

Mental Health and Substance Abuse Professionals' Attitudes Toward
Dually Diagnosed Clients in a Community-Based Treatment Center

by

Joseph Edward Bullock, Jr.

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APPROVED:

Octavia D. Madison-Colmore, Ed.D., Chair

Marilyn Lichtman, Ed.D.

Mercedes ter Maat, Ph.D.

David Hutchins, Ph.D.

Ruby Brown, Ph.D.

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Dr. Octavia Madison-Colmore, Chair

(ABSTRACT)

Mental health and substance abuse treatment systems have a history of incompatible philosophies and conflicts that have been associated with poor treatment outcomes for persons dually diagnosed. The purpose of this study was to determine whether or not there are differences in attitudes between mental health and substance abuse professionals toward the dually diagnosed client and whether or not academic discipline, levels of training and experience, occupation, and amount of contact affect the attitudes of these professional groups. A non-experimental survey research design was used for this study, and data were collected by means of a revised Opinions About Mental Illness (OMI) survey instrument and supplemental demographic questionnaire.

The modified OMI instrument was piloted by a panel of subject matter experts experienced in the treatment of persons who are dually diagnosed in which they rated each item for favorableness to concepts of dual diagnosis. The modified OMI survey and a demographic questionnaire were administered to a sample consisting of mental health and substance abuse professionals employed at a local community mental health center. A total of 86 respondents representing 95% of the sample population completed the modified OMI survey and demographic questionnaire.

Data were analyzed using descriptive, independent sample t-test, and multiple analysis of variance (MANOVA) statistics. Results revealed no statistically significant differences in attitude between mental health and substance abuse professionals toward dually diagnosed clients. Analysis of the independent variables academic discipline, level of training and experience, occupation, and amount of contact demonstrated no significant interaction effects between mental health and substance abuse professionals. Despite the absence of statistically significant differences in attitude between the mental health and substance abuse professionals, the similarities may be significant in terms of the psychological value for building positive relationships. The atmosphere of agency culture and the significance of co-location of mental health and substance abuse professionals were also potentially important factors in the outcome of the present study.

DEDICATION

This dissertation is dedicated in memory of Joseph E. Bullock Sr., Issac King Sr., Issac King Jr., and William King, who all, as role models, epitomized what hard work and sacrifice are all about and whose essence continues to inspire me daily in my journey. God bless you.

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CHAPTER ONE

INTRODUCTION

The Substance Abuse and Mental Health Services Administration (SAMHSA) contends that in any given year up to 10 million people in the nation have at least one episode of co-occurring mental illness and substance abuse-related disorders. The term dual diagnosis is used to describe a heterogeneous group of individuals who have a mental disorder (e.g., depression) and abuse one or more psychoactive substances (e.g., alcohol, cocaine, marijuana, heroin).

Two groups of professionals who have an impact on the lives of persons with dual diagnosis disorders are mental health and substance abuse professionals (MH/SA). The actions of these two groups of professionals affect the level of care received as well as the quality of life for persons with dual diagnoses. Mental health and substance abuse service delivery systems traditionally have been designed to operate independent of one another, each with its own treatment philosophies and funding streams. Because of this independent operation between mental health and substance abuse programs along with the limited cross-training among practicing professionals, there is growing concern that consumers with dual diagnoses probably are significantly underserved. Several studies indicate that some mental health and substance abuse programs fail to make specific assignment of responsibility for the dually diagnosed (Clement, Williams, & Waters, 1993; Drake, Mueser, Clark, & Wallach, 1996; Howland, 1990). This often leads to a process of “ping-pong” therapy for the dually diagnosed client as she or he is either referred back and forth between the two systems of care or excluded from receiving any services whatever.

People living in the community with any type of disability are often subjected to negative attitudes and behaviors directed toward them from others. However, significant legislative changes have occurred over the past 20 years, making it possible for disabled children and adults to be more fully accepted in schools, workplaces, and neighborhoods. As a result of these changes, counseling professionals have become a major influence in the socialization and quality of life experiences of persons with mental and physical disabilities in their role as professional helpers for this population.

The quality of services that the client receives might be greatly affected by the counselor’s attitude toward him or her. With this in mind, this researcher investigated attitudes toward the dually diagnosed client. Specifically, this researcher examined attitudes of mental health and substance abuse professionals toward dually diagnosed clients to determine whether their attitudes present a significant barrier to providing treatment services for the defined group. First, the researcher will provide a brief overview of the background of the problem. Second, the statement of the problem will be addressed followed by the significance of the study, purpose of the study, definitions, assumptions, and limitations of the study.

BACKGROUND OF THE PROBLEM

Since the late 1980s, persons with co-occurring substance abuse and mental illness disorders (dually diagnosed) have received a considerable amount of attention from researchers and clinicians alike. In fact, over the past 10 years, rapid system changes brought on by managed care have broadened the interest in the dually diagnosed client to include other professionals, administrators, and policymakers. For instance, in 1987, McKelvy, Kane, and Kellison found that more than 60% (not the perceived 10%-15% originally believed) of admissions to a state psychiatric hospital were of patients who had both mental health and substance abuse problems. McKelvy, et al. (1987), also found that their patients responded more positively when both MH/SA disorders were treated concomitantly. Other researchers (Brown, 1996; Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998; Marshall, 1992; Rachbeisel, Scott, & Dixon, 1999) have also found that clients respond positively when both mental health and substance abuse disorders are treated concomitantly.

Persons with dual diagnoses are described as disproportionately young, male, impoverished, and of color—often with poor social skills and limited social networks (Drake & Wallach, 1989). Because of such limited skills, treatment can indeed be challenging, especially if it consists of traditional, separate treatment models. Young and Grella (1998) note that persons with dual diagnoses continue to be under-diagnosed and to receive treatment from one system (e.g., MH or SA). This single-system approach to treatment is attributed to a history of antagonism, conflicting philosophies, and competition between mental health and substance abuse service professionals. The longstanding philosophical “division” between mental health and substance abuse treatment systems is rooted in separate traditions, differing views of etiology and relationship of the disorders, and separate administrative systems (Ortman, 1997). An example of conflict in etiology is the ongoing argument between MH and SA professionals over which disorder, substance abuse, or mental illness is primary and which is secondary. According to Evans & Sullivan (1990), “Individuals stricken by the disease of chemical dependency and suffering from a psychiatric disorder, the dually diagnosed individual, is not well armed to deal with systems’ conflicts” (p. 10). Unfortunately, these conflicts between MH and SA treatment systems often lead to “minimal services for persons with dual diagnoses” (Schiacca & Thompson, 1996, p. 289).

The historical conflict between mental health and substance abuse professionals extends beyond philosophy to include the therapeutic styles of the counselors. Mental health and substance abuse professionals have conflicts over the level of directiveness used in therapy with clients (Ortman, 1997). For example, there seems to be a high level of directiveness associated with styles used by substance abuse professionals versus what appears to be a high level of nondirectiveness used by mental health professionals. However, Jacobs and Warner (1981) conducted an investigation on the therapeutic styles of professionals working in a community mental health center and concluded that “neither extreme nondirectiveness or authoritarianism (directiveness) was as likely to be associated with patient improvement as was moderate limit setting and encouragement” (p. 80). Unfortunately, this dichotomy has contributed significantly to poor outcomes for the dually diagnosed population (Drake, et al., 1998; Young & Grella, 1998).

According to Drake, et al. (1996), general findings from several research studies evaluating the dually diagnosed population have consistently shown that treatment outcomes for this population are worse than are those for discrete mental illness or for substance abuse disorders. For example, results of a literature review conducted by Drake, et al. (1996), revealed that many long-term studies found non-substance abusing patients with mental illness attained a lower risk status for negative outcomes than did patients with a mental illness who also had abused substances. In a similar study, Ridgely, Goldman, and Willenbring (1990) reported that the traditional separation of treatment for the two disabilities had been proved to be inefficient and ineffective for the dually diagnosed client.

As the dually diagnosed population continues to grow, community mental health agency administrators and counselors are becoming increasingly concerned about training issues and gaps in service delivery. There also seems to be concern about liability issues related to the complete exclusion of persons with dual diagnoses from treatment services (Kelly, 1997). Given the complexity of problems typical for dually diagnosed patients in community-based settings (e.g., lack of housing, the exorbitant cost of continuous care, and poor outcomes), the probability is high that many of these patients will be either misdiagnosed or dismissed from treatment for noncompliance if they are treated independently in either the mental health or the substance abuse system. Numerous studies have independently demonstrated that as a group, the dually diagnosed population is receiving fewer services and has poorer outcomes than are clients with a single mental illness or substance abuse disorder (Brown, 1996; Drake, et al., 1998; Marshall, 1992; Rachbeisel, Scott, & Dixon, 1999). These concerns have led to increasing discussion and support for the development of some type of integrated treatment model or, at the very least, improving collaboration.

Recently there has been a significant effort by major organizations such as SAMHSA to bring together leaders from the mental health and substance abuse disciplines to examine the efficacy of integrating substance abuse and mental health treatments for the dually diagnosed population (SAMHSA, 1998). The purported advantage of this type of treatment approach is two-fold: 1) It simultaneously addresses the patient's substance use and psychiatric issues and 2) It cross-trains treatment professionals in order to reduce the potential for conflict between them (Doweiko, 1999). The issue of conflict between mental health and substance abuse professionals is a longstanding one that has linkages to social, cultural, political, financial, educational, and training issues. Although a number of integrated treatment models have been established for patients with dual diagnoses, research on attitudes of mental health and substance abuse professionals toward the dually diagnosed population is a largely unexplored area.

IMPORTANCE OF ATTITUDE

The role that attitudes of nondisabled persons play in the lives of people with disabilities is an important area to understand because negative attitudes might limit the integration of disabled people in the community. Studying the attitudes of professional counselors is important because the presence of negative attitudes might present barriers to treatment services as well as negatively affect the social developmental process for persons who are disabled. There are

numerous research studies and several theories on attitude formation and attitude change toward the disabled. Antonak and Livneh (1988) developed a multilayered model for attitude formation toward persons with disabilities, described as follows:

The first level consists of an inner circle, which is comprised of attitudes of the relatives, friends, and peers of persons with disabilities. The second level, a middle level, is comprised of the attitudes that professionals have toward persons with disabilities. The outer circle is comprised of attributes that society has toward persons with disabilities (p. 14).

What is evident in the Antonak and Livneh (1988) model is that members of all levels influence members of all the other circles, which in turn impact on the lives of the disabled. Generally, this model can draw attention to the basic ways in which professional counselors influence disabled clients in their role as helpers. As noted by Potts and Brandt (1986), the attitudes manifested by health professionals are important in shaping lifestyle roles that persons with disabilities are encouraged to adopt in society.

The impact a professional counselor's attitude might have on persons with disabilities is an area that has received considerable attention in the research literature. For example, Mackey (1969) states that the attitudes of professionals toward other persons or groups may either enhance or destroy the potential for relating to them as individuals. Geskie and Salasek (1988) extensively investigated the research literature on attitudes of mental health professionals toward mental illness and concluded that attitudes of professionals are influenced by four factors: 1) occupational group; 2) level of education; 3) authoritarian belief system; and 4) the model of mental ideology to which professionals ascribe.

Another area of potential impact can be found in the research conducted by Walker and Spengler (1995). The authors found that diagnostic overshadowing bias was identified as an underlying factor in clinicians' misdiagnosing or under-diagnosing disorders. Diagnostic overshadowing bias occurs when one clinical problem (e.g., alcohol dependence) is so obvious that it inhibits the clinician's ability to process information related to a second clinical problem (e.g., major depression) that might also be afflicting the client. Diagnostic overshadowing bias has been shown to occur regardless of the clinician's professional orientation, expertise, or experience and regardless of the client's mental disorder (Walker & Spengler, 1995). This type of bias in clinical judgment could have a major impact on the clients' experience of treatment as well as the overall treatment outcome.

One final area of possible negative effect of counselors' attitudes is the use of stereotypical labels to describe or discuss the clients with whom they are working. For example, labels such as addict, HIV positive, and mentally ill are commonly used descriptors in substance abuse and mental health treatment settings that stigmatize clients. A study conducted by Link, Struening, Rahav, Phelan, and Nuttbrock (1997), offered two different perspectives as to the effect of stigma with mental health clients. One perspective suggests that the effects of stigma are relatively small because "In a vast majority of patients, stigma appears to be transitory and

does not appear to pose a severe problem' (p. 178). This claim is supported by two substantial research efforts. First, Link, et al. (1997), reported that several meta-analysis studies of psychotherapy outcome research demonstrated positive effects "across types of therapies and types of outcomes" (p. 178). Second, a large-scale multisite clinical trial also showed positive effects for two highly standardized psychotherapy techniques. The counter argument suggested by Link, et al. (1997), is that many of the positive benefits received by clients from treatment are "short-lived and simultaneously offset by the negative effects of stigma" (p. 178). Furthermore, Link, et al. (1997), state that more recent studies have demonstrated that stigma has equally strong negative effects that create dual and opposite processes on the dimensions of quality of life. Link, et al. (1997), conducted a study specifically focusing on dually diagnosed men and found that stigma continued to complicate the lives of these men even with treatment improvement. Either way, the issue of negative attitudes and stigma toward persons with disabilities appears to play a significant role in contributing to probable barriers that lead to certain client populations being under-diagnosed and, ultimately, underserved in community-based treatment systems.

STATEMENT OF THE PROBLEM

It is widely accepted in the research community that persons with dual diagnoses require specialized treatment from programs developed with an integrated treatment concept (Drake, et al., 1998; Mercer, Mueser, & Drake, 1998; Minkoff, 1994). To endorse this approach to treatment and, thus, work more effectively with the dually diagnosed population, counseling professionals will need to be cross-trained to treat both mental illness and substance abuse disorders concurrently. This researcher believes that failure to recognize the historical division (and conflict) between mental health and substance abuse professionals, along with the poor outcomes of dually diagnosed clients in separate treatment models, might unknowingly perpetuate negative attitudes and substandard care for these clients. According to Champlain and Herr (1999), "The combined stigma of mental illness and substance abuse can lead to bias and discrimination, barring access to necessary and appropriate services resulting in substandard care for individuals with dual diagnoses" (p. 229).

SIGNIFICANCE OF THE STUDY

During the last decade, research has clearly demonstrated the increasing prevalence of dually diagnosed clients among mental health and substance abuse treatment program populations (Brown, 1996; Doweiko, 1999; Drake, et al., 1996; Kelly, 1997; Marshall, 1992; Pulice, 1994; Sciacca & Thompson, 1996). Research has also demonstrated the promise that integrated treatment models hold for meeting the clinical needs of persons with dual diagnoses (Drake, et al., 1996; Drake, et al., 1998; Hellerstein, Rosenthal, & Miner, 1994; Jerrell & Ridgely, 1995; Sciacca & Thompson, 1996). Most of these integrated models have been implemented in residential and hospital-based settings. Furthermore, many of the training programs for integrated treatment emphasize the need for increased clinical exposure, revised curricula, and improved peer support for professionals in order to meet the needs of the dually diagnosed population. Many researchers and professionals believe that community-based treatment resources for dually diagnosed clients are largely uncoordinated and that professional counselors

are not adequately prepared to work with these clients (Brown, Ridgely, & Levine, 1989). This lack of coordination and training might be linked to the long history of incompatible philosophies and treatment approaches as well as conflicting attitudes across community-based mental health and substance abuse treatment programs.

There are substantial numbers of research investigations cited in the literature (e.g., Carney, Werth, & Emanuelson, 1994; Knight, 1986; Knox, 1976; Livneh, 1982; Mackey, 1969; Moodley-Kunnie, 1988) on professional attitudes toward persons with various disability types including HIV positive men and women, mental retardation, and physical disabilities, as well as toward the elderly adult. There is, however, a dearth of literature focusing on professionals' attitudes toward clients with dual diagnoses. Overall, many of the aforementioned studies on professional attitudes toward the various disability groups concluded that research in this area is important because the quality of services will be lower than clients have a right to expect if negative, biased attitudes are present and go unnoticed.

As yet, the hypothesis that mental health and substance abuse professionals have negative attitudes toward clients with dual diagnoses has not been established. However, a review of the literature indicates that numerous research studies have demonstrated a strong connection between the negative experience of stigma and the well-being of the stigmatized client (Allison-Bolger, 1999; Brunton, 1997; Kilty, 1981; Link & Struening, 1997). Antonak and Livneh (1988) further state that the full acceptance by nondisabled people of those who are disabled "will not occur until subtle barriers can be eliminated" (p. 5). Therefore, the historical division and conflict between mental health and substance abuse professionals might have significantly affected their attitudes toward a group of clients (dually diagnosed) who are difficult to serve and require treatment from both systems of care.

Because the attitudes of MH and SA professionals toward the dually diagnosed client must be well understood, it is hoped that additional research in this area might contribute to eliminating barriers and bring about adequate treatment for clients with dual diagnoses. The goal of the present investigation is to add to the body of knowledge on attitudes toward persons with the dual diagnosis disability. This study builds on previous research that has focused on professionals' attitudes toward persons with disabilities, including the areas of attitude formation and attitude change.

PURPOSE OF THE STUDY

The purpose of this study was to determine whether there are differences in attitude between mental health and substance abuse professionals toward the dually diagnosed client. This research will be guided by the following questions:

1. What are the attitudes of MH and SA professionals toward dually diagnosed clients? Are the attitudes of MH and SA professionals toward persons with dual diagnosis similar?

2. Is there a difference between the attitudes of MH and SA professionals toward dually diagnosed clients and demographic variables (including levels of training, amount of contact, occupation, years of experience, and academic discipline)?

BASIC ASSUMPTIONS

Three basic assumptions were made in conducting this investigation. First, it was assumed that MH and SA professionals who participated in this study met the basic competency requirements to perform counseling in the setting in which they are employed. Second, it was assumed that MH and SA professionals who participated in this study have awareness and understanding of the concept of dual diagnosis. Finally, it was assumed that MH and SA professionals who participated in this study would be honest and accurate in their responses to the questionnaire on attitudes.

LIMITATIONS OF THE STUDY

Due to sampling methods, this study is not generalizable to the general population. Rather, the study reflects the attitude opinion responses of a group of counseling professionals currently working at a community-based mental health and substance abuse treatment center located in a Northern Virginia suburb of Washington, D.C.

DEFINITIONS

1. Dual Diagnosis–The concurrent diagnosis of chemical dependency plus a coexisting psychiatric disorder that requires simultaneous treatment (Doweiko, 1999).
2. Attitude–An organization of beliefs that are learned or are implicit tendencies and predispositions to respond in some evaluative way (Marshall, 1992).
3. Integrated Treatment–A combination of substance abuse and mental health treatment in one program (Drake, et al., 1998).
4. Stigma–A societal reaction that singles out certain attributes, evaluates them as undesirable, and devalues the persons who possess them (Brunton, 1997).
5. Stereotype–An inference about a person based on her or his membership in some group (Hamilton, 1979).
6. Contact–Actual interaction between people, ranging from observation of outgroup members without communication to direct, prolonged, and intimate interaction (Nagler, 1993).
7. Mental Health Professional–A practitioner trained to work with patients suffering from psychiatric disorders (Ortman, 1997).
8. Substance Abuse Professional–A practitioner trained to work with alcoholics or drug addicts or both (Ortman, 1997).
9. Disabled–A class of individuals with physical, sensory, and cognitive impairments (Silverman, Wasserman, & Mahowald, 1998).

CHAPTER TWO

REVIEW OF THE LITERATURE

The focus of this investigation was to examine the attitudes of mental health and substance abuse professionals toward clients who are dually diagnosed. The twofold purpose of the study was to determine whether there are differences in attitude between mental health and substance abuse professionals toward the dually diagnosed client and whether work environment, experience, education, and client characteristics affect the attitudes of these professional groups.

The current literature review provides an overview of research on attitudes as it relates to mental health and substance abuse professionals. The information is presented in five sections. The first section explores factors that influence attitude structure and formation. The second section discusses various definitions of stigma, stereotypes, and bias related to persons with disabilities. The third section gives an overview of the parallel history of substance abuse treatment and mental health treatment. The fourth section is a discussion of dually diagnosed client types and treatment outcomes for this population. The fifth section focuses on possible barriers to treatment for dually diagnosed clients.

ATTITUDE STRUCTURE

Historically, the social scientific study of attitude and attitude formation has focused on the general relationship between attitude and behavior. More specifically, social scientists were interested in determining the degree of “connectedness” between what we are and what we do. Most social science researchers (e.g., Allport, Bandura, Goffman) would agree that any attempt to define attitude could be a little complex because attitudes are not observable. Antonak and Livneh (1988) estimate that there are as many as 500 published definitions of attitude. Studying and understanding attitude is important for three major reasons: 1) attitudes guide our thoughts; 2) attitudes influence our feelings; and 3) attitudes affect our behavior. (Myers, 1990, p. 90)

In the present research, the structural model of attitude that will be used is the Theory of Reasoned Action (TRA). This model was developed by Fishbein (1980), and the theory is based on the idea that the “proximal cause of behavior is intention to behave, which is caused by attitude and subjective norm.” (p. 47). Fishbein further states that “attitude is the target person’s opinion about whether the behavior is positive or negative, and a subjective norm is the target person’s perception of social pressure from significant others to perform the behavior they ought to do” (p.47). Attitudes and subjective norms are determined by beliefs about the consequences of the behavior and beliefs about the opinions of specific importance to others. The TRA model builds on a history of attitude research that occurred in three phases: 1) issues of measurement and relation to behaviors; 2) dynamics of individual attitude change; and 3) understanding the structure and function of attitudes (Hogg & Terry, 2000).

Other researchers have contributed to the expansion of the TRA model by adding the tenet that behavior can result from less intentional processes such as previous behavior, habit, and perceived behavior control (Ajzen, 1988; Bentler and Speckart, 1981). However, Fishbein

(1980) and others (e.g., Ajzen, 1988; Bentler & Specart, 1981; Triandis, 1980) have demonstrated numerous times that the two key components in determining behavior are attitudes and subjective norms. According to Trafimow and Fishbein (1994), in the TRA model, “most behaviors can be classified under attitudinal control (AC) and slightly under normative control (NC) for most people” (p.51). Trafimow and Fishbein go on to state that attitudes are global judgments about behavior (positive or negative), and subjective norms are the target person’s judgments about what others who are important think he or she should do. Bagozzi, Baumgartner, & Yi (1992) conducted a study demonstrating that action-oriented people have greater tendencies toward attitudinal control. Action people are those who decide what they want to do, and then do it. Conversely, normative control (NC) people tend to go along with what other people want to do. Whether action-oriented or normative control, people differ in the degree to which they are under attitudinal control or normative control.

Finally, several researchers (Fishbein & Ajzen, 1975; Rosenberg & Hoveland, 1960; Triandis, 1971) introduce the tripartite components (affect, cognitive, behavior) that build on the idea that beliefs affect the formation of attitudes and subjective norms in the TRA model. According to Ajzen (1993), the tripartite components develop from beliefs that people have about the object of the attitude. The cognitive component of attitude refers to the individual’s ideas, beliefs, or opinions about the attitude referent. The affective component of attitude refers to the feeling or emotional underpinnings of the attitude. The behavioral component refers to the individual’s intent or readiness to behave in a certain manner with respect to the attitude object.

ATTITUDE FORMATION

There are numerous theoretical propositions regarding the topic of attitude formation. For example, Fishbein & Ajzen (1975) present the concept that attitudes are formed by information processing, and they develop from those beliefs that people have about the attitude object. Another investigation (Arvey, 1989) introduced a genetic basis for attitudes after the finding that identical twins raised in different environments had similar attitudes. According to Myers (1990), despite these findings, the theory that attitudes are learned through mere exposure, conditioning, and socialization is more widely accepted by the psychologist and social scientist. Socialization refers to the acquisition of language, values, and attitudes gradually through reinforcement, observation, and learning processes (Forsyth, 1995). In addition, Forsyth (1995) and Myers (1990) individually reported that attitudes can be acquired from others through social learning in the form of classical conditioning, modeling, and direct experience.

According to Baron & Byrne (1994), classical conditioning can be defined as the “learning through association process.” This occurs when one stimulus regularly precedes another: The one that occurs first may soon become a signal for the one that occurs second. An example of how attitudes can be influenced in this way is when a supervisor frowns whenever she or he interacts with a particular employee.

Bandura's (1969) "Social Learning Theory" says that behaviors and attitudes are acquired by observing and imitating the actions displayed by parents and peers. An example of this type of imitating behavior would be when a person is observed enjoying a particular drink or plate of food and another person selects the same drink or meal and enjoys it, regardless of her or his personal taste.

Finally, according to Bornstein (1989), direct experience can be acquired from exposure to a particular object. Direct experience repeated over time results in a preference for or against that object as compared to objects experienced less frequently. The more familiar the object or task, the more we generally like it (Bornstein, 1989). In another example, Fazio & Zanna (1981) demonstrated that attitudes that are experience based are more readily accessed in memory. They went on to say that "direct experience produces a well-defined and certain attitude. These, in turn, enhance that attitude's capacity to predict later behavior."

The area of attitudes toward persons with disabilities has also become a focus in research. Livneh (1982) reported that some researchers went a step further by seeking a specific cause for negative attitudes toward disability. Subsequently, a plethora of empirical work has been focused on the goal of supporting a specific cause or root basis for negative attitudes toward persons with disabilities (Livneh, 1982). According to Nagler (1993), the process of forming attitudes toward persons with disabilities is related to biases, stereotypes, and stigma. During the time period that much of the research on developmental theories of attitude formation took place, one population group that was largely ignored was people with disabilities (Makas, 1993). Work on attitudes toward people with disabilities appears not to have begun until after disability rights laws were enacted in the early seventies (Nagler, 1993). Moreover, much of the early work focused on relationships between contact (with nondisabled persons) and reaction. Others, such as Rabkin (1975), focused on the perceived roots of prejudicial attitudes toward the disabled by developing classification systems. Gellman (1959), for example, perceived the roots of prejudicial attitudes as belonging in the following categories: 1) social customs and norms; 2) child-rearing practices; 3) reoccurrence of childhood fears in frustrating/anxiety-provoking situations; and (4) discrimination-provoking behavior by persons with disabilities. Rabkin (1975) later developed a fourfold classification system he categorized as follows: 1) psychodynamic factors; 2) situational factors; 3) sociocultural factors; and (4) historical factors. These and other models contributed to a growing focus on attitude formation in the area of attitudes toward persons with disabilities

The research results of several studies (e.g., Heinemann, Pellander, Vogelbusch, & Wojtek, 1981; Yunker, Block, & Young, 1970) demonstrated a link between degree of contact or proximity to disabled persons and attitudes toward them. The term contact can be narrowly defined as a situation in which interaction has actually taken place between disabled and nondisabled persons (Makas, 1993). Makas (1993) went on to say that the critical flaw in past research regarding persons with disabilities was the lack of a clear definition for contact as well as researchers' inattentiveness to factors associated with contact. In order to develop a full understanding of the impact of contact between nondisabled and disabled persons, the type of contact needs to be clearly defined. For example, Makas (1989) reviewed studies that attempted

to assess the relationship between contact and attitude and found that most of the questions about contact “were primitive and based on a priori assumptions” (p. 124).

As mentioned earlier, contact has been recognized as a powerful influence on attitude formation, and high levels of contact are generally associated with positive attitudes. However, contact is not necessarily positive in and of itself. In fact, a number of studies suggest that unguided contact (distress and deficiencies highlighted) with persons with disabilities has resulted in no attitude change or negative attitudes (Gething, 1982; Lyons & Haynes, 1993). One explanation for the relationship between contact with people with disabilities and attitude formation is a concept called “in-group individuation and stereotyping of out-group members” (Makas, 1993, p. 129). Makas espoused the idea that “negative attitudes may be the result of illusory correlations between deviant persons and deviant behaviors” (p. 129). Furthermore, she described the concept of in-group individuation as follows:

Individuals seek to increase identification with their own group and to distance themselves from other groups. This unconscious behavior can lead to contrast and assimilation biases in cognitive processing in which people fail to acknowledge differences that exist between groups. The contrast and assimilation biases work together to allow an individual to strengthen her/his feelings of cohesiveness with the “in-group” and distance from the “out-group” (p. 129).

Taking this concept a step further, another investigation (Wills, 1978) found that professionals (e.g., social workers, rehabilitation counselors, medical professionals) have obvious contrast and assimilation biases toward their clients. Wills reported that a majority of studies on this topic (e.g., Elliott, 1990; Yuker, 1988) found that professional helpers hold more negative attitudes toward people with disabilities than does the general public. Wills attributed this finding to the service providers’ need to perceive two entirely separate groups—the helpers and the clients—in order to assure the cohesiveness of their (the service providers’) own group (p. 129).

Livneh (1982) describes a more complex origin of negative attitudes toward persons with disabilities. According to Livneh (1982), sources of negative attitudes toward persons with disabilities occur along six dimensions that include sociocultural-psychological, affective-cognitive, conscious-unconscious, past experience-present situation, internally originated-externally originated, and theoretical-empirical. Examples of the sociocultural dimension include perceptions of the physical body, personal appearance, personal achievement, and productivity in employment. But Livneh (1982) states that the biggest factor for the sociocultural dimension is “status degradation to being disabled” (pg. 36). Status degradation is most often drawn from the stigma of having a disability and being treated as an outsider. Opposite to the sociocultural dimension are characteristics typically used to describe the psychological dimension. Examples of the sociocultural dimension include the association of many unrelated negative attributes to a person who has one specific physical or mental disability characteristic. The psychological dimension might also include associations related to a nondisabled person’s expectation that the disabled person mourn or grieve the loss of a body function or part in order to safeguard her or his own (the nondisabled group’s) values about the importance of a “whole and functioning body” (Livneh, 1982). However, the area most investigated in this dimension is the perception held by

nondisabled people that a disability is a form of punishment for personal or ancestral sins and transgressions, thereby associating responsibility with the disability (Livneh, 1982).

The affective-cognitive dimension is another area of attitude formation theory that has been heavily investigated. The affective domain is characterized as the emotional feelings of anxiety and guilt experienced by nondisabled persons when in the presence of persons with physical or mental disabilities. According to Livneh (1982), these emotional reactions tend to be aversions to aesthetics at the sight of certain body deformities or observed odd behavior. Livneh (1982) goes on to state that “the source most frequently cited is the threat to one’s intact body image when in the presence of a person with a disability” (pg. 39). On the other hand, the cognitive aspects of this dimension include a disruption in social rules for interaction between nondisabled and disabled persons and typically present aspects of a fertile opportunity for all sorts of misconceptions, beliefs, and worries. Livneh (1982) states that the “unfamiliarity and disruption often leads to avoidance or withdrawal from the situation” (pg. 39).

While all six domains have significant influence in the development of attitudes toward the disabled, the four remaining dimensions of Livneh’s (1982) model can be summarized as follows:

1. Consciousness-Unconsciousness: full awareness of attitudes; associating personal responsibility vs. childhood experiences; childrearing practices; threats to body image.
2. Past Experience-Present Situation: specific negative experience; social/moral belief vs. ambivalence triggered by conflicts of sympathy and aversion toward the disabled person.
3. Internally Originated-Externally Originated: demographic and personality attitude variables vs. prejudice-provoking behaviors by persons with disabilities.
4. Theoretical Sources-Empirical Sources: majority of determinants for negative attitudes vs. growing body of research evidence associating negative attitudes and situational/personal variables (pp. 38-45).

Other investigations (e.g., Yunker, 1988) believe that training is a key component in the strong association between negative professional attitudes and people with disabilities. Yunker reports: “Training that emphasizes the central role of the disability and the competence of the professional in contrast to the incompetence of the person with the disability tends to predispose one toward negative attitudes” (p. 195).

In summary, it appears that attitude formation among helping professionals can be associated with multiple sources and multiple dimensions. The possibility that helping professionals can develop group membership attitudes in addition to negative personal experiences might be the foundation for stigma, bias, and stereotyping toward persons with physical and mental disabilities.

STIGMA

People with disabilities, as a minority group, are involved in the same struggles as other minority groups in terms of overcoming discrimination, prejudice, and the stigma associated with negative labels. Entering into and interacting with mainstream society has led many with disabilities to challenge the way others view disabilities as well as combat their own negative self-perception about their disability. For professional helpers, a counselor's feelings and attitude toward their clients may either enhance or destroy the potential for establishing a therapeutic relationship. According to Marshall (1992), "Uniform positive attitudes are necessary to the development and the maintenance of a successful therapeutic relationship with the patient" (pg. 12).

The discussion on the concept of stigma can begin with the work of Erving Goffman (1963), which is considered to be classic in numerous studies. Stigma can be defined as a visible mark used to disgrace, shame, condemn, or ostracize. Goffman (1963) has defined stigma as an attribute that is deeply discrediting and as an undesired differentness. Goffman has identified six general dimensions of social stigmas relevant to people with disabilities: a) concealability - the extent to which a condition is hidden or apparent to others; b) disruptiveness - the degree of interference with social interactions and relationships; c) aesthetics - how others react to the condition with dislike or disgust; d) origin - the responsibility attributed for causing or maintaining the stigmatized condition; e) course - the degree to which the condition is alterable or progressively degenerative; and f) peril - whether the condition will physically, socially, or morally contaminate others. Therefore, the concept of stigma includes both cognitive and behavioral components. People who are characterized by these dimensions are subject to the adverse effects of social stigmas and related prejudices. While these dimensions may be clear enough, Allison-Bolger (1999) says that the true meaning of a concept may only emerge through use and gives this example:

The attitudes we normals have toward a person with a stigma. The key phrase here is "a person with a stigma." This implies stigma is something a person has, which is attached to, but somehow separate from, him or her (p. 627).

This example highlights the fact that stigma is considered both an attitude and an attribute. Allison-Bolger further observed that regardless of the concept applied, stigma is separate from the individual.

All six of Goffman's dimensions can apply to persons with mental illness and substance abuse disorders. Champlain and Herr (1999) point out the fact that the "combined stigma of mental illness and substance abuse can lead to bias and discrimination, barring access to necessary and appropriate services [and] resulting in substandard care for individuals with dual diagnoses" (p. 229). In looking at the dimension of concealment, many persons with substance abuse disorders choose anonymity because of the stigma associated with being an alcoholic or drug addict. The same experience of stigma is true for people with various mental illness disabilities. According to Allison-Bolger (1999), the very label of mental illness is almost "universally regarded as a negative attribute and a potentially handicapping burden" (p. 627).

In the dimension of disruptiveness, the level of disruptiveness for substance abuse disorders on the family is well documented. In the early 1940s, Alcoholics Anonymous (AA) formed Al-Anon support groups for family members to focus on their own emotional and spiritual health as a result of the disruptive nature of alcoholism (White, 1998). The impact on families of people with mental illness is equally disrupting. According to Allison-Bolger (1999), families of people with mental illness “respond with stigma, secrecy, withdrawal, and concealment.”

Dimension Three concerns the reaction of others with dislike and disgust. Many of the preconceptions of mental illness and substance abuse have been sensationalized by the negative images that pervade our society. In the field of substance abuse, the characteristics of Dimension Three have also been well documented in the Big Book of Alcoholics Anonymous. The Big Book of AA and other writings have long documented the perception of alcoholics as “social misfits” and a public nuisance. AA instituted anonymity as a primary device to counter the stigma associated with alcoholism and to widen the gateway of entry into the fellowship (White, 1998). The menacing images surrounding mental illness have historically created societal fear and paranoia about the public’s safety. This powerful stereotype helps fuel the existing stigmatization of persons with mental illness. Unfortunately, many of these same perceptions exist between traditional mental health professionals and members of AA and NA (Narcotics Anonymous). According to Ortman (1997), there is a long history of antagonism between the two, with members of AA citing a lack of trust because they experienced mental health therapists as uninformed about and incompetent in treating alcoholism. Brown (1985) noted that many therapists have a strong prejudice against alcoholics and are ignorant of AA. Because the dually diagnosed have suffered problems with drug and alcohol use, the possibility of experiencing an integration of these two treatment modalities will be difficult as long as the antagonism exists between the two groups.

Dimension Four concerns the origin or the responsibility attributed for causing or maintaining the stigmatized condition. This domain is very controversial for substance abuse and mental illness for different reasons. According to Bhugra (1989), stigma is inherent to mental illness. Psychotic illness may be among the most stigmatized because it is most identified with the person. Allison-Bolger (1999) says critically that mental illness is “diagnosed on the basis of unusual behavior” and that the criteria for diagnosis therefore transcends class, race, and gender. Similarly, the history of alcoholism is full of controversy over its etiology as evidenced by propositions ranging from character or personality disorders to its recognition as a disease. These battles over the classification of both substance abuse and mental illness disorders highlight how the belief that stigma is inherent in illness persists.

The experience of stigma in the final two domains, course and peril of the illness, can be summed up best by Hahn (1988), who explains that our society expects everyone to achieve a modal level of functioning and that people with disabilities threaten this ideal. Goffman’s six domains help expose the types of subtle and not-so-subtle stigma that exist for people with disabilities. However, not all disabilities carry the same weight of stigma as demonstrated in research studies conducted by Jones (1974) and Tringo (1970). These researchers found that

people with physical disabilities were most accepted and people with mental retardation, alcoholism, and mental illness were least accepted. People with mental illness or substance abuse problems constantly face the enduring threat of being stigmatized and experiencing the harmful consequences of being rejected. The hierarchy aside, stigma is powerful in its effects on people with disabilities.

STEREOTYPE

According to Bogdan & Biklen (1993), ‘Belief and assumptions about people with disabilities that promote the differential and unequal treatment practices are usually because of apparent or assumed physical, mental, or behavioral differences’ (p. 69). Two terms that point ultimately to discrimination are prejudice and stereotype.

The topic of prejudice has been highly researched, and the generally agreed-upon description is that of a negative bias or disliking of people because they belong to a particular group one dislikes. The group is often an ethnic, racial, or other social category (Wasserman & Mahowald, 1998). Bogdan & Biklen (1993) define the term prejudice as ‘any overgeneralized or oversimplified belief about the characteristics of a group or category of people’ (p. 69). Prejudiced assumptions directed toward the disabled include such statements as: they are incapable; they are naturally inferior and I thank God I’m not them; and they have more in common with each other than with nondisabled persons (Bogdan & Biklen, 1993). These are the types of assumptions and beliefs that enable preconceptions and negative reactions toward people with disabilities. Among professional helpers, some studies have already demonstrated that helping professionals have attitudes toward the disabled that are consistently lower than expected (Yuker, 1988). Wicas and Carluccio go further by stating: ‘It would be erroneous to assume that an accumulation of credits in a counselor training program will alter deep-rooted attitudes, prejudices, and beliefs held by counselor trainees’ (pg. 26).

As mentioned earlier, the subject of prejudice is a widely researched topic, and several theories have evolved from this research. These theories include the ego-defense theory; scapegoating, or believing that people will blame frustration and setbacks on others (Forsyth, 1995); and cognitive theories suggesting that prejudice stems from the tendency of people to categorize others into groups—particularly groups of ‘us’ and ‘them’ (Myers, 1990). Although most theorists will probably agree that no one theory can be accountable for the complex interaction of numerous factors, the cognitive theory will be discussed further.

According to Myers (1990), the cognitive theory for the causes of prejudicial attitudes builds on the categorization concepts mentioned earlier. There are five different areas associated with how people categorize others into groups:

- Ingroup-Outgroup bias is the idea that we favor our own group, its members, and products and reject the outgroup, its members, and its products.

- Outgroup Homogeneity Bias is the assumption that all members of the outgroup possess similar characteristics and are therefore “all alike.”
- Ingroup Differentiation Bias is the opposite assumption, in that the ingroup is composed of members who possess unique and distinctive qualities.
- Extremity Bias suggests that we make more extreme judgments about people in the outgroup.
- Group Attribution Error asserts that we base judgments about individuals on the general characteristic of the group and often hold the group at blame for the behavior.

The clients known for their substance abuse and mental illness disabilities are also vulnerable to some of these same prejudicial attitudes. As noted by Allison-Bolger (1999), clients are diagnosed based on the description of symptoms in diagnostic manuals and the “utterances or accounts” by clients of their experiences. In order for an utterance to be regarded as a symptom, “one must already have decided that the person who utters it is ill” (Allison-Bolger, 1999). Overshadowing bias is a form of ingroup behavior that occurs when one clinical problem is so salient that it inhibits the clinician’s processing of information related to a second clinical problem also afflicting the client (Walker & Spengler, 1995). A study conducted by Reiss, et al. (1982), investigating overshadowing bias, found that most clinicians succumbed to the overshadowing bias, but not all do. The fact that not all clinicians showed a bias could indicate the presence of some characteristics that may be less prone to overshadowing bias (Walker & Spengler, 1995).

Prejudice is generally considered to be the broader cognition, while stereotype refers to the specific content of the prejudice directed toward specific groups. Hamilton (1979) says: “Stereotyping occurs when a perceiver makes inferences about a person because of that person’s membership in some group” (p. 54). Hamilton also noted that there is a relationship between cognitions, attributions, bias, and research on stereotyping. This notion is played out in the following examples given by Bogdan & Biklen (1999):

The mentally retarded, for example, are believed to be childlike, to enjoy boring routine work, and to be oversexed. The elderly are said to have deteriorated intelligence and are presumed to be unhappy and undersexed. The mentally ill are expected to be erratic in their behavior, are considered dangerous and bizarre, especially during the full moon. The deaf are supposed to be melancholy, and supposedly, once an alcoholic always an alcoholic (pg. 70).

Treating people on the unfair and unequal basis of prejudice and stereotyping form the basic foundation for the concept of discrimination. Hamilton (1979) notes that the “cognitive bias of noticing distinctive behaviors results in the misattribution of these behaviors to the minority group, with consequent differential perceptions of the groups” (p. 54). Beatrice (1988) defines a similar concept, fundamental bias, as a force toward the negative that is set up by three conditions: 1) if something that is observed stands out sufficiently (saliency); 2) if, for whatever reason, it is regarded as a negative (value); and 3) if its context is vague, then the negative value assigned to the object of observation will be a major factor in guiding perception, thinking, and

feeling toward negative character. In the context of professionals, the fundamental negative bias can play itself out in both subtle and not-so-subtle ways. For example, a clinician typically describes behavioral/psychological symptoms characteristic of a particular DSM-IV diagnosis on Axis I and II, while also including more clinically relevant symptoms under Axis IV, psychosocial functioning. Unless the clinician is asked whether the client has any positive attributes, the motion for the fundamental negative bias is set forward, guiding the perception and thinking of the clinician while the positives remain largely neglected. Beatrice (1988) points out that uncovering the positives in this situation seems obvious once it is pointed out but that the fundamental bias all too often directs attention away from the positive attributes of a client. It is the function of stereotyping and concepts such as the fundamental negative bias that contribute inadvertently to myths and stigmas and ill serves persons with disabilities who are already perceived to be disadvantaged when they present for services. This is despite the fact that disability tells almost nothing about what a person is like or about her or his potential as a human being.

HISTORICAL PERSPECTIVE

The history of conflict and separateness between substance abuse and mental health dates back as far as the 19th century. According to White (1998), there are four major events in history that helped shape the development of the substance abuse treatment field. These four events as outlined by White (1998) are as follows:

- The emergence of inebriate homes and asylums in the mid-nineteenth century.
- The drug prohibition movements that resulted in the passage of the Harrison Anti-Narcotic Act in 1914.
- The founding of Alcoholics Anonymous (AA) in 1935.
- The opening of two federal narcotics farms in 1935 and 1938. These openings resulted in the federal government's direct involvement in addiction treatment (p. xii).

The history of addiction treatment and recovery in America is a combination of a wide range of political, social, and professional strategies to reform, rehabilitate, and convert the alcohol and/or drug dependent individual (White, 1998). These events in history not only shaped the evolution of substance abuse treatment but also established the boundaries that formed parallel treatment with mental health services. Therefore, an overview of the addiction treatment field will also highlight the conflicts related to mental health systems over time.

In 1784, a physician by the name of Benjamin Rush proclaimed alcoholism a self-contained disease and became recognized as the first American authority on alcoholism (White, 1998). According to White (1998), a Swedish physician named Magmus Huss first used the term "alcoholism" in 1849 to describe a state of chronic intoxication and severe physical pathology. However, by the second half of the nineteenth century, inebriety and dipsomania were the most common terms used to describe alcoholism. It was also during this time that alcoholics were

primarily treated in inebriate asylums and inebriate homes that specialized in the treatment of alcoholism and other addictions (White, 1998). These institutions were publicly supported predominately as a result of the belief that they would take the burden away from general and psychiatric hospitals and jails. Ridgely, Goldman, & Willenbring (1990) describe the treatment for psychiatric patients during this time as the primary domain for state asylums and institutions. This distinction is an important early sign of disagreement over the appropriate place for treatment of the alcoholic as well as the person with dual diagnosis. White (1998) goes a step further by detailing the state of affairs regarding the nature of disagreement in the following excerpt:

State psychiatric hospitals at this time had adopted a pattern of excluding alcoholics and addicts. Often, disagreements inevitably occurred over which institutions bore the responsibility for people who presented dimensions of both insanity and inebriety. Psychiatric institutions not only acknowledged that they were ill-equipped to care for the inebriate but went as far as to declare that mixing inebriates within their institutions would prove prejudicial to the welfare of those inmates for whom the institutions were designed (pg. 25).

The beginning of the twentieth century was a period of declining public support for inebriate asylums and a movement toward supporting community-oriented approaches to treating the mentally ill. This transition period increased the number of alcoholics requiring treatment, and much of the burden fell on the general hospitals, local jails, newly formed psychopathic hospitals, and, ultimately, state hospitals (Osher & Drake, 1996; White, 1988). According to the research literature, the mental hygiene movement characterized the transition period and was based on the concept of providing inexpensive, intermediate, community-based care in psychopathic hospitals (Osher & Drake, 1996; Ridgely, et al. 1990; White, 1998). These psychopathic hospitals were designed to serve local areas by providing intervention and services for the acutely mentally ill patient.

Another event that took place during this transition period, the passing of the Harrison Act in 1914, had a major impact on the treatment for drug addiction. In the years prior to the Harrison Act, the stigma associated with drug addiction had increased significantly. During this period, the terms addiction, addict, and dope fiend were commonly used to designate a person suffering from addiction to drugs other than alcohol (White, 1998). Additionally, the use of opiates and cocaine was largely unregulated prior to the Harrison Act of 1914. Therefore, most of those addicted to the aforementioned substances hid their addictions and avoided treatment for fear of public exposure. According to White (1998), the Harrison Act was the product of a campaign for federal drug control legislation that was designed to restrict the use of opiates and cocaine for only legitimate medical purposes. The impact of this legislation created the criminalization of narcotic addiction by “turning the status of the addict from that of a patient receiving treatment to that of a criminal” (p. 113). The relationship between physicians and their patients was severely altered as physicians were fined and or incarcerated for prescribing opiates to treat addicts withdrawing from opiates. The Harrison Act resulted in numerous court battles over the interpretation of the Act and the responsibility for treating this client population. These legal battles continue to impact the relationship between narcotic addicts and physicians to this day.

The struggles over whether the responsibility for the care of the alcoholic and addict fell on local community hospitals, state psychiatric hospitals, specialized treatment facilities, or local jails fluctuated considerably in the early twentieth century. Some events like the temperance movements, the Harrison Act, and numerous claims by various profit seekers of professed cures for alcoholism and addiction influenced where these clients received treatment. Osher and Drake (1996) reported that the mental hygiene movement provided for considerable growth of community-based care. This movement was driven by declining public support for the expensive type of care provided by asylums and institutions. During the 1930s, Alcoholics Anonymous (AA) became the primary mechanism for moving the treatment of addictions from segregated institutions to community settings (Osher & Drake, 1996). According to White (1998), the first decade of AA was characterized by close involvement with local hospitals due to the fact that the typical alcoholic was physically dependent on alcohol. Hospitals created separate wards for alcoholics, and AA members helped recruit physicians who would take responsibility for the medical detoxification of alcoholics. This movement of community-based approaches eventually led to the establishment of a parallel system of care by diverting addictions treatment away from medical practitioners (Osher & Drake, 1996).

During the same period of time, narcotic addicts were either involuntarily committed to state psychiatric institutions or sentenced to jail for violations of the Harrison Act (White, 1988). Passage of the Porter Act in 1929 allowed for the creation of two narcotic farms designed to house and rehabilitate addict offenders who had been convicted of violating federal drug laws. The two facilities that served as primary treatment for narcotic addiction—Lexington, Kentucky, and Ft. Worth, Texas—opened in the mid-1930s. The next major event to impact the narcotic addict was the start of Narcotics Anonymous (NA) around 1950. However, few resources existed for the narcotic addict between 1940 and 1960. On the mental health side, Ridgely, Goldman, and Willenbring (1990) reported that the treatment of mental disorders in the early twentieth century “amounted to mostly custodial care within State asylums. The advent of health insurance in the 1930s led to a shift of the mentally ill out of asylums into a variety of private and public mental health facilities” (p. 124). At time of the establishment of AA, many physicians and psychiatrists subscribed to the view that alcoholism was due to an underlying personality disorder. These differences in philosophical concepts regarding the nature and cause of alcoholism persisted throughout the evolution of the alcohol and drug treatment fields.

In 1956 the American Medical Association (AMA) and the World Health Organization (WHO) recognized alcoholism as a disease amenable to treatment. This was followed by the work of a physician named E.M. Jellinek, who is credited with providing a renewed rationale for medical personnel to treat alcoholism (Osher & Drake, 1996). By the 1960s, short-term inpatient treatment along with long-term outpatient fellowship with AA/NA became the model treatment across the country. Osher and Drake (1996) note that “although addiction treatment returned to medical settings, it remained separate from mental health services” (p. 6). The National Institutes of Mental Health (NIMH) was founded in 1946 as part of the federal response to mental and addictive disorders and was charged with the responsibility for developing mental health, alcohol, and drug initiatives and policy (Osher & Drake, 1996). According to Osher and Drake (1996), 1966 was the year the NIMH was authorized to make grants to establish community-based drug treatment programs, therapeutic communities, and methadone-maintenance

programs. The passage of decriminalization laws in the late 1960s allowed for the redirection of interventions for persons with drug addictions from the criminal justice system to the health care system (White, 1988).

In 1970, the Comprehensive Alcoholism Prevention, Treatment and Rehabilitation Act was passed to support increased and improved treatment for people with alcoholism. Osher and Drake (1996) report that this Act created a new federal agency called the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to “administer a formula grant program allocating money to the states based on population and need” (p. 6). Osher and Drake (1996) go on to state that the passage of the Drug Office and Treatment Act created a parallel agency called the National Institute on Drug Abuse (NIDA) with a similar formula grant program to administer. The critical point to note here is that treatment centers designed specifically to treat addictive illness arose during this time, and insurance companies were willing to pay for this treatment. According to Miller (1994), during the same time period traditional psychiatric treatment providers resisted the view of treating addiction independently as a disease and chose to attempt to treat mental illness apart from addictive illness. Subsequently, in the 1980s the monies for NIAAA and NIDA were merged into a single block grant, and the alcohol and drug agencies were merged together. As a result, these actions led to a narrowing of target populations to try to contain both mental health and substance abuse treatment costs (Osher & Drake, 1996). Many view the period from the early seventies through the eighties as the time when the alcohol and drug fields formally developed a distinct parallel system separate from and in competition with the mental health system (Osher & Drake, 1996; Ridgely, et al. 1990; White, 1998).

As epidemiologic data from the 1980s and early 1990s began to accumulate, the application of traditional substance abuse treatments to clients with mental disorders within mental health programs began to be examined. Meanwhile, at the federal government level, the Substance Abuse and Mental Health Services Administration (SAMHSA) was developed to manage resources provided to the states and consisted of three centers: 1) the Center for Substance Abuse Treatment, 2) the Center for Substance Abuse Prevention, and 3) the Center for Mental Health Services. SAMHSA block grant money is split into two separate block grants to the states. Although SAMHSA’s national advisory committee supports the collaboration of mental health and substance abuse services and recognizes the dual diagnosis population, it has declined to integrate disability funding or create a third funding level for the dually diagnosed population. For the most part, this division at the federal level predominately leads states to maintain separate mental health and substance abuse administrative structures and parallel treatment systems.

DUAL DIAGNOSIS CLIENT TYPES

A review of the literature on the client characteristics and prevalence of dual diagnosis resulted in a wide range of descriptions and estimates that depended on several factors. These include: 1) heterogeneity in dual diagnosis; 2) identification of dually diagnosed clients; and 3) methods for assessing psychiatric and substance use disorders (Drake, 1996; Minkoff, 1994; Rachbeisal, 1999; Sciacca, 1996).

It is important to begin by defining the term dually diagnosed before discussing the factors mentioned previously. Medical journals tend to use the term comorbidity. Psychological and social science literature generally use dual diagnosis or dually diagnosed. Other descriptors used to identify the dually diagnosed client include: mentally ill chemical abuser, substance-abusing mentally ill, and mental disorders with chemical dependency. The consensus in the research literally wholly supports the fact that the dual diagnosis population is heterogeneous and difficult to define (Lehman & Dixon, 1995; Ortman, 1997). Defining dual diagnosis must begin with two terms commonly used to describe individuals with psychiatric or chemical dependency problems. First, Ortman (1997) states that the term mental illness is used to broadly cover a range of psychiatric symptoms and dysfunction. This would include symptoms of psychopathology ranging from stress and adjustment reactions to narcissistic to borderline and severe psychotic symptoms. Second, the Diagnostic and Statistical Manual, fourth edition (DSM-IV) (American Psychiatric Association [APA], 1994), classification of substance related disorders (SRDs) refer broadly to “disorders related to the taking of a drug of abuse, to the side effects of medication, and to toxin exposure” (APA, p. 175). SRDs are further divided into substance use disorders (SUDs), including abuse and dependence, and substance-induced disorders (SIDs). This study will focus only on the SUDs, which include abuse and dependence.

DSM-IV defines substance abuse as a “maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by recurrent use resulting in a failure to fulfill major role obligations, recurrent use in situations in which it is physically hazardous, recurrent use despite persistent or recurrent social or interpersonal problems related to substance use, and/or recurrent substance-related legal problems (APA, 1994, pp. 182-183). Additionally, substance dependence may include any of these symptoms of abuse, but also involves physical tolerance, withdrawal, or compulsive drug-taking. In DSM-IV, all Axis I disorders that are not due to some other known organic factor are referred to as “independent mental disorders” (IMDs).

The origins for defining dually diagnosed “clients” draws from the APA definitions for SUDs and IMDs. According to Schukit (1994), “mental illness and substance abuse can co-occur by chance or by the interactive nature of the conditions” (p. 1,723). Doweiko (1999) states the term dual diagnosis is used to describe “individuals with a coexisting psychiatric problem and a substance abuse problem that requires simultaneous treatment” (p. 292). Lehman & Dixon (1995) define dual diagnoses as “clients with comorbid psychoactive substance use disorder and chronic mental illness” (p. 29). Finally, Ortman (1997) states that dual diagnosis can refer to “almost innumerable combinations of both disorders with varying degrees of severity” (p. 11). Lehman, et al., (1989), go on to suggest the following as models for linking mental illness and substance abuse:

In the secondary substance abuse model, higher comorbidity rates are the result of the mental illness increasing patients’ vulnerability to substance abuse. In the secondary psychiatric disorder model, some cases of psychiatric illness develop as a consequence of substance abuse. The bi-directional model stipulates that substance abuse and mental illness interact so that either disorder can initiate or influence the other (pp. 20-21). The empirical support for these research models remains debatable and further demonstrates the fact that dually diagnosed clients are extremely vulnerable to misdiagnosis and poor treatment recommendations. In addition to the ranking of characteristics in the

aforementioned models, the presence, nature, and severity of other factors such as medical problems, disability, poverty, and homelessness directly impact these models (Lehman & Dixon, 1995).

During the last twenty years, research has clearly demonstrated that a substantial number of clients receiving treatment in residential and community-based substance abuse and mental health programs have co-occurring substance abuse and psychiatric disorders (dual diagnosis). Included in this category are clients covering the full diagnostic range from serious mental illness and substance dependence to the less seriously disturbed substance abuser. A major precondition to engaging the dually diagnosed client in treatment is identification of the co-occurring disorders. A model of client types developed by the Washington Council of Governments (1996) divides the dually diagnosed population into four major subgroups. These four subgroups can be characterized as follows:

Subgroup I: Individuals who experience major severe substance use symptoms and major psychiatric symptoms.

Subgroup II: Individuals who experience major severe substance use symptoms and mild to moderate psychiatric symptoms.

Subgroup III: Individuals who experience mild to moderate substance use symptoms and mild to moderate psychiatric symptoms.

Subgroup IV: Individuals who experience mild to moderate substance use symptoms and major to severe psychiatric symptoms.

According to the Washington Council of Governments, these four subgroups generally serve as a conceptual framework for policy makers, providers, and in some cases, funders to plan services for individuals regardless of their specific diagnoses or the structure of the delivery system. The incidence of dually diagnosed individuals appears to be relatively high among the substance abuse and mental health populations. According to researchers, the prevalence rates of the mentally ill who also abuse substances varied greatly in ranges from 7% to more than 60% (Drake, et al., 1998; Mueser, Bennett, & Kushner, 1995; Ortman, 1997; Rachbeisel, Scott, & Dixon, 1999). According to Mueser, et al. (1995), assessing the prevalence of substance abuse in psychiatric clients creates several methodological issues, which influences the results. Problem areas include diagnostic factors caused by the lack of a universally accepted definition of the dually diagnosed population. Sampling errors can also create fluctuations in results due in part to the transient nature of the dually diagnosed population and to the location or setting in which the study is conducted. Lastly, demographic characteristics often are not accounted for in the results of many studies and therefore result in the wide variation in estimates of prevalence (Mueser, et al., 1995).

Rachbeisel, et al. (1999), reported that one of the largest epidemiological studies on psychiatric illnesses to date was the Epidemiologic Catchment Area (ECA) study done in the early 1990s. The ECA study provided some of the strongest evidence that substance abuse disorders are more prevalent (2.7 times the general population) among persons with mental illness than in the general population. The study showed that individuals with a psychiatric disorder (22.3%) also had an alcohol abuse disorder, and 14.7% had a drug abuse disorder

(Mueser, et al., 1995). For individuals who ever had a substance abuse disorder, 53% have also had one or more psychiatric disorders (4.5 times the general population). More specifically, the lifetime rate for substance abuse disorders in the general population was 17% versus 48% in persons with schizophrenia and 56% in persons with bipolar disorder (Drake, et al., 1996; Mueser, et al., 1995; Ortman, 1997). Many studies suggest that between 25% and 50% of persons with severe mental illness have had a substance use disorder in the previous six months (Clement, Williams, & Waters, 1993; Drake, et al., 1996; Drake, et al., 1998; Mueser, et al., 1995; Mercer, Mueser, & Drake, 1998). Therefore, one can conclude that substance use disorders are common among persons with severe mental illness.

In any clinical context, a major requirement to developing interventions derives from the initial screening to identify the possible presence of one or both disorders. The quality and accuracy of available assessment procedures becomes critical. According to a 1997 report by the SAMHSA National Advisory Council, of the estimated 7.2 million adults between the ages of 18 and 54 with co-occurring disorders who are living in households, a majority receive inappropriate or no treatment at all. The absence of any assessment for dual diagnosis creates a major barrier to effective intervention.

BARRIERS TO TREATMENT

Persons with dual diagnosis are considered by many treatment professionals to be untreatable, inappropriate for most treatment programs, and basically not worth the efforts of coordinating the level of services needed because of their poor history of follow through. These attitudes on the part of counselors might be a serious obstacle to clients with dual diagnoses engaging in treatment. This is important to mention here because there is no definitive, empirically supported model for providing addiction treatment to psychiatric populations (Drake, et al., 1998; Miller, 1994; Ortman, 1997).

Numerous barriers have delayed and interfered with the progress of instituting new treatment models on system and program levels. Some investigations have documented that psychiatric settings have resisted providing addiction treatment services because of a view that other agencies or programs were 'responsible' for these services (Drake, 1996; Minkoff, 1994). From a systems standpoint, there has been a historical separation of addiction and psychiatric services at the federal, state, and local levels. In the literature, some researchers attribute the resistance to irreconcilable philosophic differences and pervasive mistrust between the two fields. These differences play out in several different ways depending on the perspective of the author. The differences generally can be grouped into four categories: 1) treatment philosophy offered; 2) nature of treatment; 3) type of treatment relationship; 4) case management versus detachment (Doweiko, 1998; Drake, et al. 1998; Minkoff, 1994; Ridgely, et al., 1990).

The treatment philosophy often leads to a type of resistance that includes the view that there are significant differences between the fields in education and philosophy. For example, Ridgely, et al. (1990), state in their investigation that, philosophical conflicts, different training

and credentialing of caregivers, and lack of respect for one another's competency have exacerbated the barriers between service systems' (p. 127). Miller (1994) stated: "Tension that arose between the addictive view [i.e., addictive illness leads to a number of psychological and psychiatric consequences] and the psychiatric view [i.e., addictive illness is caused by an underlying psychological/psychiatric illness] have made interactions and cooperation in clinical practice problematic" (p. 5). The biggest difference between traditional mental health professionals (social workers, psychologists, psychiatrists) and substance abuse treatment programs is the belief that alcoholism is not a disease but a symptom. Consequently, professional training programs often provide comprehensive training in the areas of understanding individuals, families, and organizations without recognizing treatment of alcoholism as a specialty area. This often leads to clinicians choosing not to work with substance abusers and referring them to experts in the field of substance abuse treatment.

Finally, the differences in treatment philosophy can also be associated with the concept of de-institutionalization ideology versus recovery ideology. Substance treatment historically has a tradition of using residential treatment as a primary care approach to "breaking the cycle of addiction" and establishing recovery for patients. Minkoff (1994) states that the primary goal of professionals in the mental health field is to "move patients from institutions back into the community" (p. 412).

An example of the nature of treatment includes the point of view that the identification of the primary diagnosis is a source of resistance. According to Minkoff (1994), "even where addiction is recognized and treated in psychiatric populations, it has often been considered a 'secondary' diagnosis, either because of the sequence of causation, the severity of the presenting psychiatric disturbance, and/or the requirement of a primary psychiatric diagnosis for reimbursement purposes" (p. 412). Interestingly, this view is in contrast to the view adopted by the American Medical Association since 1956 that recognizes addiction as a primary and progressive disease that has no known cure. Minkoff (1994) further stated that "the concerns over the nature of treatment involves the use of medication versus 12-step recovery; science versus spirituality; and professional help versus peer help" (p. 413). Issues such as the aforementioned address the core of treatment approaches that define the mental health and substance abuse treatment fields. Many in the mental health field believe that professional training is necessary to work with chronic mentally ill persons. Many in the substance abuse field believe that personal experience is the best training for working with substance abusers (Drake, 1996; Minkoff, 1994). Either way, the clinician must determine where the client will benefit most from services. Watkins, Lewellen, and Barrett (2001) suggest that "the diagnosis and treatment are determined by the bias of the professional who sees the client rather than by the client's needs. A dually diagnosed person may be barred from treatment because he/she does not fit into the diagnostic category of a specialization group" (p. 16). Ridgely, et al. (1990), sum up this section by stating the following: "The problem might be addressable were it not for the multiplicity of views within each field about the nature of the disorders and philosophies of interventions" (p. 127). These examples exemplify the dichotomous relationship that has characterized the history of conflict between the mental health and substance abuse fields.

According to Drake (1996), the concern over the type of treatment relationship involves the use of predominantly support approaches versus confrontation, and case management versus

detachment. Substance abuse treatment personnel believe in using confrontation as a mechanism for breaking through denial and manipulative behavior characteristic of addiction. Mental health personnel regard mental illness as unpredictable at times and seek more permissive, supportive approaches to stabilize psychiatric symptoms in clients. To complicate matters further, Beeder and Millman (1992) state that counselors on both sides “often consider the dually diagnosed client untreatable, inappropriate, and not worth the efforts of the treatment team since they seem to be unwilling to help themselves” (p. 688). Also according to Beeder and Millman (1992), the feelings the therapist or treatment team develops toward the dually diagnose client are “termed counter-transference and are believed to be an inevitable result of a therapist’s past experiences or current feelings” (p. 688). These attitudes on the part of MH/SA professionals might be a serious obstacle to dually diagnosed clients presenting for treatment.

Finally, treatment issues for persons dually diagnosed become even more complicated when funding issues are discussed. With the rapid changes in funding streams due to the managed care movement, the concern over cost issues exacerbates the conflict over responsibility for treating the dually diagnosed client. The major consequence from funding concerns is that the dually diagnosed client most frequently receives outpatient treatment. The weakness in the treatment is a reduction in external control over client behaviors and increased reliance on client motivation (Watkins, Lewellen, & Barrett, 2001).

The sum total of all the aforementioned barriers lead this researcher to believe there is a prevailing negative attitude that the counselor develops toward the dually diagnosed patient that may be the inevitable result of the counselors’ own past experiences or current feelings. Identifying and developing an understanding for these attitudes can help remove them as obstacles to treatment and, rather, enhance the treatment process for the dually diagnosed client.

CHAPTER SUMMARY

Chapter one presented a general overview of the background of the problem concerning persons with dual diagnosis that included the significance of the problem and the rationale for conducting this investigation. Additionally, the purpose of the study was presented and two research questions were proposed. How the study builds upon previous research and adds to the body of research knowledge about attitudes toward the dually diagnosed client were also discussed.

In Chapter Two, several specific topics related to the purpose of this investigation were discussed as part of a review of the literature. The first section examined relevant theoretical concepts and research on attitude formation and the development of stigma, stereotypes, and bias toward persons with disabilities. The Theory of Reasoned Action (TRA) is a model developed by Fishbein (1980) and based on the idea that the “proximal cause of behavior is intention to behave, which is caused by attitude and subjective norm” (p. 47). General propositions about how attitudes are formed put forward by several scholars include theories such as classical learning theory, social learning theory, information processing, and a genetic basis for attitude formation.

For persons with disabilities, propositions suggest that biases, stigma, and stereotypes are part of the process for forming attitudes toward persons with disabilities. For example, ingroup individuation and stereotyping of outgroup members was discussed and identified as significant in the relationship between both nondisabled persons' contact with people with disabilities and attitude formation. Attributions and the biases that influence attributions affect how people think about other people. Discussion in Chapter Two also focused on the evolvement of alcohol and drug treatment in American society and the inherent history of philosophical conflict between mental health and substance abuse treatment systems. Additionally, this chapter defined and discussed the dual diagnosis population along with known barriers that prevent treatment for this population.

During the last fifteen to twenty years, research has clearly demonstrated that a substantial percentage of clients with dual diagnoses drop out of treatment, have poor outcomes, or are excluded from treatment altogether. Furthermore, research has also documented known barriers that highlight the complexity of treatment for the dually diagnosed population. Therefore, the goal of the present investigation is to contribute to the body of knowledge for eliminating barriers to treatment by determining whether the attitudes of MH/SA professionals toward clients with dual diagnosis are a barrier to treatment.

CHAPTER THREE

METHODS

The purpose of this investigation was to determine whether there were differences in attitude between mental health and substance abuse professionals toward the dually diagnosed client and whether academic discipline, levels of training and experience, occupation, and amount of contact affect the attitudes of these professional groups. Three hypotheses, which are listed below, were formulated for this study:

- 1) MH and SA professionals demonstrate specific descriptive attitudes toward dually diagnosed clients.
- 2) There are differences in attitudes toward dually diagnosed clients between MH and SA professionals.
- 3) Professional background variables (including academic discipline, levels of training and experience, amount of contact, and occupation) have an effect on MH and SA professionals' attitudes toward dually diagnosed clients.

This chapter, which is divided into six sections, will delineate the methodology used to conduct this study. Section one discusses the research design used in this study. Section two discusses the sample population along with the criteria for participation. Section three discusses the instruments used in this study. Sections four and five discuss the data collection procedure and analysis. Section six presents the chapter summary.

RESEARCH DESIGN

The most common type of nonexperimental study is the survey research method, which was used in this study. Survey research involves any measurement procedure that asks questions of respondents. Surveys pertain to almost any topic and can be divided into two broad categories: the questionnaire and the interview (Rea & Parker, 1997). The purpose of surveys is to describe the attitudes, beliefs, and behaviors of a population. The independent variables used for this study were academic discipline, training and experience, occupation, and amount of contact. This researcher administered a Likert-type rating scale instrument for the purpose of determining professional attitudes toward the dually diagnosed client.

PARTICIPANTS

The participants for this study consisted of a convenient sample of mental health and substance abuse professionals employed at a local community mental health center located in a Northern Virginia suburb of Washington, D. C. A convenience sample consists of any participants who happen to be available at the time of data collection. The criteria for participation in this study included: 1) meeting all the guidelines for employment as a mental health or substance abuse treatment provider as defined by the local community agency and 2) voluntary participation.

Of the 90 MH/SA professionals employed at the community mental health center, 86 volunteered to participate in the study. All 86 survey forms were complete and were included in the data analysis. Of the 86 participants, 32 identified themselves as substance abuse professionals and 54 identified themselves as mental health professionals.

INSTRUMENTS

Attitude Measurement

The history of research on attitude seems to have largely centered around the argument of whether attitudes and behavior have a reciprocal relationship. The history of research on attitudes began in Germany in the mid-1850s with a focus on responses to certain classes of social stimuli (Antonek & Livneh, 1988). The British psychologist Herbert Spencer first used the term attitude in 1862, and by the turn of the century it was widely accepted by most social psychologists that a person's thoughts and actions were strongly influenced by attitudes (Antonek & Livneh, 1988). In 1928, Thurstone declared that "the concept of attitude will be used to denote the sum total of a man's inclinations and feelings, prejudice or bias, preconceived notions, ideas, fear, threat and convictions about any specific topic" (Summers, 1971, p. 2). Thurstone further argued that attitudes could be measured on a single continuum ranging from most favorable (positive) to unfavorable (negative).

In 1932, Rensis Likert proposed an alternative and simple technique for attitude measurement in an effort to reduce the complexity of measurement of attitudes proposed by Thurstone (Antonek & Livneh, 1988). According to Antonek and Livneh (1988), Likert's method derives a single score that presumably represents the favorableness (or unfavorableness) of the respondent toward the attitude referent. During the same time period, E.S. Bogardus viewed attitude measurement behaviorally and modified Thurstone's model to measure the degree of endorsement of items suggesting differing levels of social proximity to an attitude referent (e.g., religious or racial groups) (Antonek & Livneh, 1988). In 1957, Charles Osgood developed a semantic differential scale that was quickly applied to the study of attitudes. The scale consisted of a series of bipolar evaluative scales in which a respondent rated the attitude referent. Criticism about these two early methods of attitude measurement was that the definition of attitude was too narrow. However, Summers (1971) stated that despite wide variation, the consensus was that an attitude was a predisposition to respond to an object rather than the actual behavior toward the object.

In 1943, Mussen and Barker first attempted the measurement of attitudes of non-disabled people toward people who are disabled (Antonek & Livneh, 1988). According to Yucker (1988), the measurement of attitudes toward people with disabilities range from subjective, informal, and psychometrically unsound instruments to more carefully planned and methodologically sound instruments. In the 1960s, scales were developed to measure attitudes toward deafness, mental illness, and other disabilities. Yucker, Block, and Campbell (1960, as cited in Yucker, 1988) developed the Attitudes Toward Disabled Persons Scale (ATDP), the most widely used and carefully studied instrument measuring attitudes toward people with disabilities. Cohen and Struening (1962) developed the Opinions About Mental Illness Scale (OMI) to measure the attitude held by various groups of personnel employed in mental hospitals toward psychiatrically disabled people (Antonek & Livneh, 1988). A modified version of the OMI was used in this study.

The most frequently used method devised to measure attitude is the self-report. This information is primarily obtained by direct and indirect methods. Direct methods for measuring attitude can be defined as instances in which the respondents are aware that they are participating in an attitude measurement experiment, and indirect methods are unobtrusive measures of respondent attitudes (Antonek & Livneh, 1988). Of the two aforementioned methods, direct methods are the most common for measuring attitudes toward people with disabilities. However, direct methods, as noted by Antonek and Livneh (1988), have limitations including the fact that: 1) some scales are unidimensional and imply an underlying continuum that is important to respondents; 2) some scales narrow the universe of dimensions to those on the scale used; and 3) some dimensions may not be articulated effectively enough to be captured on a scale. In response to these limitations, researchers have placed more emphasis on the value of developing indirect methods of measuring attitudes toward people with disabilities.

Opinions About Mental Illness Scale (OMI)

According to Yuker (1988), standard attitude measures generally consist of written items representing single statements about feelings, beliefs, or knowledge with respect to a particular object. The most commonly used empirical approach to attitude measurement is the Summated Rating Scale (SRS), developed by Rensis Likert (Antonak & Livneh, 1988). The SRS comprises attitude statements in which a respondent can agree or disagree with differing levels of intensity. Antonak and Livneh (1988) state that the individual items on an SRS are opinions and the summed score is the overall attitude that the person has about the referent.

Cohen and Struening (1962) developed the multidimensional OMI 51-item scale to assess attitudes of health care personnel toward mental illness. The authors believed that the answer to items on the OMI scale reflected an opinion regarding the cause, treatment, and prognosis of mental illness. The sum of those opinions reflected attitude (Yuker, 1988). Construct validation of the OMI was done by using a pool of 200 opinion items that had face validity in regard to an opinion about mental illness across five factor domains (Antonak & Livneh, 1988). People experienced in the mental health field analyzed the pool of items and finally derived a 51-item scale from extensive factor analytic studies with more than 8,000 respondents. The OMI was originally used to measure the attitudes of workers employed in psychiatric hospitals. The OMI is an ordinal-level scale of measurement, and the identified factors of the scale are as follows: "Factor A: Authoritarianism (A, 11 items)," "Factor B: Unsophisticated Benevolence (UB, 14 items)," "Factor C: Mental Hygiene Ideology (MII, 9 items)," "Factor D: Social Restrictiveness (SR, 10 items)," and "Factor E: Interpersonal Etiology (IE, 7 items)" (Cohen & Struening, 1962). The current OMI consists of 51 opinion statements with six possible responses: "Strongly Agree," "Agree," "Not Sure but Probably Agree," "Not Sure but Probably Disagree," "Disagree," and "Strongly Disagree."

The extensive factor analytic studies serve as evidence of the OMI scale's validity (Antonak & Livneh, 1988). Dielman, Stiefel, and Cattell (1973) reviewed the OMI scale using more modern factor analysis methods to determine if the original factors held up over time. The researchers concluded that the replication of the original five factors across samples and within samples across time supported the original factorial structure of the OMI with only minor

differences noted in the Mental Hygiene Ideology dimension (Antonak & Livneh, 1988). Since the initial studies were conducted by Cohen and Struening, the same basic factors of the scale have held up over time and continue to be used.

Reliability and Validity of the OMI

Finally, Cohen and Struening (1962) reported that the OMI scale appears to have satisfactory degrees of internal consistency reliability (with the exception of subscale MII) as demonstrated by values that ranged from +.77 to +.80 for subscale A, +.70 to +.72 for subscale UB, +.29 to +.39 for subscale MII, +.71 to +.76 for subscale SR, and +.65 to +.66 for subscale IE. Subsequent factor analyses conducted by different researchers (Dielman, Stiefel, & Cattell, 1973) with different subject pools confirmed the existence of the original five factors, while others (Allon & Graham, 1970; Fracchia, Crovello, Sheppard, & Merlis, 1972; and Moore & Castles, 1978) yielded equivocal results.

For this study, to include concepts to measure MH/SA professional attitudes toward dual diagnosis in a community-based setting, this researcher made some modifications to the OMI. These modifications included the following: 1) the term mental illness was replaced with the term dually diagnosed for 15 of the 51 items; 2) nine items from the Drug Abuse Questionnaire and four items from the Attitudes Toward Mental Health Questionnaire replaced 13 items (14,17,23,26,28,31,33,34,36,40,44,49,50) on the OMI scale that were incompatible with a community-based treatment setting. For example, question 34 on the OMI, "If a patient in a mental hospital attacks someone, he should be punished so he doesn't do it again," was replaced with "A person who is dually diagnosed should not be excused for a crime that he commits." This group of items was reviewed by a panel of counseling professionals experienced in the treatment of persons with dual diagnoses for relevance of content and balance with regard to other questions on the instrument. The Drug Abuse Questionnaire, developed by Ferneau and Mueller (1971), is a 40-item survey questionnaire designed to measure attitudes toward drug abuse and the drug abuser. The Attitudes Toward Mental Health scale (AMH) was developed in 1972 by Richard Pasework and is designed to measure attitudes toward mentally ill people. The 56-item scale measures attitudes about origins of illness, behaviors, mentally ill persons in the community, and physical appearance (Pasework, 1972). All 51 items on the modified OMI scale were presented in Likert format with options to respond on a five-point agreement continuum.

The dependent variables for this research were the mean scores for each of the five OMI factors. The independent variables of respondents completing the survey were occupation, level of training and experience, academic discipline, and amount of contact with the dually diagnosed client.

VARIABLES

Dependent Variables

Factor analysis of the OMI scale developed by Cohen and Struening in 1960 demonstrated that there are five factors:

A-Authoritarianism: Includes authoritarian submission and anti-intraception and reveals a view of the mentally ill as an inferior class requiring coercive handling. High scores on this factor indicate a belief that the mentally ill are inferior to normal individuals.

B-Benevolence: A kindly paternalism whose origins lie in religion and humanism rather than science or the sophistication of professionalism. A higher score reflects an orientation toward care in general, not on a particular professional or scientific model.

C-Mental Hygiene Ideology: A positive orientation which embodies the beliefs of the present day mental health worker and the tenets of the mental hygiene movement. Its core concepts are partially summarized by the item “mental illness is an illness like any other.” Higher scores on this factor would be desirable in professionals, suggesting positive and optimistic views regarding serious mental illness.

D-Social Restrictiveness: The germinal idea here is that the mental patient constitutes a threat to society, particularly to the family unit, and must therefore be restricted in his functioning during hospitalization and afterward. There is some similarity in this factor and factor A. Low scores on this factor would be conducive to the development of lesser restrictive environments and treatment protocols for patients.

E-Interpersonal Etiology: A cognitive factor which reflects the belief that mental illness arises from interpersonal experience, especially deprivation of parental love during childhood. A high score on this factor reflects the respondent’s opinion that mental health is subject to individual’s choices in life, and as such minimizes biomedical causes of serious mental illness (Cohen & Struening, 1962).

The OMI is a form of summated rating scale; the scores on the items are averaged and yield a respondent’s attitude score. This places the respondent on an agreement continuum of the attitude factor being measured. The modified OMI was used as an ordinal scale of measurement.

Independent Variables: Background of MH/SA Participants

While the definition and discussion of the “attitude” variable have already been presented, attention has not been previously accorded to definitions and discussions of the professional background variables identified in one of the hypotheses for this study. The following are discussions and definitions of these independent variables.

Academic Discipline:

According to Klee (1990), a discussion of academic discipline must acknowledge the existing hierarchy of disciplines with Behavioral Health. The hierarchy establishes psychiatry at the top, followed by psychology, social work (master’s level), counseling, nursing, and addictions counseling. Both historically and in the present, there appears to be a continuing struggle between (and among) these academic disciplines for parity in issues of economic compensation as well as political influence on social policy. As the group most recently recognized as a discipline, addictions counselors appears to be relegated to the bottom of the hierarchy even though the discipline has established and codified professional standards (Klee, 1990; McLellan, et. al., 1988).

For the purposes of this study, academic discipline refers to formal education that results in a degree in a specific academic area and has the broad goal of knowledge and skill acquisition. Questions regarding academic discipline were included in the demographic portion of the survey.

Training and Experience:

Given the differing philosophies of disciplines in the aforementioned hierarchy, it is reasonable to expect differences in curriculum and training to the degree that information gained by students is disparate. Moreover, given that addiction treatment historically has not been the focus of psychiatry, psychology, and social work, there are significant gaps in information and training about substance abuse within those disciplines. For example, within the addiction counselor category, professional and paraprofessional (including ex-addicts or counselors in recovery) counselors are the typical service providers. Professional addiction counselors can be defined as those who have attained a high degree of education, usually a master's degree or more. Paraprofessional is a term generally attributed to addiction counselors having a bachelor's degree or less training. By comparison, the mental health field tends to define professional as those having a master's degree or higher. Mental health systems also commonly employ a variety of psychiatric aides and technicians who generally possess a bachelor's degree or less.

What an individual knows about a disability has been shown to influence attitudes. Education, a factor associated with socioeconomic status, also has been found to affect attitude formation (Geskie & Salasek, 1988). According to Lieberman (1970), those most tolerant of individuals with mental disorders tended to be best informed about them. Several studies have attempted to distinguish the differences between the therapeutic skill of more highly trained professional counselors and the lesser-trained paraprofessionals. One study conducted by Durlak (1979) found that professionals did not demonstrate superior skills as compared to paraprofessionals. In another study, McLellan, et al. (1988), found that additional training was associated with improved effectiveness; however, training alone did not appear to explain the differences in counselor effectiveness.

Specifically on the mental health side, Geskie and Salasek (1988) reported that years of experience working with persons with a mental illness have an effect on attitude development. Older and more experienced aides endorsed more prejudicial attitudes than did workers with less experience. Perry (1974) used a modified version of the Opinions about Mental Illness Scale (OMI) with a group of psychiatric aides and reported that unfavorable attitudes, such as social restrictiveness and authoritarianism, increased with age and years of experience, while favorable attitudes decreased. However, Myers (1990) reported that those attitudes that are formed as a result of experience tend to last longer, predict actions, and are more resistant to change. By the same token, Wu and Shaffer (1987) found that attitudes formed through direct experience are salient and are therefore more accessible.

For the purposes of this study, training refers to certificate programs, workshops, experiential processes, and seminars designed with the goal of specific skill acquisition (Thomas, 1990). Experience includes the percentage of persons with dual diagnosis on a professional's

caseload or years of experience that a professional has worked in her or his occupation or both. Questions regarding training and experience were included in the demographic portion of the survey.

Occupation

According to Geskie and Salasek (1988), investigators studying attitudes of health care professionals usually examined occupational subgroups separately. In addition, Geskie and Salasek stated that “findings consistently indicate distinct attitudinal patterns for the various occupational groups, regardless of the attitude measure used” (p. 189). Cohen and Struening (1962) extensively investigated the attitudes of mental health professionals using the OMI and identified the following four categories of occupations working with the mentally ill:

- a. Blue-collar workers- psychiatric aides
- b. White-collar workers- technicians, nurses, dentists, and non-psychiatric physicians
- c. Psychologists and Social workers
- d. Clergy

For the purposes of this study, occupation refers to the job title. The occupational groups in this study are MH and SA professionals working for a local public, community-based mental health center. Typical job titles under the mental health and substance abuse divisions include: 1) counselor/therapist; 2) case manager; and 3) nurse as designated by agency personnel policies. Questions regarding occupation were included in the demographic portion of the survey.

Pilot Study

The focal point for this study was to ask mental health and substance abuse treatment personnel working for a local community mental health center in Northern Virginia to participate in the survey. As previously mentioned, in order for this study to include concepts to measure MH/SA professional attitudes toward dual diagnosis in a community-based setting, this researcher made some modifications to the OMI. The modified version of the OMI was then presented to a panel of subject matter experts. This group consisted of ten professional counselors experienced in the treatment of persons dually diagnosed who serve on a regional dual diagnosis committee in the local metropolitan region. The group was instructed to rate each item in terms of its favorableness to the concepts of dual diagnosis, substance abuse, and mental illness using a three-point agreement continuum including “yes relevant,” “not sure,” and “eliminate.” Each item on the modified OMI instrument received strong approval (> 65% for each item), and the expert panel unanimously approved the items on the modified OMI instrument.

DATA COLLECTION PROCEDURE

The steps taken to gather data for this research occurred after the Virginia Polytechnic Institute and State University's Human Subjects Review Board granted permission to conduct the research. The Executive Director at the local community center for Mental Health and Substance Abuse Services was contacted by letter and by telephone for permission to conduct research at the center. The following parameters for this research project were reviewed with the Executive Director: anonymity was assured, participation was voluntary, no program or individual would be identified, the time to take the modified OMI scale was approximately 20 minutes, the modified OMI would be administered in group format only, the survey questionnaire and demographic questionnaire were the only tools used to collect data from participants, there was no expense to the agency, and the information gained would provide valuable information about the dually diagnosed population served at the agency.

After permission from the Executive Director was granted, the managers for each program in MH/SA were contacted to discuss the research and counselor involvement. Each program manager invited this researcher to naturally occurring group staff meetings held with the counseling staff to discuss the project and ask for volunteers. Participants were oriented to the problem and purpose of the research project and given instructions for completing the survey instrument by verbal presentation of the researcher. As the consent forms were completed, they were checked for signatures, and the modified OMI survey and demographic questionnaires were distributed. Participants were asked to complete the 51-item survey questionnaire along with an 11-item demographic questionnaire. Copies of the survey and demographic questionnaire are in Appendix D. This same group procedure was followed throughout the data collection process for each program. Instructions to participants who volunteered stressed anonymity and the fact that the issues identified on the instrument were matters of opinion, that each professional could/would differ in opinion, and that there were no right or wrong answers.

For the demographic portion of the survey, work setting was determined by the employing agency of participants and the job classification. Only those employees meeting the agency criteria to be classified as a mental health professional, substance abuse professional, or professional administrator were eligible to participate in this investigation. Questions regarding education levels were included on the demographic portion of the survey, and participants were asked to indicate the highest educational level attained from the following options: High School, Some College or Special Training, Bachelor's Degree, Master's Degree, and Master's-plus. Participants were also asked to indicate the category that best describes the academic program they completed as part of their education.

Based on the responses, participants were placed in five categories: Social Work; Rehabilitation Counseling; Psychology; Nursing; and Other. These groupings were adopted from several comparative studies on professional effectiveness with various client populations (Durlak, 1979; McLellan, Woody, & Lubrosky, 1988; Moodley-Kunnie, 1988; and Szymanski, 1991). Questions related to experience were included on the demographics survey. Participants

were asked to indicate years of experience working as a service provider and the percentage of their caseload comprised of clients with dual diagnosis.

When all MH/SA programs had been visited, the response sheets were checked for completion. The consent forms were placed in one envelope and the demographic and OMI questionnaire were placed in another envelope. A total of 86 (out of 90) participants volunteered for a 95% participation rate and no questions or surveys were eliminated for incompleteness.

DATA ANALYSIS

Data collected for this study were analyzed using the Statistical Package for the Social Sciences software (SPSS), version 8.0. Statistical analysis of data included a number of statistical procedures including descriptive statistics, t-test (independent sample), factor analysis, multiple analysis of variance (MANOVA), and summary statistics.

Descriptive statistics such as cross-tabulation, measure of central tendency (mean), and measure of variability (e.g., range and standard deviation) were used to describe or summarize the data. The t-test is a parametric statistic that was used to determine whether or not the means of MH/SA data responses were significantly different at a probability level of $p \leq .05$.

Multiple Analysis of Variance (MANOVA) is a statistical procedure that was used to assess group differences across multiple dependent variables simultaneously based on a set of categorical variables acting as independent variables (Gravetter & Wallnau, 1999).

CHAPTER SUMMARY

This chapter discussed the methodology used in this study, which included the research design, sample population, instruments, procedures, data collection, and analyses. Also discussed was the modification of the OMI based on responses from a pilot study.

CHAPTER FOUR

RESULTS

The purpose of this investigation was to determine whether there are differences in attitudes between mental health and substance abuse professionals toward the dually diagnosed client and whether or not academic discipline, levels of training and experience, occupation, and amount of contact affect the attitudes of these professional groups.

A total of 86 respondents completed the survey. This represents 95% of employees used as the research population. Sixty-three percent of respondents identified mental health as the primary disability area in which they work, while 37.2 percent identified substance abuse as their primary disability area. Level of direct clinical experience of respondents ranged from less than 1 year to 28 years. Supervisory experience ranged from none to 20 years. Percentage of dual diagnosed clients on current caseloads ranged from zero to 100 percent.

DATA ANALYSIS

Factor analysis was conducted in order to determine whether the items on the scale in the present study represented the five constructs identified on the OMI by Struening and Cohen (1963). Principle components factor analysis with varimax rotation was attempted. However, the analysis resulted in 18 ill-defined factors with variables loading equally on multiple factors. The analysis was re-run with a forced number of factors (5). Results were similar to those in the first analysis: No distinct factors were identified and variables loaded equally on more than one factor. Possible reasons for the lack of distinct factor loadings include the following:

- (1) Sample size—As a general rule, a sample size of five cases for each variable is needed to run a factor analysis (Tabachnick & Fidel, 1989). In the present research, a total of 255 cases would be the minimum needed for an analysis containing 51 variables;
- (2) Modified questions—The original OMI questionnaire measured attitudes toward the mentally ill. In the present study, all questions were modified to query respondents about attitudes toward dually diagnosed clients, and 13 of the original questions were changed completely from their original form; and
- (3) Population and time of the study—The original OMI study was conducted during the 1960s in a hospital setting. During that time, and in that setting, attitudes about mental illness were far less evolved than they currently are. De-institutionalization beginning in the 1980s has resulted in increased community-based services. Additionally, consumer advocacy and public awareness campaigns have targeted the removal of much of the stigma associated with mental illness and receiving mental health services. In the present study, survey respondents are employed at a community-based program in a progressive metropolitan area and are, therefore, more likely to be more knowledgeable about mental health issues.

Due to the inability of the data to generate factors, mean scores were calculated to create variables to represent the five OMI factors. The mean scores were generated based on the questions illustrated in Table 1 as representing each modified OMI measure as follows:

Table 1
Identified Factor Questions on the Modified OMI Scale

Factor	Questionnaire Items Included in Mean Score
Authoritarianism	1, 6, 9, 11, 16,19, 21, 39, 43, 46, 48
Benevolence	2, 12, 17, 18, 22, 26, 27, 32, 34, 36, 37, 40, 47, 49
Social Restrictiveness	3, 13, 23, 28, 31, 33, 38, 44, 50
Mental Hygiene Ideology	4, 7, 8, 14, 24, 29, 41, 42, 45, 51
Interpersonal Etiology	5, 10, 15, 20, 25, 30, 35

Once values were generated for factor variables, descriptive statistics were run to determine if there were differences in measures of training, education, and work experience based on the primary disability area (mental health or substance abuse) of respondents. Crosstabs were generated for level of education, specialized credentials, years of direct and supervisory experience, and contact with dually diagnosed clients, sorted by primary disability area. Means were generated with primary disability area, undergraduate and graduate degree discipline, and occupation as independent variables and the five factor variables as dependent. T-tests were run to determine whether MH and SA professionals differ in their attitudes toward dually diagnosed clients. Multiple Analysis of Variance (MANOVA) was also conducted to determine the extent to which measures of training, education, and work experience impact respondents' attitudes toward dually diagnosed clients. Results of all analyses are discussed below.

RESULTS

Attitudes Toward Dually Diagnosed Clients

As indicated in Table 2, there are no differences in attitudes toward dually diagnosed clients based on respondents' identified primary disability area. The researcher attributes the lack of differences to two possibilities: 1) although mental health and substance abuse professionals work with different disability populations, they belong to the same occupation group because they were both trained for mental health work and (2) MH/SA respondents in this sample are unique because of their co-location in the same work setting, a finding similar to the indifference of the data results in Cohen and Struening's (1963) classification of psychologists and social workers into the same profile because of considerable similarity of attitude on the OMI scale in a

hospital setting. Viewing the results in this way is based on the analyses of the mean factor scores for mental health and substance abuse professionals.

Table 2

Mean of Factor Scores for Mental Health and Substance Abuse Professionals

Factor	Mental Health	Substance Abuse
Authoritarianism	Mean 2.7508 N 54 SD 1.0841	Mean 2.8949 N 32 SD 1.0089
Unsophisticated Benevolence	Mean 3.2394 N 54 SD .5677	Mean 3.2076 N 32 SD .5855
Mental Hygiene Ideology	Mean 3.1626 N 54 SD .3061	Mean 3.2604 N 32 SD .3061
Social Restrictiveness	Mean 2.7630 N 54 SD .9727	Mean 2.7813 N 32 SD 1.0072
Interpersonal Etiology	Mean 2.7804 N 54 SD 1.1776	Mean 2.7321 N 32 SD 1.1046

T-tests were also conducted on each of the five factor variables to determine if there were statistically significant differences in attitude of mental health and substance abuse professionals toward dually diagnosed clients. As illustrated in Table 3, results of the analyses indicate no statistically significant difference relative to the five attitude factors for the two groups. The absence of a statistically significant difference between mental health and substance abuse professionals on the five attitude factors might give importance to the similarities of these two groups in relationships with the dually diagnosed client population.

Table 3

Independent Samples T-Test

	F	Sig.	t	df	Mean Difference	Std. Error Difference	95% Confidence Interval	
							Lower	Upper
<u>AVG1</u>	1.70	.195	.611	84	.144	.235	-.324	.612
<u>AVG2</u>	.168	.683	-.248	84	-3.18	.128	-.286	.223
<u>AVG3</u>	.035	.851	1.46	84	9.78	6.66	-3.46	.230
<u>AVG4</u>	.244	.623	.083	84	1.82	.219	-.419	.455
<u>AVG5</u>	.266	.608	-.188	84	-4.82	.256	-.559	.462

Avg. 1= Authoritarianism

Avg. 2= Benevolence

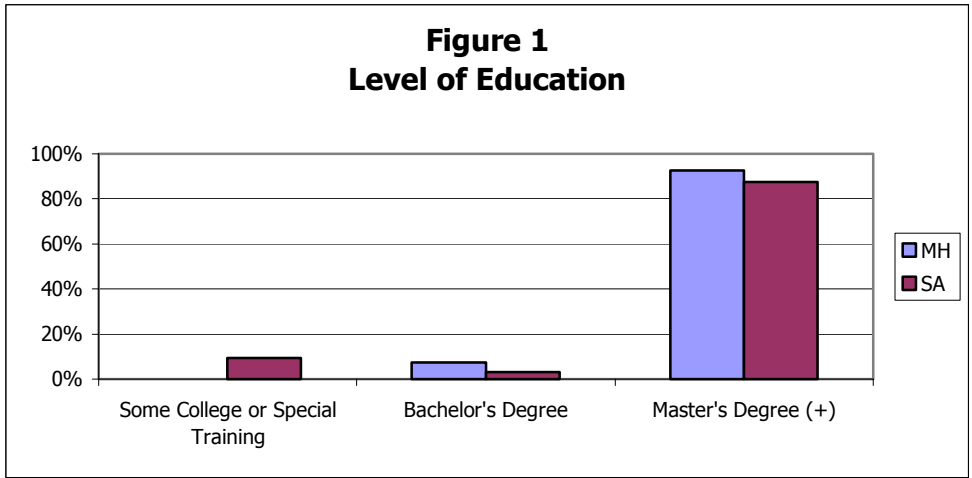
Avg. 3= Mental Hygiene Ideology

Avg. 4= Social Restrictiveness

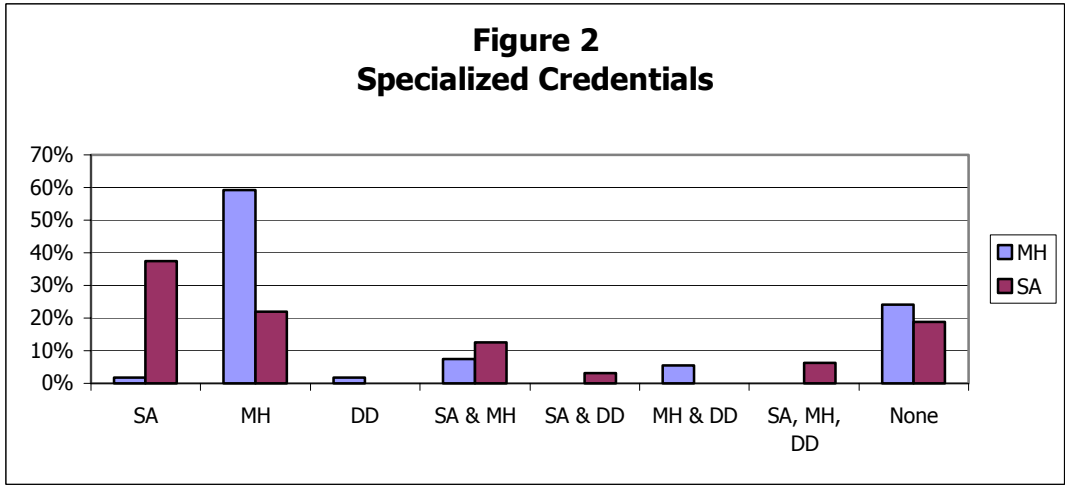
Avg. 5= Interpersonal Etiology

Level of Training

As indicated in Figure 1, most survey respondents possessed a master's degree. Ninety-three percent of mental health professionals have attained a master's level of training (mostly in the area of social work), compared with 88 percent (mostly rehabilitation counseling/social work) of substance abuse professionals surveyed. Seven percent of mental health professionals and 3 percent of substance abuse professionals have Bachelor's degrees, and 9 percent of substance abuse professionals surveyed have some college or special training.



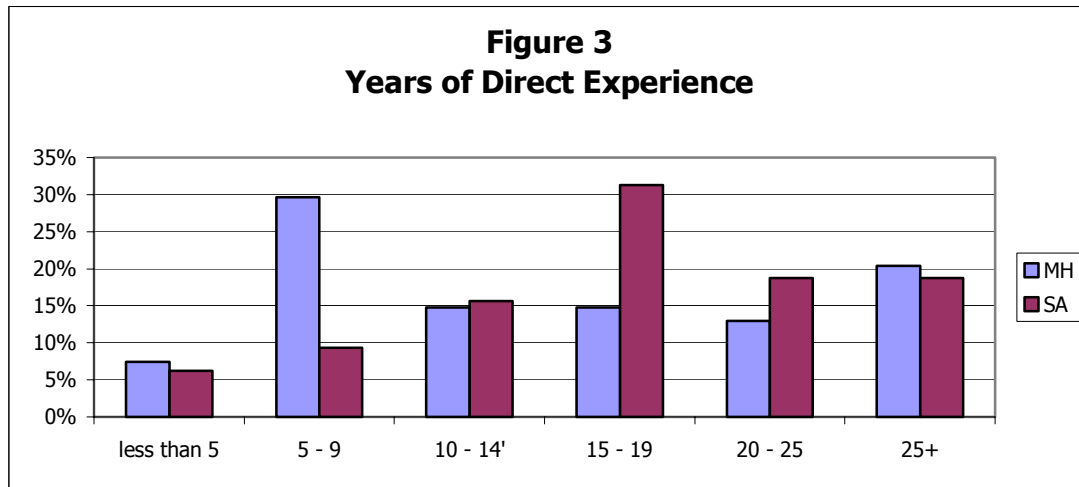
With regard to specialized credentials, the majority of respondents hold such credentials in the primary disability area in which they work. Figure 2 demonstrates that 59 percent of mental health professionals have specialized credentials in mental health, compared to 22 percent of substance abuse professionals. Thirty-eight percent of substance abuse professionals hold specialized substance abuse credentials, versus 2 percent of mental health professionals.



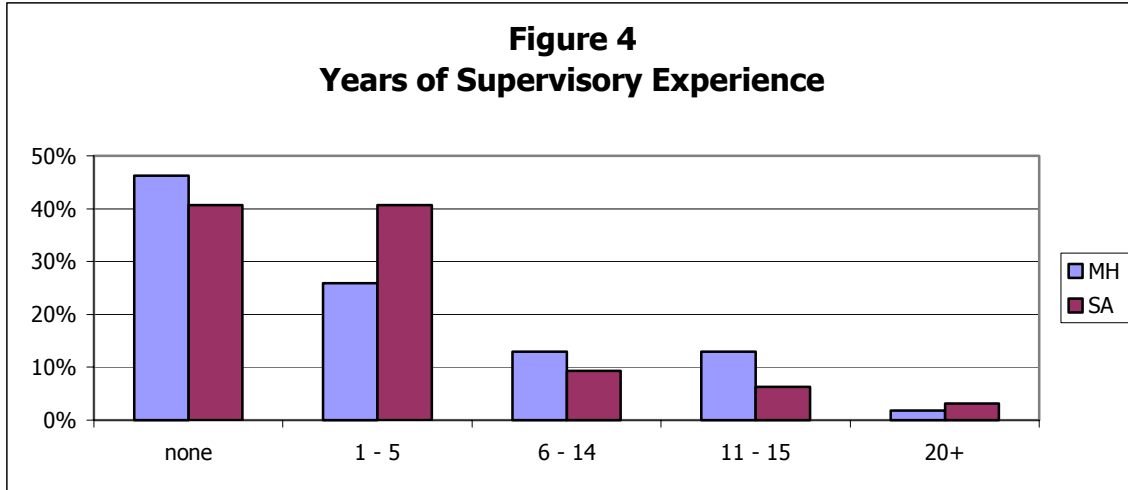
Regarding dual diagnosis, 8 percent of mental health professionals held specialized credentials, compared to 3 percent of respondents whose primary disability area is substance abuse. Lastly, a good number of both groups of professionals possess no specialized credentials at all: 24 percent for mental health and 19 percent for substance abuse.

Years of Experience

In the present research, substance abuse professionals had slightly more direct client experience on average (17.1 years, $N = 32$, $SD = 7.6088$) than did mental health professionals (15.1 years, $N = 54$, $SD = 9.9269$). Both groups had an average of approximately three years supervisory experience (MH = 3.9 years, SA = 3.0 years). The vast majority of both groups had 15 or more years of direct care experience, 69 percent for substance abuse professionals and 63 percent for mental health professionals. And persons new to the professions were approximately equal: 7 percent for mental health and 6 percent for substance abuse. However, 30 percent of mental health professionals had between five and nine years of direct care experience, compared with only 9 percent of substance abuse professionals (See Figure 3).

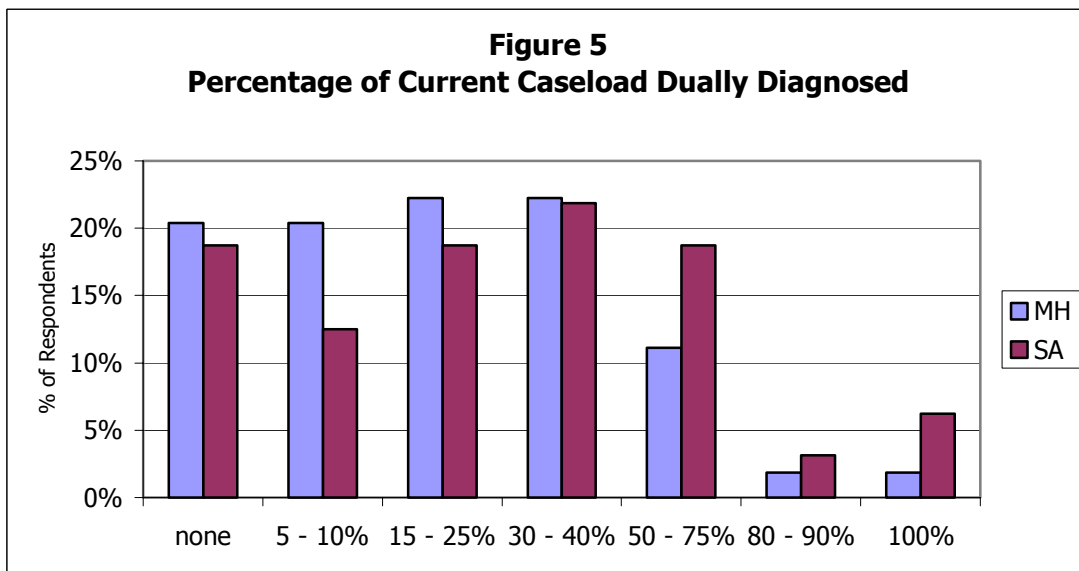


With regard to supervisory experience, mental health professionals in the sample have slightly more long-term experience than do substance abuse professionals. Twenty-eight (28) percent of mental health respondents have five or more years as supervisors, compared to 18 percent of substance abuse professionals. Both groups have a significant number of respondents with no supervisory experience: 46 percent for mental health respondents and 41 percent for substance abuse respondents (see Figure 4).



Contact with Dually Diagnosed Clients

On average, survey respondents report a modest amount of contact with dually diagnosed clients (MH mean = 23.4%, SD 26.7; SA mean = 32.1%, SD 29.6). As indicated by Figure 5, 42 percent of mental health respondents reported that between 5 percent and 25 percent of clients on their caseloads are dually diagnosed, in comparison to 32 percent of substance abuse professionals. Twenty percent of mental health and 19 percent of substance abuse professionals report no current clients who are dually diagnosed. Conversely, 2 percent of mental health professionals and 6 percent of substance abuse professionals report having 100 percent of current clients who are dually diagnosed.



Impact of Occupation on Attitudes Toward Dually Diagnosed Clients

In considering the means of factors by respondent's occupation, Counselor/Therapist accounted for the majority of respondents (53%), while Supervisor/Administrators (21%), Case Managers (20%), and Nurses (6%) accounted for the remainder of respondents in the sample. The profile of occupational groups in Table 4 shows considerably low differentiation between occupational groups relative to each of the five OMI-defined factors. The greatest difference between any two groups is the mean score for Nurses (1.97) on the Interpersonal Etiology factor and the mean score for Counselor/Therapist (3.34) on the Benevolence factor. The clustering of mean scores for the four occupational groups shows a nearly undistinguishable pattern, making it difficult to discern any statistically significant tendencies toward a particular attitude domain.

Individual occupation groups also showed small within-group differences between mean scores for each of the five attitude factor variables. For example, Nurses showed the greatest difference between mean scores on the Interpersonal Etiology variable (1.97) and the Benevolence (3.47) variable. By comparison, the greatest distance for the overall group was between the Interpersonal Etiology variable (2.76) and the Benevolence variable (3.22). Again, these differences are not statistically significant.

Table 4
Mean of Factors by Respondent's Occupation

		AVG1	AVG2	AVG3	AVG4	AVG5
Counselor/Therapist	Mean	2.6107	3.3494	3.1280	2.6326	2.5994
	N	46	46	46	46	46
	SD	.9993	.5772	.2963	.9613	1.0786
Case Manager	Mean	3.2674	2.9244	3.3007	3.2000	3.1933
	N	17	17	17	17	17
	SD	.9521	.5079	.3305	.8761	1.1122
Nurse	Mean	2.4545	3.4714	3.4000	2.3200	1.9714
	N	5	5	5	5	5
	SD	1.0890	.5903	.2558	1.0281	1.0122
Supv/Administratoor	Mean	2.9596	3.1349	3.2284	2.8389	2.9921
	N	18	18	18	18	18
	SD	1.1796	.5156	.2542	1.0404	1.2526
Total	Mean	2.8044	3.2276	3.1990	2.7698	2.7625
	N	86	86	86	86	86
	SD	1.0530	.5712	.3006	.9798	1.1447

AVG1 = Authoritarianism

AVG2 = Unsophisticated Benevolence

AVG3 = Mental Hygiene Ideology

AVG4 = Social Restrictiveness

AVG5 = Interpersonal Etiology

Impact of Academic Discipline on Attitudes Toward Dually Diagnosed Clients

As indicated in Table 5, most survey respondents were trained as undergraduates in the discipline area of psychology (38%). Thirty-five (35) percent of respondents indicated “other” as their area of undergraduate degree discipline, and 10 percent indicated social work as their undergraduate discipline. In considering the mean of factors by respondent’s undergraduate degree discipline, the results indicate very low average scores for the five OMI-defined variables and make no contribution to any differentiation between undergraduate discipline areas.

Table 5

Mean of Factors by Respondent’s Undergraduate Degree Discipline

		AVG1	AVG2	AVG3	AVG4	AVG5
N/A	Mean	2.5152	3.2143	3.3333	2.4333	2.5714
	N	3	3	3	3	3
	SD	1.0218	.5151	.1111	1.1060	.8571
Social Work	Mean	2.9091	3.1984	3.0864	2.7667	2.9206
	N	9	9	9	9	9
	SD	1.0295	.4414	.3323	.9721	1.2333
Rehab Counseling	Mean	2.3409	3.5000	3.3611	2.4000	2.0000
	N	4	4	4	4	4
	SD	.7973	.1304	.2778	.4967	.5345
Psychology	Mean	2.9174	3.2208	3.1886	2.8788	2.9437
	N	33	33	33	33	33
	SD	1.0566	.6046	.2933	.9367	1.1600
Nursing	Mean	2.5195	3.3571	3.3968	2.4143	2.1633
	N	7	7	7	7	7
	SD	1.1424	.6389	.2634	1.1187	1.1850
Other	Mean	2.8061	3.1786	3.1630	2.8167	2.7762
	N	30	30	30	30	30
	SD	1.1146	.6144	.3098	1.0674	1.1616
Total	Mean	2.8044	3.2276	3.1990	2.7698	2.7625
	N	86	86	86	86	86
	SD	1.0530	.5712	.3006	.9798	1.1447

AVG1 = Authoritarianism

AVG2 = Unsophisticated Benevolence

AVG3 = Mental Hygiene Ideology

AVG4 = Social Restrictiveness

AVG5 = Interpersonal Etiology

Conversely, Table 6 indicates that most survey respondents holding a graduate degree were trained in the discipline area of social work (36%, n = 31). Twenty-one (21) percent (n = 18) of respondents indicated “other” as their area of discipline, and 17 percent (n = 15) indicated psychology as their area of discipline. Twelve (12) percent (n = 12) of respondents holding a graduate degree indicated rehabilitation counseling as their area of discipline, and 7 percent (n = 5) indicated nursing as their area of discipline. Overall, the mean factors by respondent’s graduate degree discipline indicated that graduate discipline areas make no contribution to any differentiation between the five OMI-defined variables. Small individual differences were present between respondents who identified Other as their area of discipline, with Nursing on the authoritarianism and interpersonal etiology OMI-defined variables. However, these differences are not statistically significant.

Table 6

Mean of Factors by Respondent’s Graduate Degree Discipline

		AVG1	AVG2	AVG3	AVG4	AVG5
N/A	Mean	2.8182	3.0476	3.2407	2.9667	2.7143
	N	6	6	6	6	6
	SD	.7606	.5654	.2476	1.0463	.8853
Social Work	Mean	2.8152	3.2765	3.1577	2.8613	2.9263
	N	31	31	31	31	31
	SD	1.2180	.5267	.3047	1.0298	1.2360
Rehab Counseling	Mean	2.9091	2.9929	3.2889	2.9000	2.7429
	N	10	10	10	10	10
	SD	1.1233	.6167	.3321	1.0842	1.3227
Psychology	Mean	2.7030	3.3571	3.1481	2.6067	2.5143
	N	15	15	15	15	15
	SD	.9042	.6073	.2711	.8430	.9626
Nursing	Mean	2.2273	3.5000	3.4630	2.1500	1.9048
	N	6	6	6	6	6
	SD	.9213	.5642	.2156	.9566	1.0601
Other	Mean	3.0000	3.1349	3.1605	2.8167	3.0000
	N	18	18	18	18	18
	SD	.9959	.5920	.3171	.9642	1.0869
Total	Mean	2.8044	3.2276	3.1990	2.7698	2.7625
	N	86	86	86	86	86
	SD	1.0530	.5712	.3006	.9798	1.1447

AVG1 = Authoritarianism

AVG2 = Unsophisticated Benevolence

AVG3 = Mental Hygiene Ideology

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MULTIPLE ANALYSIS OF VARIANCE

In addition to descriptive statistics, multiple analysis of variance (MANOVA) was conducted to determine the extent to which the independent variables of academic discipline, levels of training and experience, occupation, and amount of contact impact MH/SA respondents' attitudes toward dually diagnosed clients. Analysis of the five dependent variables (authoritarianism, benevolence, mental hygiene ideology, social restrictiveness, interpersonal etiology) demonstrated no significant interaction effects between mental health and substance abuse professionals on any of the independent variables. Possible reasons for lack of differences may be that the factor power was too low to show any differences on the dependent variables. Conversely, while there are no statistically significant differences between the two groups, their similarities may be significant in terms of psychological value and building positive relationships. The following is a summary of results by each factor:

Authoritarianism

Results of the analysis on academic discipline ($F = .02$; $p = 1.000$), levels of training ($F = .005$; $p = 1.000$), experience ($F = 1.03$; $p = .45$), and occupation ($F = .14$; $p = 1.000$) did not reach significance in interaction effects and showed no difference between respondents working as mental health professionals and respondents working as substance abuse professionals in the authoritarian dependent variable.

Benevolence

Academic discipline ($F = .01$; $p = 1.000$), levels of training ($F = .05$; $p = 1.000$), occupation ($F = .15$; $p = .99$) and experience ($F = .67$; $p = .87$) did not reach significance in interaction effects and showed no difference between respondents working as mental health professionals and respondents working as substance abuse professionals in the benevolence dependent variable.

Mental Hygiene Ideology

Academic discipline ($F = .02$; $p = 1.000$), levels of training ($F = .00$; $p = 1.000$), occupation ($F = .18$; $p = .98$) and experience ($F = .79$; $p = .74$) did not reach significance in interaction effects and showed no difference between respondents working as mental health professionals and respondents working as substance abuse professionals in the mental hygiene dependent variable.

Social Restrictiveness

Academic discipline ($F = .03$; $p = 1.000$), levels of training ($F = .00$; $p = 1.000$), experience ($F = .99$; $p = .49$), and occupation ($F = .03$; $p = .99$) did not reach significance in interaction effects and showed no difference between respondents working as mental health professionals and respondents working as substance abuse professionals in the social restrictiveness dependent variable.

Interpersonal Etiology

Academic discipline ($F = .03$; $p = 1.000$), levels of training ($F = .00$; $p = 1.000$), experience ($F = 1.00$; $p = .47$), and occupation ($F = .03$; $p = .99$) did not reach significance in interaction effects and showed no difference between respondents working as mental health professionals and respondents working as substance abuse professionals in the interpersonal etiology dependent variable.

CHAPTER SUMMARY

The present data analyses reveal that initial attempts to create a set of variables that represented the five constructs identified on the OMI scale by Struening & Cohen (1963) resulted in 18 ill-defined factors, resulting in the calculation of mean scores based on the questions identified on the modified OMI scale. Descriptive statistics were run to determine if there were differences in measures of training, education, and work experience for the respondents identified in the mental health and substance abuse disability areas. The results indicated that the means for mental health and substance abuse respondents are virtually identical on each of the OMI-defined factors on the scale.

Multiple Analysis of Variance (MANOVA) and t-tests were conducted on each of the five factor variables in order to determine if there were statistically significant differences in attitudes of mental health and substance abuse professionals toward dually diagnosed clients. The results of these analyses indicated no statistically significant interactive effects relative to the five OMI-defined attitude factors for the two groups.

CHAPTER FIVE DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

INTRODUCTION

The purpose of this investigation was to determine whether there are differences in attitude between mental health and substance abuse professionals toward the dually diagnosed client. This investigation continues to build on established research regarding the attitudes of professionals toward persons with disabilities. A nonexperimental research design was used for this investigation to uncover the attitudes of mental health and substance abuse treatment personnel working for a local community mental health center in Northern Virginia. This chapter contains sections including the discussion of results, conclusions, implications of this investigation, limitations, and recommendations for further research.

DISCUSSION

A modified version of the 51-item OMI multidimensional attitude scale developed by Struening and Cohen (1963) was used for this investigation to address three research hypotheses: (1) MH/SA professionals will demonstrate specific attitudes; (2) there will be differences in the attitudes of MH/SA professionals; and (3) academic discipline, levels of training and experience, occupation, and amount of contact will affect MH and SA professionals' attitudes toward dually diagnosed clients. The five factors of the modified OMI scale (authoritarianism, unsophisticated benevolence, mental hygiene ideology, social restrictiveness, and interpersonal etiology) were the dependent variables; academic discipline, levels of training and experience, occupation, and amount of contact were used as the independent variables. Cohen and Struening (1962, 1963) identified that higher mean scale scores for any factor by respondents indicated greater endorsement of opinions for that factor.

A total of 86 respondents (95%) from a community-based mental health treatment facility in Northern Virginia completed the modified OMI instrument for this study. The mental health and substance abuse professionals who responded to the survey work in a community agency that recognizes the principle that mental health and substance abuse disabilities provide specialized services for dually diagnosed clients regardless of what door they should come in through. Both MH and SA disability areas have designated trained specialists capable of providing integrated treatment for individuals with dual diagnosis disorders. Typically, dually diagnosed individuals presenting to the facility with substance dependence disorders and a less serious mental illness are assigned to the substance abuse service specialists, while dually diagnosed individuals who have a substance abuse disorder and are seriously mentally ill get assigned to the mental health service specialists. Specialized integrated services are provided by these specialists and include: treatment groups, psycho-education groups, and individualized services for dually diagnosed clients in both English and Spanish.

One additional distinguishing factor to note about this agency is the co-location of outpatient mental health and substance abuse programs and services in the same facility. According to the literature, many community mental health systems operate in parallel treatment models in which the services for psychiatric and substance abuse disorders are concurrent but separate and occur in different physical locations with different staffing patterns and treatment philosophies (Minkoff, 1989; Rosenthal, Hellerstein, & Miner, 1992). This separation of services often results in fragmented care with the dually diagnosed client being shunted back and forth between mental health and substance abuse treatment facilities (Wallen, & Weiner, 1989).

Data were analyzed using descriptive statistics, t-test, and Multiple Analysis of Variance (MANOVA). The results of the statistical analysis of this investigation indicated that there were virtually no statistically significant differences between mean scores of mental health and substance abuse professionals on the five attitude factors of the OMI. The analyses also indicated that the two groups were demographically similar and that there was no significant interaction effect between mental health and substance abuse professionals on any of the independent variables (academic discipline, levels of training and experience, occupation, and amount of contact).

Attitudes of Mental Health and Substance Abuse Counselors

Mental health and substance abuse treatment systems traditionally have been designed to operate independent of one another to include having separate treatment philosophies and funding streams. The literature indicates that a history of this separate operation has led to conflicts over philosophical approaches to treatment for clients and a process of ping-pong therapy for the dually diagnosed client. Furthermore, treatment for persons dually diagnosed is documented in the literature as being challenging and difficult, with the most common result ending in failure at therapeutic engagement or relapse to substance use or both. Engagement with persons dually diagnosed by MH/SA professionals is strongly believed to be the first impact of successful treatment for this population.

The finding from the data analysis that there is no statistically significant difference in attitudes of mental health and substance abuse professionals toward the dually diagnosed client may suggest the absence of a divergence in attitude and, quite possibly, a lack of friction between these two groups as well. The apparent absence of disparate views toward dually diagnosed clients between these two personnel groups may also add some context to the outcome of this investigation. For example, the notion that organizational culture might play a role in influencing the attitudes of the mental health and substance abuse respondents who participated in this investigation can add some context to the results. Another example of context to consider is that the profile that can be drawn from the results has some similarities to occupational cluster and profiles derived from Cohen and Struening's (1963) use of the OMI instrument. A final example of context is the significance of MH and SA respondents' being co-located in the same facility and the possible influence this situation might have on their attitudes toward dually diagnosed clients.

In reference to the first example, the literature indicates that an institution of employees has a culture that influences the attitudes and behaviors of those employees (Huse & Cummings, 1985). If the organizational culture in which mental health and substance abuse professionals are employed is consistent with the theories of social influence, they will most likely compare their attitudes to the attitudes of their reference group (Baron & Misovich, 1993). Pulice & Lyman (1994) conducted a study of mental health and substance abuse provider perceptions of individuals dually diagnosed and found that both groups identified and respond to the dually diagnosed client. An area of discrepancy was that MH professionals tended to view the dually diagnosed client as more seriously disordered than did SA professionals. Because the nature of the work performed by mental health and substance abuse professionals could potentially involve them in all aspects of the lives of persons with whom they work, the likelihood that they would identify with belonging to the same unit seems probable. Yuker (1988) defines a concept called the Gestalt principle of similarity as a unit-forming theory that “posits an interdependence between a person’s liking for someone and the feeling of belongingness with that person. The strongest factor influencing the perception that two people belong to the same unit is similarity” (p. 6). Further, according to Yuker (1988), “the similarity between entities, whether they be external objects or intrapsychic events, is a powerful factor in a person’s perceiving them as a unit, as belonging together” (p. 6). Conversely, research on dissimilarity as associated with perceived differences can have inconsistent results. According to Yuker (1988), dissimilarity inducing any form of dislike leads to prejudice, although perceived dissimilarity can be seen as a compliment to oneself and lead to a positive reaction by the individual. The main point here is that the possibility for similarity between mental health and substance abuse professionals might be indicated in the results of this investigation and is too important a factor to ignore.

In addition to the possible influence of organizational culture, an examination of the mean scores to ascertain potential profiles was also considered. Cohen and Struening (1962) suggest that “one must be prepared to find all patterns of high and low scores on the five factors” (p. 356). Cohen and Struening’s (1963) study results included grouping into clusters, a range of occupational groups working in a hospital setting. Social workers, psychologists, and chief psychologists were grouped into the same occupational cluster. The authors indicated that the profile for this cluster featured a nonauthoritarian, permissive, and positive orientation toward the mentally ill that represented the general orientation of mental health professionals. While none of the OMI’s five attitude factors of authoritarianism, unsophisticated benevolence, mental hygiene ideology, social restrictiveness, and interpersonal etiology clearly demonstrated any extreme tendencies for this investigation, there are several descriptive characteristics that can nevertheless be drawn from the results. For example, the mean scores for mental health and substance abuse respondents can be interpreted overall as low average and quite possibly ambivalence because of the small differences between average mean scores across all five OMI factors. However, interpreting the differences in mean score results (although relatively slight) suggests that the mental health and substance abuse respondents in this investigation have a slightly supportive, nonauthoritarian, positively orientated profile toward dually diagnosed clients. Again, this interpretation is based on analyses of the higher mean scores for mental hygiene ideology and unsophisticated benevolence compared to the other factor scores.

Last, although much is documented in the literature about the longstanding history of separation between mental health and substance abuse professionals, the fact that the respondents in this investigation are co-located in the same facility might be significant. Although the history of separate, parallel mental health and substance abuse treatment systems dates back many years, many believe the first major step toward this type of organization occurred with the passage of the Drug Office and Treatment Act in the early 1970s (Osher & Drake, 1996). Since then, a great deal of the research focusing on the dually diagnosed population has acknowledged that many states and localities across the country not only lack a common administrative structure for alcohol, drug, and mental health services but that the majority of these systems have separate treatment facilities as well (Drake, et al., 1996; Drake, et al., 1998; Ridgely & Dixon, 1995; Sciacca & Thompson, 1996).

Services occurring in separate treatment systems results in clients emerging from either system with unmet needs. Ryglewicz and Pepper (1992) state that “it is also a system failure that reinforces the lack of a perceived connection between substance abuse and the persistence of psychiatric symptoms. Failure of the treatment system to respond to the needs of dual-disorder clients has three aspects: a) limitations within the mental health system; b) limitations within the substance abuse system; and c) lack of integration between the two systems” (p. 80). Many experts have recommended integrating treatment within one system for dually diagnosed clients. The anticipated consequence of integration would be that one group or team of clinicians would address both disorders concurrently in the same setting (Drake, et al., 1996). The creation of a co-located social atmosphere might be significant in reducing the perceived separateness between mental health and substance abuse professionals.

Education

The research literature indicates that a relationship exists between education and attitudes. In general, a person, group, or label is a source for attitude change. As the amount of education increases, the tolerance for people who are viewed as different also increases (Jones, et. al., 1984; Myers, 1990). Cohen and Struening (1962, 1963) also found educational grouping differences on the OMI scale in their research that were more strongly related to the Mental Hygiene Ideology factor. In this investigation, the overall mean scores on the five factor variables did not demonstrate significant differences between undergraduate and graduate discipline areas. The mean scores of respondents with an undergraduate degree were low average and scattered almost evenly across the five factor variables. The mean scores of respondents holding a master’s degree were similar to undergraduates in that they were low average scores, although the highest mean scores clustered into two factor areas: Unsophisticated Benevolence and Mental Hygiene Ideology factor variables.

However, one perspective to consider in analyzing the results is the influence of the professional identity of respondents who participated in this investigation. The four major professional categories included in this investigation were: 1) social work; 2) rehabilitation counseling; 3) psychology; and 4) nursing. Most survey respondents were trained as undergraduates in the discipline area of psychology (38%), while most holding a graduate degree were trained in the discipline area of social work (36%). Each academic label carries an

orientation to which the student identifies to give her or him a sense of credibility and professionalism. For example, an educational program in rehabilitation counseling emphasizes to students the learning of a unique process of increasing the effective functioning of impaired individuals through coordinated, goal-oriented, and comprehensive services (Wright, 1983). This professional identity may influence, for example, a student's opinion about mental illness or substance abuse and bring it more in line with the mental hygiene ideology factor. When a student graduates with a specialty in rehabilitation counseling, subsequent attitudes are most likely to continue to be congruent with this professional identity and be carried into a work environment. A different example of profession identity was suggested by Drolen (1993), who reported that some social work students seek a master's degree to avoid employment with the seriously mentally ill adult, while others are drawn to master's programs expressly to learn more about work with this population. A number of studies indicate that social workers prefer careers with less chronic patients, have a propensity toward private sector practice, and view the seriously mentally ill as the least desirable type of client (Drolen, 1993; Minkoff, 1987).

Therefore, because the original OMI was designed for hospital personnel in the 1960s, it may be that attitudes of professionals working in the community may not be significantly different on the modified OMI instrument used for this investigation. According to Lieberman (1970), those most tolerant of individuals with mental disorders tend to be best informed about them. Lieberman's point seems to hold some significance for the results of this investigation.

Levels of Training and Experience

Given the differing philosophies of treatment between mental health and substance abuse treatment systems, it is reasonable to expect differences in curriculum and training to the degree that information about students would be disparate. This may be an especially reasonable assumption because substance abuse treatment has historically not been the focus of psychiatry, psychology, and social work academic programs. From a research perspective, the literature suggests that the nature of training does not correspond with the actual behaviors of graduate professionals. Furthermore, according to Bernstein and Lecomte (1982), other researchers have cautioned that experience level, when studied, frequently has been confounded with level of training. However, the literature does predict the existence of a relationship between experience and attitudes. According to Yuker (1988), several researchers found that years of service working with the mentally ill had an effect upon attitude development. For example, Perry (1974) reported after using a modified OMI that unfavorable attitudes such as social restrictiveness and authoritarianism increased with years of experience, while favorable attitudes decreased. Creech (1977) correctly predicted that subjects' scores on the interpersonal etiology factor would increase as a result of a nursing course that included direct experience with persons with mental illness. The interpersonal etiology factor is a cognitive factor reflecting the belief that mental illness arises from interpersonal experience, especially deprivation of parental love during childhood (Cohen & Struening, 1962).

For this investigation, contrary to expectations, the results indicated no significant interaction effects between mental health and substance abuse professionals on the independent variables training and years of experience. Interestingly, on average the vast majority of substance abuse professionals (69%) and mental health professionals (63%) had 15 or more years of direct experience. Apparently, as professionals for this investigation gain experience in working with persons dually diagnosed, they do not strongly endorse statements about the cause, treatment, and prognosis for the dually diagnosed population. It is also interesting to note that 42 percent of mental health respondents reported that between 5 percent and 25 percent of clients on their caseloads are dually diagnosed, in comparison to 32 percent of substance abuse professionals. This is significant because contact with persons with disabilities has been recognized as a powerful influence on attitude formation, and high levels of contact are generally associated with positive attitudes. Couple this with the fact that the OMI was designed for and factor analyzed on personnel working in a hospital setting. The professionals participating in this investigation work in the community, and their attitudes may not be significantly different on the scale used for this research study. Furthermore, no personnel of the selected agency working in a hospital setting were included in this investigation, and this may have affected the results as well.

Occupation

While the results in the present investigation yielded results that show no statistically significant tendencies for occupation on the five attitude factor variables, the mean scores of the four occupational groups can be analyzed further. According to the literature, occupational classification has been identified as affecting the pattern of scores obtained on the OMI scale. Cohen and Struening (1961, 1962, 1963) identified four occupational clusters with different profiles using the OMI scale. One cluster, Blue Collar Workers, included psychiatric aides and

kitchen workers. Another cluster, White Collar Workers, included technicians, nurses, and dentists, while the third cluster included psychologists and social workers. The fourth cluster comprised the clergy. All four occupational clusters formed by Cohen and Struening identified different profiles for each occupation. The literature further supports the position that an institution of employment has a culture that influences the attitudes and behaviors of employees (Huse & Cummings, 1985), a view that is consistent with theories of social influence of attitude change.

In this investigation, the majority of mental health and substance abuse respondents made up the occupation group categorized as Counselor/Therapist (53%). Supervisor/Administrators (who are also clinically trained professionals) made up 21%, while Case Managers (20%) and Nurses (6%) accounted for the remainder of respondents in the sample. The Counselor/Therapist (3.3) and Nurse (3.4) groups had their highest mean scores occur on the benevolence factor of the modified OMI scale, while Case Managers (3.3) and Supervisor/Administrators (3.2) had their highest mean scores occur on the mental hygiene ideology factor. According to Cohen and Struening (1962), Benevolence is:

. defined as a kindly paternalism which is encouraging and nurturing but is based on religion and humanism rather than professionalism or science. This is a type of view that is pro-mental illness in that clients are seen not as failures in life but rather like children, and it is wrong to laugh about them (p. 111).

While the mean scores of Nurses for this investigation were similar to the high benevolence profile of Nurses described by Cohen and Struening (1963), it is important to note that the profile for mental health professionals in that same study featured higher scores on the mental hygiene ideology factor. In analyzing the mean scores, it is important to also consider the nature of the work performed by the Counselor/Therapists and Nurses employed in a community-based outpatient setting. The atmosphere and agency culture of this setting may encourage a nurturing and paternalistic view of the dually diagnosed client. Mental health workers in community-based outpatient settings generally find themselves in jobs that demand that they function in multiple roles while serving a priority population of seriously mentally ill clients. Mental health workers typically function in multiple roles including therapist, sponsor, nurse, teacher, and administrator. These roles add up to functions that do not mix well because they typically cover a wide variety of therapeutic and nontherapeutic tasks. The key point is that the likelihood these mental health workers can strictly perform therapy functions is probably impractical and most likely unrealistic. Nurses employed in community-based settings also function in multiple roles with the seriously mentally ill client. Typical functions for nurses working in an outpatient setting include administering injections and medication, promoting health, counseling, and advocating. Because Nurses rarely see individuals who are not severely disordered or behaviorally disruptive, developing a protective, paternalistic attitude may be a reflection of their experience with the dysfunctional aspects of the people with whom they work. Other research using the OMI (Creech, 1977) to study the attitudes of nurses found that low scores on the authoritarian and social restrictiveness factors were more consistent with nurses having contact with psychiatric patients versus nurses with little to no contact with this population.

Similarly, substance abuse professionals generally serve a higher-functioning client in a community-based outpatient setting, but their role is also multifunctional in nature. Most commonly, outpatient substance abuse counselors emphasize counseling, addiction education, and training in social skills with a focus on helping the client break free of circumstances that support continued substance use. Substance abuse counselors typically function in roles including counselor; teacher; nurse; and legal, financial, and vocational advisor. As a result of the multiple roles typically defining the jobs of mental health and substance abuse professionals in community-based settings, the responsibility for coordinating the care of clients over an indefinite period of time may encourage a nurturing and paternalistic attitude. The literature documents the dually diagnosed client as being challenging, difficult to engage, and often resistant to treatment recommendations in outpatient settings. Although the overall mean score is not strongly represented in the results, the fact that the unsophisticated benevolence factor had the highest mean score may represent how the respondents view the dually diagnosed client or may be a reflection of the culture of the agency.

Case managers and Supervisor/Administrators had higher mean scores on the mental hygiene ideology variable. According to Cohen and Struening (1963), mental hygiene ideology is:

a positive orientation which embodies the beliefs of the present day mental health worker and the tenets of the mental hygiene movement. Implicit in this conception is the idea that mental patients are much like normal people, differing in degree but not in kind. The core concepts are partially summarized by the item "mental illness is an illness like any other" (p. 111).

Generally speaking, case managers are responsible for providing a high-intensity level of care in community-based outpatient settings. The case manager is also responsible for the day-to-day functioning of the clients on their caseload and carry out this responsibility by performing the planning, implementation, or coordination—or all three—of all aspects of care. Because the case manager's function/role with the client is a primary one, engaging and developing a relationship with the client is critical. The priority population of clients often engaged by mental health or substance abuse case managers in an outpatient setting is likely going to comprise the most seriously impaired with multiple treatment needs. One would think that the case managers as a group would have had higher mean scores on the unsophisticated benevolence or social restrictiveness variables because of the nature of their work. The fact that the case managers scored higher on the mental hygiene ideology variable could translate to a view of the dually diagnosed client that forfeits control and a focus on the dysfunctional aspects of the individual for a positive, permissive orientation toward the dually diagnosed client.

The Supervisor/Administrator group had their highest mean score occur on the mental hygiene ideology variable. Of particular interest is the finding that Supervisors/Administrators, though clinically trained, differed from the direct care Counselor/Therapist group in their mean scores for this factor. Perhaps this result suggests a difference in perception between the two groups. One reason for this interpretation could be that Supervisor/Administrators are removed from regular interaction with behaviorally difficult clients and are therefore less affected by

them. In fact, because these workers are not used to dealing with behaviorally difficult clients, they may be more prone to perceive dually diagnosed clients from a positive, permissive, and philosophical point of view. Other studies such as the one conducted by Pulice, et. al. (1994), have demonstrated differences between administrators and direct care providers in their perceptions of the dually diagnosed client.

Typically, much of the client-specific information routinely processed by Supervisor/Administrators comes in the form of secondhand reports and verbal conversations with subordinate staff. This removal from the direct treatment setting may influence the attitudes of Supervisor/Administrators because they are forced to rely on the secondhand information. Another way to view the Supervisor/Administrator group is to recognize that their overall mean score profile could be indicative of a positive, nonauthoritarian, and permissive pattern, with an orientation toward mental health concepts. It could, therefore, be said that this type of profile might be expected from professionals functioning in a leadership capacity. Although staff responsible for direct care typically handles a multiproblem, behaviorally difficult client population, the intended culture or atmosphere promoted by agency leaders may be to encourage a positive view toward clients that includes endorsing the idea that "mental illness is an illness like any other."

CONCLUSION

Research in the area of dual diagnosis has primarily focused on the treatments and programs with little attention paid to the attitudes of professionals toward dually diagnosed clients. Widespread endorsement of integrated dual diagnosis services has become popular in the research literature, and while cross-training professionals is emphasized, there continues to be agreement that the widespread implementation of integrated dual diagnosis programs and services has not occurred (Drake, et. al., 2001). The barriers known to hinder implementation of integrated services are well documented in the literature and include organizational, policy, and financial barriers. However, there also continues to be a general lack of attention in addressing the significance of the attitude differences of a diverse, multidisciplinary group of treatment professionals. The goal of the present study was to add to the body of knowledge and information on the differences in attitudes of mental health and substance abuse professionals toward persons dually diagnosed and to recommend strategies that would be helpful for the elimination of barriers to treatment. The results of the present study shed no new light on the differences in attitudes of mental health and substance abuse professionals toward dually diagnosed clients. However, the findings did suggest some descriptive patterns that reflect a positive view toward the dually diagnosed client. The atmosphere of agency culture and the significance of co-location of mental health and substance abuse professionals were also potentially important factors in the outcome of the present study. More important, the findings support the significance and need for further research on the attitudes of mental health and substance abuse professionals toward persons dually diagnosed.

IMPLICATIONS OF THE CURRENT STUDY

The attitudes of professionals toward people with disabilities may be related to what the professionals know and understand about disabilities or to whether they have feelings of like or dislike for persons with disabilities. According to Horne (1985), the components of attitudes include affect, cognition, and conation. Affect refers to emotional responses directed toward the attitude referent. Cognition refers to an individual's knowledge, thoughts, and beliefs about the attitude referent, while conation refers to an individual's intentions or behaviors with respect to the attitude referent. In Antonak & Livneh's (1988) social circle of attitudes toward persons with disabilities model, attitudes operate in three interacting circles: an inner circle composed of the attitudes of the relatives, friends, and peers of the person with a disability; a middle circle comprising the attitudes that professionals have toward persons with disabilities; and an outer circle of the attitudes that society has toward persons with disabilities. In this model, the members of each attitudinal circle influence the attitudes of the members of the other circles, which then affect the lives of people who have disabilities. Considering the fact that the three components of attitudes (affect, cognition, and conation) are interrelated, Antonak and Livneh (1988) suggest that the factors known to influence attitude formation and change must be researched in order to determine how negative attitudes can be changed. Because mental health and substance abuse professionals hold a social and professional position to affect the socialization, employment, and quality of life of people dually diagnosed, any negative attitudes present will result in reinforcing the stigma of devalued status that these persons already have to overcome.

The goal of this present study was to focus on the middle circle: the professionals who work closely with people with disabilities. More specifically, the two groups of professionals having the most impact upon the lives of persons dually diagnosed with mental illness and substance abuse disorders are mental health and substance abuse professionals. According to Antonak and Livneh (1988), when measuring attitudes, the intent is to get at stereotypes, at attitudes that are tied to the label designating the group. The results of the present study revealed no differences in the attitudes of mental health and substance abuse professionals toward dually diagnosed clients. An observation made by this researcher to consider as an implication of this research study is that the modified OMI instrument contained a high number of negatively focused questions leaving one to wonder whether a particular mindset for answering the questions became a factor for respondents. According to Yucker (1988), attitude tests frequently, but not always, are characterized by negatively focused items. These negatively loaded items can contribute to a 'negative mindset' and lead to unfortunate consequences. One example might be that a negative response bias could be the result of negatively worded questions influencing thinking toward the negative side of possibilities. It is this researcher's opinion that the other possibility is that the gap between the time of the original study and the present study (40 years) has dated the basic premise of the five dimensions of the OMI instrument. This is despite the fact that the instrument was modified and piloted by a pool of dual diagnosis experts.

Another implication of the present research study is to consider the vantage point of the respondents participating in the investigation. Because this researcher is known by many of the respondents, the conditions for this study included an investigator whose status was positive. In the context of attitude studies, Beatrice (1988) describes a type of response intensification that

can occur and lead to a decidedly positive (or negative) context. Beatrice (1988) likens the different context in which the subjects and experimenter perceived the situation to differences in perspectives of insiders and outsiders. Beatrice goes on to suggest that:

Researchers must be aware of possible differences in perspectives between themselves and subjects, especially in terms of issues of the saliency and context of variables under study (p. 14).

Although the impact of the aforementioned statement is unknown, the context it describes seems relevant to the present research study.

A third implication to consider is the social atmosphere or agency culture. As mentioned earlier in this study, if the organizational culture in which mental health and substance abuse professionals are employed is consistent with the theories of social influence, they will most likely compare their attitudes to the attitudes of their reference group (Baron & Misovich, 1993). Therefore, agency administrators at this local community-based mental health center may be advised (if they are not already sensitive) to explore agency policies and agency culture to determine whether the policies and culture are promoting positive or negative attitudes and behavior toward client populations as well as toward professional relationships.

LIMITATIONS

The present research study is one of only a few to investigate the attitudes of mental health and substance abuse professionals toward persons dually diagnosed. As far as this researcher is aware, this modified OMI is a unique multidimensional attitude assessment instrument used to survey a multidisciplinary professional population. Analysis of non-respondents was not performed, as it was not possible to access these individuals beyond the original research design. However, because the present research study captured 95% of the sample, the data can be viewed as strongly representative of the population surveyed. Other uncontrolled variables that may have confounded the results of this study include the example of a respondent's personal experience with mental illness, substance abuse, or a dual diagnosis as a primary and/or secondary consumer of mental health or substance abuse services. Other limiting factors include: 1) the small sample size of this study limits the generalizability of the results; 2) use of a modified version of the OMI in a community-based outpatient setting differs from the original design of the OMI instrument; and 3) the knowledge and awareness of mental health professionals has most likely evolved, and substantial changes in philosophy, research findings, and subsequent treatment methods have occurred since the original research conducted by Cohen and Struening in a hospital setting during the 1960s.

RECOMMENDATIONS FOR FUTURE RESEARCH

The results of the present study advance the need for continued research on the attitudes of professionals toward persons with disabilities, and recommendations for future research include:

1. Although there were no significant differences between the two groups of professionals, it is possible that there may be differences with a larger sample size. A sample size of five cases for each variable is generally needed to run a factor analysis. The researcher suggests that future studies consider administering the modified OMI instrument with a larger sample of mental health and substance abuse professionals to determine whether any differences between the two groups are present.
2. Historically, there have been a number of barriers to the provision of appropriate treatment for dually diagnosed individuals. Most notably, the mental health and substance abuse treatment systems operate independent of one another, often as separate cultures and in separate facilities. Because this researcher was not actively aware of the uniqueness of mental health and substance abuse professionals being co-located in the same facility, it is recommended that future studies consider including both separate and co-located facilities as part of replicating the present research investigation.
3. Cohen and Struening (1962) designed the original OMI instrument with the goal of developing measures of the salient dimensions underlying opinions about severe mental illness among hospital personnel. They further considered the idea that hospital employees created the attitudinal atmosphere and played a role in the success of reintegrating patients into society. Cohen and Struening (1962) therefore divided hospital personnel having daily patient contact into ten occupational groups. Because this present research included only two professional groups having contact with persons dually diagnosed, replication of this study should broaden the occupational groups having contact with this client population.
4. Because the attitudes displayed by mental health and substance abuse professionals toward the dually diagnosed client can have important implications for identifying behavior targets for training purposes, quite possibly reducing or eliminating barriers to appropriate treatment, this researcher suggests that future studies include attitudes assessment strategies in all multidisciplinary training programs designed for treating the dually diagnosed client in order to elicit attitudes toward as well as enhance knowledge of treating the dually diagnosed client.
5. The original study by Cohen and Struening was conducted in the 1960s using the OMI on hospital personnel in an inpatient setting. Because this investigation used a modified OMI for assessing the attitudes of professionals employed at a community-based program, it is recommended that future research be conducted to better determine the precision of using the OMI in a community-based outpatient setting.
6. According to Bernstein and Lecomte (1982), training level among different groups of professionals was distinct from level of experience. Yucker (1988) reported that a relationship existed between experience and attitude. Because the results of this investigation failed to yield any significance in this area, it is recommended that future research include these variables to further clarify their significance for this type of study.
7. Because many community-based mental health and substance abuse programs face the dilemma of providing appropriate treatment to the dually diagnosed client population, a predictive study that would compare attitudes about persons dually diagnosed with client outcomes would be another helpful perspective to consider.
8. Professionals in both the treatment and research communities have expressed concern about research findings not having an impact on the service delivery in the community. Historically, curriculum and training on addiction have not been included in traditional academic programs

such as social work, school guidance, psychology, and psychiatry. Subsequently, most training programs do not produce professionals who can assess and treat substance use disorders as well as they can treat other common psychological conditions (Carey, Bradizza, Stasiewicz, & Maisto, 1999). Research focusing on treating the dually diagnosed as well as the on attitudes of professionals who will be working with that population will support the integration of substance abuse education into said programs and indirectly have an impact on the quality of professionals completing these training programs.

9. It is apparent in the research literature that there is no consensus on specific dual diagnosis treatment approaches, be they individual counseling, group treatment, family intervention, housing, or medications. Future research should also include the assessment of attitudes of professionals and persons dually diagnosed as part of ongoing research to ensure that a comprehensive treatment approach is ultimately developed.

10. Also apparent is the perception that the substance abuse and mental health communities first need to develop a shared perspective and learn to speak the same language before any progress can be made toward working closely together with the dually diagnosed population.

CHAPTER SUMMARY

This chapter included a discussion of the results of the present study, conclusions, the implications of the results for mental health and substance abuse professionals, limitations of the study, and recommendations for future research.

REFERENCES

- Ajzen, I. (1988). Attitudes, personality, and behavior. Chicago: Dorsey.
- Ajzen, I. (1993). Attitudes Theory and the attitude-behavior relation. In D. Krebs & P. Schmidt (Eds.). New directions in attitude measurement. (pp. 41-58). Berlin: Walter deGruyer.
- Allison-Bolger, V. Y. (1999). The original sin of madness: how psychiatrists can stigmatize their patients. International Journal of Clinical Practice, 53(8), 627-630.
- Ananth, V., Vandewater, S., Kamal, M., Brodsky, A., Gamal, R., and Miller, M. (1989). Missed diagnosis of substance abuse in psychiatric patients. Hospital and Community Psychiatry, 40(5), 297-299.
- Antonak, R., and Livneh, H. (1988). The measurement of attitudes toward people with disabilities: Methods, psychometrics, and scales. Springfield: Thomas.
- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders. (4th ed.). Washington, D.C.: Author.
- Bagozzi, R. P., Baumgartner, H., and Yi, Y. (1992). State versus action orientation and the theory of reasoned action: An application to coupon usage. Journal of Consumer Research, 18, 505-518.
- Bandura, A. (1996). Social foundations of thought and action: A social cognitive theory. Englewood Cliffs, NJ: Prentice-Hall.
- Barreira, P., Espey, B., Fishbein, R., Moran, D., and Flannery, R. B. (2000). Linking substance abuse and serious mental illness service delivery systems: Initiating a statewide collaborative. The Journal of Behavioral Health Services and Research, 27(1), 107-113.
- Beeder, A., and Millman, R. (1992). Treatment of patients with psychopathology and substance abuse. In Lowinson, J., Ruiz, P., Millman, R., Langrod, J., (Eds.), Substance abuse: A comprehensive textbook (2nd ed., pp. 675-60). Baltimore: Williams and Wilkins.
- Bentler, P. M., and Speckart, G. (1981). Attitudes cause behavior: A structural equation analysis. Journal of Personality and Social Psychology, 40, 226-238.
- Bernstein, B. L., Lecomte, C. (1982). Therapist expectancies: Client gender, and therapist gender, profession, and level of training. Journal of Clinical Psychology, 38(4), 744-754.
- Bhugra, D. (1989). Attitudes towards mental illness: A review of the literature. Acta Psych Scand 80, 1-12.
- Bogdan, R., and Biklen, D. (1993). Handicapism. In M. Nagler (Eds.). Perspectives on disability (pp. 69-76). California: Health Markets Research.

Brown, A. L., and Saura, K. (1996). Vocational rehabilitation needs of individuals dually diagnosed with substance abuse and chronic mental illness. Journal of Applied Rehabilitation Counseling, 27(3), 3-10.

Brown, F., Amos, J., and Mink, O. (1975). Statistical Concepts: A Basic Program. New York: Harper and Row.

Brown, M., and Basel, D. (1988). Understanding differences between mental health and vocational rehabilitation: A key to increased cooperation. Psychosocial Rehabilitation Journal, 12(2), 23-33.

Brown, S., (1985). Treating the Alcoholic: A Developmental Model of Recovery. New York: John Wiley.

Brown, V., Ridgely, M., and Levine, I. (1989). The dual crisis: Mental illness and substance abuse. American Psychologist, 44(3), 565-569.

Brunton, K. (1997). Stigma. Journal of Advanced Nursing, 26, 891-898.

Carey, K. B., Bradizza, C. M., and Stasiewicz, P. (1999). The case for enhanced addictions training in graduate programs. The Behavior Therapist, 27-31.

Champlain, L., and Herr, S. (1999). Double jeopardy: Some legal issues affecting persons with dual diagnoses. In A. Lehman and L. Dixon (Eds.). Double jeopardy: Chronic mental illness and substance use disorders. Baltimore: Harwood Academic.

Chiert, T., Gold, S. N., and Taylor, J. (1994). Substance abuse training in APA accredited doctoral programs in clinical psychology. Professional Psychology: Research and Practice, 25(1), 80-84.

Clement, J., Williams, E., and Waters, C. (1993). The client with substance abuse/mental illness: Mandate for collaboration. Archives of Psychiatric Nursing VII (4), 189-196.

Cohen, J., and Struening, E. (1959). The factors underlying opinions about mental illness in the personnel of a large mental hospital. American Psychologist, 339.

Cohen, J., and Struening, E. (1960). Attitudes toward the mentally ill of psychiatric hospital personnel as a function of occupation, education, sex and age. American Psychologist, 15, 417.

Cohen, J., and Struening, E. (1962). Opinions about mental illness in the personnel of two large mental hospitals. Journal of Abnormal and Social Psychology, 64 (5), 349-360.

Cohen, J., and Struening, E. (1963). Opinions about mental illness: Mental hospital occupational profiles and profile clusters. Psychological Reports, 12, 111-124.

Cohen, J., and Struening, E. (1964). Opinions about mental illness: Hospital social

atmosphere profiles and their relevance to effectiveness. Journal of Consulting Psychology, 28(4), 291-298.

Cohen, J., and Struening, E. (1965). Opinions about mental illness: Hospital differences in attitude for eight occupational groups. Psychological Reports, 17, 25-26.

Daley, D., Moss, H., and Campbell, F. (1987). Dual Disorders: Counseling Clients with Chemical Dependency and Mental Illness. Center City, MN: Hazelden.

Dielman, T. E., Stiefel, G., and Cattell, R.B. (1973). A check on the factor structure of the opinions of mental illness scale. Journal of Clinical Psychology, 29, 92-95.

Doweiko, H. (1999). Concepts of Chemical Dependency (4th ed.). California: Brooks/Cole Publishing.

Drake, R. E., Bartels, S. J., Teague, G. G. (1993). Treatment of substance abuse in severely mentally ill patients. Journal of Nervous and Mental Disease, 181, 606-611.

Drake, R. E., Mueser, K. T., Clark, R. E., and Wallach, M. A., (1996). The course, treatment, and outcome of substance disorder in persons with severe mental illness. American Journal of Orthopsychiatry, 66 (1), 42-51.

Drake, R., Mercer-McFadden, C., Mueser, K., McHugo, G., and Bond, G. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. Schizophrenia Bulletin, 24 (4), 589-608.

Drake, R. E., Wallach, M. A. (1989). Substance abuse among the chronic mentally ill. Hospital and Community Psychiatry, 40, 1041-1046.

Drolen, C. (1993). The effect of educational setting on student opinions of mental illness. Community Mental Health Journal, 29(3), 223-234.

Durlak, J. (1979). Comparative effectiveness of paraprofessional and professional helpers. Psychological Bulletin, 86(1), 80-92.

Elliott, T. R., Frank, R., Corcoran, J., Beardon, L., and Byrd, E. K. (1990). Previous personal experience and reactions to depression and physical disability. Rehabilitation Psychology, 35, 111-119.

Fawcett, J. (1992). Alcoholism and substance abuse disorder treatment can no longer be separated from psychiatric practice. Are we ready for it? Psychiatric Annals, 22(8), 401.

Fazio, R., and Zanna, M. (1981). Direct experience and attitude-behavior consistency. In L. Berkowitz (Ed.). Advances in experimental social psychology. (Vol. 14). New York: Academic Press.

Ferneau, E., and Mueller, S. (1971). Attitudes toward alcoholism among a group of college students. The International Journal of the Addiction, 6, 443-451.

Fishbein, M. (1980). Theory of reasoned action: Some applications and implications. In Howe, H. and Page, M. (Eds), Nebraska Symposium on Motivation, (pp. 65-116). Lincoln: University of Nebraska.

Fishbein, M., and Ajzen, I. (1975). Belief, attitude, intention, and behavior: An introduction to theory and research. Reading: Addison-Wesley.

Foreman, R., Bovasso, G., and Woody, G. (2001). Staff beliefs about addiction treatment. Journal of Substance Abuse Treatment, 21, 1-9.

Geskie, M., and Salasek, J. (1988). Attitudes of health care personnel toward persons with disabilities. In H.E. Yuker (Ed.). Attitudes toward persons with disabilities. (pp. 187-200). New York: Springer.

Gething, L. (1982). A preliminary report on the Cumberland disability program. Australian Rehabilitation Review, 6(2), 58-62.

Goffman, I. (1963). Stigma: Notes on the management of spoiled identity. New Jersey: Prentice-Hall.

Gravetter, F., and Wallau, L. (1997). Essentials of Statistics for the Behavioral Sciences. California: Brooks/Cole.

Hahn, H. (1988). The politics of physical differences: Disability and discrimination. Journal of Social Issues, 44 (1), 39-47.

Hall, R. C., Poplin, M. K., DeVaul, R. (1977). The effect of unrecognized drug abuse on diagnosis and therapeutic outcome. American Journal of Drug and Alcohol Abuse, 4, 455-465.

Hamilton, D. (1979). A cognitive-attributional analysis of stereotyping. Advances in Experimental Social Psychology, 12, 53-84.

Heinemann, W., Pellander, F., Vogelbusch, A., and Wojtek, B. (1981). Meeting a deviant person: Subjective norms and affective reactions. European Journal of Social Psychology, 11, 1-25.

Hellerstein, D., Rosenthal, R., and Miner, C. (1994). A prospective study of integrated outpatient treatment for substance abusing schizophrenic patients. The American Journal on Addictions, 4 (1), 33-42.

Hogg, M., and Terry, D. (2000). Attitudes, Behaviors, and Social Context. New Jersey: Lawrence Erlbaum Associates.

Howland, R. (1990). Barriers to community treatment of patients with dual diagnoses. Hospital and Community Psychiatry, 41 (10), 1134-1135.

Jacobs, M., and Warner, B. (1981). Interaction of thereapeutic attitudes with severity of clinical diagnosis. Journal of Clinical Psychology, 37, 75-82.

- Jaffe, J. (1966). Attitudes of adolescents towards the mentally retarded. American Journal of Menatal Deficiency, 70, 907-912.
- Jerrell, J., and Ridgely, S.M. (1995). Comparative effectiveness of three approaches to serving people with severe mental illness and substance abuse disorders. The Journal of Nervous and Mental Disease, 183 (9), 566-576.
- Jerrell, J., and Ridgely, S. M. (1995). Evaluating changes in symptoms and functioning of dually diagnosed clients in specialized treatment. Psychiatric Services, 46, 233-238.
- Jones, E., (1974). The hierarchical structure of attitudes toward the exceptional. Exceptional Children, 40, 430-442.
- Jones, E., Farina, A., Hastoff, A., Markus, H., Miller, D., and Scott, R. (1984). Social stigma: The psychology of marked relationships. New York: Freeman.
- Jones, B. E., and Katz, N. D. (1992). Madness and addiction: Treating the mentally ill chemical abuser. Journal of Health Care for the Poor and Underserved, 3(1), 39-48.
- Kelly, S., Benschoff, J. (1997). Dual diagnosis of mental illness and substance abuse: Contemporary challenges for rehabilitation. Journal of Applied Rehabilitation Counseling, 28 (3), 443-49.
- Kilty, K.M. (1981). Drinking status and stigmatization. American Journal Drug Alcohol Abuse, 8 (1), 107-116.
- Knight, B. (1986). Therapists' attitudes as explanations of underservice of elderly in mental health. International Journal of Aging and Human Development, 22 (4), 261-269.
- Knopf, A. (1992). How dual diagnosis is affecting the substance abuse treatment field: Mediplex psychiatrist on treating mentally ill addicts. Business Research Publications, 23(3), 1-3.
- Knox, W.J. (1976). Attitudes of psychologists towards drug abusers. Journal of Clinical Psychology, 32, 179-188.
- Lehman, A., and Dixon, L. (1995). Double Jeopardy: Chronic Mental Illness and Substance Use Disorders. Baltimore: Harwood Academic.
- Link, B., and Cullen, F. (1986). Contact with the mentally ill and perceptions of how dangerous they are. Journal of Health and Social Behavior, 27, 289-303.
- Link, B., Struening, E., Rahav, M., Phelan, J. C., and Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnosis of mental illness and substance abuse. Journal of Health and Social Behavior 38, 177-190.
- Livneh, H. (1982). On the origins of negative attitudes toward people with disabilities. Rehabilitation Literature, 43, 338-347.

Lyons, M., and Haynes, R. (1993). Student perceptions of persons with psychiatric and other disorders. American Journal of Occupational Therapy, 47 (6), 54-548.

Mackey, R. (1969). Views of caregivers and mental health groups about alcoholism. Quarterly Journal of Studies on Alcohol, 30, 665-671.

Makas, E. (1993). Getting in touch: The relationship between contact with and attitudes toward people with disabilities. In M. Nagler (Eds.). Perspectives on Disability. California: Health Markets Research.

Marshall, L. (1992). Defining MMPI-2 profiles of dually diagnosed substance abusers: The effect of counselor attitude and levels of training on treatment outcome. Unpublished doctoral dissertation, Kent State University: Ohio.

McKelvy, M. J., Kane, J., and Kellison, K. (1987). Substance abuse and mental illness: Double trouble. Journal of Psychosocial Nursing, 25 (1), 20-25.

McLellan, A.T., Woody, G., and Lubrosky, L. (1988). Is the counselor an active ingredient in substance abuse rehabilitation. The Journal of Nervous and Mental Disease, 176 (7), 423-430.

Mercer, C., Mueser, K., and Drake, R. (1998). Organizational guidelines for dual disorders programs. Psychiatric Quarterly, 69 (3), 145-168.

Miller, N. (1994). Addictions and mental health evolve under managed care. Treatment Today, 8, 5-8.

Minkoff, K. (1994). Models for addiction treatment in psychiatric populations. Psychiatric Annals, 24 (8), 412-417.

Minkoff, K. (2001). Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. Psychiatric Services, 52(5), 597-599.

Moodley-Kunie, T. (1988). Attitudes and perceptions of health professionals toward substance use disorders and substance dependent individuals. International Journal of the Addictions, 23 (5), 469-475.

Moore, G., and Castles, M. (1978). Intercorrelations among factors in opinions about mental illness scale. Psychological Reports, 876-878.

Mueser, K., Bennett, M., Kushner, M. (1995). Epidemiology of substance use disorders among persons with chronic mental illness. In A. Lehman and L. Dixon (Eds.). Double Jeopardy: Chronic Mental Illness and Substance Use Disorders. Baltimore: Harwood Academic.

Myers, D. (1990). Social Psychology. (3rd ed.). New York: Teachers College Press.

Nagler, M. (1993). Perspectives on Disability. California: Health Markets.

Ortman, D. (1997). The Dually Diagnosed: A Therapist's Guide to Helping the

Substance Abusing, Psychologically disturbed patient. New Jersey: Jason Aronson.

Osher, F. (1989). The dually diagnosed client: Patient characteristics and treatment strategies. Community Support Network News, 5, 1-11.

Osher, F., and Kofoed, L. (1989). Treatment of patients with psychiatric and psychoactive substance abuse disorders. Hospital and Community Psychiatry, 40, 1025-1030.

Osher, F., and Drake, R. (1996). Reversing a history of unmet needs: Approaches to care. American Journal of Orthoscopy, 88, 4-11.

Pedersen, P. (1990). The multicultural perspective as a forth force in counseling. Journal of Mental Health Counseling, 12(1), 93-95.

Pulice, R., Lyman, S., and McCormick, L. L. (1994). A study of provider perceptions of individuals with dual disorders. The Journal of Mental Health Administration, 21(1), 92-99.

Rabkin, J. (1972). Opinions about mental illness: A review of the literature. Psychological Bulletin, 77(3), 153-170.

Rachbeisel, J., Scott, J., and Dixon, L. (1999). Co-occurring severe mental illness and sustance use disorders: A review of recent research. Psychiatric Services, 50(11), 1427-1434.

Rea, L., and Parker, R. (1997). Designing and conducting survey research: A comprehensive guide. San Francisco: Jossey-Bass.

Reiger, D. A., Farmer, M. E., Rae, D. S. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. Results from the epidemiologic catchment area study. Journal of the American Medical Association, 264, 511-534.

Ridgely, M. S., Goldman, H. H., and Willenbring, M. (1990). Barriers to the care of persons with dual diagnosis: Organizational and financing issues. Schizophrenia Bulletin, 16 (1), 123-132.

Rogers, E., Anthony, A., and Danley, K. (1989). The impact of interagency collaboration on system and client outcomes. Rehabilitation Counseling Bulletin, 33(2), 100-109.

Rosenberg, M., and Hoveland, C. (1960). Cognitive, affective, and behavioral components of attitudes. In Hoveland, C., and Rosenberg, M. (Eds.). Attitude Organization and Change, (pp. 1-4) New Haven: Yale University Press.

Roskin, G., Carsen, M., Rabiner, C., and Marell, S. (1988). Attitudes toward patients among different mental health professional groups. Comprehensive Psychiatry, 29(2), 188-194.

Ryglewicz, H., and Pepper, B. (1992). The dual disorder client: Mental disorder and substance use. In S. Cooper and T. H. Lentner (Eds.), Managing the dually diagnosed patient, (pp. 270-290). Sarasota, FL: Professional Resource Press.

Salend, S. (1994). Strategies for assessing attitudes toward individuals with disabilities. The School Counselor, 41(5), 338-342.

SAMHSA National Advisory Council (1998). Improving services for individuals at risk of or with co-occurring substance related and mental health disorders. Rockville, MD.

Schaller, M., and Maass, A. (1989). Illusory correlation and social categorization: Toward an integration of motivational and cognitive factors in stereotype formation. Journal of Personality and Social Psychology, 56(5), 709-721.

Schukit, M. A., and Hesselbrock, V. (1994). Alcohol dependence and anxiety disorders: What is the relationship? American Journal of Psychiatry, 151, 1723-1734.

Sciacca, K., and Thompson, C.M. (1996). Program development and integrated treatment across systems for dual diagnosis: Mental illness, drug addiction, and alcoholism. Journal of Mental Health Administration, 23 (3), 288-97.

Siegfried, N., Ferguson, J., Cleary, M., Walter, G. (1999). Experience, knowledge and attitudes of mental health staff regarding patients' problematic drug and alcohol use. Australian and New Zealand Journal of Psychiatry, 33(2), 267-272.

Spengler, P.M., and Strohmer, D.C. (1994). Clinical judgmental biases: The moderating role of counselor cognitive complexity and counselor client preferences. Journal of Counseling Psychology, 41, 8-17.

Struening, E., and Cohen, J. (1963). Opinions about mental illness: Scoring, norms, and factorial invariance. Education Psychology Measurement, 23(2), 289-298.

Summers, G. (1971). Attitude Measurement. Chicago: Rand McNally.

Szymanski, E. (1991). Relationship of level of rehabilitation counselor education to rehabilitation client outcomes in the Wisconsin Division of Vocational Rehabilitation. Rehabilitation Counseling Bulletin, 35 (1), 23-37.

Szymanski, E. (1989). Relationship of rehabilitation client outcome to level of rehabilitation counselor education. Journal of Rehabilitation, 32-36.

Tabachnick, J., and Fidell, M. (1989). Using Multivariate Statistics. HarperGilins Publishers, Inc: NY, pp. 597-643.

Trafimow, D., and Fishbein, M. (1994). The moderating effect of behavior type on the subjective norm/behavior relationship. The Journal of Social Psychology, 134, 755-763.

Triandis, H.C. (1980). Values, attitudes, and interpersonal behavior. In D. Terry, M. Hogg, (Eds.). Attitudes, Behavior, and Social Context. (pp.47-48), New Jersey: Lawrence Earlbaum.

Triandis, H.C. (1971). Attitude and Attitude Change. New York: Wiley.

Tringo, J.L. (1970). The hierarchy of preferences toward disability groups. Journal of Special Education, 4, 295-306.

Walker, B.S., and Spengler, P.M. (1995). Clinical judgement of major depression in AIDS patients: The effects of clinician complexity and stereotyping. Psychology: Research and Practice, 26 (3), 269-273.

Washington Council of Governments, (1996). Treatment of Dual Diagnosis: A Policy Report for the Washington Metropolitan Region. Washington, D.C.

Wasserman, D., Mahowald, M., and Silvers, A. (1998). Disability, Difference, Discrimination: Perspectives on Justice in Bioethics and Public Policy. New York: Rowman and Littlefield.

Watkins, T., Lewellen, A., and Barrett, M. ((2001). Dual Diagnosis: An Integrated Approach to Treatment. Thousand Oaks, CA: Sage Publications, Inc.

White, W. (1998). Slaying The Dragon: The History of Addiction Treatment and Recovery in America. Bloomington, Illinois: Chestnut Health Systems/Lighthouse Institute.

Wicas, E. A., and Carluccio, L. (1971). Attitudes of counselors toward three handicapped client groups. Rehabilitation Counseling Bulletin, 15, 25-34.

Wills, T. A. (1978). Perceptions of clients by professional helpers. Psychological Bulletin, 85, 968-1000.

Wu, C., and Shaffer, D. (1987). Susceptibility to persuasive appeals as a function of source credibility and prior experience with the attitude object. Journal of Personality and Social Psychology, 52(4), 677-688.

Young, N. K., and Grella, C. E. (1998). Mental health and substance abuse treatment services for dual diagnosed clients: Results of a statewide survey of county administrators. Journal of Behavioral Health Services and Research, 25 (1), 83-92.

Yuker, H. E., (1988). Attitudes Toward Persons with Disabilities. New York: Springer-Verlag.

Yuker, H. E., Block, J. R., and Campbell, W. J. (1960). A scale to measure attitudes toward disabled persons. In Yuker (Ed.). Attitudes Toward Persons with Disabilities. New York: Springer Publishing.

Yuker, H. E., Block, J. R., and Youngg, J. (1970). The Measurement of Attitudes Toward Disabled Persons. Albertson, NY: Human Resources Center.

APPENDIX A
INFORMED CONSENT FORM
INFORMED CONSENT FORM

I. Purpose of this Research Project

The purpose of this research project is to survey the attitudes of mental health and substance abuse professionals toward dually diagnosed clients.

II. Procedures

For this study, a Likert-type survey instrument will be administered to mental health and substance abuse professionals. The survey instrument consists of 61 items and can be completed in about 20 minutes. All participants consenting to complete the survey will be oriented to the problem and purpose of the research project and given instructions for completing the survey instrument.

III. Risks

I understand that taking part in this research project will be entirely voluntary. All answers from the survey will be grouped for analysis and therefore no individual response will be attached to any individual name. Once data are transferred from survey sheets to data sheets, the original survey sheets will be destroyed.

IV. Benefits

The potential for increasing knowledge about the attitudes of professional counselors might play an important role in the delivery of services to people with mental health and substance abuse problems. However, no promise or guarantee of benefits has been made to encourage me to participate in this research project.

V. Anonymity and Confidentiality

I understand that information collected for this research project is strictly confidential. Names are **not** to be recorded on the survey sheets, nor will they be used in any way to group answers for analysis. The researcher will not discuss or describe any participant to anyone else. All analysis will be performed at group level, and once analyses are completed, all original survey sheets will be destroyed. If I notice any information on the survey that may identify any client or myself, I may eliminate that category of survey items.

VI. Freedom to Withdraw

I understand that I have the right to revoke this authorization and stop the survey process at any time.

VII. Participant Responsibility

I hereby volunteer and agree to attend the staff meeting when the survey will be administered for the research project conducted by Joseph Bullock, Virginia Tech doctoral student.

VIII. Subject's Permission

I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:

_____ Date _____

Subject Signature

_____ Date _____

Investigator Signature

APPENDIX B
LETTER OF REQUEST

John Russotto
Executive Director
Arlington County Community Services Board
Division of Mental Health and Substance Abuse Services

I am a doctoral candidate at Virginia Tech University and I am writing to request permission to do research as part of my dissertation at your agency. My research project will focus on assessing the attitude of mental health and substance abuse professionals toward persons with dual diagnosis. I want to research this topic because of the important role that attitudes of professional counselors might play in the delivery of services to people with mental illness and substance dependence disabilities.

This research project will involve administering a 61-item survey questionnaire to mental health and substance abuse professionals at your agency. The survey questionnaire will take no more than 20 minutes to complete and can be done in small groups. The questionnaire is entirely confidential and voluntary. Participants will be able to stop at any time during the survey or not respond to any particular item on the survey instrument. All answers will be grouped for analysis and therefore will not be identified as coming from any one individual.

Finally, in order to participate each respondent must sign an informed consent form that identifies the methods by which anonymity is assured. Mr. Russotto, if you want to know more about my research project, please call me at (703) 751-2310. The project has been approved by Virginia Tech University and if you have any questions about my status as a student, please contact my advisor, Dr. Octavia Madison-Colmore at (703) 538- 8483. Thank you very much in advance for your assistance.

Sincerely,

Joe Bullock
Doctoral Student Researcher

APPENDIX C
OPINIONS ABOUT MENTAL ILLNESS SCALE
(PILOT VERSION)
OPINIONS ABOUT DUAL DIAGNOSIS SCALE

Directions:

The statements that follow are opinions or ideas about mental illness, substance abuse, dual diagnosis and clients with these disorders. Mental illness means the kinds of disorders that bring clients to community mental health centers. Substance abuse means the kinds of disorders caused by the use of drugs and/or alcohol singly or in combination. Dual diagnosis means combined psychiatric and addictive disorders occurring simultaneously. It is important to know what you think about these statements. Please RATE each statement according to how favorable or relevant it is to the topics of dual diagnosis, substance abuse, and mental illness with one of the following options:

1	2	3
YES	NOT SURE	ELIMINATE
Relevant Question		

Please circle one answer on the sheet which corresponds with how you feel about each statement. There are no right or wrong answers, you are only indicating your opinion. It is important that you answer every question. **PLEASE DO NOT SIGN YOUR NAME.**

1.	Nervous breakdowns usually result when people work too hard.	1 YES	2 NOT SURE	3 ELIMINATE
2.	Mental illness is an illness like any other.	1 YES	2 NOT SURE	3 ELIMINATE
3.	Most patients in mental hospitals are not dangerous.	1 YES	2 NOT SURE	3 ELIMINATE
4.	Although patients discharged from mental hospitals may seem all right they should not be allowed to marry.	1 YES	2 NOT SURE	3 ELIMINATE
5.	If parents loved their children more, there would be less mental illness.	1 YES	2 NOT SURE	3 ELIMINATE
6.	It is easy to recognize someone who once had a serious mental illness.	1 YES	2 NOT SURE	3 ELIMINATE
7.	People with dual diagnosis let their emotions control them, normal people think things out.	1 YES	2 NOT SURE	3 ELIMINATE

8.	People who were once patients in mental hospitals are no more dangerous than the average citizen.	1 YES	2 NOT SURE	3 ELIMINATE	
9.	When a person has a problem or worry, it is best to think about it, but keep busy with more pleasant things.	1 YES	2 NOT SURE	3 ELIMINATE	
10.	Although they usually aren't aware of it, many people become mentally ill and substance dependent to avoid the difficult problems of everyday life.	1 YES	2 NOT SURE	3 ELIMINATE	
11.	There is something about dually diagnosed clients that makes it easy to tell them from normal people.	1 YES	2 NOT SURE	3 ELIMINATE	
12.	Even though clients in mental hospitals behave in funny ways, it is wrong to laugh about them.	1 YES	2 NOT SURE	3 ELIMINATE	
13.	Most dually diagnosed clients are willing to work.	1 YES	2 NOT SURE	3 ELIMINATE	
14.	People who become addicts are usually lacking in will power.	1 YES	2 NOT SURE	3 ELIMINATE	
15.	People who are successful in their work seldom become mentally ill.	1 YES	2 NOT SURE	3 ELIMINATE	
16.	People would not become mentally ill if they avoided bad thoughts.	1 YES	2 NOT SURE	3 ELIMINATE	
17.	People become addicts because they inherit a weakness for drugs.	1 YES	2 NOT SURE	3 ELIMINATE	
18.	More tax money should be spent in the care and treatment of people with dual diagnosis.	1 YES	2 NOT SURE	3 ELIMINATE	
19.	A heart patient has just one thing wrong with him, while a dually diagnosed person is completely different from other patients.	1 YES	2 NOT SURE	3 ELIMINATE	

20.	Very few people with addictions come from homes where both parents took interest in them as children.	1 YES	2 NOT SURE	3 ELIMINATE
21.	People with mental illness should never be treated in the same hospital with people with physical illness.	1 YES	2 NOT SURE	3 ELIMINATE
22.	Anyone who tries to better himself deserves the respect of others.	1 YES	2 NOT SURE	3 ELIMINATE
23.	An alcoholic's basic troubles were with him long before he had a problem with alcohol.	1 YES	2 NOT SURE	3 ELIMINATE
24.	A person would be foolish to marry someone who had a dual diagnosis problem, even though they seem fully recovered.	1 YES	2 NOT SURE	3 ELIMINATE
25.	If the children of mentally ill parents were raised by normal parents, they would not become mentally ill.	1 YES	2 NOT SURE	3 ELIMINATE
26.	Once a person becomes an addict he can never learn to use drugs occasionally again.	1 YES	2 NOT SURE	3 ELIMINATE
27.	Many clients with dual diagnoses are capable of skilled labor, even though in some ways they are very disturbed.	1 YES	2 NOT SURE	3 ELIMINATE
28.	A person who often uses drugs or alcohol to the point of being high is almost always an alcoholic or addict.	1 YES	2 NOT SURE	3 ELIMINATE
29.	Anyone who is in a hospital for a dual diagnosis problem should not be allowed to vote.	1 YES	2 NOT SURE	3 ELIMINATE
30.	The mental illness of many people is caused by the separation or divorce of their parents during childhood.	1 YES	2 NOT SURE	3 ELIMINATE
31.	The best way to recognize or spot most dually diagnosed persons is that they talk to themselves or see things that are not real.	1 YES	2 NOT SURE	3 ELIMINATE
32.	To become a client in a substance abuse treatment program is to become a failure in life.	1 YES	2 NOT SURE	3 ELIMINATE

33.	The harm done by alcoholics is generally overestimated.	1 YES	2 NOT SURE	3 ELIMINATE
34.	A person who is dually diagnosed should not be excused for a crime that he commits.	1 YES	2 NOT SURE	3 ELIMINATE
35.	If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.	1 YES	2 NOT SURE	3 ELIMINATE
36.	Nobody who drinks is immune from alcoholism .	1 YES	2 NOT SURE	3 ELIMINATE
37.	The law should allow a person to divorce their spouse as soon as they have been confined in a psychiatric hospital with a dual diagnosis problem.	1 YES	2 NOT SURE	3 ELIMINATE
38.	People (both veterans and non-veterans) who are unable to work because of psychiatric or substance abuse problems should receive money for living expenses.	1 YES	2 NOT SURE	3 ELIMINATE
39.	Mental illness is usually caused by some disease of the nervous system.	1 YES	2 NOT SURE	3 ELIMINATE
40.	Most people are uncomfortable when they learn that someone they meet has been in a substance abuse treatment program.	1 YES	2 NOT SURE	3 ELIMINATE
41.	Most women who were once patients in a psychiatric hospital could be trusted as baby sitters.	1 YES	2 NOT SURE	3 ELIMINATE
42.	Most clients who are dually diagnosed don't care how they look.	1 YES	2 NOT SURE	3 ELIMINATE
43.	College professors are more likely to become mentally ill than are business men.	1 YES	2 NOT SURE	3 ELIMINATE
44.	The dually diagnosed client is more difficult to manage and control than the normal person.	1 YES	2 NOT SURE	3 ELIMINATE

45.	Although some dually diagnosed clients seem all right, it is dangerous to forget for a moment that they are dually diagnosed.	1 YES	2 NOT SURE	3 ELIMINATE
46.	Sometimes mental illness is punishment for bad deeds.	1 YES	2 NOT SURE	3 ELIMINATE
47.	Our community mental health centers should be organized in a way that makes the client feel as much as possible like he/she is a normal person.	1 YES	2 NOT SURE	3 ELIMINATE
48.	One of the main causes of substance abuse is a lack of moral strength or willpower.	1 YES	2 NOT SURE	3 ELIMINATE
49.	Most dually diagnosed clients could not be rehabilitated even if more help were available to them.	1 YES	2 NOT SURE	3 ELIMINATE
50.	The alcoholic is basically a spineless person who has found an easy way out of his problems.	1 YES	2 NOT SURE	3 ELIMINATE
51.	All clients who are dually diagnosed should be prevented from having children by a painless operation.	1 YES	2 NOT SURE	3 ELIMINATE

52. Which primary disability area do you work for?

- A. Substance Abuse B. Mental Health

53. What is the highest level of education that you have completed?

- A. High School B. Some College/Special Training C. Bachelor's Degree
D. Master's +

54. Please indicate the category which best describes your **Undergraduate** academic program:

- A. Not Applicable B. Social Work C. Rehabilitation Counseling D. Psychology
E. Nursing F. Other _____ (please describe).

55. Please indicate the category which best describes your **Graduate** academic program:

- A. Not Applicable B. Social Work C. Rehabilitation Counseling D. Psychology
E. Nursing F. Other _____ (please describe).

56. Please circle all disability areas where you hold a specialized credential:

Substance Abuse Disorders	Mental Illness Disorders	Dual Diagnoses Disorders
------------------------------	-----------------------------	-----------------------------

57. Within the past 3 years have you had training in any of the following areas:

Substance Abuse Disorders	Mental Illness Disorders	Dual Diagnoses Disorders
------------------------------	-----------------------------	-----------------------------

58. Please circle the option that most closely matches your current job:

Counselor/Therapist Case Manager Nurse Supervisor/Administrator

59. How many years of experience do you have providing direct services to clients?

_____ Years

60. How many years of experience do you have working in a supervisory-level position or higher?

_____ Years

61. What percentage of your current caseload are diagnosed as:

_____	Substance Use Disorders
_____	Mental Illness Disorders
_____	Dually Diagnosed

(Please total 100%)

PLEASE CHECK BACK AND MAKE SURE YOU HAVE ANSWERED ALL QUESTIONS

Modified and reprinted from Cohen, J., and Struening, E.L. (1959). Factors underlying opinions about mental illness in the personnel of a large mental hospital. American Psychologist, 14, 339.

THANK YOU FOR COMPLETING THIS SURVEY. PLEASE MAKE SURE THAT YOU HAVE NOT WRITTEN YOUR NAME ON THE SURVEY. THANKS AGAIN!

APPENDIX D
OPINIONS ABOUT MENTAL ILLNESS SCALE
(REVISED)
OPINIONS ABOUT DUAL DIAGNOSIS SCALE

Directions:

The statements that follow are opinions or ideas about mental illness, substance abuse, dual diagnosis and clients with these disorders. Mental illness means the kinds of disorders that bring clients to community mental health centers. Substance abuse means the kinds of disorders caused by the use of drugs and/or alcohol singly or in combination. Dual diagnosis means combined psychiatric and addictive disorders occurring simultaneously. There are many differences of opinion about this subject. In other words, some people agree with each of the following statements while others disagree. Some people will have no opinion one way or the other. It is important to know what you think about these statements. Please respond to each statement with one of the following options:

1	2	3	4	5
strongly agree	agree	no opinion	disagree	strongly disagree

Please circle one answer on the sheet which corresponds with how you feel about each statement. There are no right or wrong answers, you are only indicating your opinion. It is important that you answer every question. **PLEASE DO NOT SIGN YOUR NAME.**

1.	Nervous breakdowns usually result when people work too hard.	1	2	3	4	5
		SA	A	NO	D	SD
2.	Mental illness is an illness like any other.	1	2	3	4	5
		SA	A	NO	D	SD
3.	Most patients in mental hospitals are not dangerous.	1	2	3	4	5
		SA	A	NO	D	SD
4.	Although patients discharged from mental hospitals may seem all right they should not be allowed to marry.	1	2	3	4	5
		SA	A	NO	D	SD
5.	If parents loved their children more, there would be less mental illness.	1	2	3	4	5
		SA	A	NO	D	SD

6.	It is easy to recognize someone who once had a serious mental illness.	1 SA	2 A	3 NO	4 D	5 SD
7.	People with dual diagnosis let their emotions control them, normal people think things out.	1 SA	2 A	3 NA	4 D	5 SD
8.	People who were once patients in mental hospitals are no more dangerous than the average citizen.	1 SA	2 A	3 NO	4 D	5 SD
9.	When a person has a problem or worry, it is best to think about it, but keep busy with more pleasant things.	1 SA	2 A	3 NO	4 D	5 SD
10.	Although they usually aren't aware of it, many people become mentally ill and substance dependent to avoid the difficult problems of everyday life.	1 SA	2 A	3 NO	4 D	5 SD
11.	There is something about dually diagnosed clients that makes it easy to tell them from normal people.	1 SA	2 A	3 NO	4 D	5 SD
12.	Even though clients in mental hospitals behave in funny ways, it is wrong to laugh about them.	1 SA	2 A	3 NO	4 D	5 SD
13.	Most dually diagnosed clients are willing to work.	1 SA	2 A	3 NO	4 D	5 SD
14.	People who become addicts are usually lacking in will power.	1 SA	2 A	3 NO	4 D	5 SD
15.	People who are successful in their work seldom become mentally ill.	1 SA	2 A	3 NO	4 D	5 SD
16.	People would not become mentally ill if they avoided bad thoughts.	1 SA	2 A	3 NO	4 D	5 SD

17.	People become addicts because they inherit a weakness for drugs.	1 SA	2 A	3 NO	4 D	5 SD
18.	More tax money should be spent in the care and treatment of people with dual diagnosis.	1 SA	2 A	3 NO	4 D	5 SD
19.	A heart patient has just one thing wrong with him, while a dually diagnosed person is completely different from other patients.	1 SA	2 A	3 NO	4 D	5 SD
20.	Very few people with addictions come from homes where both parents took interest in them as children.	1 SA	2 A	3 NO	4 D	5 SD
21.	People with mental illness should never be treated in the same hospital with people with physical illness.	1 SA	2 A	3 NO	4 D	5 SD
22.	Anyone who tries to better himself deserves the respect of others.	1 SA	2 A	3 NO	4 D	5 SD
23.	An alcoholic's basic troubles were with him long before he had a problem with alcohol.	1 SA	2 A	3 NO	4 D	5 SD
24.	A person would be foolish to marry someone who had a dual diagnosis problem, even though they seem fully recovered.	1 SA	2 A	3 NO	4 D	5 SD
25.	If the children of mentally ill parents were raised by normal parents, they would not become mentally ill.	1 SA	2 A	3 NO	4 D	5 SD
26.	Once a person becomes an addict he can never learn to use drugs occasionally again.	1 SA	2 A	3 NO	4 D	5 SD
27.	Many clients with dual diagnoses are capable of skilled labor, even though in some ways they are very disturbed.	1 SA	2 A	3 NO	4 D	5 SD
28.	A person who often uses drugs or alcohol to the point of being high is almost always an alcoholic or addict.	1 SA	2 A	3 NO	4 D	5 SD
29.	Anyone who is in a hospital for a dual diagnosis problem should not be allowed to vote.	1 SA	2 A	3 NO	4 D	5 SD

30.	The mental illness of many people is caused by the separation or divorce of their parents during childhood.	1 SA	2 A	3 NO	4 D	5 SD
31.	The best way to recognize or spot most dually diagnosed persons is that they talk to themselves or see things that are not real.	1 SA	2 A	3 NO	4 D	5 SD
32.	To become a client in a substance abuse treatment program is to become a failure in life.	1 SA	2 A	3 NO	4 D	5 SD
33.	The harm done by alcoholics is generally overestimated.	1 SA	2 A	3 NO	4 D	5 SD
34.	A person who is dually diagnosed should not be excused for a crime that he commits.	1 SA	2 A	3 NO	4 D	5 SD
35.	If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.	1 SA	2 A	3 NO	4 D	5 SD
36.	Nobody who drinks is immune from alcoholism .	1 SA	2 A	3 NO	4 D	5 SD
37.	The law should allow a person to divorce their spouse as soon as they have been confined in a psychiatric hospital with a dual diagnosis problem.	1 SA	2 A	3 NO	4 D	5 SD
38.	People (both veterans and non-veterans) who are unable to work because of psychiatric or substance abuse problems should receive money for living expenses.	1 SA	2 A	3 NO	4 D	5 SD
39.	Mental illness is usually caused by some disease of the nervous system.	1 SA	2 A	3 NO	4 D	5 SD
40.	Most people are uncomfortable when they learn that someone they meet has been in a substance abuse treatment program.	1 SA	2 A	3 NO	4 D	5 SD
41.	Most women who were once patients in a psychiatric hospital could be trusted as baby sitters.	1 SA	2 A	3 NO	4 D	5 SD

42.	Most clients who are dually diagnosed don't care how they look.	1 SA	2 A	3 NO	4 D	5 SD
43.	College professors are more likely to become mentally ill than are business men.	1 SA	2 A	3 NO	4 D	5 SD
44.	The dually diagnosed client is more difficult to manage and control than the normal person.	1 SA	2 A	3 NO	4 D	5 SD
45.	Although some dually diagnosed clients seem all right, it is dangerous to forget for a moment that they are dually diagnosed.	1 SA	2 A	3 NO	4 D	5 SD
46.	Sometimes mental illness is punishment for bad deeds.	1 SA	2 A	3 NO	4 D	5 SD
47.	Our community mental health centers should be organized in a way that makes the client feel as much as possible like he/she is a normal person.	1 SA	2 A	3 NO	4 D	5 SD
48.	One of the main causes of substance abuse is a lack of moral strength or willpower.	1 SA	2 A	3 NO	4 D	5 SD
49.	Most dually diagnosed clients could not be rehabilitated even if more help were available to them.	1 SA	2 A	3 NO	4 D	5 SD
50.	The alcoholic is basically a spineless person who has found an easy way out of his problems.	1 SA	2 A	3 NO	4 D	5 SD
51.	All clients who are dually diagnosed should be prevented from having children by a painless operation.	1 SA	2 A	3 NO	4 D	5 SD

52. Which primary disability area do you work for?

- A. Substance Abuse B. Mental Health

55. What is the highest level of education that you have completed?

- A. High School B. Some College/Special Training C. Bachelor's Degree
D. Master's +

56. Please indicate the category which best describes your **Undergraduate** academic program:
A. Not Applicable B. Social Work C. Rehabilitation Counseling D. Psychology
E. Nursing F. Other _____ (please describe).

55. Please indicate the category which best describes your **Graduate** academic program:
A. Not Applicable B. Social Work C. Rehabilitation Counseling D. Psychology
E. Nursing F. Other _____ (please describe).

59. Please circle all disability areas where you hold a specialized credential:
Substance Abuse Mental Illness Dual Diagnoses
Disorders Disorders Disorders

60. Within the past 3 years have you had training in any of the following areas:
Substance Abuse Mental Illness Dual Diagnoses
Disorders Disorders Disorders

61. Please circle the option that most closely matches your current job:
Counselor/Therapist Case Manager Nurse Supervisor/Administrator

59. How many years of experience do you have providing direct services to clients?
_____ Years

60. How many years of experience do you have working in a supervisory level position or higher?
_____ Years

61. What percentage of your current caseload are diagnosed as:
_____ Substance Use Disorders
_____ Mental Illness Disorders
_____ Dually Diagnosed

(Please total 100%)

PLEASE CHECK BACK AND MAKE SURE YOU HAVE ANSWERED ALL QUESTIONS

Modified and reprinted from Cohen, J., & Struening, E.L., (1959). Factors underlying opinions about mental illness in the personnel of a large mental hospital. *American Psychologist*, 14, 339.

THANK YOU FOR COMPLETING THIS SURVEY. PLEASE MAKE SURE THAT YOU HAVE NOT WRITTEN YOUR NAME ON THE SURVEY. THANKS AGAIN!

VITA
JOSEPH E. BULLOCK, JR.
4316 Vermont Ave.
Alexandria, VA 22304
(703) 751- 2310

EDUCATION

- Ed.D. **Virginia Polytechnic Institute & State University**
Northern Virginia Graduate Center
Major: Counselor Education/Community Agency Counseling
May 2002
- M.S. **Virginia Commonwealth University**
Richmond, Virginia.
Major: Rehabilitation Counseling
December 1989.
- B.S. **Morgan State University**
Baltimore, Maryland
Major: Human Ecology
May 1985

PROFESSIONAL EXPERIENCE

- 2001- **Acting Substance Abuse Director**, Substance Abuse Services, Arlington County
Department of Human Services, Arlington, VA. Direct and supervise the treatment programs of the Substance Abuse Bureau; design and monitor evaluation systems for substance abuse programs; preparation of the budget; meet with managers regarding the planning and supervision of program operations; participate on leadership team for the Division; attend Community Service Board meetings and report to/advise the substance abuse subcommittee.
- 1994-01 **Clinical Supervisor**, Substance Abuse Services, Arlington County
Department of Human Services, Arlington, VA. Responsible for providing Administrative management, operational and clinical supervision for outpatient

substance abuse treatment program. Specific duties include monitoring clinical caseloads and provide case related supervision; evaluating need for changes in services; management of day to day operations, assistance with policy setting and budget development.

1993-94 **Program Coordinator**, Substance Abuse Services, Williamsburg Community Hospital, Williamsburg, Virginia.

Provide operational supervision for chemical dependency, smoking cessation, compulsive overeating and employee assistance programs. Assist with development of capital and operational budgets and ensure efficient use of resources. Responsible for outreach activities, inservices, census development and maintaining relations with consulting medical staff, managed care/insurance companies.

1990-1993 **Clinical Coordinator**, Substance Abuse Services, Williamsburg Community Hospital, Williamsburg, Virginia.

Supervised the chemical dependency program. Implemented/coordinated clinical services and provided individual, group, and family counseling. Responsible for treatment planning, case management, and discharge/aftercare planning for inpatients and outpatients. Assisted with training, inservices, interviewing and hiring of staff, and communication with multidisciplinary treatment team.

1990- 1994 **Assistant Football Coach**, College of William and Mary, Williamsburg, VA

MILITARY EXPERIENCE

U.S. Marine Corps Reserves, 1980–84

PUBLICATIONS

Hendrickson, E., Ekleberry, S., Schmal, M., & Bullock, J. (1999). Supervising staff treating the dually diagnosed. The Counselor, 17(2), 18-22.

PROFESSIONAL LICENSES AND CERTIFICATIONS

Licensed Professional Counselor, Commonwealth of Virginia

Licensed Clinical Professional Counselor, State of Maryland

Licensed Substance Abuse Treatment Practitioner, Commonwealth of Virginia

Certified Substance Abuse Counselor, Commonwealth of Virginia

Master Addictions Counselor, National Association of Alcoholism and Drug Abuse

PROFESSIONAL MEMBERSHIPS

National Association of Alcoholism and Drug Abuse Counselors

Virginia Association of Alcoholism and Drug Abuse Counselors

Maryland Mental Health Counselors Association