongly agree* to *strongly disagree* Likert format. Lower scores indicated a higher level of stigma with the exception of those items followed by a (*R*), in which case the scoring is reversed (Link, 1987). This scale is presented in Appendix B: Devaluation Discrimination Measure.

Social distance. The variable social distance was measured using a modified version of the Social Distance Scale, which was designed specifically to measure social distance towards individuals with schizophrenia and was adapted from the Whatley Social Distance Scale (Yoshii, Watanabe, Kitamura & Akazawa, 2012). This scale consists of eight questions using a 4-point Likert Scale (0 to 3 points), higher scores representing increased social distance (Smith & Cashwell, 2011). The Social Distance Scale was modified to generalize from individuals with schizophrenia to individuals with mental illness for measuring social distance between this population and mental health professional trainees, mental health professionals, and nonmetal health professionals (Smith & Cashwell, 2011). In this study, I used the modified version generalizing to individuals with mental illness. Researchers have indicated that even though times have

changed, the Social Distance Scale remains relevant, providing consistent results in both large and small scale studies (Parrillo & Donoghue, 2013). This scale is presented in Appendix C: Modified Social Distance Scale.

Blameworthiness and fear of unpredictable behavior. Blameworthiness an fear of unpredictable behavior were measured using Items 1, 3, 4, 6, 10, 11, 12, 13, 18. 19, 21, 22, 23, 24, and 27 from the AQ-27 Questionnaire (see Corrigan et al., 2003). The scale was limited to questions specific to blameworthiness and unpredictable behavior since they were specific to the research questions. This scale was developed from attribution theory, which explained the relationship between attitudes of stigma and discriminatory actions (Corrigan et al., 2003). Using a hypothetical vignette, participants responded to questions about familiarity with mental illness, fear of unpredictable behavior, and responsibility for causing one's own condition (blameworthiness), all of which are responses of rejection (Corrigan et al., 2003). Corrigan et al. (2003) introduced this scale in 2003 to measure components of public stigma toward mental illness. Since its inception, this scale has been used repeatedly, demonstrating consistency even when translated into Italian with a Cronbach's alpha of .82 and a test retest reliability of .72 for the total scale (Pingani et al., 2011). This scale is presented in Appendix D: Attribution Questionnaire Short Form.

Threats to Validity

This inquiry used a correlational design in which the data collected was used to examine a relationship between stigma, the dependent variable and blameworthiness, social distance, and unpredictable behavior, independent variables. Although this type of

data collection is becoming widely used, there are threats to internal and external validity. One threat to internal validity was selection bias, which means that the study population may not have been representative of the sampling population, creating the need to repeat the study to obtain reliability (Janssens & Kraft, 2012). Another threat to internal validity was information bias that occurs from errors in data collection because participants' do not clearly understanding the questions, creating misclassifications of outcome (Janssens & Kraft, 2012). There was also a threat to internal validity due to the convenience sample, such as the inability to verify the qualifications of each participant and to authenticate their responses. Finally, the issues that were surveyed are controversial and therefore participants may have felt they should answer the questions in a particular way as opposed to answering them honestly. There was no comparison group to ascertain whether there were more or less negative attitudes toward mental illness in rural areas as opposed to urban areas creating a threat to external validity. Because of the narrow characteristics of the participants, the researcher could not generalize to individuals who did not share the characteristics of the participants, causing a threat to external validity (Creswell, 2009). Due to the extreme nature in which emergency responders are providing care to mental health patients, the researcher could not generalize to other settings (Creswell, 2009). Although the biases may have affected the interpretation and the generalizability of the study, in many cases, this form of data collection may still prove very useful.

Ethical Procedures

This study was approved by the Walden Institutional Review Board (IRB) #05-04-16-0181828. The participants in this study were adult male and female volunteers who chose to participate of their own free will. There was no known harm in participating in this survey. The participants would be free to stop participation at any point during the survey without any questions or penalty. All data and participant information were kept confidential and was printed and locked in a cabinet. After completion of statistical information, Survey Monkey purged the information from their records.

Data Analysis Plan

Data were analyzed using SPSS 21. The research questions (RQ) are below.

RQ1: What are the levels of public stigmatization felt toward mental health patients by emergency responders in rural communities while providing care?

To measure the level of stigma felt by emergency responders, first I created a scale score on the Devaluation Discrimination Scale. This scale will use a 6-point *strongly agree* (1) to *strongly disagree* (6) format, the items followed by (*R*) are reversed. The scale is numbered 1 through 6 with the higher numbers indicating higher stigma. I will then examine the descriptive statistics of this measure, especially the mean, to determine the level of stigma in this population.

RQ 2: Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' fear of unpredictable behavior of this population?

To measure the relationship between stigma felt by emergency responders and unpredictable behavior, I will first create a scale score using the subset of items in the Attribution Questionnaire that measure perceptions of unpredictability. To test for a relationship between stigma and unpredictability, I will run a correlation.

RQ 3: Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' need for social distance from this population?

To measure the relationship between stigma felt by emergency responders and the need for social distance, I will first create a scale score using the Social Distance Scale. I will then calculate a mean score with this sample. To test for a relationship between stigma and the need for social distance, I will run a correlation.

RQ 4: Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' perceptions of blameworthiness regarding the behaviors exhibited by this population?

To measure the relationship between stigma felt by emergency responders and feelings of blameworthiness, I will first create a scale score using the subset of items from the Attribution Questionnaire. This scale will use a nine point not at all (1) to very much (9). I will then calculate a mean score with this sample. To test for a relationship between stigma and perceptions of blameworthiness, I will run a correlation.

Summary

In this chapter I provided detailed information in relation to the type of quantitative design and methodology of the inquiry. I discussed the data source and the

statistical analysis related to the research question and hypotheses. I discussed the independent and dependent variables and any threats to internal and external validity. In chapter four, I presented statistical analysis results of the present study.

Chapter 4: Results

Introduction

The purpose of this study was to explore the possible relationships between the dependent variable of public stigma and the independent variables of social distance, blameworthiness, and fear of predictable behavior through quantitative inquiry. My intent was to look at correlations between the dependent and independent variables as related to emergency responders' perceptions of mental health patients in rural communities. In this study, I sought to fill the gap in literature by assessing levels of mental health stigma felt by emergency responders specific to rural areas. Previous researchers found that self-reported levels of stigma are higher among rural area first responders compared to those in urban areas (Girma et al., 2013). To address this gap in literature, the research questions and hypotheses that were used in this study were as follows:

1. What are the levels of stigmatization felt toward mental health patients by emergency responders in rural communities while providing care?
2. Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' fear of unpredictable behavior of this population?
3. Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' need for social distance from this population?
4. Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders'

perceptions of blameworthiness regarding the behaviors exhibited by this population?

H_0 There is no relationship between the level of stigma felt, the need for social distance, the fear of unpredictable behavior, the perception of blameworthiness and stigmatization toward mental health patients by emergency responders in rural communities.

H_1 There is a relationship between the level of stigma felt, the need for social distance, the fear of unpredictable behavior, the perception of blameworthiness and stigmatization toward mental health patients by emergency responders in rural communities.

In this chapter, I discuss the data collection and the modifications in the process that varied from the original plan presented in Chapter 3. Included is a discussion of the research questions and hypotheses that were tested. Lastly, I present the results of the multiple regression analyses.

Data Collection

Data collection began on May 6, 2016 and was completed on July 17, 2017. Participants were recruited through Facebook, an online social media format. An invitation briefly explained the study, eligibility criteria, and listed a link to the complete survey (Appendix A). Participants who were eligible provided informed consent by clicking the button, allowing them access to the survey. Originally, data were to be collected within a 100-mile radius of the California/Arizona border, which would include Blythe, Ca., Indio, Ca., Parker, Az., Yuma, Az., Ehrenberg, Az., and Salome, Az. A

sample was going to be drawn from this population of emergency responders. However, after 6 months, only 50 completed questionnaires had been collected compared to the 92 needed for the proposed statistical analysis. Therefore, a request was made to the IRB to modify the collection area to include the State of California, Arizona, and New Mexico. This request was approved by the IRB on July 14, 2017, and the Facebook invitation was modified to include the enlarged area.

Data were collected on Survey Monkey, an online survey and data collection site (Surveymonkey.com/r/8JKY6LD). Prior to taking the survey, potential participants read an informed consent. At the end, it stated that by clicking "Proceed" they agreed to the informed consent. Participants completed the Devaluation Discrimination Measure (Appendix B), Modified Social Distance Scale (Appendix C), and the Attribution Questionnaire Short Form (Appendix D).

Criteria for potential participants were 18 years of age and currently working in the capacity of an emergency responder as a police officer, sheriff's deputy, ambulance driver, fireman, emergency room personnel, doctor, nurse, mental health clinician, or mental health crisis technician. A person was disqualified if he or she was under the age of 18 or did not work in the capacity of emergency responder.

All data were collected anonymously via personal computer, tablet, or cell phone. Only one survey response was allowed per device. After completion, Survey Monkey blocked any attempts of multiple responses by displaying the message "thank you for taking the survey." Completed data collection included 96 surveys, with two surveys incomplete, each leaving one answer blank.

Results

Tests of Assumptions and Reliability

Ninety-two surveys were completed, and frequencies with standard deviation were analyzed. I evaluated the assumptions for multicollinearity, linearity, normality, and independence of residuals. Originally, the Mahalanobis distance test was performed to evaluate for outliers. In this test, the Mahalanobis scored high at 30.330. The critical value of this test with a confidence interval of 95% should have scored no higher than 7.81, indicating there may be outliers that should be removed from the data (Field, 2009). A check for outliers showed Responses #42, #51, and #61 were outliers and therefore were taken out of further analysis, leaving 89 responses in the data set or 96% of the 92 original responses. After making this adjustment, the assumptions for multicollinearity, linearity, normality, independence of residuals, and homoscedasticity were analyzed again. The collinearity diagnostics revealed the independent variables social distance, blameworthiness, and fear of unpredictable behavior were not highly correlated or biased since the average of the Collinearity VIF scores was 1 (see Field, 2009). The Mahalanobis Distance test resulted in a score of 8.7 after the removal of the outliers. This is high since the critical value with a 95% confidence interval should be 7.81; however, the Cooks Distance score was low at .16 with a critical value of 1, so this test assumption was met (see Field, 2009).

RQ 4: Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' perceptions of blameworthiness regarding the behaviors exhibited by this population?

To measure the relationship between stigma felt by emergency responders and feelings of blameworthiness, I will first create a scale score using the subset of items from the Attribution Questionnaire. This scale will use a nine point not at all (1) to very much (9). I will then calculate a mean score with this sample. To test for a relationship between stigma and perceptions of blameworthiness, I will run a correlation.

As explained in Chapter 3, the participants of this study were emergency responders 18 years of age or older and currently working within the field of providing emergency care to patients with mental illness. There was no other demographic information collected. The sample was taken from the population of California, Arizona, and New Mexico.

As reflected in Table 1, the independent variables, social distance, blameworthiness, and unpredictable behavior show the mean, indicating the average score for each item and the standard deviation. The standard variability for the set of variables was measured, and unpredictable behavior scored the widest spread of variability.

Table 1

Means and Standard Deviations for Quantitative Study Variables

	M	*SD*	*N*
Stigma	3.61	.52	89
Social distance	1.20	.48	89
Blameworthiness	2.65	.85	89
Unpredictable behavior	2.81	1.56	89

Note. Dependent variable was stigma; independent variables were social distance, blameworthiness, and unpredictable behavior.

To test the normality of residuals, Figure 2 shows the histogram having a normal distribution as indicated by the bell curve. In Figure 3, the probability plot (P-P) indicates that the assumption of linearity has been met (see Field, 2009). This is indicated by the residuals being plotted evenly on graph. This is also an indication that the assumptions of linearity and homoscedasticity have been met (Field, 2009).

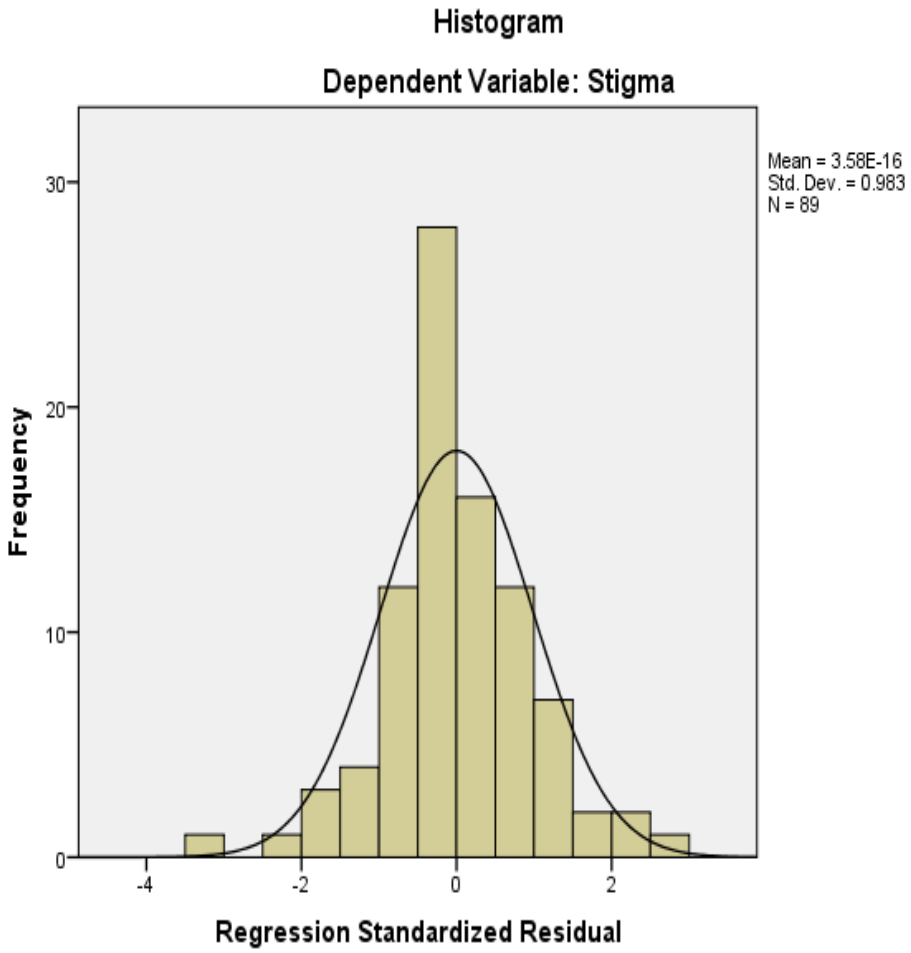

Figure 2. Histogram standardized residual.

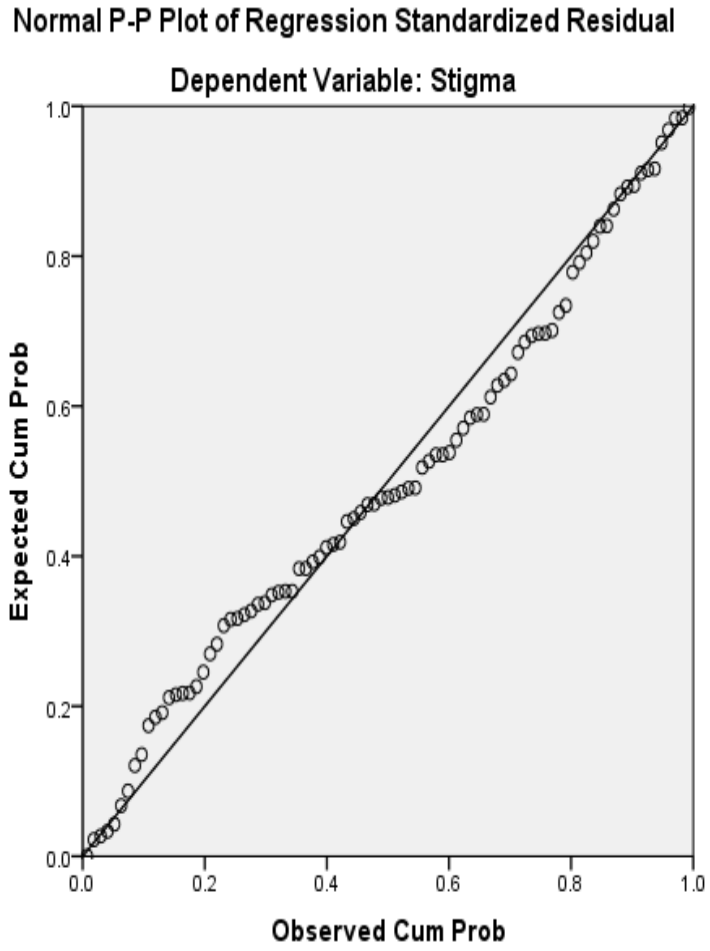

Figure 3. Probability plot.

Inferential Statistics

A standard multiple regression was used to show whether social distance, blameworthiness, or fear of unpredictable behaviors were predictors of public stigma. Analyses were run to ensure there were no violations of multicollinearity, normality, linearity, homoscedasticity, and independence of residuals. The first analysis showed a violation on the Mahalanobis scale, therefore outliers were removed. Data was then reevaluated and results confirmed no violation with the removal of the outliers so there

were no violations of multicollinearity, normality, linearity, homoscedasticity, and independence of residuals.

Below, the results for each research question are presented.

1. What are the levels of stigmatization felt toward mental health patients by emergency responders in rural communities while providing care?

The results for the regression indicate that only 0.077 of the variance of variability of the dependent variable Stigma can be explained by the combination of independent variables, Social Distance, Unpredictable Behavior, and Blameworthiness. The regression's Significance score of .075 also indicate there is not a significant correlation between the dependent variable Stigma, and the independent variables, Social Distance, Unpredictable Behavior, and Blameworthiness.

2. Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' fear of unpredictable behavior of this population?

The results indicate that the relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' fear of unpredictable behavior is not significant (r^2=1.481,ρ=.142). The 0.077 variance means that only 7.7% the variance can be explained between the dependent variable Stigma and the independent variable Unpredictable Behavior. The correlation between Stigma and Fear of Unpredictable Behavior is 0.182, with a significance score of 0.044 indicating that there is a significant correlation between the dependent variable of stigma and the independent variable fear of unpredictable behavior.

3. Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' need for social distance of this population?

The results indicate that there is not a significant relationship between the level of stigma felt toward mental health patients by emergency responders and emergency responders' need for social distance (r^2=1.552,ρ= .124). The correlation between Stigma and Social Distance is .197 with a significant score of 0.032 indicating that there is a significant correlation between the dependent variable Stigma and the independent variable Social Distance.

4. Is there a significant relationship between the level of stigma toward mental health patients by emergency responders and emergency responders' perceptions of blameworthiness regarding the behaviors exhibited by this population?

The results of this regression resulted in a nonsignificant score (r^2=-1.381,ρ=.171). The correlation between Stigma and Blameworthiness is -1.01with a significance of .173. These scores indicate that there is no correlation between the level of stigma felt toward mental health patients and perceptions of blameworthiness.

The independent variables Social Distance, Unpredictable behavior, and Blameworthiness did not predict the dependent variable of Stigma felt by emergency responders toward mental health patients with the results statistically insignificant $F(3,85) = 2.379$, $\rho < .075$. Looking at the t values and significant levels none of each of the independent variables contributed to the multiple regression. The R^2 for this analysis was .07, however, the adjusted R^2 was .045, demonstrating a wide gap and indicating a

very small proportion of variability of the dependent variable Stigma that could be explained by the independent variables Social Distance, Unpredictable Behavior, and Blameworthiness.

Summary

The purpose of this study was to explore the possible relationships between the dependent variable stigma, and the independent variables need for social distance, blameworthiness, and fear of predictable behavior. A survey design was used to assess whether there was a relationship between the independent variables and the dependent variable, public stigma. There was not a statistically significant difference between the attitudes of stigma towards mental health patients when providing care due to attitudes of social distance, blameworthiness, and fear of unpredictable behavior. Chapter five will discuss and further interpret the findings of this study, explain the limitations of this study, and finally discuss recommendations for further research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to extend prior knowledge of the possible relationships between the dependent variable of public stigma and the independent variables social distance, blameworthiness, and unpredictable behavior through a quantitative inquiry. Emergency responders, as defined in this study, included law enforcement, emergency medical teams, mental health crisis clinicians, and doctors and nurses in emergency rooms. The survey instrument was uploaded to Survey Monkey with an invitation and link to the questionnaire on Facebook. Research conducted by Corrigan et al. (2014) indicated that patients felt discriminated against while they received care from emergency responders. These patients reported that healthcare personnel did not believe their symptoms were genuine, and they were ignored in the emergency room during their visits, feeling discriminated against (Druss & Perlick 2014; Gras et al. 2015; Marchand, Pales, & Oviedo-Joekes, 2016; Sarkin et al., 2015). Emergency responders included law enforcement, ambulance personnel, emergency room doctors and nurses, and mental health clinicians (Corrigan et al., 2014). The literature identified public stigma experienced in urban areas; however, there was very little research found on public stigma experienced by emergency responders toward mental health patients in rural areas. Therefore, in this study, I sought to address this gap in the literature. In this chapter, I discuss the findings and limitations of this study. I also address implications for social change because of the study and recommendations for future inquiries.

Interpretation of Findings

Prior researchers identified social distance, blameworthiness, and unpredictable behavior as predictors of public stigma felt by emergency responders towards mental health patients (Broussard et al., 2011; Corrigan et al., 2014; Husbands et al., 2011; Kerr et al., 2011, Morabito et al., 2010; Morabito et al., 2012). The results of these studies were similar in that they all found social distance, blameworthiness, and unpredictable behavior to be predictors of public stigma. The results of the present study did not confirm previous findings in the current research. While I found significant correlations between stigma and social distance and stigma and fear of unpredictable behavior, I did not find a significant correlation between stigma and blameworthiness. Though the correlations were significant, they were small. This was unexpected since I predicted there would be a strong correlation between the variables. The findings indicated that none of my independent variables was a significant contribution to the regression. Only 0.077 of the variance in the dependent variable public stigma was explained by the combination of the independent variables social distance, unpredictable behavior, and blameworthiness.

Several possible interpretations may explain the present study's results. It is possible that the correlations between the dependent variable of public stigma and the independent variables of social distance, unpredictable behavior, and blameworthiness were too low initially, although previous researchers consistently demonstrated high correlations (see Arboleda-Florez & Stuart, 2012; Corrigan & Perlick 2014; Jines, 2013; Morabito et al., 2012; Pingani et al., 2012; Shrivastava et al., 2012;). Furthermore, public

awareness and trainings on how to respond to this population have increased, and it is possible that people are more self-conscious regarding their attitudes towards mental illness. Dar-Nimrod, Ganesan, and MacConn (2018) conducted a study to assess whether an individual would present oneself in a more favorable way than one actually is socially. They used the Marlow-Crowne Social Desirability Scale, which is a forced choice self-report used to measure whether one is attempting to be presented more favorably than they actually are (Dar-Nimrod et al., 2018). Participants read a prompt such as "I never hesitate to go out of my way to help someone in trouble" and then answered *true* or *false*, true indicating a social desirability, but unlikely real answer (Dar-Nimrod et al., 2018). Dar-Nimrod et al. found that the variable being cool correlated highly with social desirability. The results of this study show a possible link between the small correlations resulting from the current study and individuals' feelings of self-consciousness regarding attitudes toward mental illness.

Another study was conducted using the Social Desirability Response Bias scale and the MACH IV Scale to look for a possible relationship between Machiavellianism and social desirability (Trihi, Cook, & Bay 2015). Machiavellianism is the ability to employ duplicity in one's own conduct, meaning a person may feel one way but act out more ethically due to opinions of those around (Trihi et al., 2015). This attribute may not be limited to behavior but may also influence answers when given questions that reflect personal values (Trihi et al., 2015). A person high in machiavellian characteristics may feel they might benefit from appearing more ethical (Trihi et al., 2015). Trihi et al. (2015) found a significant positive relationship between machiavellianism and social

desirability, indicating that individuals high in machiavellianism are more likely to answer questions in a way that would make them appear more ethical in front of others. This study provides additional support that individuals may represent themselves in a more favorable light. Corrigan, Guase, Michaels, Buckholz, and Larson (2015) conducted a study using the California Assessment of Stigma Change tool. This assessment showed sensitivity when measuring levels of stigma before training in mental health awareness and levels after training. The tool showed sensitivity to changes in stigma and yielded positive results for reduction in stigma when people with experience in the field (Corrigan et al., 2015) deliver programs. However, it also showed inconsistencies when ethnicity was a variable (Corrigan et al., 2015). These studies reviewed offer possible explanations for current changes in feelings of public stigma.

The questionnaires, Modified Devaluation Discrimination Scale, Attribution Questionnaire Short Form, and the Social Distance Measure were not created specifically to designate emergency responders. Therefore, they may have missed important areas of concern that would be considered unique to this population, including the need to appear more ethical. Finally, public opinion toward emergency responders and their possible attitudes toward mental illness may influence their willingness to share those attitudes (Alexander & Link, 2003; Broussard et al., 2011; Corrigan et al., 2014). The theoretical framework for this study was the modified labeling theory (see Link et al., 1989). This theory explains how cultural perceptions of mental illness become relevant when an individual is diagnosed and in treatment (Link et al., 1989). Once a person is labeled with a mental disorder, negative consequences generally follow in the form of lower self-

esteem and possibly lower earning power (Link et al., 1989). This may ultimately result in increased manic episodes and possibly prolonged illness (Link et al., 1989).

Finally, research has indicated that the public has become more sophisticated in their thinking. This may have led to more open thinking and acceptance when it comes to mental health issues, although stigma is still quite prevalent (Pescosoledo, 2013). If society has become more open about feelings of mental illness, this could account for lower levels of stigma within the study.

Stigmatizing attitudes that may negatively affect response care from emergency responders toward mental health patients was the focus of this study. Continued research in this area is needed to provide more insight into public stigma and to assess the measures used. Although I did not find correlations that confirm previous studies, the study yields results that are consistent with current change that is being studied. This is a topic that should be revisited using the current tools.

Limitations of Study

The study has several areas of limitation. Social media was used for participant recruitment. The invitation required a potential participant to be 18 years of age or older and currently working in the capacity of an emergency responder in a rural area. Since recruitment was completed online through social media, authenticity was unable to be confirmed. Additionally, it is possible that those individuals who regularly use the Internet do not share the same attitudes as those who do not. According to Creswell (2007), those who use the Internet may be of higher socioeconomic status and, therefore, may have a different mindset, possibly contributing to different results. It is also possible

that the diversity of the emergency responders in the population confounded the results. It may be necessary to narrow down the sample population into specific emergency responders i.e., police officers or emergency room personnel rather than combining them. These different emergency responders are required to have different levels of training. It could be that this factor also contributed to confounding results. The area of recruitment was initially meant to seek participants from a 100-mile radius on the Arizona-California border on Highway 95. This area is very rural, and law enforcement limits communication regarding personal attitudes and bias, especially since social media has made public different incidents that reflect attitudes negatively regarding law enforcement agencies. The survey I used in this study may have seemed too invasive to this population. Future researchers may consider another form of data collection that might include conducting the survey in person. This may build more confidence between the researcher and the participants and may ensure more accurate results.

Recommendations

In this study, I sampled emergency responders through social media to look for correlations between the dependent variable public stigma and the independent variables social distance, unpredictable behavior, and blameworthiness. Though the present study found two significant correlations, they were still smaller than expected based on previous research. It may be helpful in future research to reevaluate the survey tools used since there could be differences between types of first responders i.e., law enforcement versus healthcare providers. It is possible that in the current survey there was little correlation in the beginning. However, using one of the Social Desirability scales or the

MACH IV scale may help bring understanding to the way the questions are answered. Both the Social Desirability Scale and the MACH IV Scale measure an individual's desire to present oneself in a more positive light (Trihi, Cook & Bay, 2015). The California Assessment of Stigma Change (CASC) tool may provide insight into the effect that current training is having on emergency responders. It may be helpful to conduct the research in person instead of social media, possibly ensuring more accurate results. Conducting a study in person will ensure the authenticity of sampled population. In addition, it may encourage more honesty when answering questions. Mental health awareness has become a topic of discussion and training for emergency responders. They may find a survey regarding their personal attitudes towards mental illness as invasive or an attempt to judge their personal biases. Since there has been an increase in education both publicly and in the work place, it may be helpful to measure how much training on mental health awareness participants have had prior to taking the survey, more training may result in fewer correlations.

Implications

Since this research yielded little correlation, it may be beneficial to retest the population and look for reasons that would demonstrate why the correlations were so low. Is this research still relevant, or have the attitudes of stigma changed in society? If they have changed then what are the reasons for the change and is the change a positive one for society? It is possible that awareness has not changed the attitudes, but has forced attitudes of discrimination to be hidden. If society understands that negative attitudes about stigma and discrimination are no longer acceptable, it may cause them to hide those

feelings. It is also important to consider that society's attitudes along with time, have changed and these findings may be considered a sign of hope. Has increased training and education in the workplace provided increased awareness and knowledge about attitudes of stigma toward mental health patients causing improvement in overall feelings of stigma? If increased education and awareness are responsible for improved attitudes in stigma then it is possible that improved care would follow. A study that surveyed mental health patients' attitudes about their care during emergency situations would be another area to explore. A qualitative approach in future research may provide a better lens for more accurate findings.

Conclusion

Stigma experienced by emergency responders toward mental health patients has been an important subject that has gained public attention since 1987 when relatives of a mental health patient called the police because the relative had been cutting himself and was threatening to cut others (Husbands et al., 2011). The patient continued to exhibit manic behavior when the officers arrived on the scene. The patient had a knife in his hand and continued in his manic behavior towards the officer who shot and killed him (Husbands et al., 2011). After the incident had been investigated it was found that the resulting death was due to the officer's lack of knowledge regarding mental health patients' behavior. Additional research conducted by Corrigan, Druss, and Perlik (2014) found that patients receiving care from emergency responders and hospital staff during crisis incidents felt discriminated against. The current study found little correlation between stigma and discrimination, blameworthiness, and the need for social distance.

However, it may be that there are underlying reasons for this change. It is my hope that the findings of this study provoke further research in this area to either confirm or deny the results and to bring new understanding for the results. Have emergency responders' attitudes changed toward this population or have they become educated enough to become aware of the negative impact of their attitudes? Is it possible that society has become aware of attitudes that are no longer acceptable and therefore, emergency responders find subduing feelings of stigma to be more appropriate?

Future research should address the possible error of the study, the possible shift in societal attitudes toward discrimination and even more interesting, the possible need for individuals in society to appear more ethical than they really are when revealing their personal opinions.

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