The Journal of Counselor Preparation and Supervision

Volume 14 | Number 1 Article 1

2021

Attitudes and Action: Social Tolerance and Legal Coercion towards Those Suffering from Schizophrenia

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Abstract

This study examines stigma towards those suffering from schizophrenia on two levels: social tolerance and support for legal coercion. Recent research has found that counselors are more tolerant towards those suffering from schizophrenia than the general population (Smith & Cashwell, 2010; Smith & Cashwell, 2011; Crowe & Averett, 2015; Crowe et al., 2016). These studies have not examined support for legal coercion. Findings from this study indicate that counseling students have greater levels of social tolerance than undergraduates in other educational programs, there were no differences in social tolerance for counseling students when compared to other graduate students. No significant difference was found between groups in support for legal coercion. The authors examine results through humanistic and social justice lenses.

Keywords

Social Justice, Tolerance, Schizophrenia, Counselor Training

Stigma represents inequitable treatment including the removal of resources and opportunities based on a particular circumstance, quality, or personal trait. Research focuses on the process of stigmatization, as external labels are internalized becoming negative beliefs (Finlay et al, 2001; Gray, 2002). For the *stigmatizer,* it is an effective defense mechanism against a psychological threat (Yang et al., 2007). For the *stigmatized,* it can intensify experiences that life is dangerous, uncertain, and influence their beliefs about themselves (self-stigma; Yang et al. 2007). Research links stigma towards those suffering from mental health problems with greater difficulty finding work and housing, (Corrigan et al., 2005; Seeman, 2005), rejection by friends and family (Gonzalez-Torres et al., 2007), and poor treatment outcomes (Fung & Tsang, 2008; Lysaker et al., 2008; Norman et al., 2008). Stigma represents the reduction of a human to a label. In opposition to stigma is humanism, espousing the ideal of human irreducibility (Matson, 1971) and social justice advocacy. Perepiczka & Scholl (2012) refer to humanism as the "heart and conscience of the counseling profession" (p. 7). As such, counselors and counselor educators, who fundamentally believe in the inherent holism of all people, stand in opposition to stigma.

Humanistic philosophy fundamentally focuses on the dignity and value of all humans. While social justice is the action based on those humanistic ideals; the goal is to provide individuals and groups' equitable access to treatment, resources, and opportunities (Chung & Bemak, 2012). Counselors for Social Justice (CSJ), an official division of the American Counseling Association (ACA) highlighted the multifaceted and action-oriented nature of social justice that addresses distributive justice, individual empowerment, confrontation of injustice, and confrontation of the systems of power and privilege (CSJ, n.d.; "What is social justice in counseling?", 2003). Humanism, therefore, offers counselors the philosophical underpinnings, while social justice provides the action-focused orientation fundamental in their work combatting mental health stigma.

Recent research on stigma amongst counselors found that counselors in training (CITs) and professional counselors hold fewer stigmatizing attitudes than the general population (Crowe & Averett, 2015; Crowe et al., 2016; Smith & Cashwell, 2010, 2011). These findings stand in contrast to those found in the other helping professions, where stigmatizing attitudes are not significantly different than the general population (Lauber et al., 2004; Lauber et al., 2006; Schulze, 2007; Whitley & Campbell, 2014). Crowe and Averett's (2015) qualitative analysis of mental health professionals' attitudes towards those suffering from mental illness indicate educational training plays an important role in decreasing stigma, highlighting the humanistic and social justice cores of counseling.

Counselor education has a unique focus on developing a person-centered understanding of clients (Zalaquett et al., 2008). This focus allows counselors and CITs to understand personal biases and work through potentially stigmatizing attitudes. Processing personal bias and developing new attitudes, beliefs, knowledge, and skills of various cultural groups is a hallmark of the counseling profession, often referred to as the fourth force in counseling (Pedersen, 1999). Multiculturalism and social justice further illuminate the importance of counselor self-awareness, understanding of client worldview, developing a counseling relationship, and developing advocacy interventions (Ratts et al., 2016). Previous research has explored CIT and counselor attitudes towards those suffering from mental illness and provides an important foundation for understanding the role of multicultural training (Crowe & Averett, 2015; Crowe at al., 2016; Smith & Cashwell 2010, 2011). What remains to be addressed in the counseling literature on mental health stigma is an examination of the relationship between attitudes and action. Action-based counseling falls under the fifth force in counseling, social justice (Ratts et al., 2004). The purpose of this article to examine the potential for CITs to support legal coercion for those suffering from

schizophrenia. Legal coercion in this article is defined as mandated treatment, which is the most common form of coercion in counseling and accounts for 15-30% of all people receiving treatment for serious and pervasive mental illness (Bonnie & Monahan, 2005).

Clients receiving mandatory treatment for severe mental health diagnosis are at a higher risk of being the object of stigma. Foucault (1965) illustrates how stigmatizing attitudes towards those suffering from mental illness are long-held socially constructed culturally normative and heavily influenced by predominant social powers (e.g., religion and science) and utilized to maintain power structures. While stigma occurs on an interpersonal level, it is shaped by larger cultural norms. This framing of mental illness is clear in Pescodolido et al. (1996) and Schnittker's (2008) somewhat confounding results, with greater acceptance of a biological and genetic understanding of the illness and treatment comes a greater social distance from the person suffering from that illness. The specific research question is: Are there differences in stigmatizing attitudes (social tolerance) and actions (support for legal correction) across educational programs (graduate counseling, graduate non-counseling, and undergraduate)?

Methodology

Design of Study

This ex post-facto study was designed to assess differences in participants' social tolerance and support for legal coercion towards those suffering from schizophrenia. Participants were grouped according to their program of study (graduate counseling students, graduate students enrolled in other educational programs, and undergraduate students). All data were collected after IRB approval. This research followed the American Counseling Association's ethical guidelines (ACA, 2014).

Data analysis consisted of an analysis of covariance. Within the analysis, the dependent variable was stigma, the independent variable –educational program–had three levels (undergraduate student, master's level graduate student enrolled in a counseling program, and master's level graduate student enrolled not enrolled in a counseling program). Follow-up tests were run to test for significant differences on the subscales (social tolerance and support for legal coercion) across educational levels. Knowing someone who suffers from schizophrenia was used as a covariate in the model to control for the effects of a historical relationship among the participants.

Participants

Participants were graduate and undergraduate students enrolled in programs at a mid-sized university and collected via convenience sampling using a university-wide online research-recruiting platform. A total of 150 students logged into the study, 135 accepted to participate in the study, and 118 completed the study. Of the eligible participants, 79% completed the study and 87% of the participants who began the study finished it.

Forty-seven participants were female, 59 were male, and 12 declined to identify their gender. Participants' ages ranged from 17 to over 40 years old, with the majority (70.7%) between the ages of 21-25. Eighty participants identified as Caucasian, 14 as African American, 2 as Asian, 2 as Latinx, and 20 participants declined to share their racial/ethnic background.

Of the 118 participants, 22 (18.5%) were students enrolled in a master's level counseling program, 74 (63%) were undergraduate students and 22 (18.5%) were master's level students enrolled in another educational program.

Instruments

Pescosolido et al. (1996) developed the social tolerance and support for legal coercion scale. The scale is a seven-point Likert-type scale with one being definitely unwilling and seven being definitely willing. The first six questions address social tolerance while the final three questions measure support for legal coercion. Higher scores for social tolerance indicate greater levels of tolerance while lower scores indicate less tolerance. Higher scores on support for legal coercion indicate greater support for legal coercion while lower scores indicate less support. Items on the support for legal coercion scale are reversed scored to compute the total score. Total scores for the social tolerance and support for legal coercion are the sum of the social tolerance scale and the reversed scores for the support for legal coercion scale. Total scores at or above 36 indicate tolerance. All participants completed the social tolerance and the support for legal coercion scale. Nordt et al. (2006) reported good reliability (Cronbach's α = 0.82) of the social tolerance and support for legal coercion scale for mental health professionals and for the general population (Cronbach's α = 0.85).

One written case vignette was used to mediate responses on the social tolerance and support for legal coercion scale. All participants were given the vignette before filling out the scale. The case vignette, developed by Pescosolido et al. (1996), described someone suffering from schizophrenia without specifying the diagnosis to help disguise the mental illness and collect data based on symptoms rather than diagnosis. The vignette was adapted so that the person described in the vignette would be considered a peer to the participants.

Results

Assumptive Tests

Due to the small number of participants enrolled in the counseling and other graduate programs compared to the number of participants enrolled in undergraduate programs it was important to ensure that the assumptions of statistical analysis were met. A Kolmogorov-Smirnov test was used to test for the normality of the participants' distribution of scores. The Kolmogorov-Smirnov test demonstrated nonsignificant results for participants in the counseling program $D(22) = .166$, $p = .116$ and other graduate programs $D(22) = .175$, $p = .08$. The Kolmogorov-Smirnov test demonstrated non-significant results for participants in undergraduate programs $D(74) = .06$, $p = .2$. These results indicate a normal distribution for all groups. Other assumptions for the ANCOVA (missing data, outliers, homogeneity of variance and covariance, and homogeneity of regression slope) were also met.

ANCOVA Data

Covariate of the Total Score

The covariate of knowing someone who suffers from schizophrenia was dummy coded for the ANCOVA analysis. Knowing someone suffering from schizophrenia was a significant covariate $F(1,118) = 5.55$, $p = .020$, $= .046$) in the total score.

Mean data for the ANCOVA

Mean scores for the total score for the total scale showed counseling students with a higher total mean ($M = 40.95$) and a lower standard deviation ($SD = 6.64$) than participants enrolled in another graduate educational programs ($M = 37.32$, $SD = 6.94$) and undergraduate students ($M = 33.12$, $SD = 9.08$). The mean for the counseling and other graduate student participants fell above the cut-off of 36 and indicate low levels of stigma. The mean for undergraduate participants fell

below the cut-off of 36 and indicated high levels of stigma. The total mean for all groups (M = 35.36, SD = 8.82) also indicated high levels of stigma.

Analysis of Covariance. The ANCOVA demonstrated a significant difference between program types in total scores $F(2,114) = 5.43$, $p = .006$, $= .087$, $d = .84$). The program of study accounted for 8.4% of the differences in total scale scores. A post hoc power analysis showed a large effect size for the results (Cohen, 1969). Because the overall ANVOCA was significant, an analysis was also run to test for significance on the two sub-scales (support for legal coercion and social tolerance).

Table 1

Analysis of Covariance of Total Scores and Subscales

Program	F	df	Error df	p	η_p^2	d
Total score	5.43	2	114	.006	.087	.84
Legal coercion subscale	1.5	2	114	.228	.025	.31
Tolerance subscale	5.5	2	114	.005	.088	.84

Means on the Support for Legal Coercion Sub-Scale

Mean scores for the support for legal coercion subscale show counseling students with a higher mean (M = 12.59) and a lower standard deviation (SD = 4) than participants enrolled in another graduate program (M = 12.18, SD = 5.08) and undergraduate students (M = 10.54, SD = 4.4). The total mean and standard deviation for all groups was (M = 11.23, SD = 4.51).

Analysis of Covariance. The ANCOVA (Table 1) demonstrated a non-significant difference between groups in the support for legal coercion sub-scale scores $F(2,114) = 1.5$, $p = .228$, = .026, $d = .31$). The program of study accounted for 0.4% of the differences in total scale scores. A post hoc power analysis showed a small effect size for the results (Cohen, 1969).

Means on the Tolerance Sub-Scale. Mean scores for the tolerance subscale show counseling students with a higher mean ($M = 28.36$) and a higher standard deviation ($SD = 6.07$) than participants enrolled in another graduate program ($M = 25.15$, $SD = 4.7$). Counseling students also had a higher mean and lower standard deviation than undergraduate students ($M = 24.13$, $SD = 6.52$). The total mean and standard deviation for all groups is ($M = 24.13$, $SD = 6.5$). Mean scores indicate that counseling students have higher levels of tolerance than counterparts in other programs.

Analysis of Covariance. The ANCOVA (Table 1) demonstrated a significant difference between groups in the social tolerance subscale sub-scale scores $F(2,114) = 5.5$, $p = .005$, = .088, $d = .84$). The program of study accounted for 8.8% of the differences in total scale scores. A post hoc power analysis showed a large effect size for the results (Cohen, 1969).

Discussion

These results confirm, in part, other empirical findings comparing counselors' tolerance levels to tolerance levels of non-counselors (Crowe & Averett, 2015; Crowe et al., 2016; Smith & Cashwell, 2010, 2011). Counseling students, in this study, scored significantly lower on total stigma than undergraduate students. A unique contribution of this study demonstrated that these lower stigma scores are mitigated by education. There was no significant difference between master's level counseling students and other students enrolled in different graduate programs. Indicating that for total stigma higher levels of education play an important mitigating role.

Follow-up tests showed that counseling students scored significantly higher when compared to both undergraduates and other graduate students on levels of social tolerance. Counseling education's focus on multiculturalism, humanism, and social justice has provided dividends in greater levels of tolerance to those suffering from schizophrenia. Other mental health-related professions have not shown the same levels of tolerance when compared to the general public (Lauber et al., 2004; Lauber et al., 2006; Schulze, 2007; Whitley & Campbell, 2014). Studies, including the present study, examining counseling students or counselors' levels of tolerance are unique in their findings of significant differences (Crowe & Averett, 2015; Crowe et al., 2016; Smith & Cashwell, 2010, 2011). These findings should be celebrated and enhanced as the counseling profession moves forward as a leader in social justice.

Levels of support for legal coercion are not significantly different between counseling students and students enrolled in either undergraduate studies or other graduate programs. These results point to important implications for counselor educators and practicing counselors.

One direction to examine as the counseling field progresses is increasing the role of social justice for those suffering from mental illness in counseling programs, beginning with accreditation standards. An examination of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2016 Standards (CACREP, 2015) shows a distinct divide between people living with serious mental illness and other multicultural groups. With mental illness, students have a foundation of psychological assessments and tests, which measure mental illness and highlight the biological and psychological etiology of mental illnesses. The end goal of this training is to enable students to diagnose and then reduce the biological or psychological symptoms, which create mental illness. This standpoint, however, exacerbates the problem of stigma, by focusing on alleviating symptoms to reduce stigma (Corrigan et al., 2005).

With no other cultural group are students trained to ameliorate the symptoms of being a member of that group.

The difference lies in the contrast between diagnosis and social justice. Diagnosis entails imposing a pre-conceived standard of clinical judgment whereas humanism focuses on the intrinsic value of all people, and their inherent ability to be agents in their own lives. Social justice also encourages the suspension of pre-conceived dominant cultural values and highlights empowerment. The question remains, how can counselor educators effectively teach mental health diagnostics while respecting and empowering those who suffer from mental illness as a distinct cultural group, allowing that group the affordances allowed to other cultural groups; agency, dignity, and distinct identity.

On the surface, the task of stigma reduction for persons suffering from schizophrenia may be unreachable. Bio-medical models (Phelan et al., 2008), and education (Schomerus & Angermeyer, 2008) are insufficient to reduce stigma, in part because they highlight the importance of symptom reduction as a means of stigma reduction, rather than focusing on empowerment. However, all these methods can be grouped into what Foucault (1965) referred to as "theoretical unity" and are thus unable to capture the "torn presence" of schizophrenia (p. 164).

Implications

Stigma operates from two converging levels: individually it manifests as fear and assumptions about individuals suffering from mental illness, socially it manifests as collectively perpetuated myths about people with severe mental illnesses (e.g. people with mental illnesses are unpredictable and violent; Corrigan et al., 2005). Counselors must develop an understanding of the role of stigma on both these levels. Reflexivity is integral in this process. The current study indicates that counseling students retain stigmatizing attitudes, especially related to legal coercion,

much like those of the general population, the challenge becomes helping counselors recognize and overcome the stigma they have about their future clients. Developing case formulations that focus on clients' symptoms from their perspective, taking into account the multiple and intersecting identities may provide CITs, and practicing clinicians a clearer understanding of clients presenting symptoms considering the multiple factors that influence clients' experience of those symptoms (Zalaquett et al., 2008).

The stigma surrounding mental illness operates from an individualistic perspective, assuming the client or some internal and/or biological factors are responsible for their symptoms. This perspective renders power differentials invisible, placing the blame and the responsibility for recovery on the clients' shoulders (Fung & Tsang, 2008; Lysaker et al., 2008; Norman et al., 2008). The medicalization of mental disorders, especially severe mental illnesses like schizophrenia may function to enhance stigma and self-stigma for this group (Corrigan et al., 2005). Counselors in training, clinicians, and counselor educators' applications of reflexive practices about the limitations of diagnostic categories, and recognition of the structural barriers to wellness that clients encounter including: self-determination, access to nutritious food, economic sufficiency, and access to safe housing (Fung & Tsang, 2008; Lysaker et al., 2008; Norman et al., 2008).

Reflexivity in practicing counselors may aid in client empowerment by focusing on client strengths (Corrigan et al. 2005), rather than medication compliance and biomedical treatments. Community mental health settings are an ideal environment to shift the focus, although counselors carry heavy caseloads and are influenced by institutional cultures that focus on client deficits. Counselors are one part of a multidisciplinary treatment team wherein, counselors have multiple opportunities to empower their clients and enhance awareness about the social inequalities that clients encounter (CSJ, n.d.; "What is social justice in counseling?", 2003). Counselors can begin

to change instutional cultural norms, and help other mental health professionals recognize the multifaceted nature of mental health, thus reducing stigma.

Counselor educators also need to pay close attention to student work and identify students who may not be ready to work with clients suffering from schizophrenia or other severe mental illnesses because they hold stigmatized beliefs about those clients. The results of this study indicate that personal relationships with people living with schizophrenia and other severe mental illnesses reduce support for legal coercion, counselor educators may, therefore, seek opportunities for CITs to interact with this population through guest speakers or service-learning opportunities. Professors and supervisors can also begin to discuss mental illnesses in multicultural classroom settings wherein students examine the balance and distinction between alleviating suffering and empowering clients.

Limitations

Results from this research are contextualized within the limitations of the study. A goal of quantitative data is its generalizability to populations outside of the sample, the generalizability of this research is limited by methodology and statistical power. Methodologically survey data is limited by bias, as participants' responses can be influenced by social desirability. Results based on desirable responses are not indicative of genuine reactions towards those suffering from schizophrenia. Statistical power ranged from small to medium effect sizes, indicating that these results are limited in their generalizability and require follow-up studies to confirm or refute findings. Finally, this study only examined counseling students and not counseling professionals. These results may be limited only to students; however, Smith and Cashwell (2010) found that tolerance increased as students moved into professional roles.

Recommendation for Future Research

The limitations of the study provide insight into future research. Expanding the sample size to increase effect is an important next step. Also, including professional counselors and counselor educators as participants, this expanded sample could provide a fuller examination into tolerance and stigma within the whole of the counseling profession. In addition to addressing the limitations of this study future research can also expand and enhance findings. Examining tolerance and stigma towards different types of mental illness would expand the findings of this study and promote an understanding that goes beyond schizophrenia. Including the variable of self-efficacy in working with clients who suffer from severe and persistent mental illness could serve as a mediating variable for tolerance and stigma.

Conclusion

The purpose of this study was to examine social tolerance and support for legal coercion for someone suffering from schizophrenia. The results provide additional confirmation of a promising trend in the counseling profession. Counselor educators are helping students develop greater levels of tolerance for those suffering from schizophrenia when compared to their peers in other programs (Crowe & Averett, 2015; Crowe et al., 2016; Smith & Cashwell, 2010, 2011). In addition to confirming the results of previous studies, this study also showed graduate education as an equalizing force in legal coercion. The legal coercion results represent a unique value of graduate education that goes beyond counseling. As the counseling professions continue to engage in the causes of social justice it is important to continue to promote social justice for those suffering from mental illness in conjunction with other cultural groups. It is also important to acknowledge the role of graduate education itself as a vehicle for social justice.

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