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# Stigma and Self-Disclosure: Mental Health Professionals' and Nonprofessionals' Perceptions of Therapist Self-Disclosure of Past Mental Illness

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STIGMA AND SELF-DISCLOSURE:  
MENTAL HEALTH PROFESSIONALS' AND NONPROFESSIONALS'  
PERCEPTIONS OF THERAPIST SELF-DISCLOSURE OF PAST MENTAL ILLNESS

by

RILEY BENKO

(Under the Direction of C. Thresa Yancey)

ABSTRACT

Research indicates the general public stigmatizes individuals across a number of circumstances, including people with a mental illness. Individuals with a mental illness are more likely to be perceived by members of the general public as responsible for their illness, dangerous, or helpless compared to those with physical illnesses, and such stigma appears higher in rural areas. Compared to members of the general public, mental health professionals and trainees hold more positive perceptions of those with mental illness, viewing them as less dangerous, untrustworthy, and unpredictable. In working with clients, mental health professionals may choose to use self-disclosure as a therapeutic tool. A therapist who discloses a past history of mental illness for example may help clients feel more understood, less alone, or more connected with their therapist. However, therapists are often cautioned in their use of self-disclosure and the client impact of a therapist disclosing a past history of mental illness is not well understood. It is still unclear how mental health professionals perceive other mental health professionals who disclose a past history of mental illness to their clients. The current study compared perceptions of people with mental illness between mental health professionals, including psychologists, social workers, and counselors, and nonprofessionals. Brief therapeutic vignettes were utilized, followed by a questionnaire to measure perceptions of therapists who disclose a past mental illness compared

to ones who do not disclose. Results indicated that, as expected, mental health professionals held less personal stigma toward people with mental illness than did nonprofessionals. While nonprofessionals rated disclosing and nondisclosing therapists similarly, mental health professionals endorsed significantly more negative views of a self-disclosing therapist. Lastly, no differences in stigmatizing attitudes or perceptions of the vignette therapist were found based on rural or non-rural upbringing. The results suggest that mental health professionals more negatively evaluate a self-disclosing therapist than do nonprofessionals. Furthermore, this perception is not accurately predicted by one's stigmatizing attitudes. Recommendations for future research are also provided.

INDEX WORDS: Dissertation, Georgia Southern University, Stigma, Mental illness, Mental health professional, Therapist self-disclosure, Rurality, Vignette

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## DEDICATION

For Ira and Karol. Thank you.

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## CHAPTER 1

### INTRODUCTION

While research shows individuals with mental illnesses are stigmatized by the general population, mental health professionals hold more positive perceptions of those with mental illness (Callicchia, 1981; Chambers et al., 2010; Corrigan et al., 2000; Farina & Felner, 1973; Granello & Gibbs, 2016; Kingdon, Sharm, & Hart, 2004; Link, 1982; Link, 1987; Rusch, Angermeyer, & Corrigan, 2005; Steadman, 1981; Weiner, Perry, & Magnusson, 1988). In their work with clients, therapists may choose to use the tool of self-disclosure during therapy. Disclosing a past history of mental illness, for example, may be a beneficial way to connect with clients, helping them to feel understood and less alone. Mental health professionals, however, are generally cautioned in their training to use self-disclosure sparingly (Carew, 2009; Edwards & Murdock, 1994; Hayes, Strosahl, & Wilson, 2012; Linehan, 1993; Yalom & Leszcz, 2005; Ziv-Bieman, 2013). So, while mental health professionals hold less stigma toward those with mental illness, it is uncertain how they may stigmatize other mental health professionals who disclose a past history of mental illness. The aims of the current study were to (1) determine differences in personally stigmatizing views of people with mental illness between mental health professionals and nonprofessionals, (2) determine differences in perception of public stigma toward people with mental illness between mental health professionals and nonprofessionals, (3) determine differences in perceptions of therapists who self-disclose a past history of mental illness between mental health professionals and nonprofessionals, and (3) determine if personal and public stigma toward those with mental illness differs between self-reported rural or nonrural upbringing. The results of this research offer a look into how mental health professionals and nonprofessionals perceive a therapist differently based on his or her use of self-disclosing a past

history of mental health treatment. Furthermore, the results suggest that one's personally stigmatizing attitudes may not accurately predict perceptions of a therapist disclosing such information.

### **Background and Significance**

Stigma can be defined as, “when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them” (Link & Phelan, 2001, p. 377). The degree to which one is stigmatized can vary depending on labels, associations with negative traits, and the extent of discrimination or status loss an individual has encountered (Link & Phelan, 2001). Studies demonstrate stigma across a variety of groups, including those with leprosy, exotic dancers, and those with cancer, HIV or AIDS (Fife & Wright, 2000; Lewis, 1998; Opala & Boillot, 1996; Parker & Aggleton, 2003). Stigma also exists toward those with mental illness (Corrigan et al., 2000; Farina & Felner, 1973; Link, 1982; Link, 1987; Rusch et al., 2005; Steadman, 1981; Weiner et al., 1988). Furthermore, stigma toward individuals with a mental illness is stronger in rural areas when compared to non-rural ones (Heflinger, Wallston, Mukolo, & Brannan, 2014; Hoyt et al., 1997; Komiti, Judd, & Jackson, 2006; Stewart, Jameson, & Curtin, 2015; Williams & Polaha, 2014). Stigma toward people with mental illness can have negative impacts on their self-esteem, quality of life, willingness to seek help, and adherence to treatment (Corrigan, 1998; Link, 1987; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Livingston & Boyd, 2010; Vogel, Wade, & Hackler, 2007; Williams & Polaha, 2014). Research shows mental health professionals and mental health trainees hold more positive views of those with mental illness (Callicchia, 1981; Chambers et al., 2010; Covarrubias & Han, 2011; Granello & Gibbs, 2016; Kingdon et al., 2004; Lauber, Anthony, Adjacic-Gross, & Rossler, 2004; Smith & Cashwell, 2010; Smith & Cashwell, 2011; Stull, McGrew, Salyers, & Ashburn-

Nardo, 2013). However, research has yet to explore how mental health professionals perceive other professionals with a history of mental illness or mental health treatment, an important aspect of the current study.

While practitioners of a variety of therapeutic orientations advocate the use of therapist disclosure as a tool, many mental health professionals are trained to use caution when considering its use (Carew, 2009; Hayes et al., 2012; Linehan, 1993; Yalom & Leszcz, 2005). Mental health professionals are defined as licensed, masters or doctoral level practitioners in a field of mental health, including but not limited to: psychology, counseling, and social work. An important aspect of the study was to explore the ways in which both mental health professionals and nonprofessionals perceived therapeutic self-disclosure, particularly that of a previous history of mental health treatment. The final aim of the study was to also determine whether results would vary depending on where one was raised (i.e. rural or non-rural environments).

### **Purpose of the Study**

The central purpose of the current study was to determine differences in perceptions of a therapist who discloses a past history of mental illness between mental health professionals and nonprofessionals. The secondary purposes were to determine differences in stigma toward mental illness between mental health professionals and nonprofessionals, and to determine rural versus nonrural differences.

We investigated differences in attitudes toward mental illness, perceptions of public attitudes toward mental illness, perceptions of a therapist based on the use of self-disclosure of a mental illness or no disclosure via a vignette, and differences between individuals based on self-reported rural or nonrural upbringing.

## CHAPTER 2

### LITERATURE REVIEW

#### **Stigma**

In the literature, there are many different definitions of stigma. Unfortunately, explicit or clear definitions of stigma are often not given, and even when definitions are provided they can appear vague (Link & Phelan, 1963; Parker & Aggleton, 2003). Definitions can vary from simplistic dictionary definitions to descriptions involving social rejection (Link & Phelan, 2001). The term stigma was first defined by Erving Goffman in his 1963 books *Notes on the Management of Spoiled Identity* as “an attribute that is deeply discrediting” (p. 3). Goffman specifies that stigma is about a relationship between an attribute an individual has and some associated stereotype that reduces or discounts that individual. Though this definition has become the most used, stigma is often under-defined (and even overused according to Manzo, 2004) and later definitions have varied to add aspects of social norms, stereotypes, and discrimination onto Goffman’s original definition (Link & Phelan, 2001; Parker & Aggleton, 2003).

Definitions of stigma may vary for several reasons. First, stigma has been, and can be, applied to numerous circumstances or individuals, including those with leprosy (Opala & Boillot, 1996), exotic dancers (Lewis, 1998), people with cancer (Fife & Wright, 2000), individuals with HIV and AIDS (Fife & Wright, 2000; Parker & Aggleton, 2003), and those with mental illness (Link & Phelan, 2001). These differing circumstances may involve different conceptualizations of stigma. Due to this wide field of applicability for stigma, the second reason definitions vary is stigma involves significant multidisciplinary study, beyond psychology alone (Link & Phelan, 2001). The scope of an individual author or researcher, including discipline or theoretical

orientation, can impact one's conceptualization of stigma (Link & Phelan, 2001).

The most comprehensive definition for stigma, encompassing its many components, appears to come from Link and Phelan (2001, p. 377), who state, "Stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them." The authors also specify there are different degrees of stigma depending on labels, connections with undesirable traits, and the degree to which one has been discriminated against or the degree of status loss (Link & Phelan, 2001).

While stigma can have a broad definition, it can also be divided into three different levels: social, structural, and internalized (Livingston & Boyd, 2010). *Social stigma*, referred to as *enacted stigma*, involves holding stereotypes and prejudice against a stigmatized population (Herek, Gillis, & Cogan 2015; Livingston & Boyd, 2010). This may include ostracism, violence, abuse, or harassment (Herek, 2007; Herek et al., 2015). Social stigma also includes *public stigma*, that is, how much one believes society around them holds negative stereotypes or prejudice toward a population (Herek et al., 2015; Link et al., 1991; Livingston & Boyd, 2010). Public stigma and enacted stigma can differ, namely that enacted stigma refers to one's own perception of a specific population, while public stigma refers to one's perception of how the public perceives a particular population. In the current study, enacted stigma will be referred to as "personal stigma," referring to one's own personal beliefs and perceptions. "Public stigma" will continue to be referred to as such, delineating one's perception of how the general population perceives a particular population. Measures of personal stigma and public stigma, namely the two used in the current study, have not been shown to correlate with each other, suggesting they are distinct concepts.



Another level of stigma, *Structural stigma*, also referred to as *institutional stigma*, occurs when the policies of institutions restrict the rights or power of a stigmatized group (Livingston & Boyd, 2010). *Internalized stigma* occurs when individuals believe they fit stereotypes of a stigmatized group, expect social rejection, and perceive themselves as less valuable (Livingston & Boyd, 2010). Internalized stigma can be divided into sublevels as well. *Perceived stigma*, or *felt stigma*, relates to one's awareness or anticipation of stereotypes or discrimination (Livingston & Boyd, 2010). *Self-stigma* refers to the extent to which people incorporate negative public views or stereotypes into their own sense of self-worth or value (Herek et al., 2015; Livingston & Boyd, 2010). For example, individuals who are of a sexual orientation minority and who hold negative attitudes toward their own sexuality are said to have internalized homophobia or internalized heterosexism (Herek, 2007; Herek et al., 2015).

**Stigma of Mental Illness.** Studies show people tend to hold more stigmatizing views toward individuals with a psychiatric illness compared to those with physical illnesses such as cancer or AIDS (Corrigan et al., 2000; Rusch et al., 2005; Weiner et al., 1988). People are also more likely to perceive those with mental illness as responsible for causing or being able to control the illness, or that their illness is reversible (Corrigan et al., 2000; Rusch et al., 2005; Weiner et al., 1988). Individuals with mental illness are less likely to be hired for a job, less likely to earn well-paying jobs, less likely to be able to rent an apartment, and more likely to be arrested for assault and robbery, including false arrests for violent crimes (Farina & Felner, 1973; Link, 1982; Link, 1987; Rusch et al., 2005; Steadman, 1981). For example, an individual with a physical illness such as diabetes is less likely to encounter public stigma in the same way someone with schizophrenia might, including the loss of a job, the loss of friends, or changes in residence or housing (Rusch et al., 2005).

This information can be startling given the statistics on mental illness in the United States. In 2012, 18.6% of American adults, roughly 43 million people, in the country had a mental illness within the past year (Substance Abuse and Mental Health Services Administration & Center for Behavioral Health Statistics and Quality, 2012). Of those, 9.6 million had a serious mental illness, composing just over 4% of the total population (Substance Abuse and Mental Health Services Administration & Center for Behavioral Health Statistics and Quality, 2012). Stigma appears to have increased in America over recent decades. Compared to people in 1950, people in 1996 were over twice as likely to perceive an individual with a psychotic mental illness as violent or scary (Phelan, Link, Stueve, & Pescosolido, 2000). Factor analysis research finds common factors associated with perceptions of individuals with mental illness, including that they should be feared, excluded, are irresponsible, or are childlike and need to be cared for (Rusch et al., 2005; Taylor & Dear, 1981). Misconceptions like these may be portrayed and perpetuated through media accounts such as in movies or in print (Rusch et al., 2005).

Differences in perceptions of mental illness may depend somewhat on the use of labels. Link's modified labeling theory (Link et al., 1989) suggests the stereotyping and discrimination an individual with mental illness may experience is not based on that individual's severity of symptomology, but rather on labels and societal or cultural ideas or perceptions (Link, 1987). For example, when mental illness is perceived as dangerous, participants are more likely to reject an individual who has been hospitalized for psychiatric reasons (Link, 1987). Meanwhile, Corrigan's (2000) social attribution model indicates a perception of danger can be a signaling event leading to affective responses like anger or fear toward individuals with mental illness. These emotional reactions can result in behavioral or discriminatory reactions including punishment and avoidance. Research suggests terms like mental disorder, mental disease, mental

health problem, and mental illness are perceived similarly (Szeto, Luong, & Dobson, 2013). More specific labels, notably depression and schizophrenia, may be more negatively perceived than these general terms (Szeto et al., 2013). In regard to individuals with schizophrenia or substance addictions, people endorse feeling these individuals can control and are somehow responsible for their illnesses (Corrigan et al., 2000). Other research does not support these findings. A study in Germany revealed participants were more likely to endorse beliefs that people with schizophrenia are incompetent, unpredictable, or dangerous as opposed to holding them responsible for their mental illness (Angermeyer & Matschinger, 2004). Such stereotypes of individuals with schizophrenia contribute to discriminatory attitudes such as a desire to maintain greater social distance from those with schizophrenia (Angermeyer & Matschinger, 2004). Other research demonstrates when people are presented with the term “the mentally ill,” they endorse significantly lower tolerance compared to people who are presented with the term “people with mental illness” (Granello & Gibbs, 2016).

Individuals who perceive more public stigma toward mental illness tend to hold more self-stigma, which in turn negatively impacts attitudes toward counseling (Vogel et al., 2007; Williams & Polaha, 2014). This can be detrimental because more negative attitudes toward counseling are associated with less willingness to seek counseling when needed (Vogel et al., 2007). Furthermore, meta-analysis reveals internalized stigma in individuals with mental illness is positively correlated with symptom severity and negatively correlated with adherence to treatment (Livingston & Boyd, 2010). This indicates the more individuals with mental illness internalize negative public perceptions (such as devaluing themselves), the more likely they are to experience severe symptomology and fail to maintain adequate mental health treatment.

Research shows higher levels of perceived stigma among those with a mental illness correlate with lower self-esteem and more withdrawal as a means of coping (Link, 1987; Link et al., 2001). More specifically, someone with very high levels of perceived devaluation and discrimination may be up to nine times more likely to have lower self-esteem than someone who perceives little devaluation and discrimination (Link et al., 2001). Stigma can also be conceptualized as detrimental to one's quality of life. Members of the community may be less willing to help those with severe mental illness in particular, leading to a loss of social opportunities (Corrigan, 1998). Without social roles in work, housing, or finances, individuals with severe mental illness may report a lower quality of life (Corrigan, 1998).

**Stigma of Mental Illness in Rural Areas.** Research indicates individuals living in rural communities hold higher levels of personal stigma toward those with mental illness than those living in larger communities or cities (Hoyt et al., 1997). Higher levels of stigma can be attributed to feelings of embarrassment and a sense of a lack of privacy while living in a smaller community (Hoyt et al., 1997). Individuals living in a rural area report more perceived stigma, viewing mental illness as a talking point or source of gossip for others (Komiti et al., 2006). Rural individuals may perceive public stigma toward family members of a child with emotional or behavioral concerns (Heflinger et al., 2014; Williams & Polaha, 2014). Older adults in rural areas also hold higher levels of public and self-stigma compared to those living in more urban areas (Stewart et al., 2015). Increased stigma in rural areas is related to lower levels of openness and less willingness to seek formal help for mental health concerns (Hoyt et al., 1997; Komiti et al., 2006; Stewart et al., 2015). Studies of rural individuals indicate higher perceptions of public and self-stigma are associated with less positive attitudes toward seeking help (Williams & Polaha, 2014). Not seeking help for depressive symptoms for example is likely to account for

worsening symptoms (Hoyt et al., 1997).

**Stigma of Mental Illness among Mental Health Professionals.** Though less widely studied than stigma within the general population, there is some attention in research devoted to investigating perceptions of mental illness among mental health employees and professionals. Research in this area, however, is less common and less understood as it is a comparatively newer field of research compared to that of stigma among the general population (Schulze, 2007).

Some studies demonstrate mental health professionals hold more positive perceptions of those with mental illness compared to the general population. Studies of European psychiatrists demonstrate they are less likely to rate people with mental illness as dangerous, difficult to speak to, untrustworthy, or unpredictable when compared with attitudes of people from the general public (Kingdon et al., 2004). Psychiatrists do not differ on measures of social distance (how comfortable one is holding close interpersonal interactions) compared to the general population; however, psychiatrists do hold significantly more positive attitudes toward community mental health facilities and are more likely to disagree with ideas that mental illness is caused by a lack of self-discipline (Lauber et al., 2004; Kingdon et al., 2004). Psychiatric nurses, much like psychiatrists, also tend to hold positive perceptions of those with mental illness, endorsing them to be nonthreatening and equal, while also endorsing positive perceptions of community care (Chambers et al., 2010). Members of community treatment teams as well have reported more positive explicit and implicit perceptions of those with mental illness, including perceptions of them as good, innocent, and competent (Stull et al., 2013). Counselors and psychologists endorse less social distance when compared to social workers, indicating some variability among professional orientations even within the field of mental health (Smith & Cashwell, 2011).

While mental health professionals typically endorse more favorable perceptions of individuals with mental illness, it also appears that trainees in mental health endorse similarly positive perceptions. When compared with non-mental health professionals or students (including teachers, lawyers, and engineers), professionals and graduate-level trainees in mental health endorse lower levels of authoritarian and socially restrictive views, hold more benevolent attitudes, have more favorable perceptions of community mental health, and have less desire for social distance toward individuals with mental illness (Callicchia, 1981; Smith & Cashwell, 2010; Smith & Cashwell, 2011). Mental health professionals currently receiving supervision also hold more favorable views than those who are not receiving supervision (Smith & Cashwell, 2010). Counselors and counseling students have generally high levels of tolerance for those with mental illness compared to members of the general population, including more willingness to include those with a severe mental illness in their social circles, hire them for a job, or rent them a place of residence (Covarrubias & Han, 2011; Granello & Gibbs, 2016).

Through their training, mental health professionals may endorse changing attitudes about individuals with mental illness via increased understanding, more focus on empathy or acceptance, using a person-first orientation, and adopting a strengths-based approach (Crowe & Averett, 2015). Experience may also influence perceptions. For example, occupational therapy students endorse significantly lower levels of authoritarianism and social restrictiveness after experiencing course and field work exposing them to people with mental illness (Penny, Kasar, & Sinary, 2001). Exposure to individuals with mental illness is implicated in other studies as correlated with more favorable attitudes as well. Master's level trainees hold more positive attitudes toward those with mental illness when they have greater contact with friends who have a severe mental illness (Covarrubias & Han, 2011).

Studies of professionals in training have not consistently demonstrated these patterns. For example, occupational therapy students still endorse more favorable perceptions of those with physical disabilities compared to individuals with mental illness (Penny et al., 2001). Master's level mental health trainees still endorse some negative attitudes toward those with mental illness, including that they would be less likely to hire someone who has a mental illness as a baby sitter or they would be less likely to let their children marry someone with a mental illness (Covarrubias & Han, 2011).

In addition, not all studies of mental health professionals demonstrate patterns of more positive perceptions. For example, although mental health professionals may hold more positive perceptions than the general population, they may share similar levels of stigma with medical professionals, seeing individuals with a past psychiatric hospitalization as unpredictable, ineffectual, and undesirable to some extent (Calicchia, 1981; Rao et al., 2009). Even among mental health professionals, perceptions may still be influenced by labels. For example, like the general public, mental health professionals and trainees endorse more restrictive attitudes and less tolerance when presented with the term "the mentally ill" as opposed to "people with mental illness" (Granello & Gibbs, 2016).

### **Therapist Self-Disclosure**

Self-disclosing statements made by a therapist during sessions can be divided into two main types: *immediate* and *non-immediate*. Immediate self-disclosure refers to the therapist disclosing something to a client in the moment that relates to the therapist's feelings about something, such as a disclosure that he or she is frustrated when a client is consistently late to scheduled sessions (Audet, 2011). Non-immediate self-disclosure refers to a therapist revealing some personal information about his or herself, including life circumstances, life history, and

beliefs or values (Audet, 2011). An example of non-immediate self-disclosure is a therapist disclosing personal information about his or her experience with a past divorce (or even that he or she simply went through a divorce). A therapist disclosing information about his or her own mental health symptoms or history would be making a non-immediate self-disclosure.

Both types of disclosure can have therapeutic value, though immediate disclosure is intended to focus on process or interpersonal issues during session (Audet, 2011). Disclosure is used for a variety of reasons. Mental health professionals report utilizing self-disclosure as a tool to model behavior, increase client perceptions of similarity with their therapist, and to help clients feel understood (Burkard, Knox, Groen, Perez, & Hess, 2006; Edwards & Murdock, 1994).

**The Impact of Therapist Self-Disclosure.** Research indicates therapist self-disclosure has mixed results on therapeutic outcome. Several studies report self-disclosure does not correlate with client outcomes such as symptom reduction (Hill et al., 1988; Kelly & Rodriguez, 2007; Williams & Chambless, 1990). Other studies, meanwhile, report positive effects on therapeutic outcome, including clients perceiving disclosure as helpful and reporting lower levels of distress when therapists disclose more (Barrett & Berman, 2011; Ramsdell & Ramsdell, 1993).

Therapist self-disclosure appears to have a clearer impact on the therapeutic relationship or perceptions of one's therapist, though the specifics of how are not always consistent. Increased therapist self-disclosure is correlated with clients liking their therapists more (Barrett & Berman, 2011). Increased self-disclosure from therapists is also associated with clients rating their therapists as more helpful, more insightful, more authentic, and more human (Hill et al., 1988; Knox, Hess, Petersen, & Hill, 1997). Self-disclosing responses from a therapist may even



be rated as more helpful by clients than other types of therapist responses such as confrontation, interpretation, or questioning (Hill et al., 1988). Clients may also express more willingness to disclose information themselves to a therapist who uses self-disclosure, especially when disclosures are infrequent and not of deep intimacy (Henretty & Levitt, 2010; Henretty et al., 2014). There still remains some variation of findings in the effectiveness of disclosure on improving the therapeutic relationship, however. For example, self-disclosure has both positive and negative results on perceptions of therapeutic boundaries and professionalism of the therapist, with more positive perceptions occurring when disclosure was infrequent and limited in its intimacy (Audet, 2011). Other studies note therapist disclosure, while it does help clients to see their therapist as warmer, does little to improve client perception of a therapist's trustworthiness, empathy, or overall regard (Henretty & Levitt, 2010). Another study reported disclosure had no association with change in working alliance between therapist and client (Kelly & Rodriguez, 2007). Should a strong relationship not exist between therapist and client, disclosure can even have a negative effect on clients (Henretty & Levitt, 2010). While the results of research in this area vary, it appears the therapeutic relationship can benefit through therapist self-disclosure despite some risks.

The potential benefits of self-disclosure may possibly be gained by strengthening the therapeutic alliance, that is, the relational aspects of a therapeutic relationship considered to be independent from the treatment technique or approach used (Elvins & Green, 2008). Meta-analytic reviews of therapeutic alliance confirm it consistently relates to therapeutic outcomes, including for children, adolescents, and adults (Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). While procedural aspects of the therapeutic alliance are present, including collaborative interaction or goal-setting, interpersonal interactions between therapist and client are also

considered critical (Ackerman & Hilsenroth, 2003). The therapist's conduct and attributes can have an influence on the therapeutic alliance. Therapist traits, particularly early on in therapy, such as understanding, openness, warmth, honesty, and confidence, are associated with stronger client perceptions of the therapeutic alliance (Ackerman & Hilsenroth, 2003). In addition, how the therapist portrays both nonverbal and verbal cues, including making self-disclosing statements, influences client feelings of connectedness (Ackerman & Hilsenroth, 2003). It is possible therapist self-disclosure may not only be a potential therapeutic intervention, but also a way for therapists to convey meaningful interpersonal information to a client who is looking to connect with his or her therapist in a meaningful way. By doing so, self-disclosure may be one way a therapist can present his or herself in a way that increases bonding and alliance.

**Variations in Research on Therapist Self-Disclosure.** Information disclosed by a therapist is widely variable regarding type. Therapists report disclosing more content related to professional issues and background as opposed to more personal or intimate information such as success and failure, interpersonal relations, attitudes or feelings, and especially sexual issues (Edwards & Murdock, 1994; Hill & Knox, 2001). One limitation of the body of research on disclosure is it does not often identify the impact of specific content revealed in disclosures. Studies often use varying definitions of what self-disclosure may be referring to in terms of content (Hill & Knox, 2001). For example, an immediate disclosure is likely to be perceived differently than a non-immediate one, and so better defining therapist disclosure is important in research. Standardizing a single definition of therapist self-disclosure to fit all studies, however, is likely impossible (Gibson, 2012).

Certain aspects of disclosure appear to have received more research focus. Most often, disclosure research explores immediate (intratherapy) compared to nonimmediate (extratherapy)

disclosures, positive compared to negative content valence, and disclosures suggesting similarity to a client compared to ones that do not (Henretty et al., 2014). One study found clients reported therapist disclosure to be more helpful when disclosures made the client and therapist seem more similar and when disclosures were of negative emotional content (Henretty et al., 2014). While both immediate and nonimmediate disclosures were perceived as more helpful than nondisclosure, nonimmediate disclosures were perceived as most helpful (Henretty et al., 2014). Other studies, however, note clients had more positive responses to disclosures that were immediate and involved feelings about the client compared to nonimmediate disclosures (Henretty & Levitt, 2010).

Another challenge in reviewing research on disclosure is it often focuses particularly on the frequency of exposure, rather than the content of disclosure (Hill & Knox, 2001). The vast majority of mental health professionals endorse making self-disclosures in therapy at times, though they appear to do so limitedly, utilizing it infrequently as a therapeutic intervention (Edwards & Murdoch, 1994; Kelly & Rodriguez, 2007). As one study reports, many clients do not expect their therapists to disclose much, and tend to see their therapist in a role of listening, questioning, and offering solutions (Audet, 2011). Therapists themselves may disclose more often to clients who present to therapy with fewer mental health symptoms, disclosing less to clients with more severe concerns such as personality disorders (Henretty & Levitt, 2010; Kelly & Rodriguez, 2007). It is also suggested therapists are more likely to disclose to more challenging clients where building rapport is more difficult (Hill & Knox, 2001). So, while it does appear mental health professionals disclose with some clients at some times, it does not appear to be a frequent occurrence with the majority of clients. As such, there does not appear to be a reason to suggest more disclosure correlates with improved outcomes (Hill & Knox, 2001).

It is important for research to consider other aspects of disclosure, including the quality and content of disclosure.

**Therapist Self-Disclosure of Mental Illness.** Research is limited on therapeutic disclosure of personal information related to mental health. Mental health professionals with a history of mental illness may provide unique benefits in their work with clients. For example, professionals who have recovered from mental illness themselves can act as role models and may offer important insight and understanding in helping clients deal with their own mental health concerns (Fisher, 1994). A professional with a past history of mental illness may also hold a stronger belief that recovery is possible, may hold fewer stigmatizing beliefs, and may provide more education and advocacy to clients (Cain, 2000). Professionals still must consider the potential risks and benefits of sharing such a history.

Research within the eating disorder literature proves relevant to this question. Roughly 38% of members of the Eating Disorders Association, including individuals with an eating disorder, those in recovery, relatives, and mental health professionals, endorse that people involved in eating disorder treatment should be obliged to disclose if they had a history of an eating disorder (Johnston, Smethurst, & Gowers, 2005). Forty percent of EDA members disagree with this obligation however, while 20% are undecided (Johnston et al., 2005). A third of EDA mental health professionals reported a history with an eating disorder (Johnston et al., 2005). The results suggest a fair proportion of professionals within this area of clinical practice may have personal experience similar to their clients. However, the results also suggest making disclosures about such mental health symptoms mandatory may be inappropriate. EDA mental health professionals are more likely to oppose such an obligation to disclose (Johnston et al., 2005). This may be unsurprising given the intimate nature of the content. Roughly 20% of EDA

members with a history of an eating disorder reported a member of their treatment team disclosed he or she had experienced an eating disorder (Johnston et al., 2005). The majority of participants reported a positive influence from such a disclosure (Johnston et al., 2005). So, while many participants did not express outright agreement with an obligation to disclose, there was often some advantage when disclosure did occur. Individuals currently or previously in treatment for an eating disorder, as well as their families, were more likely to rate therapists with a previous eating disorder as more beneficial to the therapeutic relationship as opposed to ones without such a past (Johnston et al., 2005). This finding indicates clients may hold more positive perceptions of their therapist upon hearing a disclosure of a history of mental illness similar to their own.

Therapist self-disclosure of psychological concerns is also relevant to substance abuse treatment. Therapists are more likely to self-disclose in substance abuse treatment settings than in other treatment settings (Gibson, 2012). With the popularity of self-help models of substance abuse treatment like Alcoholics Anonymous (AA), emphasis is often placed on the benefits of sharing experience and self-disclosure (Mallow, 1998; Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001). Therapists who self-disclose previous substance abuse concerns tend to be perceived by their clients as trying to normalize or reassure (Knox et al., 1997). Therapist self-disclosure of previous substance abuse can be a helpful tool in counseling, although if it is done because of over-identification with clients for example, disclosure can be made for inappropriate reasons like seeking approval from the client (Doukas & Cullen, 2010). In fact, in recent years, mental health professionals like substance abuse counselors have been encouraged to use self-disclosure less and with more consideration, as opposed to AA sponsors or recovery coaches who may use it more liberally (White, 2006).

Therapist self-disclosure of continued substance abuse recovery can be complicated, as it may establish a dual relationship if both the client and the therapist attend local AA meetings for example (Doyle, 1997). So while therapist self-disclosure may be more common in substance abuse treatment, it is still cautioned against by many mental health professionals, as it may lead a professional relationship to become too personal (Doyle, 1997).

Undergraduate students rate therapists who self-disclose previously being in therapy as more personally attractive, specifically as more likable, easygoing, responsible, flexible, sincere, stronger, courteous, cooperative, and mature than therapists who do not disclose (Fox, Strum, & Walters, 1984). Furthermore, disclosing therapists are rated as more professionally attractive, including more competent, more able to understand the client, and more agreeable (Fox et al., 1984). Undergraduate participants are also significantly more likely to endorse greater willingness to see a similar therapist to one who discloses as opposed to a therapist similar to the nondisclosing one (Fox et al., 1984). This particular study, which used brief descriptive histories of a psychologist, found that participant ratings remained constant whether the disclosing therapist initially presented to therapy for personal reasons or for a training requirement (Fox et al., 1984).

Furthermore, undergraduate students rate therapists who disclosed previously experiencing similar symptoms to their clients as significantly more likable, sincere, and warm than therapists who did not disclose (Somers, Pomerantz, Meeks, & Pawlow, 2014). The same study however found that therapist self-disclosure did not have an effect on perception of the therapist's ability to get along with or understand the client, nor did it have an effect on perception of the therapist's ability to be considerate of the client's needs (Somers et al., 2014). However, participants perceived a stronger therapeutic relationship and anticipated more positive

therapeutic outcomes (Somers et al., 2014). Though this study utilized vignettes, it did not utilize vignettes of therapeutic conversations. Rather, this study utilized vignettes that described a patient, “Sally,” and her experience in therapy with a particular therapist. Participants read one of three vignettes, which varied by diagnosis: depression, PTSD, or alcohol dependency (Somers et al., 2014). However, despite the differences in these vignettes, the above mentioned results were observed regardless of the reason for presenting to therapy (i.e. depression, PTSD, or alcohol dependency) (Somers et al, 2014).

Though these results shed some light on perceptions of self-disclosing mental health professionals among a more general population, how mental health professionals perceive such disclosures has yet to be investigated. Nonetheless, there is some indication that therapist self-disclosure of a history with mental illness may improve perceptions of a therapist, which may be beneficial to the therapeutic alliance.

**Theoretical Approaches to Using Therapist Self-Disclosure.** Perspectives on self-disclosure may vary among mental health professionals. In particular, different theoretical backgrounds and training offer different guidelines on the use of self-disclosure in therapy. In classical psychoanalysis or ego psychology for example, therapists avoid self-disclosure so the client’s conflicts may be projected or transferred onto the therapist or the therapeutic relationship (Ziv-Bieman, 2013). Therapists practicing later varieties of psychoanalysis, including object relations theory and self-psychology, place more importance on self-disclosure in therapy (Ziv-Bieman, 2013). In contrast, humanistic and existential therapies hold self-disclosure to be a more critical therapeutic intervention (Carew, 2009; Edwards & Murdock, 1994; Ziv-Bieman, 2013). Though Rogers never explicitly uses the term “disclosure” in his book *On Becoming a Person* (1961), he does stress the importance of therapist transparency. Congruence happens when a

therapist is authentically his or herself with a client (Rogers, 1961). Without any façade, a therapist being his or her genuine self can facilitate personal change in a client (Rogers, 1961). Disclosing personal information, such as experiences or feelings, may then be a way for a therapist to be more authentic, promoting a stronger sense of congruency. Therapists who practice from a humanistic orientation in particular were the first to see self-disclosure as a therapeutic tool, and continue to use it therapeutically as a way to be authentic, build strong therapeutic relationships, model sharing of emotional information, and establish empathy (Carew, 2009; Edwards & Murdock, 1994; Henretty & Levitt, 2010).

Existential therapists like Irvin Yalom also encourage therapists to maintain congruence or transparency with their clients (Carew, 2009; Yalom & Leszcz, 2005). Yalom writes about the use of therapist self-disclosure in process group therapy in particular. He writes therapist self-disclosure can help therapists to be more flexible and to more easily maneuver group dynamics, while also increasing openness amongst a group or family dynamic (Yalom & Leszcz, 2005). Therapist self-disclosure is a way to help resolve transference, model norms, and aid with interpersonal learning (Yalom & Leszcz, 2005). Yalom argues in support of the Rogerian idea that therapist self-disclosure is most effective when it authentically engages the client, adding that positive emotions and ambitions are more warmly received by clients compared to negative ones such as hostility (Yalom & Leszcz, 2005). Though Yalom encourages the use of therapist self-disclosure, he also warns therapists to consider several factors when contemplating the use of self-disclosure, namely timing, the group's needs, and knowing when to take a backseat to the dynamic of the group (Yalom & Leszcz, 2005).

Other therapies, such as feminist and multicultural therapies, hold self-disclosure as having an important role in promoting equality between therapist and client (Henretty & Levitt,



2010; Henretty et al., 2014; Ziv-Bieman, 2013). Mental health professionals with an eclectic approach meanwhile often vary in their views on self-disclosure as eclectic approaches themselves can so widely vary (Edwards & Murdock, 1994). Family therapies also vary in their stances on the use of self-disclosure, with some holding non-disclosure to be more ideal while others utilize it more openly (Gibson, 2012).

Modern therapeutic orientations can be vague or brief in their discussion of using self-disclosure as a tool in therapy. Even among the more common, third-wave therapeutic treatment manuals, the discussion of therapist self-disclosure differs significantly. For example, in Cognitive Behavioral Therapy (CBT), self-disclosure is identified as a tool, similar to how a therapist may use Socratic questioning, to help clients reframe their thoughts (Beck, 2012). Self-disclosure allows a therapist to demonstrate how to adapt more flexible ways of thinking to a client (Beck, 2012). However, in the CBT training manual, only one paragraph composed of several sentences is explicitly used to discuss therapist self-disclosure. In general, therapists with cognitive-behavioral orientations use self-disclosure to achieve many goals, including modeling appropriate behavior, though are cautioned in their training to first consider their reasons for doing so (Edwards & Murdock, 1994; Ziv-Bieman, 2013).

The Acceptance and Commitment Therapy (ACT) training manual describes therapist self-disclosure over several scattered paragraphs as a way to develop a strong relationship with a client by helping the client to feel more camaraderie, aiding the therapist to be perceived as more credible (Hayes et al., 2012). It is specified only that the therapist should not “spend more time self-disclosing than the client does” (Hayes et al., 2012, p. 152). ACT therapists view self-disclosure as a natural human process, and a way to help the client see his or her therapist “has struggled with some of the same issues that he or she is struggling with” (Hayes et al., 2012, p.

152). This helps remedy client concerns that they may be different or abnormal in some way because of their concerns by sharing in this with someone who has similarly struggled (Hayes et al., 2012). Self-disclosure is common during ACT as it helps the therapist model openness to facing some of the difficult tasks of therapy (Hayes et al., 2012).

The training manual for Dialectical Behavior Therapy (DBT) meanwhile has a more prolonged discussion of the use of self-disclosure across several pages. In DBT, self-disclosure can be a way to effectively accomplish many things, including validation and normalization of client experiences, modeling problem solving or skills use, contingency management, and exposure exercises for the client (Linehan, 1993). It is also noted how self-disclosure is beneficial to the therapeutic relationship as it can strengthen intimacy and warmth (Linehan, 1993). In terms of personal disclosure, it is specified only that, “so long as a disclosure is in a patient’s best interest, there are no rules (other than common sense and the guidelines above) limiting information given to the patient” (Linehan, 1993, p. 382). It is also explained that professionals with a history of substance abuse may share their experiences as a part of treatment for clients with similar disorders (Linehan, 1993). Overall, DBT summarizes disclosure by stating “such sharing is not definitional to the therapy, but it is not proscribed” (Linehan, 1993, p. 382).

The differences among therapeutic approaches to using self-disclosure is reflected in research on therapy styles. For example, humanistic psychologists report using significantly more self-disclosure than those with psychoanalytic approaches, while therapists with eclectic, cognitive, or behavioral orientations report using similar amounts of disclosure (Edwards & Murdock, 1994). However, self-disclosure appears to be commonly used in practice, as the majority of mental health professionals indicate doing so to some degree (Carew, 2009; Edwards

& Murdock, 1994). Although professionals with psychodynamic orientations may indicate using self-disclosure sparingly, this may actually be less true in practice as psychoanalysts may not disclose significantly less than other orientations (Carew, 2009; Henretty & Levitt, 2010). Other surveys of practicing mental health professionals have produced mixed results on the influence of theoretical orientation or background (Henretty & Levitt, 2010). Regardless of orientation however, most therapists report they consider the caution conveyed to them during their training prior to using self-disclosure with clients (Carew, 2009). As noted above, training manuals, even when more descriptive in the use and functions of self-disclosure, are often unspecific on describing what content to disclose, when to disclose, and how to disclose. Overall, it appears therapists use self-disclosure commonly in therapy as it is more readily indicated by training manuals as a therapeutic tool, however the specifics of its use in terms of more intimate content are not often outlined or described in training texts.

## **Conclusions**

**Personal stigma.** The literature demonstrates stigma exists toward individuals with mental illness (Corrigan, 2005; Corrigan et al., 2000; Farina & Felner, 1973; Link, 1982; Link, 1987, Rusch et al., 2005; Steadman, 1981; Weiner et al., 1988). Mental health professionals tend to have less personally stigmatizing views toward those with mental illness compared to the general population (Chambers et al., 2010; Kingdon et al., 2004; Lauber et al., 2004; Stull et al., 2013). However, the perception by mental health professionals of other professionals who have a history of mental illness has yet to be investigated. This is an important avenue to investigate because it may significantly impact how professionals view the use of disclosing one's own mental health treatment. In addition, the literature demonstrates that those from more rural areas

tend to hold more personally stigmatizing attitudes. However, research has not yet also considered how professional status may contribute to personal stigma.

**Public stigma.** There does not yet appear to be any exploration of how professional status may influence perceptions of public stigma. Personal and public stigma have been addressed as theoretically distinct concepts and there is no research support that these are similar or overlapping concepts. It is beneficial to consider whether these concepts, both forms of broader “social stigma,” are at all related or similar. Much like with personal stigma, research suggests those from rural areas tend to perceive more public stigma toward those with mental illness. However, it has also not been addressed in research how professional status may contribute to public stigma.

**Therapists and self-disclosure.** Therapist self-disclosure has been shown to generally be beneficial for the therapeutic relationship and for clients’ perceptions of their therapists (Barrett & Berman, 2011; Hill et al., 1988; Knox et al., 1997). Unfortunately however, research on therapist self-disclosure often does not address what particular content may be beneficial and what may be detrimental. Furthermore, while therapist self-disclosure may be used to accomplish goals in therapy, many professionals learn in their training to be cautious when considering it (Carew, 2009; Hayes et al., 2012; Linehan, 1993; Yalom & Leszcz, 2005). Therapist self-disclosure can be used as a tool, but may be a way to inappropriately shift focus away from the client (Yalom & Leszcz, 2005). A therapist who discloses a past history of mental distress, such as with an eating disorder or a substance abuse history, may connect with a client in a beneficial and meaningful way (Fox et al., 1984; Johnston et al., 2005; Linehan, 1993). However, an intimate disclosure like that of a past mental illness could also be risky, potentially creating distance between therapist and client. Overall, mental health training and treatment manuals are

often vague and apprehensive about directing the use of self-disclosure more specifically. Mental health professionals have been shown to under-endorse their own use of self-disclosure (Carew, 2009; Henretty & Levitt, 2010).

In addition to the mixed nature of training and education regarding therapist use of self-disclosure, research tends to explore how people generally perceive a wide variety of therapist self-disclosure. To date however, not studies have compared nonprofessionals' and mental health professionals' perceptions of self-disclosure. This is an especially important consideration to make in research, because in theory, nonprofessional participants can be considered a sort of "potential client" or "consumer" of mental health services. The overall ambivalence of mental health care providers and educators should be compared to those who would be theoretically influenced by hearing a self-disclosure from their therapists. Despite what mental health professionals may believe about using self-disclosure based on their training or experience, considering the beliefs and perceptions of potential patients can help to specifically guide and teach about the use of self-disclosure.

### **Current Study Aims**

The first and second goals of the study were to investigate differences in personal stigma and perceived public stigma between mental health professionals and nonprofessionals. The third goal of the study was to determine whether mental health professionals have more negative perceptions of therapists who disclose a past mental illness than nonprofessionals (i.e., potential clients). This is of importance as self-disclosure may be a beneficial tool to the therapeutic relationship and alliance for clients, whereas mental health professionals may be cautious and conservative with their use of self-disclosure. It can be of benefit to clarify the role and use of

personal disclosure of experience with mental illness or therapy. The fourth and final goal is to determine whether personal or public stigma vary by self-reported rural status.

**Specific Aim #1.** Examine personal stigma and public stigma held by mental health professionals and nonprofessionals. Based on the available research, we expected mental health professionals would hold more positive, less stigmatizing views of those with mental illness than nonprofessionals (Corrigan et al., 2000; Rusch et al., 2005; Weiner et al., 1988).

**Specific Aim #2.** Examine public stigma held by mental health professionals and nonprofessionals. As there does not yet appear to be specific literature comparing mental health professionals' and nonprofessionals' perceptions of public stigma, an exploratory analysis of differences in public stigma was conducted.

**Specific Aim #3.** Investigate perceptions of a vignette detailing a therapist's self-disclosure of past mental illness by mental health professional and nonprofessional participants. As no previous research has compared professional and nonprofessional perceptions of therapist self-disclosure of mental illness, an exploratory analysis was conducted. Given previous research by Fox, Strum, and Walters (1984) however, it was expected nonprofessionals (undergraduate students) would hold more positive perceptions of a disclosing therapist than a nondisclosing therapist. An exploratory analysis of other main and interaction effects was conducted.

**Specific Aim #4.** Investigate if personal and public stigma vary by self-reported rural upbringing. Research indicates those living in rural areas hold more personally stigmatizing views, and perceive more public stigma, toward those with mental illness compared to those living in nonrural areas (Heflinger et al., 2014; Hoyt et al., 1997; Komiti et al., 2006; Stewart et al., 2015; Williams & Polaha, 2014). However, no research was available regarding stigma among rural mental health professionals. While it was expected that nonprofessionals reared in a

rural area will have more personal and public stigma, it was unclear how rural mental health professionals may differ from nonrural professionals. Overall, it was expected that nonprofessionals from a rural area would hold the most stigmatizing views of individuals with mental illness, followed by nonprofessionals from nonrural areas, and professionals were expected to hold the least stigmatizing views, though rural and nonrural differences were unknown. Given the unique environment of rural areas, including more stigmatizing attitudes and a lower presence of mental health professionals, an exploratory analysis of rural and non-rural differences was conducted.

## CHAPTER 3

### METHOD

#### **Participants**

Participants were recruited in two ways. A sample of non-mental health professionals was recruited through Georgia Southern University's participant pool. This population of predominately undergraduate students served as a proxy for potential "therapy clients," as they have not received substantial training in mental health and may in fact be a consumer of mental health services, whether it be in the past, present, or future. Participation was voluntary and served as one possible way to complete course requirements. A sample of mental health professionals was recruited via listservs and social media of professional networks of mental health practitioners. Professionals were able to enter a drawing to win one of two gift cards (\$50 each) as incentive for participation. Mental health professionals included licensed psychologists (Ph.D., Psy.D.), marriage and family therapists (MFT), licensed clinical social workers (LCSW), and licensed counselors (LPC, LCPC, LCMHC), as well as other mental health providers who may have different titles based on the state of practice. One such professional network was the American Psychological Association (APA), including Division 29 (Society for the Advancement of Psychotherapy), Division 35 (Psychology of Women), Division 42 (Psychologists in Independent Practice), Division 50 (Society of Addiction), and the Early Career Psychologist listservs. Other networks included the Association for Behavioral and Cognitive Therapies (ABCT), the American Counseling Association (ACA), The Association for Psychological Science (APS), and the National Association of Social Workers (NASW).

For both samples, participation involved the online completion of a demographic questionnaire, a questionnaire of reactions after reading a therapeutic vignette, the Community



Attitudes toward the Mentally Ill, and the Perceived Devaluation/Discrimination Scale.

Completion time for the study was approximately 15 to 30 minutes.

Overall, 380 participants were recruited for the study. The overall sample contained 263 women (69.2%) and 103 men (27.1%), with 14 participants not reporting their gender. The average age was 23.99 years old and 243 participants (63.9%) identified as white.

In the overall sample, 68 participants (17.9%) were mental health professionals. Most of these participants were women ( $n = 55$ ; 80.9%) and 57(83.8%) identified as white. The average age of mental health professional participants was 41.3 years old and the average number of years in practice was 11. Most professional participants were licensed at the doctoral level ( $n = 49$ ; 72.1%) with 19 licensed at the master's level (27.9%). The majority (44) of mental health professional participants indicated their primary theoretical orientation was CBT (64.7%).

The additional 312 participants (82.1%) composed the nonprofessional participant sample. Of nonprofessional participants, 208 were women (66.7%) and 186 (59.6%) identified as white. The average age of nonprofessional participants was 20.11 years old. More detailed demographic information on the participants can be found in Table 1.

## **Materials**

All measures were obtained by the investigator with permission from the original authors or created for the current study. The following measures were used for the study: Community Attitudes Toward the Mentally Ill (CAMI), the Perceived Devaluation/Discrimination scale (PDD), and a questionnaire of items related to the vignettes created for the current study. In addition, vignettes were created by the author.

**Community Attitudes toward the Mentally Ill (CAMI; Taylor & Dear, 1981).** The CAMI assesses reactions to individuals who require treatment for a mental illness. In the current

study, the CAMI is being utilized to assess participants' personal stigmatizing attitudes, that is, how they themselves perceive others with mental illness. The CAMI consists of 40 items answered on a 5-point Likert Scale ranging from 1 (strongly agree) to 5 (strongly disagree) with 3 being neutral. The CAMI measures four factors relating to mental health stigma: authoritarianism, benevolence, social restrictiveness, and community mental health ideology; however, for the current study only the total score (using all 40 items) was used as a means of providing an overall approximation of personal stigmatizing attitudes. Sample items include: "There is something about the mentally ill that makes it easy to tell them apart from normal people;" "The mentally ill have for too long been the subject of ridicule;" "I would not want to live next door to someone who has been mentally ill;" "The best therapy for many mental patients is to be part of a normal community." CAMI total scores can range from 40 to 200, with negative items being reverse scored. Higher scores indicate more negative attitudes toward people with mental illness.

Taylor and Dear (1981) found high internal consistency for the CAMI total score ( $\alpha = .88$ ), and social restrictiveness ( $\alpha = .80$ ) and benevolence ( $\alpha = .76$ ) scales. The authors found reliability was lower for authoritarianism ( $\alpha = .68$ ). Using factor analysis, Taylor and Dear also found the CAMI to have good construct validity. Several studies found high overall reliability when considering all 40 items on the scale, with alpha estimates of .79 (Girma et al., 2013) and .90 (Barney, Corser, & White, 2010). When Cronbach's Alpha was computed to assess the reliability of all 40-items of the CAMI on the current study, it was found to have high internal reliability ( $\alpha = .94$ ).

**Perceived Devaluation/Discrimination (PDD; Link et al., 1987; 1991).** The PDD measures how much an individual believes most other people devalue individuals with mental

illness by disregarding them, seeing them as failures, or seeing them as less intelligent (Link et al., 1991). The PDD also assesses how much an individual believes most other people discriminate against individuals with mental illness in the workplace and in social or romantic relationships. The PDD is being utilized in the current study to assess participants' perceptions of general public perception, rather than their own personal perceptions, of individuals with mental illness. It was included to assess another aspect of stigma, as measures like the CAMI, which inquire about one's own personal attitudes, may be limited in terms of face validity. Social desirability may be a factor that influences participants to answer in a way that portrays their beliefs more positively on the CAMI. The PDD however, by asking how the general public perceives individuals with mental illness, may provide a more accurate perception of how much stigma one thinks exists toward people with mental illness.

The PDD consists of 12 items answered on a 6-point Likert scale ranging from 1 (strongly agree) to 6 (strongly disagree). Overall scores on the PDD can range from 12 to 72, with higher scores indicating participants perceive greater amounts of public stigma toward those with mental illness. Internal consistency for the PDD is high, with estimates of Cronbach's alpha ranging from .76 to .88 (Link et al., 1989, 2001; Vogel et al., 2007). Validity has also been demonstrated, as scores on the PDD correlate with experiences of demoralization and lower self-esteem over a span of 24 months (Link et al., 2001). Consistent with previous estimates, Cronbach's Alpha for the current study indicated high internal reliability ( $\alpha = .83$ ).

**Therapeutic Vignettes (TV).** Participants read one of two brief vignettes of a short exchange between a client and a therapist. The vignettes were created by the investigator and were designed to be neutral in regard to client and therapist gender and therapeutic orientation. Prior to the current study, the vignettes were distributed to doctoral students for feedback and

input. Using feedback generated, two vignettes were tailored for the study. One vignette served as the control condition, where a client discloses fear about coming to therapy, and the therapist responds in an orientation-neutral fashion:

*Client:* I'm so overwhelmed with everything, I just wish I could feel better. Nothing seems to help. I know that coming to treatment will help keep me feel better but I'm still scared. I've never been to therapy before.

*Therapist:* I hear that you're scared. You're trying something new and you're experiencing a lot of pain. I care a lot about your well-being and I want to do my best to help you feel comfortable.

The second vignette functioned as the experimental condition, whereby the therapist discloses a past history of attending therapy for similar emotional concerns. It was created to be as identical to the control vignette as possible. While the therapist still replies in an orientation-neutral manner, the therapist discloses he or she has had an experience in the past for which therapy was sought:

*Client:* I'm so overwhelmed with everything, I just wish I could feel better. Nothing seems to help. I know that coming to treatment will help keep me feel better but I'm still scared. I've never been to therapy before.

*Therapist:* I hear that you're scared. You're trying something new and you're experiencing a lot of pain. I've had a similar experience and have gone to therapy myself. I care a lot about your well-being and I want to do my best to help you feel comfortable.

**Vignette Questionnaire (VQ).** The vignette questionnaire was presented after reading one of the vignettes. The VQ contains six questions created by the investigator to gauge participants' reactions to the therapist's response in the vignette. Participants were asked to

respond on a 4-point Likert scale, with 1 being “Strongly Disagree” and 4 being “Strongly Agree” for the first five items. Item six is responded to on a four-point Likert scale as well, with 1 being “Not at all likely” and 4 being “Very likely.” The four-point scale was used to eliminate the possibility of a “neutral” response. Scores on the VQ overall can range from six to 24, with higher scores indicating more positive perceptions of the therapist. While each question was designed to inquire about a different aspect of the therapist, the total VQ score was of interest in the current study as an indication of general perception of the therapist. Please see Appendix A for the full questionnaire. Calculating Cronbach’s Alpha for the VQ indicated high internal consistency ( $\alpha = .90$ ).

**Demographic Questionnaire (DQ).** Participants provided basic demographic information, such as their year of birth, age, gender, race, geographic region, and highest year of education. For the nonprofessional sample group, participants also reported their year in school and academic major. For the mental health professional group, participants provided information regarding their professional practice including type of degree, license status, years in practice, treatment orientation, type of facility or treatment population, geographic region of practice, and estimated hours per week engaged directly with clients. The full DQ can also be found in Appendix A.

## **Procedures**

Students signed up for the study through the university’s Experiment Management System (SONA). Student participants were then provided with a web link to complete the survey via Qualtrics.com. For mental health professionals, a web link was provided for Qualtrics.com via the listserv or social media request for participation. After accessing the web link, participants of both groups were asked to review the informed consent document and

electronically indicate acceptance to complete the study. After providing electronic consent, volunteering participants were first randomly assigned to read one of the two vignettes of a therapeutic exchange between a therapist and a client (See Materials section above) and then answer questions about that vignette. Next, participants completed the CAMI and PDD in a randomized order. Finally, participants provided demographic information.

Following completion, participants were debriefed and the goals of the study were summarized. Contact information for the primary investigator was provided in the event a participant needed to contact the researcher.

## CHAPTER 4

### RESULTS

#### **Preliminary Analyses**

To confirm that the CAMI and PDD were independent measures that assessed separate and distinct types of stigma, a Pearson correlation coefficient was calculated between the two. There was no significant correlation between the CAMI and PDD,  $r = -.043$ ,  $p = .411$ . This suggests that the CAMI, assessing participants' personal stigmatizing attitudes, and the PDD, assessing participant's perceptions of public stigma, are in fact measuring independent factors.

#### **Hypothesis Testing**

**Personal Stigma.** A two (Professional status: Mental health professional vs. nonprofessional) by two (Disclosure condition: Disclosure vignette vs. nondisclosure vignette) Analysis of Variance (ANOVA) was utilized to examine differences on the CAMI. Results found a significant main effect for professional status on personal stigma toward individuals with mental illness,  $F(1, 369) = 105.68$ ,  $p < .001$ ,  $\eta_p^2 = .223$ , such that nonprofessionals scored higher on the CAMI ( $M = 94.13$ ,  $SEM = 1.00$ ) than did mental health professionals ( $M = 70.02$ ,  $SEM = 2.12$ ). This indicates that MHP endorsed less personal stigma toward those with mental illness than did nonprofessionals. There was not a significant main effect for disclosure condition,  $F(1, 369) = 1.05$ ,  $p = .306$ . This indicates that the vignette which participants read did not have any association with their endorsed personal stigma. The interaction between professional status and condition was not significant,  $F(1, 369) = .52$ ,  $p = .472$ .

**Public Stigma.** A two (Professional status: Mental health professional vs. nonprofessional) by two (Disclosure condition: Disclosure vignette vs. nondisclosure vignette) Analysis of Variance (ANOVA) was utilized to examine differences on the PDD. Nonsignificant

main effects were found for professional status,  $F(1, 371) = .02, p = .885$ , and condition,  $F(1, 371) = .62, p = .431$ . This indicates that professionals and nonprofessionals reported similar amounts of public stigma toward people with mental illness, and that the vignette participants read was not associated with any differences in perceptions of public stigma. The interaction between professional status and condition was also not significant,  $F(1, 371) = .009, p = .924$ .

**Perceptions of therapist.** A two (Professional status: Mental health professional vs. nonprofessional) by two (Disclosure condition: Disclosure vignette vs. nondisclosure vignette) Analysis of Variance (ANOVA) was utilized to examine differences on the VQ total score. A main effect for professional status was found,  $F(1, 375) = 4.97, p = .026, \eta_p^2 = .013$ , such that Nonprofessionals scored higher ( $M = 18.23, SEM = .19$ ) than mental health professionals ( $M = 17.24, SEM = .41$ ) on the VQ. This indicates that nonprofessional participants endorsed more positive perceptions of the vignette therapist overall than mental health professionals. A main effect for condition was also found,  $F(1,375) = 21.88, p < .001, \eta_p^2 = .055$ , such that those in the nondisclosure condition ( $M = 18.78, SEM = .31$ ) scored higher than those in the disclosure condition ( $M = 16.69, SEM = .33$ ) on the VQ. This indicates that participants in the nondisclosure condition endorsed more overall positive perceptions of the vignette therapist than did participants in the disclosure condition. The main effects were qualified by a significant interaction effect,  $F(1, 375) = 18.49, p < .001, \eta_p^2 = .047$ . Simple effect t-tests revealed an effect of condition for professional participants  $t(377) = 2.37, p = .018$ , such that professionals in the nondisclosure condition ( $M = 19.24, SEM = .49$ ) scored higher than professionals in the disclosure condition ( $M = 15.23, SEM = .55$ ). This indicates that professional participants perceived the disclosing therapist significantly less favorably than the nondisclosing therapist. There was no difference for nonprofessionals in the nondisclosure condition ( $M = 18.32, SEM =$



.28) versus those in the disclosure condition ( $M = 18.15$ ,  $SEM = .26$ ),  $t(377) = 1.79$ ,  $p = .08$ . This indicates that nonprofessionals did not rate either the disclosing or nondisclosing therapist significantly different. Results are displayed in figure 1.

**Rurality.** To investigate the possible influence of rural upbringing on stigmatizing attitudes, participants' descriptions of the area in which they were primarily raised were utilized for the analysis. The four possible responses were grouped into two categories. Those who endorsed the area in which they were raised could be described as "rural" or "small city/rural town" were categorized as "rural." Those who endorsed being raised in a "suburban" or "urban/large city" area were categorized as "non-rural."

First, a two (Professional status: Mental health professional vs. nonprofessional) by two (Rural status: Rural vs. non-rural) Analysis of Variance (ANOVA) was utilized to examine differences on the CAMI. Consistent with the ANOVA run to explore differences in personal stigma (see Personal Stigma section above), there was a main effect for professional status,  $F(1, 360) = 106.91$ ,  $p < .001$ ,  $\eta_p^2 = .229$ , such that mental health professionals scored lower ( $M = 70.17$ ,  $SEM = 2.15$ ) on the CAMI than did nonprofessionals ( $M = 94.67$ ,  $SEM = 1.00$ ). There was no significant main effect for rural status however,  $F(1, 360) = 1.79$ ,  $p = .182$ . The interaction was also not significant,  $F(1, 360) = .022$ ,  $p = .881$ . Overall, these results indicate that only professional status, but not self-reported rural status, influence personal stigmatizing attitudes toward others with mental illness.

A second two (Professional status: Mental health professional vs. nonprofessional) by two (Rural status: Rural vs. non-rural) Analysis of Variance (ANOVA) was utilized to examine differences on the PDD. Consistent with the ANOVA run to explore differences in public stigma (see Public Stigma section above), there was not a significant main effect for professional status,

$F(1, 362) = .04, p = .852$ . The main effect for rurality was also not significant,  $F(1, 362) = .15, p = .702$ . Lastly, the interaction effect was insignificant as well,  $F(1, 362) = .171, p = .68$ . Overall, these results indicate that professional status and self-reported rural status were not associated with differences in perceptions of public stigma toward those with mental illness.

## CHAPTER 5

### DISCUSSION

#### **Personal Stigma**

Our first aim was to investigate personal stigma held by nonprofessionals and mental health professionals. Consistent with previous research (Corrigan et al., 2000; Rusch et al., 2005; Weiner et al., 1988), the current study found mental health professionals held less stigmatizing attitudes toward individuals with mental illness than nonprofessionals. This is important, as it lends support to previous findings that mental health professionals hold more positive perceptions of those with mental illness than individuals of other professions. This pattern of results appears to make intuitive sense, as one would expect professionals working in mental health care to be more accepting and supportive of clients who have mental illnesses.

#### **Public Stigma**

Our second aim was to investigate perceptions of public stigma by nonprofessionals and mental health professionals. It is first important to note that we found no correlation between the CAMI and PDD, indicating that our measures used for measuring personal and public stigma respectively were in fact distinct from each other. We included both measures to not only assess different types of stigma, but as a buffer against participants possibly responding in more socially desirable ways on the CAMI. Our results suggest that participants' personally stigmatizing attitudes were unrelated to how they perceived stigma among the general population.

More specifically, our results found no significant differences in perceptions of public stigma between nonprofessionals and mental health professionals. These results regarding public stigma may be more surprising than our results regarding personal stigma. It suggests that mental

health professionals and nonprofessionals both perceive the public perception of individuals with mental illness similarly. Seemingly then, training in mental health does not appear to influence how professionals perceive public opinion toward mental illness. Furthermore, despite endorsing lower personal stigmatizing attitudes, mental health professionals do not perceive more or less stigma from the rest of the general population toward people with mental illnesses than do nonprofessionals.

### **Perceptions of a Therapist**

Our third aim was to investigate perceptions of a therapist who self-discloses a past history of mental health treatment. Previous research indicates that nonprofessional undergraduate students held more positive perceptions of a disclosing therapist compared to a nondisclosing one (Fox et al., 1984). Our analyses did not support this conclusion. Rather, our results indicated that nonprofessional participants rated a disclosing therapist and a nondisclosing therapist similarly. Mental health professionals meanwhile endorsed significantly more negative perceptions of a therapist that self-disclosed a history with mental health treatment compared to one that did not disclose such information. Our pattern of results indicate that while the self-disclosure was not associated with a more negative perception of a therapist for nonprofessional participants, our proxies for potential therapy patients, the mental health professionals found that therapist to be significantly less desirable. This finding is particularly interesting to consider. It suggests that the therapists who may make potential self-disclosures, are more off-put by self-disclosing than are potential clients.

Combining this pattern of results with our earlier findings is especially interesting. Those who hold the least personal stigma toward those with mental illness, mental health professionals, are actually less accepting of a therapist who self-discloses a past of mental health treatment. The

more personally stigmatizing group, the nonprofessionals and potential patients, are actually equally accepting of a disclosing and nondisclosing therapist. These results suggest that personally stigmatizing attitudes are actually not an accurate predictor of how one may feel about disclosure of mental health treatment. Also important to note is that mental health professionals and nonprofessionals scored similar on public stigma. This rules out a potential explanation for these findings. If mental health professionals perceived more public stigma toward people with mental illnesses, they may be more hesitant to share such information with a client out of concern of being stigmatized for having been in mental health treatment. But our pattern of results indicates that therapists are not more keenly aware of public perception differences of those with mental illnesses. It suggests that while they hold less personal stigma, they perceive the social environment toward those with mental illness similarly to nonprofessionals, who hold more personal stigma.

Rather, as explained in the literature review, it is believed that therapists' training and education influence this pattern of results. Regardless of theoretical orientation, most mental health professionals maintain a sense of caution to using self-disclosure, especially to potentially intimate disclosures such as mental health history. Training manuals in commonly practiced and empirically supported treatments like CBT, DBT, and ACT remain not only vague in their direction of how to use self-disclosure, but also caution against its use. Therefore, it seems that professionals, during their training and professional careers, reading manuals and treatment literature, likely develop a perspective that is not wholly open to using self-disclosure. In fact, it seems quite the opposite, that training and literature promote a perspective that is unfavorable of the use of self-disclosure.

What results then is a difference in perspective between mental health professionals and nonprofessionals. Mental health professionals perceive a disclosing therapist more negatively, while nonprofessionals, the potential clients in this case, show no significant preference one way or another. This is the first apparent study to compare the perspectives of nonprofessionals and mental health professionals, yet psychological training literature cautions against self-disclosure. However, it would appear that these training directives may not actually be influenced much by how potential patients may perceive disclosure. Overall, it suggests there exists disconnect between psychological training literature and how patients or clients may actually perceive self-disclosure in practice. Even though our results are not wholly consistent with previous findings, even taken together it has yet to be demonstrated that nonprofessional participants rate a self-disclosing therapist more negatively than one who does not.

Of course, it could also be the case that the mental health professionals are actually less accepting of the disclosing therapist because of the mental health treatment history itself. Given the design of this study, we are unable to identify a specific reason why mental health professionals rate the disclosing therapist more negatively. But whether it is the disclosure, or the treatment history itself, both have interesting implications. If professionals hold other professionals in lower standing due to past mental health treatment, this would suggest that they stigmatize members of their own profession differently than those among the general population with a mental illness. If professionals rate the therapist lower because of the self-disclosure, the implication may be more complex. It may be that although mental health professionals have in fact gone through treatment before themselves, many professionals may believe such information is better kept to oneself. Utilizing vignettes may be a useful way to specifically investigate this question in future research. For example, researchers could compose two vignettes in which both

therapists have previously undergone therapy themselves, but only one of which makes that disclosure to a client. In utilizing questions similar to the VQ about each therapist, researchers could determine how mental health professional participants rate each vignette therapist based only on the modified information of making a self-disclosure.

### **Rurality**

Our final aim was to explore the possible impact that a rural culture may have on stigmatizing attitudes toward individuals with mental illness. Previous research suggests those from rural areas held more personal stigma of those with a mental illness compared to those from nonrural areas, and perceive more public stigma (Heflinger et al., 2014; Hoyt et al., 1997; Komiti et al., 2006; Stewart et al., 2015; Williams & Polaha, 2014). However, the current study did not find support for these differences based on rurality. Based on self-report, participants raised in rural areas scored similarly on both the CAMI and PDD compared with those from nonrural areas. We initially predicted rural nonprofessionals would hold the most stigmatizing attitudes, followed by nonrural nonprofessionals, then rural professionals, and finally nonrural professionals holding the least stigmatizing views. This was not the case however. While nonprofessionals endorsed more stigmatizing views of those with mental illness than mental health professionals, rurality did not impact this relationship.

### **Limitations**

The current study used brief therapeutic vignettes to study perceptions of a therapist. While these allowed for targeted questions and research by manipulating just one sentence involving a disclosure of previous mental health treatment, it does not assess a real-world counseling relationship. Therapeutic relationships are complex, and so the current study offers only early findings based on a survey model. Though a useful design to initially investigate this

topic, future research would benefit from moving beyond the vignette, survey-style design of this study and toward more realistic interactions.

Another limitation to the study, one that was primarily procedural, was the sampling of mental health professionals. While we were able to gather a reasonable amount of mental health professionals, the “snowball” approach to disseminating research requests was not ideal. However, to the researchers’ knowledge, there was no convenient or ideal way to gather input from a cross-section of mental health professionals. Even of the sources that were used, some were less than receptive to the request being distributed or were less than helpful. As such, while the sampling of mental health professionals was influenced by convenience on some level, it appeared to be the only method available to gather the necessary participants. Unfortunately though, given the uneven nature of the populations sampled for this study, it also limited our sample sizes for result analyses. With fewer mental health professionals, our calculations ended up having unequal cell sizes. Future research could help support the current findings by attempting to obtain more balance sample sizes that result in more equal cell sizes and thusly more accurate analyses.

Lastly, the current study investigated only one small potential avenue related to therapist self-disclosure. Being such a vast topic, self-disclosure has many potential avenues of exploration. However, even in regard to therapist self-disclosure of mental illness, we only used one variety of ways in which such information could be disclosed. Namely, we used an unprompted self-disclosure from a therapist. That is to say, the client in our vignette did not prompt the therapist by asking a question. A prompted disclosure, one in which the client initiates by asking a therapist for some form of personal information, could in theory impact these findings. In regard to stigma, this may even be especially important. Furthermore,



prompted self-disclosure may be even more relevant to rural populations, where reputation and information may be even more important in such a small, “fishbowl,” town environment. Future research could benefit by making this simple change, attempting a similar study design to the current one, but modifying the study to have a prompted therapist self-disclosure, initiated by a client request or question.

### **Future Directions**

Future research could benefit from exploring the idea that mental health professionals are generally less stigmatizing toward individuals with mental illness, yet endorse more negative perceptions of a therapist disclosing a history of attending therapy. A question that remains unanswered is: why do professionals perceived other professionals more negatively if they disclose a previous history of therapy? Is it due to the disclosure? Is it due to the fact that a mental health professional had mental health struggles? Or some combination of both? At this time, that can only be speculated, but the current study does suggest that mental health professionals are less open to the idea of a therapist disclosing a previous history of mental health treatment to a client than are nonprofessionals.

Second, future research would benefit from more exploration on the use of self-disclosure. It is clear in reviewing theoretical models and training materials that mental health professionals will likely continue to vary in their views regarding self-disclosure as a tool. The literature thus far has outlined many potential risks and benefits, but self-disclosure can pertain to any number of topics. The current study explored one kind of intimate disclosure, though many more intimate topics could potentially be disclosed, including information regarding personal relationships or personal history. Furthermore, research should focus more on gaining nonprofessional perspectives of self-disclosure. After all, self-disclosure is a therapeutic tool that

is used with a client's best interest in mind. As such, having research focused on exploring how people may respond to self-disclosure from a mental health professional can be valuable information to help provide more specific and focused recommendations for professionals on how to use it with their clients. The specifics of how, when, and why to use self-disclosure are still not well understood, and exploring mental health professionals' and nonprofessionals' perceptions of its use is important.

Utilizing vignettes is a convenient way to begin sampling mental health professionals' and nonprofessionals' perceptions regarding therapists disclosing a variety of information. Researchers could develop therapeutic vignettes, or scripts, that flesh out more detailed therapeutic interactions. These scripts could modify the types of disclosure (intimate vs. superficial), the depth of disclosure (detailed vs. vague), the timing of the disclosure, and even the therapeutic processing that could occur after a disclosure is made. By varying this information and surveying professionals' and nonprofessionals' perceptions, researchers may begin to develop more specific and targeted guidelines for how, when, and why to use self-disclosure.

Future research may wish to explore other intimate varieties of self-disclosure with modifications that could be made to the current study. For example, one could explore how therapists are perceived when verbalizing other personal information, such as sexual orientation. It would be beneficial to better understand the role stigma has when it concerns the idea of a mental health professional, an authority or expert in many respects, sharing vulnerable personal information with a patient. Self-disclosure is a therapeutic tool utilized to help clients, and thus it is the perceptions of potential patients (i.e., nonprofessionals) that should be used to guide the therapist self-disclosure as a therapeutic intervention. Should nonprofessionals and mental health

professionals view the use of self-disclosures differently, even despite differences in baseline stigmatizing views, it is a relationship that should be better understood to help guide the instruction of self-disclosing interventions. The findings of the current study suggest that a person's stigmatizing views may not be an accurate predictor of how he or she may respond to a mental health professional's disclosure of previous treatment.

### **Conclusion**

Overall, the pattern of results from the current study highlight a few important and interesting findings. Specifically, while nonprofessionals may hold more stigmatizing attitudes toward individuals with mental illness, it is mental health professionals who more negatively perceive a therapist disclosing a past history of mental health treatment. Mental health professionals generally endorse more positive perceptions of those with mental illness but are not as receptive to the idea of a therapist disclosing a personal history of mental health treatment.

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## APPENDIX A

### VIGNETTE QUESTIONNAIRE (VQ)

1. I would refer a loved one (or someone close to me) to this therapist.

Strongly Disagree	Disagree	Agree	Strongly Agree
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2. Based upon my understanding, this therapist responded to the client in an ethical manner.

Strongly Disagree	Disagree	Agree	Strongly Agree
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3. This therapist responded to the client in a way that is consistent with what I believe professional standards should be.

Strongly Disagree	Disagree	Agree	Strongly Agree
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4. The therapist displayed appropriate empathy for this client.

Strongly Disagree	Disagree	Agree	Strongly Agree
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5. The level of self-disclosure used by this therapist was appropriate.

Strongly Disagree	Disagree	Agree	Strongly Agree
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6. If you were the therapist for this client, how likely would you be to respond in a similar way?

Not at all likely	Somewhat likely	Fairly likely	Very likely
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## DEMOGRAPHIC QUESTIONNAIRE (DQ)

All participants will be provided the following items:

- Birth year:
- Age (in years):
- Gender:
  - Male
  - Female
  - Other:
- Race:
  - White
  - African-American
  - Hispanic
  - Asian
  - Pacific Islander
  - Native American
  - Bi/multi-racial:
- Highest education:
  - Post graduate degree
  - Some post graduate
  - Bachelor's degree
  - Associate's degree
  - Some college: not currently enrolled
  - Currently enrolled in college

- High school diploma or GED
  - Less than high school diploma
- How would you describe the area in which you were raised (Or the area in which you spent most of your time prior to 18 years of age)?
  - Urban/ large city
  - Suburban
  - Small city/ rural town
  - Rural
- How would you describe the area in which you live currently?
  - Urban/ large city
  - Suburban
  - Small city/ rural town
  - Rural

Nonprofessional participants will be provided with the following items:

- Year in school:
- Academic major:

Mental health professionals will be provided with the following items:

- Type of degree:
- License:
- Years in Practice:
- Please identify the primary treatment orientation in which you operate from:
  - Acceptance and Commitment Therapy (ACT)
  - Cognitive-Behavioral Therapy (CBT)



- Dialectical Behavioral Therapy (DBT)
- Existential Therapy
- Gestalt Therapy
- Humanistic/ Person-Centered
- Narrative Therapy
- Positive Psychology
- Psychodynamic/ Psychoanalytic Theory
- Other (please specify)
- Type of facility/ treatment population:
  - Private pay
  - Hospital
  - Community mental health
  - College counseling center
  - Other (please specify)
- Estimated hours per week engaged in direct work with clients:
- How would you describe the area in which you currently practice?
  - Urban/ large city
  - Suburban
  - Small city/ rural town
  - Rural

Table 1.

<b>Demographic Information</b>				
	<u>Mental Health Professionals (<i>n</i> = 68)</u>		<u>Nonprofessionals (<i>n</i> = 312)</u>	
	Frequency	Percentage	Frequency	Percentage
Gender				
Men	13	19.1	90	28.8
Women	55	80.9	208	66.7
Race				
White	57	83.8	186	59.6
African American	5	7.4	77	24.7
Hispanic			18	5.8
Multiracial			13	4.2
Other	6	8.8	5	1.6
Therapy Orientation				
CBT	44	64.7		
Psychodynamic	7	10.3		
Other	17	25		
License type				
Doctoral	49	72.1		
Master's	19	27.9		
	Mean	Standard Deviation	Mean	Standard Deviation
Age	41.3	12.6	20.1	3.3
Years in Practice	10.7	11		

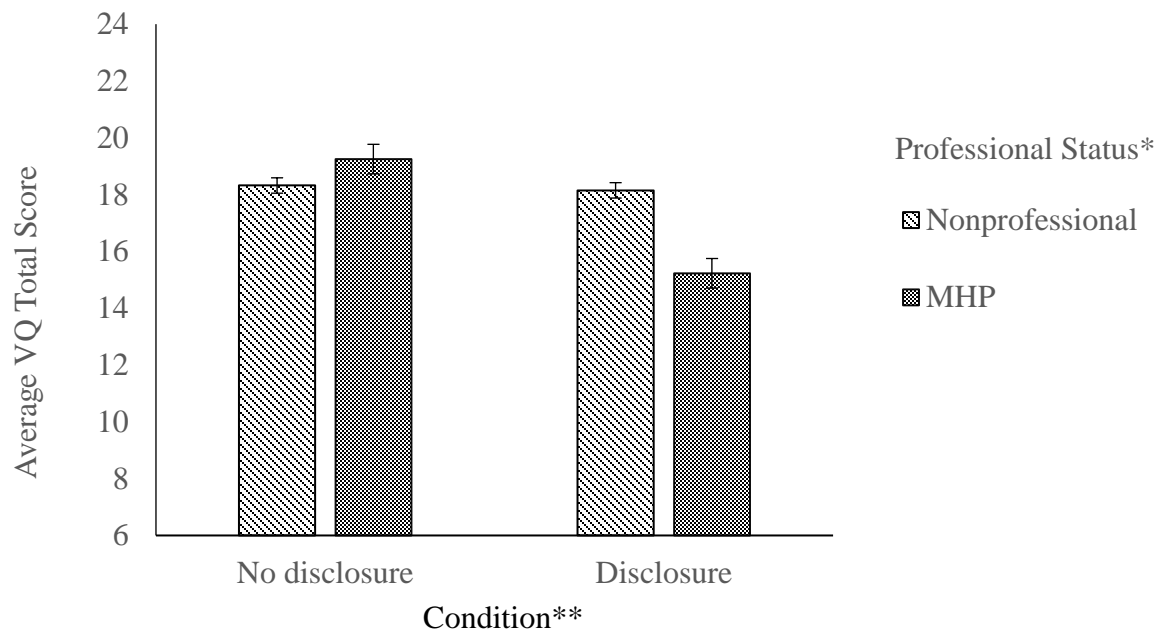


Figure 1. Average VQ total scores by condition and professional status.

Note. Condition x Professional Status interaction effect\*\*

\* $p = .026$       \*\* $p < .001$