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The effects of stigma perpetuated by substance abusers on mentally ill substance abusers in residential treatment

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THE EFFECTS OF STIGMA PERPETUATED BY SUBSTANCE ABUSERS ON MENTALLY ILL SUBSTANCE ABUSERS IN RESIDENTIAL TREATMENT

A Project

Presented to the

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California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

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by

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ABSTRACT

This study explored stigma perpetuated by non-mentally ill substance abusers and its effect on mentally ill substance abuser's well-being in residential treatment. There is very little research on the effects of stigma perpetuated by the substance abuse population on mentally ill substance abusers in residential treatment. Stigma levels were measured using Link's Devaluation-Discrimination Belief's Scale (1987) and six additional items from a later scale on Rejection Experiences and Secrecy (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997).

A measure of well-being was included in the study to determine if there is a correlation between MISA's well-being and stigma. Well-being was measured using the Friedman Well-Being Scale (1994).

This quantitative research found that respondents' somewhat agree stigma exists in residential treatment. And, they report feeling a low level of well-being in residential treatment. However, no significant correlation was found between stigma and well-being. Divided among ethnic groups, strong negative correlations were found between beliefs about

devaluation/discrimination and overall well-being, emotional stability, and happiness among the Caucasian group. No significant correlations were found among the African American and Hispanic groups. However, the Other group indicated strong negative correlations between self-esteem/self-confidence and secrecy, and rejection experiences/secrecy and sociability.

This study offers crucial knowledge to improve treatment services by showing program development staff where treatment interventions can be most helpful. In addition, the results can be used to help shape future policies to protect individuals with mental illness in residential substance abuse treatment.

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DEDICATION

This research project is dedicated to my family (Cherie, Aaron, & Christopher) who surrendered many of their own wants and desires in order to see me succeed in my higher education. Additionally, this research project is dedicated to my mother, Shirley Ann Barnstable, who never gave up on me and continues to inspire me to move forward in my life.

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CHAPTER ONE

INTRODUCTION

Problem Statement

The stigmatization of individuals with mental illness, according to the Surgeon General (as cited in Substance Abuse and Mental Health Services Administration, 2003) remains a major problem and can dissuade the individuals with mental illness from seeking necessary mental health and substance abuse services (Sartorius, 2007). For those few consumers with mental illness who do seek help for their substance abuse problem in residential alcohol and drug treatment centers that offer co-occurring disorders treatment, stigma from the remaining substance abuse population that do not have mental illness may hinder their progress, create an antagonistic environment, or cause them to terminate services before completion. Such an antagonistic environment may also lead to a lack of psychotropic medication compliance in consumers with mental illness who are already struggling with acceptance of their mental illness.

Consumers receiving only substance abuse services in a treatment center that offers co-occurring disorders treatment may perpetuate stigma in the same manner as other misinformed individuals in society. In fact, a 1996 General Social Survey revealed that more than thirty three percent of the sample were "unwilling to have people with mental health problems as neighbors, friends, or residents in a nearby group home" (Martin, Pescosolido, & Tuch, 2000, p. 219). The non-mentally ill substance abuse (SA) treatment consumer may not understand the mental health related symptomatic displays of the mentally ill substance abuser (MISA) and may fear possible attacks, view the person with mental illness with dislike (Martin et al., 2000), make fun of or put down the mentally ill substance abuser (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997), or harass and discriminate against this population. Stigma is a powerful unseen force working against individuals with mental illness.

Advocates such as the National Alliance for Mental Illness (NAMI) and the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) are major proponents in

the fight against stigma, including outright discrimination. In fact, SAMHSA recently launched an anti-stigma campaign in collaboration with the Ad Council. The ads target young adults and encourage friends of individuals with mental illness to provide support to their friends. The ads are being released through television, print, and a website (SAMHSA Launches Anti-Stigma Campaign, 2006). Social workers, as policymakers, can continue the fight against stigma on a macro level and have powerful influence on new policies that protect the rights of individuals with mental illness.

Federal laws protect individuals with mental illness from discrimination, a component of stigma, and provide guidelines for legal action against those who violate the rights of a consumer. In addition, a complaint can be filed with the Office of Civil Rights or similar government agency. The Americans with Disabilities Act and The Rehabilitation Act of 1973 both contribute to the protection of the rights of people with disabilities (Substance Abuse and Mental Health Services Administration, n.d.). However, regardless of the amount of protection offered under federal law in residential

substance abuse treatment there remain many consumers participating in substance abuse treatment that have little regard for the law. Furthermore, many consumers of residential alcohol and drug treatment have poor life skills or have been socialized in such a way as to have little awareness of their impact on others regarding various discriminatory verbal comments or behaviors.

Discriminatory verbal comments and behaviors displayed by mentally ill and non-mentally ill substance abuse treatment consumers have important implications for social workers. It is important for social workers to address such comments and behaviors in group-work and individual counseling sessions. The media have inundated society with misconceptions about individuals with mental illness. Stuart (2006) writes, "Long before people ever meet someone with a mental illness or encounter a mental health professional, they have formed opinions and developed prejudices" (p. 103). Understanding aspects of stigma that are most prevalent, and components of well-being that are least prevalent, will aid social workers to focus treatment alternatives specifically designed to compensate in these areas.

Purpose of the Study

The purpose of this study was to examine MISA's perception of stigma, and stigma experiences, perpetuated by non-mentally ill substance abusers in residential treatment and its association with MISA's level of well-being. Stigma related to mental illness has been explored and conceptualized by researchers as having various constructs that affect individuals in diverse ways. Link et al. (1997) used three components to measure stigma including coping skills, rejection experiences, and beliefs about devaluation/discrimination to determine the amount of stigma perpetuated in a sample population of 84 dually diagnosed men. His research focused on whether the effects of stigma endured over time, and not on stigma's association to well-being in the present. Similar components that Link et al. (1997) used to measure stigma will be used in this study. This study will include four items from his Rejection Experiences subscale scale and two items from his Secrecy subscale. However, this researcher will be utilizing Link's (1987) earlier twelve-question version of the Devaluation/Discrimination Beliefs scale.

Many studies have measured well-being in an attempt to understand mental health and use various mental health symptoms as items to measure well-being. The Friedman Well-Being Scale (FWBS; Friedman, 1994) measures adult well-being related to emotional stability, self-esteem/self-confidence, sociability, joviality, and happiness, using a scale from 0 to 10 that measures present feeling levels between two bipolar adjectives (Friedman, 1994; Kipper & Hundal, 2005). This study utilized the FWBS because of its ability to measure a participant's current state of well-being without directly inquiring about mental health symptoms.

The research design for this study is a cross-sectional survey design. The rationale for using this design was to gather quantitative data on levels of well-being and levels of stigma among MISAs. It was hypothesized that stigma levels are high among MISAs in residential substance abuse treatment, MISAs have a low level of well-being while accessing services, in residential substance abuse treatment, and the well-being of MISAs will be significantly correlated with stigma perpetuated by the SA population. Unfortunately, due to limited resources and time constraints a random sample

was not selected. The sample included participants from two residential substance abuse treatment centers in San Bernardino County. The independent variable was stigma and was measured using Link's (1987) Devaluation/Discrimination Beliefs Scale. Further measurement of the independent variable stigma included six items extracted from Link's (1997) Rejection Experience and Secrecy subscales and altered with the prefix 'Since entering treatment' to measure rejection experiences and secrecy as a coping response in their current residential treatment episode. The dependent variable was well-being and was measured using the Friedman Well-Being Scale (1994).

Significance of the Project for Social Work

Results from the research in this study contribute to an understanding of the degree to which MISAs are affected by stigma in a residential treatment environment that houses both non-mentally ill and mentally ill substance abusers. Thus, it paves the way for policy implementation at organizational, local, state, and federal levels to increase the protection of the MISA population. When the correct policies regarding the

dynamics of stigma are implemented in residential substance abuse treatment centers, the MISA residential treatment drop-out rate will decrease. Changes in policy related to stigma research and decreased drop-out rates will improve treatment outcomes. Improved treatment outcomes may interest funding sources who are devoted to investing in viable treatment programs for individuals with mental illness.

Advocates for the rights of individuals with mental illness, and many other members of society, are concerned about stigma attached to mental illness because this population, including MISAs, is being discriminated against and not getting needed services, including fair, safe, substance abuse treatment services. The results of this study contribute to the arsenal used by policymakers and advocates to improve residential treatment environments used by this population. This research contributes to policy that will encourage residential substance abuse treatment providers that offer co-occurring disorders treatment to educate non-mentally ill substance abusers and treatment provider staff about the impact of stigma related to mental illness on MISA. Furthermore, MISAs are concerned about stigma because it

will hinder their progress, lower their self-esteem (Kahng & Mowbray, 2004) and cause further anxiety and depression (Markowitz, 1998).

Regarding social work practice, this research contributes to educational material that targets constructs of stigma that are currently not addressed or are given minimal importance. Updated and empirically researched educational material streamlines treatment for both the SA and MISA populations. Improved stigma related educational material and practices provide a safe treatment amenable environment for MISAs, decreases psychiatric hospitalizations among the MISA population, and increases MISA well-being. Direct practice social workers and other social service workers are interested in this research due to the amount and severity of crises that are caused by stigma. Empirical data motivates skeptical staff to obtain needed training about the impact of stigma, incorporate needed material into groups, and utilize new skills and techniques in individual counseling sessions. This research provides empirically tested information to co-occurring treatment providers that can be used to improve program design in

an effort to improve services and meet the needs of the growing mentally ill population.

The level of stigma reported by MISAs and its association with the well-being of the MISA population found in this study will contribute to further research done in this type of setting. Further research may provide professionals with increased awareness about the prevalence of stigma in this type of setting and increase treatment providers, researchers, and professionals ability to reduce stigma and increase the well-being of mentally ill substance abusers.

The results from this research will be used in diverse ways to influence all levels of the generalist model of social work. Miley, O'Melia, and DuBois (2007) recognize four separate generalist practice levels to consider in social work. First, interventions with individuals, families, and small groups, termed microlevel systems, are important in generalist practice. This study provides important insight into stigma and well-being that should equip workers in the helping profession to be able to empower their clients in all microlevel systems objectives. Kirst-Ashman and Hull (2002) remind readers of the seven steps of the

Generalists Intervention Model that includes engagement, assessment, planning, implementation, evaluation, termination, and follow-up. Superimposing anti-stigma related practices on the seven steps and practicing interventions that increase well-being will enhance the quality of services to individuals with mental illness.

Miley et al. include a midlevel system whereby social workers "...locus of change is within organizations and formal groups including their structures, goals, or functions" (p. 12). This research creates awareness of stigma present in residential treatment and reports low levels of well-being among individuals with mental illness in residential treatment. Structures, functions, and goals of organizations in midlevel systems may be revamped due to the results of this study. According to Miley et al., Macrolevel systems involve societal systems. This research can be compared to existing literature and used as a catalyst to develop legislation to decrease stigma in residential substance abuse treatment. Lastly, the social work profession is considered the fourth level. This study points to the importance of confidentiality and privacy. Colleagues should hold one another accountable to best practices and

work in the best interest of the client. In light of these promising contributions to the social work profession an attempt was made by the author to gain an understanding of the research question: How is stigma attached to mental illness perpetuated by non-mentally ill substance abusers in a residential substance abuse treatment center associated with the well-being of mentally ill substance abusers receiving co-occurring disorders treatment in the same residential treatment center?

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter focused on previous research that has relevance to the current study. The first section includes a widespread conceptual understanding of stigma attached to mental illness that already exists in the literature. The second section discusses past research on well-being and explains the major components of well-being most relevant to this study. A third section discusses theoretical perspectives and how they have contributed to contemporary explanations of stigma and well-being.

Stigma Attached to Mental Illness

In the literature there are many social issues in society that have a different meaning of stigma attached to a specific issue (Link & Phelan, 2001). For example, in measuring stigma attached to obesity the measuring tool will need to include more items from a visual perspective and far less on fear. In fact, Hebl and Turchin (2005), who studied the relational patterns and reciprocal stigma between men and obesity, used

photographs and magazine pictures to develop stimuli before administering their questionnaire and fear was not a factor in determining stigma. In stigma attached to mental illness, however, fear is considered a factor that perpetuates stigma and is included on the Devaluation/Discrimination Beliefs Scale (Link, 1987; Link et al., 1997) to aid in measuring stigma attached to mental illness. Link and Phelan (2001) conceptualized stigma as four interrelated components occurring simultaneously. First, they assert that individual differences are determined and labeled. Second, beliefs from the dominant culture link individuals with a label to characteristics that are undesirable. Third, undesirable characteristics contribute to the separateness between those who are stigmatized and those who are not and create categories. Fourth, the labeled individual experiences a loss of status and is discriminated against. The conceptual understanding of stigma proposed by Link and Phelan will be used as a guide to understanding stigma in this study.

Markowitz (1998) studied the effects of stigma in a longitudinal study using cross-sectional and lagged regression models on a sample size of 610 outpatient and

self-help group participants. He used Link's (1987) Devaluation/Discrimination Beliefs Scale to measure anticipated stigma, and a one-item question to measure stigma experiences. Experienced stigma is simply actual experiences of devaluation and discrimination, including rejection, felt by a person who is mentally ill (Markowitz, 2001). The one-item question to measure stigma experiences was, "During the last six months, do you feel you were discriminated against or stigmatized because of your mental illness?" (Markowitz, 1998, p. 338). A description of the discriminatory event was requested and purportedly provided validity to the one-item scale. Anticipated stigma is a mentally ill consumer's beliefs and perceptions that they will be rejected by people in their environment (Markowitz, 2001). Markowitz (1998) found that depressive and anxiety type symptoms were more likely to be affected by stigma. What is notable, however, is the study revealed that psychotic symptoms may be less affected by stigma. Furthermore, Markowitz (1998) found that stigma affected both social outcomes and life satisfaction. The study does not include stigma attached to mental illness that

is perpetuated by non-mentally ill substance abusers in a residential treatment setting.

Link et al. (1997) completed a longitudinal study to determine if the effects of stigma on well-being endure over time. This cross-sectional design only had a sample of 84 males who participated in one year of residential co-occurring disorders treatment. The sample did not represent the co-occurring disorders population concerning race nor gender. Therefore, the results are not generalizable to the entire co-occurring disorders population. However, the results of this study have important connotations and may be more accurate than not. Link et al. measured their sample upon entry into treatment and one year later. They found that men generally improved over time due to treatment, but that stigma continued to affect men negatively. In other words, MISA's will improve in treatment to a degree, but some of the negative effects of stigma may remain with the mentally ill consumer and make it more difficult to stabilize in recovery from both diseases. Further research on the extent of such stigma in residential treatment centers may be the key to improve well-being among mentally ill substance abusers. Another important

finding of this study is that the alternative explanation that the measurement of stigma is confounded by psychiatric symptoms is proved to be incorrect (Link et al., 1997).

In another study, Perlick, Rosenheck, Clarkin, Sirey, Salahi, Struening, and Link (2001) evaluated a sample of 264 consumers of university affiliated psychiatric hospital outpatient or inpatient services with bipolar affective disorder to determine effects of stigma on social adaptation. Perlick et al. found that the higher level of concern individuals have about stigma the more their social functioning will be impaired in relations outside of their family. More specifically, when participants were concerned about being stigmatized they were much more likely to avoid social interactions with others outside their family. Such findings require further research to determine specific effects within residential programs to assess need in developing needed material to protect this vulnerable population. In contrast, Couture and Penn (2006) found that the decision of community members to remain socially distant from the mentally ill reduces as the relationship between a non-mentally ill volunteer and the mentally ill person

develops. However, the sample in this study are among a much more stigmatizing and discriminatory population of substance abusers who already have a much lower ability to function in society than the sample of community members used in their research.

Other studies reveal the effects of stigma as well. Goffman (as cited in Kahng & Mowbray, 2004) suggests that stigma hastens lower self-esteem. Self-esteem is reciprocally affected by self-concept (Corrigan, 2004; Markowitz, 2001). Corrigan (2004) indicates "self-stigma" happens when people react to their environment by turning against themselves because of their assignment in a group that is stigmatized. Self-esteem is also highly correlated with well-being and is included as one of the subscales on the Friedman Well-Being Scale (Friedman, 1994).

Well-Being

In a residential substance abuse treatment center environment the constructs that contribute to higher well-being can increase MISAs chances for recovery. Friedman (1994) uses the acronym BETSI-HI to explain some of his research findings on the Friedman Well-Being

Scale. He concluded that (B) the higher the level of well-being the more likely individuals will take on goal directed behaviors that are more challenging and (E) the amount of positive emotions are significantly greater. He reports the (T) thoughts of someone with higher well-being is more optimistic, positive, loving and hopeful and less pessimistic, attitudinal, non-loving and discouraging. Also, such people with higher levels of well-being, (S) report less somatic complaints, (I) have increased positive images, (H) decreased complaints and symptoms regarding health, and are more competent in interpersonal relations including assertiveness (Friedman, 1994, p. 32). Friedman's findings can be used to inform direct service staff of specific interventions to perpetuate a higher state of well-being in their clients. Some of these concepts are already a focus of residential treatment centers. Stigma may reduce the existence of these needed elements of a higher state of well-being.

The FWBS measures the participant's current state of well-being on five subscales including joviality, sociability, happiness, self-esteem/self-confidence, and emotional stability (Friedman, 1994; Kipper & Hundal,

2005). Kipper and Hundal (2005) used the FWBS to determine the validity of their new spontaneity and non-spontaneity scales and found the validity to be satisfactory. The FWBS has also been correlated with one hundred plus scales and subscales that measure marital, interpersonal, stress, relational, attitudinal, personality, emotional stability, and clinical constructs (Friedman, 1994; Kipper & Hundal, 2005).

In contrast, Ryff and Keyes (1995) tested a psychological well-being model that includes six factors of wellness. Environmental mastery, self-acceptance, having a purpose in life, personal growth, autonomy, and positive relations with others are included in their conceptualization of wellness. However, the scale has at least one item in the mastery component that may be scored negatively throughout a sample if it were administered to a sample population in a residential substance abuse treatment center. For example, the item is, "I am quite good at managing the responsibilities of my daily life" (Lindfors, Berntsson, & Lundberg, 2006, p. 1215). Most of the participants in a residential treatment center have major life skill difficulties and are in residential treatment because of major life

crises. Additionally, another item that measures purpose in life asks, "I sometimes feel I've done all there is to do in life" (Lindfors et al., 2006, p. 1215). This item inquires about a participant's contentment in achieving all they want out of life. Many of the participants in residential treatment for co-occurring disorders have given up on life, or have not been able to do well in life because of their co-existing diseases. In this study the FWBS was used to determine most closely the participant's current state of well-being.

In a qualitative study on transitional age homeless youth that included reports on well-being, Muir-Cochrane, Fereday, Jureidini, Drummond, and Darbyshire (2006) found that medication compliance, including acquiring medication, medication management, medication side-effects, and illicit drug interactions with medication, were factors in determining mental well-being. However, the effects of medication related issues on well-being are not an issue in this study due to the nature of the residential environment and the requirement of all participants to comply with psychotropic, and other, medication prescriptions. Additionally, staff and collaborative mental health

agencies were available to answer participants' questions about medications including the side-effects of medications.

Theories Guiding Conceptualization

In classic literature on stigma Scheff (as cited in Link, 1982; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Markowitz, 1998; Mueller, Nordt, Lauber, Rueesch, Meyer, & Roessler, 2005; Zastrow & Kirst-Ashman, 2004) introduced a new perspective on the etiology of psychiatric disorders by suggesting that mental illness is caused and perpetuated by a label. In labeling theory the person is assigned the label of being mentally ill and then adopts the behaviors and stereotypes that are connected to the label (Link, 1982; Mueller et al., 2005; Rosenfield, 1997).

Link (1982) departed from labeling theory and developed a modified labeling theory. He suggested that the effects of a label are underemphasized and that the label has a major impact on other areas of a person's life as well, such as choosing a mate, choice of friends, employment, and how the person relates to family. Since his departure from full agreement with labeling theory

many researchers have adopted his view and have continued to build on his modified labeling theory. This study follows a modified labeling theoretical framework as well.

In another study Link et al. (1989) continued to build on modified labeling theory and found results consistent with his previous conceptualization of modified labeling theory. In addition, he found that patients who enter treatment for the first time already have a negative perceptual framework of what it means to be mentally ill and immediately confront the effects of stigma. They also found that dealing with the label affects patient's social connectedness.

Zastrow and Kirst-Ashman (2004) describe life satisfaction as overall well-being in a psychological sense or being satisfied with life in general. Friedman (1994) indicates that well-being is sometimes referred to as satisfaction with life or quality of life. Friedman (1989) conceptualized higher well-being as being associated with twelve core principles: purpose and vision, creation and manifestation, attitudes and thoughts, re-perceive and reframe, alternatives and possibilities, accomplishment and satisfaction,

self-esteem and love, peace and security, affectionate and loving relationships, caring and close friendships, gratitude and abundance, and a center or source.

Summary

There is a vast amount of literature on stigma that has provided evidence for the importance of determining the effects of stigma in residential substance abuse treatment facilities to provide protection for individuals with mental illness. Research on theoretical frameworks of well-being has afforded development of a well-being model that can give an adequate measure of an individual's emotional stability in their present state. Comparing data from both scales has provided useful results that builds on previous research and pinpoints areas for program development.

CHAPTER THREE

METHODS

Introduction

This section of the paper contains an overview of the research methods that were utilized to gather data from the MISA population at two residential substance abuse treatment centers in San Bernardino County. More specifically, the design of the study, sampling methods, data collection, procedures, the protection of human subjects, and data analysis are discussed in greater detail.

Study Design

The purpose of this study was to examine MISA's perception and experiences of stigma perpetuated by non-mentally ill SAs in residential treatment centers and its association with MISA's well-being. The results of this study are useful to provide insight to treatment providers on what they can do to protect the MISA population in residential substance abuse treatment settings. In addition, the results are useful to determine the most problematic areas of stigma in a residential treatment setting so that treatment programs

can be altered and enhanced for both the MISA and SA population.

In this study an exploratory quantitative approach was implemented using a cross-sectional survey design. A quantitative approach was used simply because a vast amount of research already exists on stigma and the components of stigma have already been established. The components of well-being have been conceptualized and heavily researched as well. Therefore, this study was exploratory only to the degree to understand more about the independent variable stigma on the MISA population and how it is associated with their well-being in such a setting.

Several unforeseen factors could have contributed to limitations in this study. For instance, individuals often do not have cigarettes in residential treatment and may have some level of irritability which certainly could skew results in well-being levels. Also, the perpetuation of stigma by staff is not included in the study and may have a degree of effect on the sample population. Another limitation is that the sample included individuals that are available and not randomly selected. Therefore, it is unlikely that the sample is generalizeable to the entire

MISA population. Furthermore, each questionnaire involved self-reports which are not always answered accurately. However, the data this study generated provides preliminary and exploratory answers to the question: How is stigma attached to mental illness perpetuated by non-mentally ill substance abusers in a residential substance abuse treatment center associated with the well-being of mentally ill substance abusers receiving treatment in the same residential treatment center?

Sampling

The sample included participants from two residential substance abuse treatment centers in San Bernardino County that offer co-occurring disorders treatment to individuals with mental illness. A non-probability convenience sample of a total of 52 participants was recruited from both treatment centers. However, four of the fifty-two participants' self-report survey sheets were deemed invalid due to participants improperly answering a majority of the items on the FWBS. The revised total sample population was 48 participants. A staff member made an appearance at each facility and asked potential participants if they were interested in

participating in the study. Each participant was compensated $5.00 for their contribution.

The sample included individuals who have been in a residential substance abuse treatment setting for at least one week and had an alcohol or drug abuse or dependence diagnosis. Participants must also have had a mental health diagnosis. Each participant was age 18 or older and not mandated to residential treatment by any local, county, state, or federal authority.

Data Collection and Instruments

The independent variable stigma was measured using Link's two scales that produced an overall interval level of measurement score termed the stigma composite score in this study. First, Link's (1987) Devaluation/Discrimination Beliefs Scale (See Appendix A) included 12 items that were answered on a six point Likert scale from 1 = strongly agree to 6 = strongly disagree. The scale is comprised of questions that assess the degree to which people believe others will discriminate against or devalue an individual with mental illness and included its own separate subscale interval level of measurement score (Link, 1987). Items 5, 6, 7,

9, 11, and 12 were reversed. One of respondents missed item 1 and another respondent missed item 3. These cases were included in the study by calculating the mean of each item for the forty-eight respondents and inputting the mean scores into the data. The reliability of the measure among patients that repeat contact (α = .82) and former patients (α = .83) is adequate. The reliability among patients with first-time contact with treatment (α = .79) is adequate as well (Link, 1987).

The second scale included 6 additional items to measure rejection experiences and secrecy (See Appendix B). Link et al. (1997) included the items to measure rejection experiences and secrecy in stigma variables that contribute to the process of stigma (Link et al., 1997). The six items were selected and modified from the Rejection Experience and Secrecy subscales (Link et al., 1997). Items 1, 2, 3, and 4 were modified to measure MISA's rejection experiences in a residential treatment setting. Items 5 and 6 were modified to measure MISA's secrecy about their mental illness in a residential treatment setting. The items were scored on a six point Likert scale from 1 = strongly agree to 6 = strongly disagree. All of the items were reversed in the

Rejection/Secrecy scale. One of the forty-eight respondents circled two answers for item 3 so the mean was calculated for all forty-eight respondents and input into the data for that respondent's item. A separate interval level of measurement score was computed from the rejection experiences and secrecy scale. In addition, a separate interval level of measurement score was taken solely from the rejection experiences items. And, a separate interval level of measurement score was taken from the secrecy items. The rationale for using the modified items was that the modified items were worded in such a way as to more fully capture the experiences of rejection and secrecy as a way to cope during participants' current treatment episode. The wording of the original items is very similar and captures the same experience; however, the words 'since entering treatment' have been added to elicit responses relevant to their current treatment episode.

The dependent variable well-being was measured using the FWBS (Friedman, 1994). The FWBS measures adult participants' level of well-being using 20 bi-polar adjectives. Respondents are asked to describe how they see themselves at the present time on a scale of

0 = negative adjective to 10 = positive adjective. The FWBS can be used to obtain an overall well-being score termed the Friedman Well-Being Composite (FWBC) or to obtain scores for five subscales including emotional stability (FES), joviality (FJOV), sociability (FSOC), self-esteem/self-confidence (FSES), and happiness (FHAPP). The FES subscale consists of 10 items. Example bipolar adjectives for the emotional stability subscale items are angry/calm, tense/relaxed, emotional/unemotional, and moody/steady. The FJOV subscale consists of three items with one of the items using the bipolar adjectives unenthusiastic/enthusiastic. Example bipolar adjectives for one of the three FSOC subscale items are unneighborly/neighborly. Timid/assertive is used in one of the three items for the FSES subscale. The FHAPP subscale includes one item that measures the bipolar adjectives unhappy/happy. The Friedman Well-Being Composite (FWBC) includes all twenty bipolar adjectives and measures overall well-being. Each subscale is scored separately to obtain scores that are converted to a 100 point scale. The higher the respondent's score the higher the level of well-being (Friedman, 1994). One respondent did not circle an answer

for one item and another respondent marked three answers on one item. These cases were included in the study by calculating the mean for each item and entering into the data. In this study, the raw scores were compared to standardized scores of a public study of adults listed in the Friedman Well-Being Scale and Professional Manual (1994). The FWBC and the separate subscales are interval levels of measurement. Five studies revealed a range of alpha coefficients from .92 to .98 for the FWBC (Friedman, 1994). Four studies revealed a range of alpha coefficients from .86 to .95 on the FES (Friedman, 1994). Test-retest reliability for clients in psychotherapy at three weeks was .85 and at week 5, 10, and 13 remained at .81 (Friedman, 1994). The FWBS has been correlated and validated with over 100 other scales and subscales.

Demographic data was collected using the Demographic Questionnaire (See Appendix C). The demographic information collected was mental health diagnosis, age diagnosed, age, gender, and race. The mental health diagnosis, gender, and race data are nominal levels of measurement. Age and age diagnosed are interval levels of measurement.

Procedures

Agency participation was solicited through phone calls to eight San Bernardino County and Riverside County treatment centers that offer substance abuse treatment to both the SA and MISA populations. Two of the substance abuse treatment centers in San Bernardino responded and gave permission (See Appendices D and E) to allow research at their facility. A request by the researcher was made to enter their facility on a one-time basis to administer the questionnaires in a group setting.

Copies of a flyer that introduced the researcher, the purpose of the study, amount of time it would take to complete the study, compensation, and what was expected (See Appendix F) was distributed to representatives at each facility for approval. Representatives at each facility presented the flyer to residents to solicit participation. A set time was allocated at each facility to administer the tests. This researcher administered the tests at both sites. The participants of one facility was tested on Wednesday and the other facility on Thursday during the same week. The total test administration time at each facility was no longer than 30 minutes each. After the test administration a debriefing statement was

read to all participants. As the tests were collected, compensation of $5.00 was given to each participant.

Protection of Human Subjects

The names of participants were not collected to ensure confidentiality. Only necessary demographic data were collected to protect clients. All data was stored in a safe to further protect clients and will be destroyed after completion of the study. Only the researcher and his faculty advisor have access to the data. Each participant was required to check a box and date an informed consent (See Appendix G) that explains risks and benefits. The participants were informed that participation is voluntary and had the opportunity to withdraw from the study at any time. A debriefing statement (See Appendix H) was read and given to participants at the end of the questionnaire administration.

Data Analysis

The data was analyzed using quantitative data analysis techniques. Descriptive statistics were used to present some of the characteristics of the total sample. A frequency distribution, measures of central tendency,

and measures of variability were performed on various demographics.

Link's Devaluation/Discrimination Scale mean score was obtained and compared to a 3.5 midrange mean score (Link, 1987). The mean score on the stigma composite scale was used to compare to a 3.5 midrange mean score (Link, 1987) to determine the level of stigma the group was experiencing at that time. The Rejection/Secrecy Scale and subscales were also compared to the 3.5 midrange mean to determine levels of secrecy as a coping response, and rejection experiences, and a combination of rejection experiences and secrecy as a coping response.

The composite score from the FWBS was used to determine the overall level of well-being of the sample and was compared to standardized scores in the Friedman Well-Being Scale and Professional Manual (1994). The Friedman Sociability subscale, Self-esteem/Self-confidence subscale, Emotional Stability subscale, Joviality subscale, and Happiness subscale scores were also summed and compared to standardized scores.

Bivariate correlations were obtained between the independent variables overall stigma, beliefs about

devaluation/discrimination, rejection experiences, and secrecy and the dependent variables overall well-being, sociability, self-esteem/self/confidence, emotional stability, joviality, and happiness using Pearson's r correlation coefficients to assess the relational strengths and direction of the independent variables and dependent variables.

Pearson's r bivariate correlations were also obtained by ethnicity between the independent variables stigma, beliefs about devaluation/discrimination, rejection experiences, and secrecy and the dependent variables overall well-being, sociability, self-esteem/self-confidence, emotional stability, joviality, and happiness.

Summary

Using a quantitative approach and cross-sectional survey design further exploration into stigma and well-being will provide valuable data to enhance treatment for both the MISA and SA populations. This study was performed with little inconvenience to the treatment providers using self-administered questionnaires that maximize data collection and offer

accurate results. All data collected was safeguarded in a manner that eliminates risk to the participants and protects their confidentiality. Finally, quantitative data analyses were used to benefit social workers, treatment providers, and policymakers.

CHAPTER FOUR

RESULTS

Introduction

Chapter Four presents the results obtained from the sample utilizing a quantitative research design. The demographics of the sample are summarized first using descriptive statistics including frequencies and measures of central tendency. Secondly, univariate statistics were extracted to determine stigma and well-being levels in the sample. Third, bivariate correlations were used to determine statistical significance between variables.

Presentation of the Findings

Demographics

Forty-eight of the fifty-two respondents' cases were deemed valid for the analysis. The age range of respondents was from 21 to 54 years with a mean age of 36 ($M = 36.00$, $SD = 9.77$). A Figure in Appendix J illustrates the frequencies, mean, and standard deviation of the respondents' ages.

The sample ($N = 48$) includes twenty-six female (54.2%) and twenty-two male (45.8%) respondents. The sample was comprised of 60.4% Caucasian or White

respondents, 18.8% African American or Black respondents, 14.6% Hispanic or Latino respondents, and 6.3% of the sample checked the Other category. Figure 1 depicts the dispersion of the respondents' ethnicity.

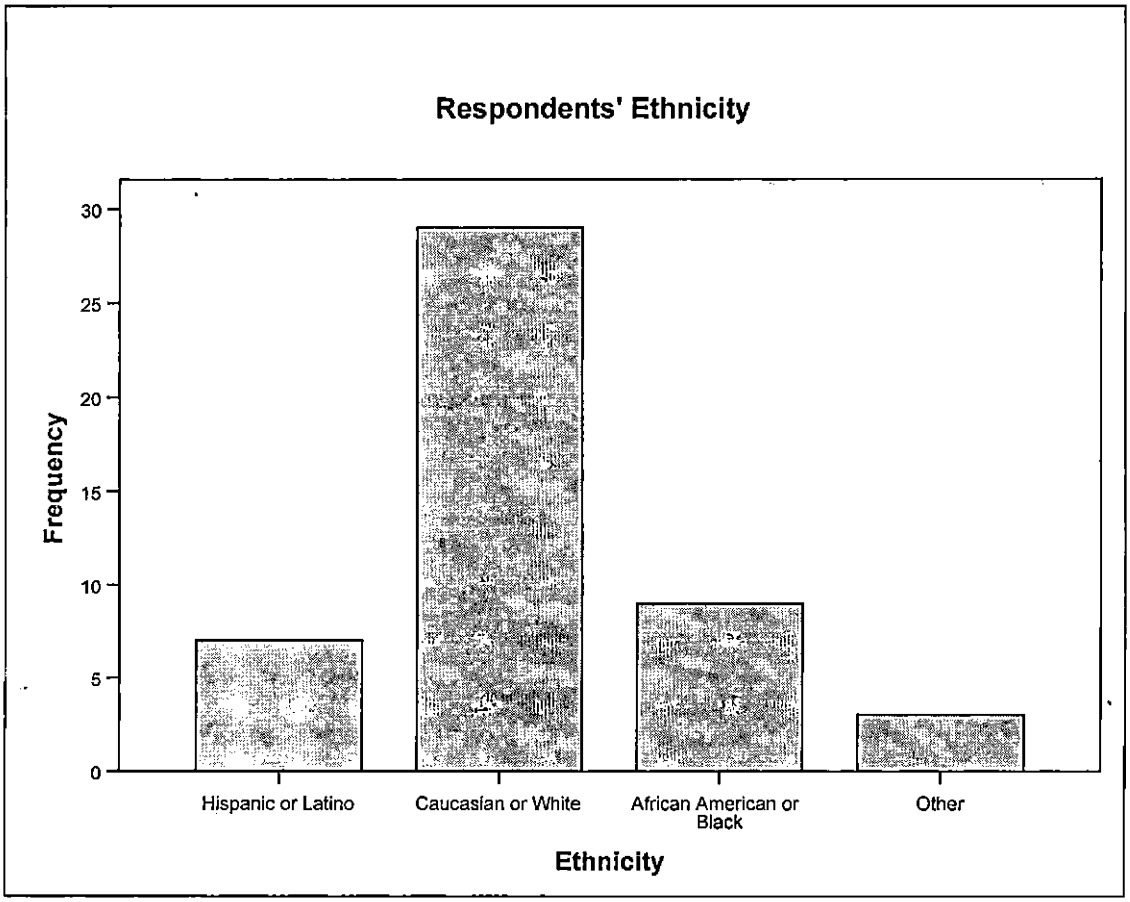


Figure 1. Dispersion of Respondents' Ethnicity

The frequencies of mental health diagnoses are listed in Table 1. In the sample, 54.2% of the respondents listed their primary mental health diagnosis

as bipolar. Major depression was ticked by 18.8% of the respondents. A 2+ Diagnoses category revealed 12.5% of the sample listed two or more diagnoses as their primary mental health diagnosis. The results show schizoaffective disorder as 6.3% percent of the sample. Schizophrenia, psychosis NOS, and the Other category each represent 2.1% of respondents. The ages of the respondents when they were first diagnosed with a mental disorder range from 5 to 50 with a mean age of approximately 31 (M = 30.66, SD = 11.24, N = 47). A Figure in Appendix J summarizes the respondents' ages when they were first diagnosed with a mental health diagnosis.

Table 1. Frequency of Respondents' Mental Health Diagnoses

Diagnosis	Frequency	Percent	Valid Percent	Cumulative Percent
Bipolar	26	54.2	55.3	55.3
Major Depression	9	18.8	19.1	74.5
Schizoaffective	3	6.3	6.4	80.9
Schizophrenia	1	2.1	2.1	83.0
Psychosis NOS	1	2.1	2.1	85.1
Other	6	2.1	2.1	87.2
2 + Diagnoses	47	12.5	12.8	100.0
Total	1	97.9	100.0	
Missing	48	2.1		
Total	9	100.0		

Stigma

Table 2 illustrates the mean stigma component scales and subscales. Results from the Devaluation-Discrimination Beliefs Scale show the mean level of stigma (M = 3.82) is higher than the 3.5 midrange originally delineated by Link in his 1987 study. This suggests that respondents somewhat agree they are being devalued and discriminated against. In addition, the stigma composite score (M = 3.54) is slightly over the 3.5 midrange suggesting respondents somewhat agree to having experienced stigma while in their current residential treatment episode.

Table 2. Mean Level of Stigma on Stigma Component Scales and Subscales

Scales/ Subscales	N	Mean	Standard Deviation
Total of Devaluation-Discrimination Beliefs Scale	48	3.82	.72
Stigma Composite Score	48	3.54	.63
Total of Secrecy Subscale	48	3.07	1.49
Total of Rejection/Secrecy Scale	48	2.98	1.02
Total of Rejection Subscale	48	2.93	1.11

The Rejection/Secrecy scale mean (M = 2.98) is slightly lower than the 3.5 midrange and reveals that respondents somewhat disagree about experiences of rejection, discrimination, or had to be secretive about their mental illness while in their current treatment episode. The Secrecy subscale mean (M = 3.07) shows respondents somewhat disagree about their need to be secretive about their mental illness in their current treatment episode. The Rejection subscale mean (M = 2.93) depicts respondents somewhat disagree that they experienced rejection while in their current treatment episode. Appendix K includes separate tables for the Devaluation-Discrimination Belief Scale item responses and the Rejection/Secrecy item responses including frequency, sum, mean, and standard deviations for each item.

Friedman Well-Being Composite Scale and Subscales

Well-being was scored utilizing the Friedman Well-Being Scale. Overall mean scores from the sample (N = 48) were extracted and listed in Table 3 to compare to standardized scores originally listed on a conversion table in the Friedman Well-Being Scale and Professional Manual (1994). The Friedman Well-Being Composite score

(M = 52.8) revealed that respondents experienced a low level of well-being during their current treatment episode.

Furthermore, respondents scored in the low range for components of well-being including sociability (M = 59.3), self-esteem/self-confidence (M = 54.3), joviality (M = 54.9), and emotional stability (M = 49.2). Interestingly, respondents scored in the average range for happiness (M = 58.1).

Table 3. Mean Level of Well-Being on the Friedman Well-Being Composite and Subscales

	R	Min.	Max.	Mean	SD
Friedman Social Subscale (FSOC)	100	0	100	59.3	24.9
Friedman Happiness Subscale (FHAPP)	100	0	100	58.1	31.7
Friedman Self-esteem/ Self-confidence subscale (FSES)	90	10	100	54.3	22.3
Friedman Joviality Subscale (FJOV)	100	0	100	54.9	21.8
Friedman Well-Being Composite (FWBC)	77	13	90	52.8	16.2
Friedman Emotional Stability Subscale (FES)	90	8	98	49.2	18.4

Bivariate Correlations

The relationship between the Stigma Composite score, including the Devaluation-Discrimination Beliefs Scale score and the Rejection/Secrecy Scale score, and the Friedman Well-Being Composite scale, including the Friedman subscales, were investigated using the Pearson product-moment correlation coefficient. Results indicated that there was no significant correlation between the independent variable stigma and the dependent variable well-being. In addition, there was no significant correlation between stigma and emotional stability. However, there was a strong negative correlation between respondents' sociability and secrecy indicating that when respondents' were more secretive about their mental illness they are more likely to experience feeling more social. Table 4 indicates relevant bivariate correlations. For a comprehensive list of bivariate correlations between variables refer to Appendix L.

Table 4. Pearson's R Bivariate Correlations

(N = 48)		Rejection Secrecy Subscale	Stigma Composite	Secrecy Subscale
FWBC	Pearson	-.117	-.173	.009
	Sig. 2 tailed	.430	.240	.951
FSOC	Pearson	-.322*	-.112	-.308*
	Sig. 2 tailed	.025	.450	.033
FES	Pearson	-.045	-.201	.153
	Sig. 2 tailed	.760	.170	.299

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

Further bivariate correlation analyses were performed by ethnicity. Respondents in the Other group showed a strong negative correlation between the Rejection/Secrecy subscale and the Friedman Sociability subscale. There was also a strong negative correlation between the Secrecy subscale and the Friedman Self-esteem/Self-confidence subscale. The Other group revealed a positive correlation between Link's Devaluation/Discrimination Beliefs Scale and the Freidman Joviality subscale. Table 5 shows relevant bivariate correlations of respondents in the Others group.

Table 5. Pearson's R Bivariate Correlations Among the Others Group

Others Group

(N = 3)		DDB Scale	Rejection Secrecy Scale	Secrecy Subscale
Sociability Subscale	Pearson Corr	.902	-.997*	-.967
	Sig 2 tailed	.284	.049	.163
	N	3	3	3
Self-esteem Self-confidence Subscale	Pearson Corr	.982	-.945	-1.000**
	Sig 2 tailed	.121	.212	.000
	N	3	3	3
Joviality Subscale	Pearson Corr	.999*	-.888	-.990
	Sig 2 tailed	.030	.304	.091
	N	3	3	3

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

Results revealed interesting significant negative correlations among the Caucasian group (N = 29) within the sample. Table 6 illustrates significant negative correlations between respondents' beliefs about devaluation and discrimination and well-being, emotional stability, and happiness. Results did not indicate a significant correlation between the Stigma Composite scale and overall well-being, emotional stability, and happiness. However, Table 6 shows some negative correlation exists between the Stigma Composite and overall well-being, emotional stability, and happiness

and the coefficients appear to be approaching significance. See Appendix M for further comparison of bivariate correlations between all ethnic groups.

Table 6. Pearson's R Bivariate Correlations Among Caucasians

Caucasian or White Group

(N = 29)		DDB Scale	Stigma Scale
Freidman Well-Being Composite Scale	Pearson Correlation	-.409*	-.346
	Sig 2 tailed	.028	.066
	N	29	29
Friedman Emotional Stability Subscale	Pearson Correlation	-.465*	-.348
	Sig 2 tailed	.011	.064
	N	29	29
Friedman Happiness Subscale	Pearson Correlation	-.369*	-.267
	Sig 2 tailed	.049	.161
	N	29	29

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

Summary

Chapter Four presented the results from the analysis of the quantitative data. Demographic data was shown using descriptive statistics including frequencies and measures of central tendency. Univariate statistics were utilized to illustrate levels of stigma and well-being. In addition, the Friedman Well-Being Composite scale and

subscales were compared to standardized scores. Bivariate correlation coefficients were utilized to determine associations between stigma and well-being. In addition, bivariate correlation coefficients were utilized between stigma and well-being among ethnic groups to show variation between ethnic groups.

CHAPTER FIVE

DISCUSSION

Introduction

Chapter Five is a discussion of the implications of this quantitative study between stigma and well-being among mentally ill substance abusers in residential substance abuse treatment centers. Limitations of the study are addressed and recommendations for social work practice, policy, and research are proposed.

Discussion

Among the forty-eight respondents in this study a somewhat equal distribution related to gender occurred with 26 female and 22 male participants. However, there were a disproportionately high percentage of bipolar respondents at 54.2% of the sample. The average age participants were first diagnosed was thirty-one years. Participants in this study were accessing residential substance abuse treatment services and may have lacked the ability to access mental health or substance abuse treatment services prior to this treatment episode. In addition, participants may have continued in their alcohol and drug use to cope with depression, mania, and

psychotic symptoms which may have resulted in the participant avoiding an earlier primary mental health diagnosis. Other factors that could have contributed to receiving a primary mental health diagnosis at a later age include homelessness, social ostracism, and religion.

Ethnicity has important implications for the results later in this discussion because data were extracted by ethnic group in order to determine if there were correlations between stigma and well-being among diverse ethnic groups within the sample. Most of the participants were Caucasian in this study at 60.4% of the total sample.

This study was a quantitative analysis between stigma related to mental illness and the level of well-being of individuals with mental illness in residential substance abuse treatment. The intent was to determine if stigma was significantly correlated with well-being in this population. Statistically significant associations were not substantiated between stigma and well-being. However, when the sample was divided among ethnic groups the Caucasian group revealed a significant negative correlation between beliefs about devaluation

and discrimination and overall well-being, emotional stability, and happiness.

Separate composite scores for stigma and well-being were obtained and compared with previous studies to determine participants' level of well-being and the level of agreement that participants believe and feel they are being stigmatized. When stigma was compared to Link's (1987) established 3.5 midrange score it revealed that participants are experiencing stigma. Because individuals with mental illness are experiencing stigma while in residential substance abuse treatment they may have increased difficulty in social interaction, have limited opportunities to broaden their social network, and may choose to deny having a mental illness and refuse medications. Medication noncompliance may contribute to crises and perpetuate and worsen their psychiatric symptoms. Their level of well-being was also in the low range compared to standardized scores on the Freidman Well-Being Scale conversion table (Friedman, 1994). Individuals with lower levels of well-being may have lower self-esteem, lack self-confidence, and have diminished hope, which can contribute to treatment failure and increase recidivism rates. In addition,

individuals with lower levels of well-being may not be as attentive in groups and may miss vital information that would increase their chances to maintain psychiatric stability over time.

Participants somewhat agree that they were being devalued and discriminated against. This finding supports the hypothesis that some level of stigma exists in residential treatment centers treating individuals with a mental illness and is consistent with Link's (1987) study that reports having a mental illness can affect an individual's belief about their standing in the environment. This finding is important because social support is considered a major contributor to relapse prevention and psychological stability. When participants' feel they are being discriminated against they are less likely to reach out to others or interact with individuals in their environment. Lundberg, Hansson, Wentz, Bjorkman (2008) found a positive correlation between social network and subjective quality of life and a negative correlation between beliefs about devaluation/discrimination and subjective quality of life in people with affective disorders. Given that this study involves more than 79.3% of individuals with an affective

related disorder, one can assume from these findings that beliefs about devaluation/discrimination will have an impact on their social network.

Interestingly, participants somewhat disagree about having to be secretive about their mental illness or having experienced direct rejection incidences by non-mentally ill substance abusers in their current treatment episode. However, results indicate that rejection experiences do occur and there are some respondents that are secretive about their mental illness. The mean from the Rejection/Secrecy subscale appears to border the somewhat agree response in the results. Nonetheless, these results do not support the hypothesis indicated earlier in this study that individuals experience incidences of rejection in residential treatment and have to be secretive about their mental illness in order to gain acceptance from non-mentally ill substance abusing peers. One explanation for this finding is that the nature of the supportive environment in residential treatment is far more supportive to their well-being than their previous environment. Or, the acquisition of even a few close friends in treatment may offset the severity with which

individuals perceive rejection by others. In fact, Couture and Penn (2006) found that social distance between community members and individuals with mental illness reduced over time as the relationship between them developed. In addition, the closed environment of residential treatment may reduce opportunities for secrecy and privacy and individuals are more likely to interact.

In comparison, rejection experiences in the Rejection subscale contributed less than secrecy in the Secrecy subscale to the total of the Rejection/Secrecy Subscale mean score. Rejection experiences may not have been as prevalent in residential treatment due to federal and state policy that prevents discrimination against individuals with mental illness and stringent rules that guide individuals' compliance to accept peers with mental illness.

When beliefs about devaluation and discrimination, rejection experiences, and secrecy about mental illness were combined to measure an overall composite score of stigma, respondents somewhat agree that they were being stigmatized in residential treatment. However, the mean score ($M = 3.54$) was only slightly over the midrange mean

(M = 3.50) required to suggest this level of agreement. Nevertheless, this finding supports the hypothesis that stigma related to mental illness exists in residential substance abuse treatment. Furthermore, it is evident that the lack of rejection experiences and the low level of need to be secretive about their mental illness decreased the stigma composite level mean score. This suggests individuals with mental illness have a higher level of agreement that they will be devalued and discriminated against more so than they have actually experienced rejection due to their mental illness in the current treatment setting.

The overall well-being of the participants in this study, as measured by the Friedman Well-Being Composite score, was in the low range (M = 52.8) according to standardized scores in a public study of adults (Friedman, 1994). This finding supports the hypothesis that individuals with mental illness have a low level of well-being in substance abuse treatment. Lower levels of individual well-being can contribute to dissatisfaction, negativity, and increased behavioral problems that require increased staff involvement. The composite score included five subscales that measured sociability,

self-esteem/self-confidence, joviality, emotional stability, and happiness. Respondents scored in the low range for all of the subscales except happiness. These results suggest treatment interventions for self-esteem, self-confidence, joviality, and emotional stability should be included in program curriculum when treating individuals with mental illness. The Friedman Happiness subscale revealed respondents were in the average range for happiness compared to standardized scores in a public study of adults. Participants' happiness could be attributed to the change that has taken place in their life thus far, freedom from the bondage of drugs and alcohol for a period of time, or the increased psychological stability they are now experiencing as a result of psychotropic medications. More than likely, it is a combination of these factors including a new peer support network and recognition they are not alone as they struggle with their mental illness.

There were no positive correlations among the independent variable stigma or its subscales and the dependent variable well-being or its subscales. However, a strong negative correlation was found between sociability and secrecy indicating that participants feel

more social when they keep their mental illness secret. Additionally a strong negative correlation was found between the sociability subscale and the rejection/secrecy subscale revealing that participants felt more social when they were not experiencing rejection and did not have to be secretive about their mental illness. However, the Rejection subscale standing alone did not show a significant correlation with sociability.

To gain a better understanding of how ethnicity played a role in this study, participants were grouped by ethnicity to determine if there were any significant correlations between the independent variables stigma, beliefs about devaluation/discrimination, rejection experiences, and secrecy and the dependent variables well-being, sociability, self-esteem/self-confidence, joviality, emotional stability, and happiness. There were no significant correlations among the Hispanic or African American groups.

The Other group revealed a strong negative correlation between self-esteem/self-confidence and secrecy. These results indicate participants in the Other group have higher self-esteem and feel more confident

when they are secretive about having a mental health diagnosis. Individuals with mental illness from various cultures may view mental illness in diverse ways. In order to increase well-being it may be necessary to allow individuals from diverse cultures increased privacy and confidentiality about matters pertaining to their mental illness. Data from the Other group also revealed a strong negative correlation between rejection experiences/secrecy and sociability which supports aforementioned results that participants feel more social when they experience less rejection and use secrecy as a way to cope. Although, data from this study suggests that individuals with mental illness are not experiencing that many incidences of rejection in residential treatment, care should be taken to reduce subtle and indirect incidences of rejection to increase opportunities for sociability. In addition, there was a strong positive correlation between beliefs about devaluation/discrimination and joviality in the Other group which indicates members believed they were being devalued and discriminated against but remained in a jovial state. Perhaps secrecy about their mental illness, fewer incidences of rejection, and higher self-esteem and

self-confidence had an indirect impact on their state of joviality. In addition, enthusiasm was used as one of the bipolar adjective to measure joviality. Naturally, individuals recently freed from homelessness and addiction and treated with psychotropic medications are going to have some increased enthusiasm regardless of the belief they are being devalued and discriminated against. Finally, the Other category only included three respondents and is not generalizable to the entire population.

In contrast, the Caucasian group involved twenty-nine of the forty-eight respondents and revealed a strong negative correlation between beliefs about devaluation/discrimination and overall well-being, emotional stability, and happiness. As beliefs about devaluation/discrimination increased the levels of well-being decreased among Caucasian respondents. Items from the Devaluation/Discrimination scale address perceived trust, perceived respect and acceptance by peers, and perceived intelligence by others. As relationships, trust, and respect are fostered between non-mentally ill substance abusers and individuals with mental illness in residential treatment well-being should

increase among the mentally ill residents. Additionally, as beliefs about devaluation/discrimination increased the Caucasian group's level of emotional stability decreased. Further, when the Caucasian group's beliefs about devaluation/discrimination increased their level of happiness decreased. Individuals with mental illness level of emotional stability and happiness should increase as well when trust, respect, and acceptance are fostered among individuals with mental illness and the non-mentally ill residents. These results support the hypothesis that stigma is associated with levels of well-being at least among the Caucasian individuals with a mental illness in residential substance abuse treatment.

Limitations

Obtaining approval from management to do research in alcohol and drug treatment facilities was difficult. Of the eight facilities this researcher requested to conduct research in only two agreed to allow research in their facility. Denial to conduct research in facilities was centered around confidentiality issues. An inability to

gain access to other facilities contributed to a small sample size.

The sample was a non-probability convenience sample that included every willing participant that met minimum criteria. The sample was not a randomized sample and is not generalizable to the entire population. In addition, most of the respondents were Caucasian and the number of respondents from diverse ethnic groups were not adequate to obtain accurate statistics.

Another limitation is the means by which the surveys were administered. Many individuals with co-occurring disorders have a range of difficulties when attempting to complete questionnaires. The surveys were administered as a group and may have proved to be more useful had they been administered in separate interviews perhaps even from a qualitative methodology. Four of the cases had to be completely discarded and several of the respondents missed answers or circled too many answers on their survey.

Recommendations for Social Work Practice, Policy and Research

This study provides insight to social workers and counselors to equip them in their work with individuals

with a substance abuse and mental health problem. It is recommended that individuals in the helping profession take a keen interest in assessing how levels of stigma are affecting the co-occurring disordered population in residential substance abuse treatment. Identifying decreased levels of well-being may signify need for increased education about stigma to clients and staff alike. In any case, the constructs of well-being, and the constructs of stigma, should be considered vital in working with individuals with mental illness in residential substance abuse treatment centers in order to decrease drop-out rates and increase success rates. Beyond fairness, it is ethically and morally right to provide quality direct practice service to individuals who are struggling psychologically and who may not have the skills to defend themselves even against the subtlest of slights.

Management, and staff in administrative positions, should become educated about the effects of stigma on individuals with mental illness in residential treatment. It is recommended that management raise awareness of the effects of stigma on clients, and employees, with mental illness. Even though respondents somewhat disagree that

there was a need to be secretive about their mental illness in residential treatment, secrecy was found to be important in feelings of sociability, and increased feelings of self-esteem and self-confidence. A client's right to privacy about medications, symptoms, diagnoses, and accessing services should be protected as much as is possible. The client's right to self-determination regarding such matters, including secrecy, should be deemed of the utmost importance. Providing for increased privacy for clients is no small task, however, it could save lives and provide an environment that is treatment amenable to otherwise unreachable human beings.

Staff involved in program and curriculum development should include stigma related concepts in worksheets and course outlines. The National Alliance for Mental Illness (NAMI) has many resources that can enhance program curriculum and decrease stigma. NAMI can also be accessed to potentially start a peer-to-peer program to support individuals with mental illness (NAMI, 2008).

Future research should focus on stigma and the well-being of a larger randomized sample of individuals with mental illness and a substance abuse problem in residential treatment. It is also important to include

more ethnically diverse respondents to be able to generalize the findings to the entire population. Researchers should consider utilizing a qualitative methodology that involves interviews to gain more accurate knowledge of rejection experiences and secrecy as a coping response to stigma in residential substance abuse treatment.

Conclusion

This quantitative research did not show a significant correlation between stigma and well-being in residential treatment. However, this study revealed stigma attached to mental illness exists in residential treatment and individuals with mental illness scored in the low range of well-being when compared to standardized scores. In addition, correlations were found between the constructs of stigma and the constructs of well-being. From this quantitative research, recommendations were made to improve direct practice social work, encourage administrative involvement in reducing stigma, and suggestions proposed for future social work research related to stigma in residential substance abuse treatment centers.

APPENDIX A

DEVALUATION-DISCRIMINATION SCALE

Devaluation-Discrimination Scale

This scale is designed to measure one component of stigma. Please take your time and circle the number of the answer that fits most accurately. All of your answers are confidential.

1. Most people would willingly accept a former mental patient as a close friend

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

2. Most people believe that a person who has been in a mental hospital is just as intelligent as the average person

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

3. Most people believe that a former mental patient is just as trustworthy as the average citizen

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

4. Most people would accept a fully recovered former mental patient as a teacher of young children in a public school

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

5. Most people feel that entering a mental hospital is a sign of personal failure

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

6. Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

7. Most people think less of a person who has been in a mental hospital

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

8. Most employers will hire a former mental patient if he or she is qualified for the job

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

9. Most employers will pass over the application of a former mental patient in favor of another applicant

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

10. Most people in my community would treat a former mental patient just as they would treat everyone

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

11. Most young women would be reluctant to date a man who has been hospitalized for a serious mental disorder

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

12. Once they know a person was in the hospital, most people will take his opinions less seriously

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

Published in:

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review, 52*, 1, 96-112.

APPENDIX B

REJECTION/SECRECY SCALE

Rejection/Secrecy Scale

This scale is designed to measure two additional components of stigma. Please circle the number of the most accurate answer. (R) = Rejection (S) = Secrecy

1. Since entering treatment you have been treated differently by non-mentally substance abusers because of your mental illness (R)

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

2. Since entering treatment non-mentally ill substance abusers have avoided you because they knew you are mentally ill (R)

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

3 Since entering treatment you have had non-mentally ill substance abusers hurt your feelings because you are mentally ill (R)

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

4. Since entering treatment you have avoided non-mentally ill substance abusers because you thought they look down on you because of your mental illness (R)

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

5. Since entering into treatment, you have purposefully avoided letting non-mentally ill substance abusers know you are mentally ill (S)

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

6. Since entering into to treatment you have learned it is better to keep your mental illness a secret (S)

1	2	3	4	5	6
Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Now I would like to ask you a few questions regarding who you are. Please answer the following questions as accurately as possible. All information is confidential.

1. What is your primary mental health diagnosis? (Circle one number below)
    1. Bipolar or Manic-Depressive
    2. Major Depression
    3. Schizoaffective
    4. Schizophrenia
    5. Psychosis-Not Otherwise Specified
    6. Post Traumatic Stress Disorder
    7. Other (Please write on line) _____

2. How old were you when you received your primary mental health diagnosis?

    Write age diagnosed: _____

3. How old did you become on your last birthday? (Write age below)

    Age _____

4. What is your gender? (Circle one number below)
    1. Female
    2. Male

5. What race do you consider yourself? (Circle one number below)
    1. American Indian
    2. Alaskan Native
    3. Hispanic or Latino
    4. Caucasian or White
    5. African American or Black
    6. Native Hawaiian or Other Pacific Islander
    7. Asian
    8. Other (Please Specify) _____

APPENDIX D

CEDAR HOUSE APPROVAL LETTER

Social Science Services, Inc. • A United Way Agency
Cedar House Rehabilitation Center
"A Good Place to Start a Total Life Change"

February 20, 2007

To Whom It May Concern:

This letter is to inform Mark Barnstable from California State University, San Bernardino that he has been granted permission to do research in our facility. We understand that the research involves administering four (4) brief questionnaires to the clients and that minimal identifying information will be collected and all data will be held in the strictest of confidence.

Cedar House Rehabilitation Center is a non-profit corporation that has been providing substance abuse treatment services since 1973. CHRC's overall goal is to educate clients on the disease concept of addiction, along with related attitudes and behaviors so that they can break the cycle of addiction and achieve healthier lifestyles.

Sincerely,

Rodger Talbott
Chief Executive Officer

RT:jv

18612 Santa Ana Avenue • Bloomington, CA 92316 • (909) 421-7120 • (909) 421-7128 Fax
Programs Licensed and Certified by the State of California Department of Alcohol and Drug Programs
www.cedarhouse.org

APPENDIX E

INLAND VALLEY APPROVAL LETTER

Inland Valley Recovery Services

www.inlandvalleyrecovery.org

Executive Offices: 916 North Mountain Avenue, Suite A • Upland, CA 91786 • 909-932-1069 • Fax 909-932-1087

March 1, 2007

Re: Research Project
Mark Barnstable

Dear Mark,
This letter is to inform you that you have been granted permission to conduct a research project at our women's residential facility located at 1260 E. Arrow Highway, Upland CA

Sincerely,

Stacy Smith, BS, LVN, CADC-II

APPENDIX F

RESIDENT PARTICIPATION FLYER

May 1, 2007

Dear Resident

Mark Barnstable, a Social Work student from California State University, San Bernardino will be conducting research at this facility between April 1, 2007 and June 1, 2007. The research is a requirement to complete my Master of Social Work degree. I am hoping to gather information about how dually diagnosed client's well-being is affected by stigma perpetuated by the non-mentally ill substance abuse population in a residential treatment setting.

The research will be conducted using four very brief questionnaires. The introduction, directions, and passing out of the questionnaires will take no longer than 5 to 7 minutes. The questionnaires will take 9 to 13 minutes to complete. There will be a short debriefing statement of 2 to 3 minutes after the questionnaires are completed. The total time should take no longer than 30 minutes. Each participant will receive compensation of $5.00 for their contribution to the research.

All of the data collected is strictly confidential and no names will be collected.

In order to participate in this study you must:

- Currently be in residential treatment at least one week for any drug or alcohol abuse or dependence
- Have a Mental Health diagnosis
- Be at least 18 years of age or older
- Not be mandated to residential treatment be any local, county, state, or federal authority

If you would like to participate please remain seated at the end of the next (or assigned group) until those who are leaving clear the room. At that time directions will follow.

Thank you very much for your participation in this study.

Sincerely

Mark Barnstable

APPENDIX G

INFORMED CONSENT

INFORMED CONSENT

The research project in which you are being asked to participate will examine stigma attached to mental illness and its effect on well-being within a residential substance abuse treatment setting. This study is being conducted by Mark Barnstable under the supervision of Dr. Thomas Davis, Assistant Professor of Social Work at California State University San Bernardino. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

In this study you will be asked to complete a brief demographic questionnaire and three brief questionnaires related to stigma and well-being. The questionnaires should take no longer than 30 minutes to complete. All of your responses will be held strictly confidential by Mark Barnstable. Your name will not be reported with your responses. You may receive the results of this study upon completion after September 2008 from the administration department at this facility.

You are free not to answer any questions and to withdraw from the study at any time. If you choose not to participate you will not be denied any services. When you have completed the questionnaires, you will receive a debriefing statement that will describe the study in more detail. After the debriefing you will receive compensation of $5.00. This study may not benefit you directly. However, it may benefit future program participants by enlightening program developers about stigma in residential facilities that cater to both non-mentally ill substance abusers and mentally ill substance abusers. The only known risk is that you may have a heightened awareness of being devalued, discriminated against, or rejected by non-mentally ill substance abusers for an unknown period of time.

If you have any questions or concerns about this study, please feel free to contact Dr. Thomas Davis at 909-537-3839.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I acknowledge that I am 18 years of age or older and I am not mandated to residential alcohol and drug treatment by a local, county, state, or federal authority.

Place a check mark here: ☐ **Date agreed:** _____

APPENDIX H

DEBRIEFING STATEMENT

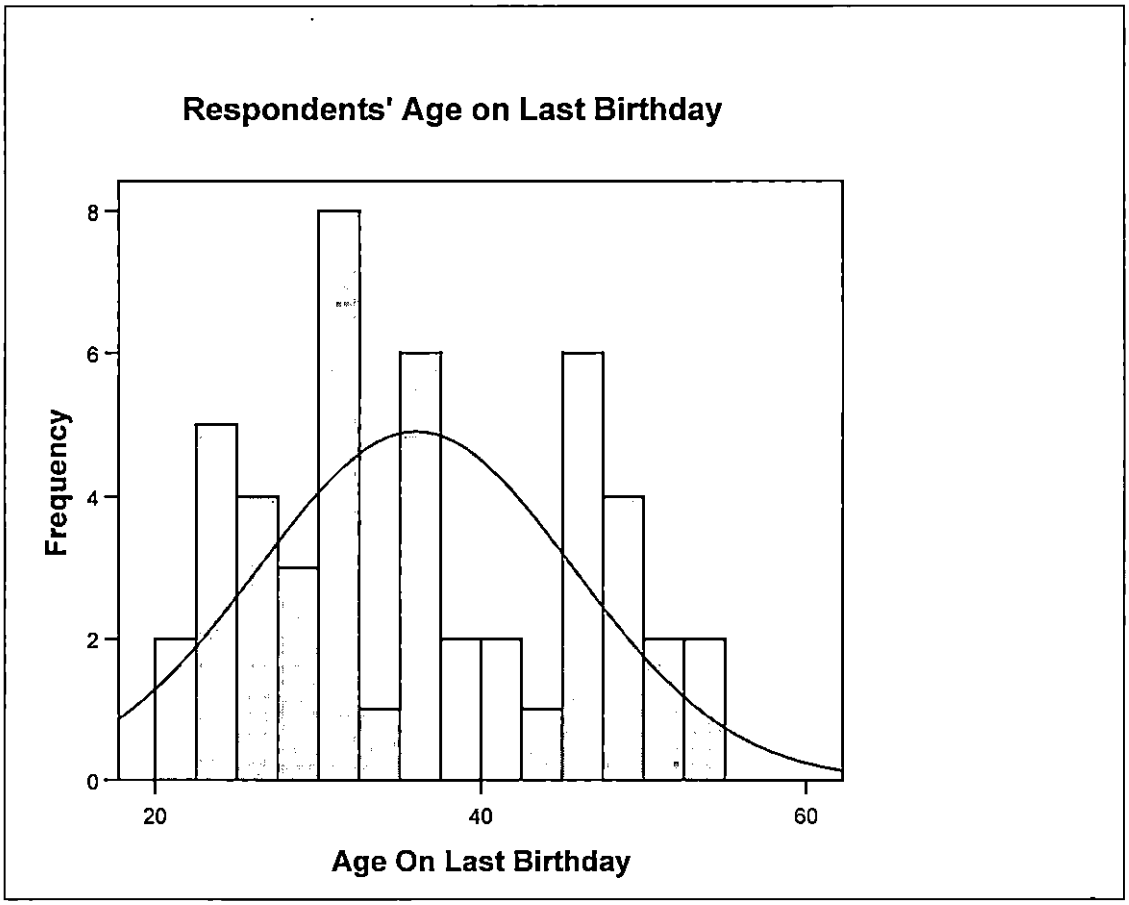
Stigma Attached to Mental Illness and Well-Being
Debriefing Statement

The study you have just completed was designed to investigate how the well-being of dually diagnosed consumers of residential substance abuse treatment is affected by stigma attached to mental illness perpetuated by the substance abuse population in a residential treatment setting. Stigma refers to the bad reputation, harassment, and discrimination one endures due to being mentally ill. Stigma was measured using three subscales. First, perceptions of devaluation and discrimination are known to be contributors to the concept of stigma. Second, rejection experiences due to mental illness are considered to be a result of stigmatization. Third, mentally ill individuals sometimes act in secrecy and withdrawal to avoid rejection, devaluation, or discrimination because of their mental illness. Your current state of well-being was measured to determine how you see yourself at the present time in the areas of emotional stability, self-esteem/self-confidence, joviality, sociability, and happiness. We are particularly interested in comparing how emotionally well the group feels in comparison to the overall level of stigmatization.

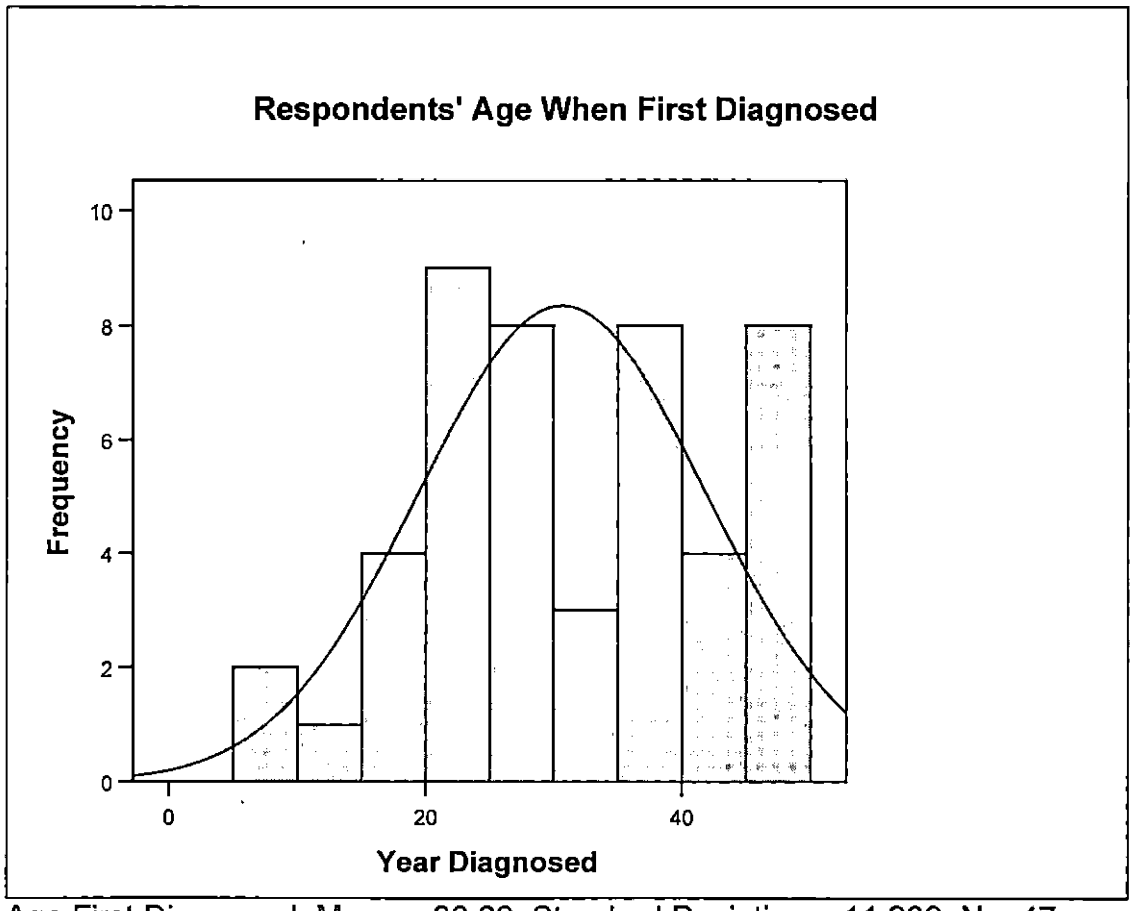
Thank you for your participation in this study. If you have any questions about the study, please feel free to contact Assistant Professor Dr. Thomas Davis at 909-537-3839. If you would like to obtain a copy of the results of this study you may contact the administration department at this.facility after September 2008.

APPENDIX I

DEMOGRAPHICS



Respondents' Age: Mean = 36, Standard Deviation = 9.768, N = 48



Age First Diagnosed: Mean = 30.66, Standard Deviation = 11.239, N = 47

APPENDIX J

PARTICIPANTS' RESPONSES TO STIGMA

COMPONENT SCALES

Devaluation-Discrimination Beliefs Scale Item Responses

Questions	Response	Frequency	Cumulative Percent
Most person would accept a mentally ill person as a friend			
	Strongly Agree	3	6.3
	Agree	13	33.3
	Somewhat Agree	17	68.8
	Somewhat Disagree	8	85.4
	Disagree	2	89.6
	Strongly Disagree	5	100.0
	Total	48	
Persons hospitalized in a mental hospital just as intelligent			
	Strongly Agree	3	6.3
	Agree	7	20.8
	Somewhat Agree	10	41.7
	Somewhat Disagree	8	58.3
	Disagree	14	87.5
	Strongly Disagree	6	100.0
	Total	48	
Former mental patient just as trustworthy as a normal person			
	Strongly Agree	1	2.1
	Agree	6	14.6
	Somewhat Agree	14	43.8
	Somewhat Disagree	11	66.7
	Disagree	8	83.3
	Strongly Disagree	8	100.0
	Total	48	
Recovered former mental patient ok as a teacher of young children in a public school	Strongly Agree	3	6.3
	Agree	5	16.7
	Somewhat Agree	10	37.5
	Somewhat Disagree	6	50.0
	Disagree	15	81.3
	Strongly Disagree	9	100.0
	Total	48	
Entering a mental hospital is a sign of personal failure			
	Strongly Agree	5	10.4
	Agree	10	31.3
	Somewhat Agree	10	52.1
	Somewhat Disagree	8	68.8
	Disagree	12	93.8
	Strongly Disagree	3	100.0
	Total	48	
People would not hire a former mental patient to take care of their children	Strongly Agree	3	6.3
	Agree	3	12.5
	Somewhat Agree	8	29.2
	Somewhat Disagree	11	52.1
	Disagree	15	83.3
	Strongly Disagree	8	100.0
	Total	48	

Questions	Response	Frequency	Cumulative Percent
People think less of a person who has been in a mental hospital	Strongly Agree	2	4.2
	Agree	4	12.5
	Somewhat Agree	9	31.3
	Somewhat Disagree	17	66.7
	Disagree	14	95.8
	Strongly Disagree	2	100.0
	Total	48	
Employers will hire a former mental patient if they are qualified for the job	Strongly Agree	2	4.2
	Agree	14	33.3
	Somewhat Agree	15	64.6
	Somewhat Disagree	9	83.3
	Disagree	7	97.9
	Strongly Disagree	1	100.0
	Total	48	
Employers will pass over application of a former mental patient in favor of another applicant	Strongly Agree	1	2.1
	Agree	3	8.3
	Somewhat Agree	7	22.9
	Somewhat Disagree	11	45.8
	Disagree	20	87.5
	Strongly Disagree	6	100.0
	Total	48	
My community would treat a former mental patient just as they would treat anyone	Strongly Agree	1	2.1
	Agree	8	18.8
	Somewhat Agree	16	52.1
	Somewhat Disagree	12	77.1
	Disagree	10	97.9
	Strongly Disagree	1	100.0
	Total	48	
Young woman would be reluctant to date a former mental patient	Strongly Agree	1	2.1
	Agree	5	12.5
	Somewhat Agree	4	20.8
	Somewhat Disagree	12	45.8
	Disagree	16	79.2
	Strongly Disagree	10	100.0
	Total	48	
After a person has been hospitalized, people take his/her opinions less seriously	Strongly Agree	1	2.1
	Agree	5	12.5
	Somewhat Agree	9	31.3
	Somewhat Disagree	17	66.7
	Disagree	13	93.8
	Strongly Disagree	3	100.0
	Total	48	

Devaluation-Discrimination Beliefs Scale Item Mean Scores

	N	Sum	Mean	Std. Deviation
Most people would accept a mentally ill person as a friend	48	152	3.17	1.342
Persons hospitalized in a mental hospital just as intelligent	48	185	3.85	1.473
Former mental patient just as trustworthy as a normal person	48	187	3.90	1.356
Recovered former mental patient ok as a teacher in a public school	48	196	4.08	1.514
Entering a mental hospital is a sign of personal failure	48	165	3.44	1.486
People would not hire a former mental patient to take care of their children	48	200	4.17	1.404
People think less of a person who has been in a mental hospital	48	187	3.90	1.171
Employers will hire a former mental patient if they are qualified for the job	48	152	3.17	1.191
Employers will pass over an application of a former mental patient in favor of another applicant	48	208	4.33	1.191
My community would treat a former mental patient just as they would treat anyone	48	169	3.52	1.130
A young woman would be reluctant to date a former mental patient	48	211	4.40	1.317
After a person has been hospitalized, people take his/her opinions less seriously	48	189	3.94	1.156

Rejection/Secrecy Scale Item Responses

Questions	Response	Frequency	Cumulative Percent
Since entering treatment you have been treated differently by nonmentally ill substance abusers	Strongly Agree	7	14.6
	Agree	11	37.5
	Somewhat Agree	9	56.3
	Somewhat Disagree	15	87.5
	Disagree	5	97.9
	Strongly Disagree	1	100.0
	Total	48	
Since entering treatment nonmentally ill substance abusers have avoided you because you are mentally ill	Strongly Agree	6	12.5
	Agree	19	52.1
	Somewhat Agree	8	68.8
	Somewhat Disagree	12	93.8
	Disagree	2	91.9
	Strongly Disagree	41	100.0
	Total	48	
Since entering treatment you have had nonmentally ill substance abusers hurt your feelings because you are mentally ill	Strongly Agree	9	18.8
	Agree	11	41.7
	Somewhat Agree	6	54.2
	Somewhat Disagree	11	77.1
	Disagree	7	91.7
	Strongly Disagree	4	100.0
	Total	48	
Since entering treatment you have avoided nonmentally ill substance abusers because you felt they look down on you	Strongly Agree	12	25.0
	Agree	14	54.2
	Somewhat Agree	5	64.6
	Somewhat Disagree	10	85.4
	Disagree	5	95.8
	Strongly Disagree	2	100.0
	Total	48	
Since entering treatment you have purposefully avoided letting nonmentally ill substance abusers know you are mentally ill	Strongly Agree	13	27.1
	Agree	12	52.1
	Somewhat Agree	3	58.3
	Somewhat Disagree	10	79.2
	Disagree	8	95.8
	Strongly Disagree	2	100.0
	Total	48	
Since entering treatment you have learned it is better to keep your mental illness a secret	Strongly Agree	10	20.8
	Agree	10	41.7
	Somewhat Agree	4	50.0
	Somewhat Disagree	13	77.1
	Disagree	3	83.3
	Strongly Disagree	8	100.0
	Total	48	

Rejection/Secrecy Scale Item Mean Scores

	N	Sum	Mean	Std. Deviation
Since entering treatment you have been treated differently by non-mentally ill substance abusers because of mental illness	48	147	3.06	1.327
Since entering treatment nonMISAs have avoided you because you are mentally ill	48	132	2.75	1.212
Since entering treatment you have had nonMISAs hurt your feelings because you are mentally ill	48	152	3.17	1.602
Since entering treatment you have avoided nonMISAs because you felt they look down on you	48	132	2.75	1.509
Since entering treatment you have purposefully avoided letting nonMISAs know you are mentally ill	48	138	2.88	1.619
Since entering treatment you have learned it is better to keep your mental illness a secret	48	157	3.27	1.747

APPENDIX K

BIVARIATE CORRELATIONS

Pearson's R: Relationships Between Stigma Composite Scale and Subscales and The Friedman Well-Being Scale and Subscales (N=48)

		DDB	Rej Sec	Stigma	Rej	Sec	FWBC	FSOC	FSES	FJOV	FES
RejSec	Pearson	.177									
	Sig. 2 tailed	.229									
Stigma	Pearson	.849**	.671**								
	Sig. 2 tailed	.000	.000								
Rej	Pearson	.264	.889**	.677**							
	Sig. 2 tailed	.069	.000	.000							
Sec	Pearson	-.032	.727**	.367*	.332*						
	Sig. 2 tailed	.831	.000	.010	.021						
FWBC	Pearson	-.146	-.117	-.173	-.167	.009					
	Sig. 2 tailed	.321	.430	.240	.258	.951					
FSOC	Pearson	.082	-.322*	-.112	-.238	-.308*	.693**				
	Sig. 2 tailed	.581	.025	.450	.104	.033	.000				
FSES	Pearson	.014	-.033	-.007	-.059	.020	.760**	.612**			
	Sig. 2 tailed	.922	.825	.964	.692	.891	.000	.000			
FJOV	Pearson	-.048	-.027	-.051	.038	-.113	.658**	.528**	.565**		
	Sig. 2 tailed	.746	.854	.732	.798	.446	.000	.000	.000		
FES	Pearson	-.235	-.045	-.201	-.164	.153	.860**	.341*	.466**	.318*	
	Sig. 2 tailed	.108	.760	.170	.265	.299	.000	.018	.001	.028	
FHAPP	Pearson	-.256	-.046	-.218	-.144	.120	.644**	.370**	.355*	.385**	.547**
	Sig. 2 tailed	.079	.756	.137	.330	.416	.000	.010	.013	.007	.000

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

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

APPENDIX L

BIVARIATE CORRELATIONS BY ETHNICITY

Correlations by Ethnicity

			DDB Scale	RejSec Scale	Stigma Scale	Rej Subsc	Sec Subsc
Hispanic or Latino	FWBC	Pearson Corr	.435	-.159	.231	-.127	-.146
		Sig 2 tailed	.329	.734	.619	.786	.755
		N	7	7	7	7	7
	FSOC	Pearson Corr	.678	-.144	.418	.008	-.326
		Sig 2 tailed	.094	.758	.351	.987	.476
		N	7	7	7	7	7
	FSES	Pearson Corr	.717	.095	.581	.112	.031
		Sig 2 tailed	.070	.839	.171	.811	.947
		N	7	7	7	7	7
	FJOV	Pearson Corr	.053	.131	.113	-.048	.361
		Sig 2 tailed	.910	.779	.809	.918	.426
		N	7	7	7	7	7
	FES	Pearson Corr	.276	-.219	.080	-.177	-.199
		Sig 2 tailed	.549	.637	.864	.705	.669
		N	7	7	7	7	7
	FHAPP	Pearson Corr	.144	-.345	-.088	-.415	-.100
		Sig 2 tailed	.758	.448	.850	.354	.831
		N	7	7	7	7	7
Caucasian or White	FWBC	Pearson Corr	-.409*	-.124	-.346	-.231	.101
		Sig 2 tailed	.028	.520	.066	.227	.604
		N	29	29	29	29	29
	FSOC	Pearson Corr	-.114	-.333	-.238	-.255	-.278
		Sig 2 tailed	.558	.078	.213	.182	.144
		N	29	29	29	29	29
	FSES	Pearson Corr	-.178	.023	-.114	-.003	.050
		Sig 2 tailed	.355	.906	.555	.989	.799
		N	29	29	29	29	29
	FJOV	Pearson Corr	-.015	-.084	-.050	.038	-.225
		Sig 2 tailed	.940	.664	.796	.844	.241
		N	29	29	29	29	29
	FES	Pearson Corr	-.465*	-.046	-.348	-.252	.287
		Sig 2 tailed	.011	.811	.064	.187	.131
		N	29	29	29	29	29
	FHAPP	Pearson Corr	-.369*	-.017	-.267	-.163	.212
		Sig 2 tailed	.049	.930	.161	.397	.271
		N	29	29	29	29	29
African American or Black	FWBC	Pearson Corr	.080	-.291	-.153	-.281	-.218
		Sig 2 tailed	.838	.447	.694	.464	.574
		N	9	9	9	9	9
	FSOC	Pearson Corr	.091	-.493	-.305	-.455	-.402
		Sig 2 tailed	.816	.177	.425	.219	.283
		N	9	9	9	9	9
	FSES	Pearson Corr	.371	-.479	-.003	-.578	-.169
		Sig 2 tailed	.325	.192	.995	.103	.663
		N	9	9	9	9	9
	FJOV	Pearson Corr	-.225	-.079	-.298	-.029	-.135
		Sig 2 tailed	.560	.840	.437	.941	.729
		N	9	9	9	9	9
	FES	Pearson Corr	.182	-.150	.067	-.120	-.153
		Sig 2 tailed	.640	.700	.864	.759	.695
		N	9	9	9	9	9
	FHAPP	Pearson Corr	-.398	-.062	-.464	-.092	.005
		Sig 2 tailed	.288	.874	.209	.815	.990
		N	9	9	9	9	9

			DDB Scale	RejSec Scale	Stigma Scale	Rej Subsc	Sec Subsc
Other	FWBC	Pearson Corr	.907	-.575	.961	-.230	-.811
		Sig 2 tailed	.277	.610	.177	.852	.398
		N	3	3	3	3	3
	FSOC	Pearson Corr	.902	-.997*	.399	-.897	-.967
		Sig 2 tailed	.284	.049	.739	.291	.163
		N	3	3	3	3	3
	FSES	Pearson Corr	.982	-.945	.619	-.756	-1.000**
		Sig 2 tailed	.121	.212	.575	.454	
		N	3	3	3	3	
	FJOV	Pearson Corr	.999*	-.888	.724	-.655	-.990
		Sig 2 tailed	.030	.304	.484	.546	.091
		N	3	3	3	3	3
	FES	Pearson Corr	.075	.434	.710	.737	.115
		Sig 2 tailed	.952	.715	.498	.472	.927
		N	3	3	3	3	3
	FHAPP	Pearson Corr	.655	-.189	.990	.189	-.500
		Sig 2 tailed	.546	.879	.091	.879	.667
		N	3	3	3	3	3

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

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

REFERENCES

Corrigan, P. W. (2004). Target-specific stigma change: A strategy for impacting mental illness stigma. *Psychiatric Rehabilitation Journal, 28*(2), 113-121.

Couture, S. M., & Penn, D. L. (2006). The effects of prospective naturalistic contact on the stigma of mental illness. *Journal of Community Psychology, 34*(5), 635-645.

Friedman, P. H. (1989). *Creating well-being: The healing path to love, peace, self-esteem and happiness.* Saratoga, CA: R & E Publishers, Inc.

Friedman, P. H. (1994). *Friedman well-being scale and professional manual.* Redwood City, CA: Mind Garden.

Hebl, M. R., & Turchin, J. M. (2005). The stigma of obesity: What about men?. *Basic and Applied Social Psychology, 27*(3), 267-275.

Kahng, S. K., & Mowbray, C. (2004). Factors influencing self-esteem among individuals with severe mental illness: Implications for social work. *Social Work Research, 28*(4), 225-236.

Kipper, D. A., & Hundal, J. (2005). The spontaneity assessment inventory: The relationship between spontaneity and nonspontaneity. *Journal of Group Psychotherapy, Psychodrama, & Sociometry,* Fall, 119-129.

Kirst-Ashman, K. K., & Hull, G. H. (2002). *Understanding generalist practice* (3rd ed.). Pacific Grove, CA: Brooks/Cole Thomson Learning.

Lindfors, P., Berntsson, L., & Lundberg, U. (2005). Factor structure of Ryff's psychological well-being scales in Swedish female and male white-collar workers. *Personality and Individual Differences, 40,* 1213-1222.

Link, B. G. (1982). Mental patient status, work, and income: An examination of the effects of a psychiatric label. *American Sociological Review, 47*(2), 202-215.

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review, 52*(1), 96-112.

Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 54*(3), 400-423.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of sociology, 27*, 363-385.

Link, B. G., Struening, E. L., Rahav, M. R., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnosis of mental illness and substance abuse. *Journal of Health and Social Behavior, 38*(2), 177-190.

Lundberg, B., Hansson, L., Wentz, E., & Bjorkman, T. (2008). Stigma, discrimination, empowerment, and social networks: A preliminary investigation of their influence on subjective quality of life in a Swedish sample. *International Journal of Social Psychiatry, 54*(1), 47-55.

Markowitz, F. E. (1998). The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. *Journal of Health and Social Behavior, 39*(4), 335-347.

Markowitz, F. E. (2001). Modeling processes in recovery from mental illness: Relationships between symptoms, life satisfaction, and self-concept. *Journal of Health and Social Behavior, 42*(1), 64-79.

Martin, J. K., Pescosolido, B. A., & Tuch, S. A. (2000). Of fear and loathing: The role of 'disturbing behavior', labels, and causal attributions in shaping public attitudes toward people with mental illness. *Journal of Health and Social Behavior, 41*(2), 208-223.

Miley, K. K., O'Melia, M., & DuBois, B. (2007). *Generalist social work practice: An empowering approach* (5th ed.). San Francisco, CA: Pearson.

Mueller, B., Nordt, C., Lauber, C., Rueesch, P., Meyer, P. C., & Roessler, W. (2005). Social support modifies perceived stigmatization in the first years of mental illness: A longitudinal approach. *Social Science and Medicine, 62,* 39-49.

Muir-Cochrane, E., Fereday, J., Jureidini, J., Drummond, A., & Darbyshire, P. (2006). Self-managementof medication for mental health problems by homeless young people. *International Journal of Mental Health Nursing, 15,* 163-170.

National Alliance on Mental Illness (NAMI). (2008). *Peer-to-Peer.* Retrieved March 29, 2008, from http://www.nami.org/template.cfm?section=Peer-to-Peer&lstid=752.

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link, B. G. (2001). Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services, 52*(12), 1627-1632.

Rosenfield, S. (1997). Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review, 62*(4), 660-672.

Ryff, C. D., & Keyes, L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69*(4), 719-727.

SAMHSA launches anti-stigma campaign. (2006, November/December). *SAMHSA News, 14,* 6. Retrieved January 21, 2007, from http://www.samhsa.gov/SAMHSA_News/VolumeXIV_6/text_only/article4txt.htm

Sartorius, N. (2007). Stigma and mental health. *Lancet, 370*(9590), 810-811.

Stuart, H. (2006). Media portrayal of mental illness and its treatments. *CNS Drugs, 20*(2), 99-106.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2003). *Anti-stigma: Do you know the facts?*. Retrieved January 21, 2007, from http://mentalhealth.samhsa.gov/publications/allpubs/OEL99-0004/default.asp

Substance Abuse and Mental Health Services Administration. (n.d.). *Are you in recovery from alcohol or drug problems: Know your rights.* [Electronic version]. Retrieved January 21, 2007, from http://download.ncadi.samhsa.gov/prevline/pdfs/phd1091.pdf

Zastrow, C. H., & Kirst-Ashman, K. K. (2004). *Understanding human behavior and the social environment*. Belmont, CA: Brooks/Cole