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Stigma for Caring for those with Mental Health Issues in the Student Nurse Community:

A survey

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An Undergraduate Thesis Submitted in Partial Fulfillment

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Midway Honors Scholars Program

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College of Nursing

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Abstract

People living with a mental health issue is elevated both nationally and internationally, and the likelihood of a person interacting with someone who has a mental health issue is high. It is even higher for those who work in the health care profession, so understanding their attitudes on this matter is important. As a review of current literature reveals, there is not only stigma in the health care system, but there is also stigma among health care professionals and students. One of the groups of students that has not been researched to a great extent is nursing students and the degree of stigma they have for caring for those with mental health issues. A cross-sectional survey was conducted to assess the degree of stigma among these individuals. A voluntary online survey was done was administered to undergraduate nursing students at a university in the southeastern part of the United States using the twenty item Opening Minds Scale for Health Care Providers (OMS-HC). The results indicated that mental illness stigma did exist within the student nurse community with no association between gender, classification, and mental health nursing course completion and total score on the OMS-HC scale.

## **Background**

People living with mental health issues is elevated both nationally and internationally. It is estimated that one in five adults in the United States of America lives with a mental illness, and, to help put that into perspective, that means 44.7 million United States adults lived with a mental illness in 2016 (National Institute on Mental Health, 2017b). Not only is this an issue with people that are eighteen years of age and older, but mental illness also affects adolescents. Based on data from the National Comorbidity Survey Adolescent Supplement (NCS-A), among those that were aged 13-18, it was estimated that 49.5% had a mental illness/disorder (National Institute of Mental Health, 2017c).

From these statistics, it can be inferred that the chances of one interacting with a person who has a mental issue is high, but, when referring to different professions and occupations, those that work in health care have an increased chance of caring for those with mental issues; however, most of those with mental illness have not been receiving treatment for their issue. Among those with any mental illness in 2016, which is 44.7 million United States adults, only 19.2 million, or 43.1%, received treatment for their mental illness (National Institute on Mental Health, 2017a).

There are many items to consider as to why many people who have mental illness do not receive treatment. For several, the reason as to not seeking and receiving mental illness treatment is that they face barriers to being able to receive such help, such as being impoverished, not having reliable transportation, housing issues or a lack of housing, having the ability to pay or a lack thereof, et al. (Bellamy et al., 2016). Another reason for this, as discovered by a survey done by the World Health Organization (WHO), is that there is a low perceived need by people that have mental illnesses, and, when a person with a mental illness does perceive a need for

treatment, a belief that they need to deal with the problem by themselves is another reason for not receiving treatment (Andrade et al., 2014). Furthermore, it is important to also consider the reason a person with mental illness started receiving treatment, but ended up dropping out and not continuing with treatment. Perceived ineffectiveness of treatment is a major reason as to why those with mental health issues drop-out of treatment and no longer wish to receive it (Andrade et al., 2014). However, another major reason, especially among those with severe disorders, is negative experience with treatment providers (Andrade et al., 2014).

As mentioned previously, with the mental illness statistics, it is inferred that the chances of interacting with a person that has a mental illness is high, but it is even higher for those that work in the health care profession. That, coupled with the fact that that negative experience with treatment providers is one of the leading causes of those with mental illness dropping out of treatment, is why it is important to look at current literature to see if there is a correlation of negativity or stigma by professionals in health care and with those that have mental issues.

### **Literature Review**

#### *Mental Illness Stigma in Health Care*

Mental illness, and the perceptions and way in which those with it are treated, is an important concept that has been addressed in current research. The health care system is one of the major sources that those with mental illness face discrimination and stigma (Ungar, Knaak, & Szeto, 2016). One of the main reasons as to why those with mental illness face such stigma is that it is not viewed with same perspective as physical health (Zolezzi, Alamri, Shaar, & Rainkie, 2018). As a result, persons living with a mental health disorder or issue have the perception that not only are health care professionals not helping decrease stigma but increasing it (Ye et al., 2016). By this perceived stigma increasing, a major barrier is created for those that have mental

illness to receive high quality care, treatment, and aid in recovery (Pellegrini, 2014). Not only does that barrier create issues for those with mental illness to receive proper care, but it also creates a deep problem in which the person who has the illness has deep feelings of stigma against them (Pellegrini, 2014). Sometimes this feeling of stigma leads a person to feel like they are sad and alone in a room that is empty (Langille, 2014), which further makes depression and other psychiatric mental health disorders worse. Health care in its current state may actually be doing more harm than good when it comes to how mental illness is handled due to extensive and damaging stigma and discrimination, which includes negativity being projected onto those with mental health issues regarding their chances of recovery, attributing unrelated complaints to a person's mental illness, and not helping a person's psychiatric symptoms in a medical setting (Pellegrini, 2014); as a result of this, those with mental illness feel dehumanized and that they are being dismissed not only by society but also those in health care (Knaak, Szeto, & Dobson, 2018).

Stigma regarding mental illness in health care is not just an issue in America but is also an issue that affects many different cultures and populations, which makes it an extensive and standardized issue in health care. Stigma that is directed towards mental illness and addictive disorders is a problem that is global and affects many different health care settings, including primary care (Sapag et al., 2018). While some positive attitudes toward those with mental illness exist in certain parts of the world by some health care professionals (Cremonini, Pagnucci, Giacometti, & Rubbi, 2018), there are many areas of the world in which mental health is underfunded and neglected and that those with mental illness are often violated and denied basic human rights, including mental health treatment and care, by society and health care ( "Mental Illness Will Cost the World \$16 USD Trillion by 2030", 2018). Furthermore, not only are those

with mental illness stigmatized by their society and health care, they also feel uncomfortable about seeking mental health care by a referral through their public health system (Ben Natan, Drori, & Hochman, 2017), which shows that stigma in health care exists across all cultures and can affect several populations.

#### *Mental Illness Stigma among Health Care Professionals*

Health care professionals and their attitudes on caring for those with mental health issues is important. Health care professionals often are met with those that have mental illnesses, whether it be while that person is receiving treatment for a medical condition that brought them to the hospital or other medical facility or while receiving treatment for the mental illness itself (Maranzan, 2016). Stigma regarding persons with mental illness, though, is common among health care professionals and students (Maranzan, 2016). These professionals and students have attitudes that are stigmatizing toward those with mental illness (Waugh, Lethem, Sherring, & Henderson, 2017), which can be perceived by those with mental health issues and lead to significant issues in their treatment and quality of life (Moxham et al., 2016). Not only does current research reveal that health care professionals and students have attitudes that are stigmatizing toward those with mental health issues, but it also reveals that several health care providers hold an attitude that is negative toward those with mental illness (Knaak, Szeto, & Dobson, 2018) and that health care professional students also have negative attitudes toward those with mental illness (Petkari, Masedo Gutiérrez, Xavier, & Moreno Küstner, 2017).

Additionally, one of the benchmark studies that showed this stigma exists in the health care profession and health care professional student community is the “The development and psychometric properties of a new scale to measure mental illness related stigma by health care providers: The opening minds scale for Health Care Providers (OMS-HC)” (Kassam, Papish,

Modgill, & Patten, 2012), which was developed in order to measure the stigma that exists among health care providers by asking questions that relate to the role of the provider instead of the public. The study revealed that the Opening Minds Scale for Health Care Providers serves as “a good basis for further validation” along with “a tool that could be used in the evaluation of programs aimed at reducing mental illness related stigma by health care providers” (Kassam, Papish, Modgill, & Patten, 2012, Conclusions). This shows that stigma for caring for those with mental issues does exist not only in the general community but also health care profession and health care student community.

### **Research Question**

From the literature review, it is known that mental illness stigma exists in health care and that stigma on mental illness exists among health care professionals and students. The Opening Minds Scale for Health Care Providers was used to survey many different health care professionals, such as general practitioners, other physicians including psychiatrists, surgeons, nurses, psychiatric nurses, social workers, occupational therapists, psychologists, and pharmacists, to see if wording of the scale was appropriate, if new items should be suggested, and to investigate their attitudes regarding those with mental illness (Kassam, Papish, Modgill, & Patten, 2012). Furthermore, the scale was also used with medical students, social worker students, and occupational therapy students for their input and attitudes (Kassam, Papish, Modgill, & Patten, 2012); however, one group of students that is missed from this list is nursing students. The question, from reviewing all the current literature and synthesizing it, then becomes to what degree stigma exists in the student nurse community on caring for those with mental health issues based on the results using the Opening Minds Scale for Health Care Providers (OMS-HC)?



## **Methods**

### *Design*

This study used the Opening Minds Scale for Health Care Providers (OMS-HC) to evaluate the degree of mental health care stigma within the student nurse community. This study used a cross-sectional online survey design and was undertaken in a university in the southeastern part of the United States. The university review board approved this study.

### *Sample*

Undergraduate nursing students in the university were invited to participate in the study via a university review board-approved electronic mail message containing the online external survey link. The inclusion criteria for participants were that these students needed to be at least eighteen years of age and be an undergraduate nursing student at the university. The exclusion criteria for participants were students younger than eighteen years of age, students classified as another type of student other than undergraduate, such as a graduate student, at the university and/or a non-nursing undergraduate student. The students were informed of the survey's purpose and estimated length of time to complete, as well as that participating in the study was entirely voluntary, and that if they decided to quit or not take part in the study, the benefits or treatment that they would have otherwise gotten would not be changed. The students were also informed that they could quit at any time, they could skip any questions that they did not want to answer, and that they could exit the online survey form at any time if they wanted to stop completely. The students were also informed that the risks of the study were that they could become physiologically or psychologically uneasy or uncomfortable when taking the survey and that, since the survey was being done on an online platform, that a possible loss of confidentiality did exist. Furthermore, the students were also informed that, for themselves, one benefit of the study

was that they may feel better after they have had the chance to express themselves about their perceptions on caring for those with mental health issues, and that, for themselves or others, another benefit of the study was getting to know what current undergraduate nursing students think about caring for those with mental health issues and implications for future of nursing students and the field of nursing. The students were also reminded that a loss of confidentiality could occur, but that safeguards, such as not having the ability to collect IP addresses and SSL encryption software, were being used in this study to prevent their names from being linked with their answers and data interception as best as possible. The students were also informed that, although their rights and privacy would be protected, the university review board, the principal investigator, the thesis mentor, and research assistant at the university would have access to the study records. Lastly, the students were also provided contact information for the principal investigator, the thesis mentor, and university review board coordinator for research-related questions, problems, or concerns, as well as the university review board chairperson's contact information to aid with answering questions about their rights as a research subject.

### *Data Collection*

Undergraduate nursing students in the university were invited to participate in the study via a university review board-approved electronic mail message containing the online external survey link. Once participants clicked on the survey link, they were directed to the face sheet of the survey, which was the university review board-approved informed consent document. Participants were then asked to verify that they consented to being a participant in the study by clicking an "I agree" button at the bottom of the face sheet before proceeding on to the next page of the survey. By clicking the "I agree" button, the participant agreed that they had read the informed consent document, that they volunteer to be a participant in the study, and that they are

at least eighteen years of age. Once consent was given by the participant, the next page of the online survey was a demographics sheet asking three basic questions:

1. What is your gender?
2. What classification are you?
3. Have you taken, currently taking, or not taken the Care of Persons with Mental Illness course?

The answer selections for the first demographics question were “Male,” “Female,” “Transgender,” and “Other.” The answer selections for the second demographics question were “Sophomore,” “Junior,” and “Senior.” The answer selections for the third demographics question were “Taken,” “Currently Taking,” and “Not Taken.” The reason for this page is to evaluate if there is an association with gender and the progress made in the program curriculum with the perceptions of a student nurse on caring for those with mental health issues and evaluating the degree of mental health care stigma within the student nurse community. Once the participant finished with that page, they were taken to the third page of the online survey, which was the twenty-item version of the Opening Minds Scale for Health Care Providers (OMS-HC) questionnaire. The OMS-HC measures the stigma that exists among health care providers by making twenty statements that relate to the role of the provider and asking if they strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with the statement.

Participation in the survey was entirely voluntary and alternatives, such as quitting at any time, skipping any questions that they wished not to answer, exiting the online survey form at any time if they wanted to stop completely, or not taking part in the study, were communicated to the participant. The survey was completed by participants using their own personal device that had internet connection, and they could take the survey wherever they wished, in order to ensure

privacy. The participant's answers to the questions on the demographics page and OMS-HC questionnaire were saved in the university account through the online survey platform.

Safeguards, such as not having the ability to collect IP addresses and SSL encryption software, were used to help keep the anonymity of the participant and facilitate optimal confidentiality of the participant and their answers.

### *Data Analysis*

Participant's answers to the demographics page and OMS-HC questionnaire were saved in the university account through the online survey platform, and safeguards, such as not having the ability to collect IP addresses and SSL encryption software, were used. The answers and data regarding the survey were accessed by a research assistant in the university, who had permission to do so through both the university and the university review board. After the data was accessed through the university account through the online survey platform, it was then exported by the research assistant, and the account was logged out of by the assistant to maintain confidentiality of participants and their answers. The results from the answers and data were put on a spreadsheet and saved using a spreadsheet software program, the data was then tabulated, analyzed, and saved using that same spreadsheet software, and pertinent statistics and graphs derived from the tabulation and analysis of data were put onto a document and saved using a word processing software program. By approval from the university review board, the research assistant saved the spreadsheets and word document onto study-specific Universal Serial Bus (USB) thumb drive provided by the principal investigator. This USB thumb drive was then physically picked up and transported by the principal investigator using proper safeguards. The principal investigator took the USB thumb drive and uploaded the results and data into this document without any alteration made to them.

## Results

The results presented in this section were not altered in any way, and the method of collecting, analyzing, and saving the data to get these results was approved by the university institution review board.

### *Scoring the Opening Minds Scale for Health Care Providers (OMS-HC)*

The OMS-HC questionnaire section of the survey was scored the same way that it was scored in its development by its creators, Aliya Kassam, Andriyka Papish, Geeta Modgill, and Scott Patten. A five point Likert scale was used to score the questionnaire and response options were associated with a particular value, one being equivalated with the “Strongly Disagree” option, two being equivalated with the “Disagree” option, three being equivalated with the “Neither Agree nor Disagree” option, four being equivalated with the “Agree” option, and five being equivalated with the “Strongly Agree” option. The scoring range was from 20 to 100, with a lower score indicating less stigma. Items 3, 8, 9, 10, 11, 15, and 19 on the OMS-HC required reverse scoring. (Kassam, Papish, Modgill, & Patten, 2012)

### *Overall Scores*

The overall results were as follows: Thirty-seven undergraduate nursing students agreed to participate in the study. The minimum score, based on the above OMS-HC scoring, was 28, the maximum score was 59, the mean, or average, score was 43.62, and the standard deviation from the mean was 8.251. These statistics can be seen in *Figure 1*.

### *Results from Association of Gender and Total Score*

The results from looking at the association between gender and total score on the OMS-HC questionnaire were as follows: Thirty-three participants identified as female for gender, four participants identified as male for gender, and zero participants identified as transgender or other

for gender participated in the study. Using the OMS-HC scoring above, for those that identified as female for gender, the minimum score was 28, the maximum score was 59, and the mean, or average, score was 43.15 with a standard deviation from the mean being 8.460. Using the OMS-HC scoring above, for those that identified as male for gender, the minimum score was 42, the maximum score was 55, and the mean, or average, score was 47.50 with a standard deviation from the mean being 5.568. These statistics can be seen in *Figure 2*.

The association between gender and total score was found by doing an Independent Samples Test and looking at the significance. The significance level was 0.326 when looking at the association between gender and total score, which indicates that there was no statistical significance when looking at the two genders presented and their total scores because 0.326 is greater than 0.05. This test and significance level can be seen in *Figure 3*.

#### *Results from Association of Classification and Total Score*

The results from looking at the association between classification and total score on the OMS-HC questionnaire were as follows: Three participants identified as being a Sophomore, eleven participants identified as being a Junior, and twenty-three participants identified as being a Senior. Using the OMS-HC scoring above, for those that identified as being a Sophomore, the minimum score was 29, the maximum score was 56, and the mean, or average, score was 42.67 with a standard deviation from the mean being 13.503. Using the OMS-HC scoring above, for those that identified as being a Junior, the minimum score was 30, the maximum score was 52, and the mean, or average, score was 42.45 with a standard deviation from the mean being 5.888. Using the OMS-HC scoring above, for those that identified as being a Senior, the minimum score was 28, the maximum score was 59, and the mean, or average, score was 44.30 with a standard deviation from the mean being 8.819. These statistics can be seen in *Figure 4*.

The association between classification and total score was found by doing an Analysis of Variance (ANOVA) Test and looking at the significance. The significance level was 0.820 when looking at the association between classification and total score, which indicates that there was no statistical significance when looking at the three classifications presented and their total scores because 0.820 is greater than 0.05. This test and significance level can be seen in *Figure 5*.

*Results from Association of Mental Health Nursing Course Completion and Total Score*

The results from looking at the association between completion of the Care of Persons with Mental Illness course and total score on the OMS-HC questionnaire were as follows: Thirteen participants identified as not having taken the Care of Persons with Mental Illness course, five participants identified as currently taking the Care of Persons with Mental Illness course, and nineteen participants identified as having taken the Care of Persons with Mental Illness course. Using the OMS-HC scoring above, for those that identified as having not taken the Care of Persons with Mental Illness course, the minimum score was 29, the maximum score was 56, and the mean, or average, score was 41.69 with a standard deviation from the mean being 6.945. Using the OMS-HC scoring above, for those that identified as currently taking the Care of Persons with Mental Illness course, the minimum score was 36, the maximum score was 52, and the mean, or average, score was 45.80 with a standard deviation from the mean being 6.017. Using the OMS-HC scoring above, for those that identified as having taken the Care of Persons with Mental Illness course, the minimum score was 28, the maximum score was 59, and the mean, or average, score was 44.37 with a standard deviation from the mean being 9.558. These statistics can be seen in *Figure 6*.

The association between mental health nursing course completion and total score was found by doing an Analysis of Variance (ANOVA) Test and looking at the significance. The significance level was 0.558 when looking at the association between mental health nursing course completion and total score, which indicates that there was no statistical significance when looking at the three course completion statuses presented and their total scores because 0.558 is greater than 0.05. This test and significance level can be seen in *Figure 7*.

### **Discussion**

The results of this study reveal that stigma for those with mental health issues does exist in the student nurse community, but stigma is such an abstract concept that has to be measured in order to fully understand to what degree it exists within the population that is being studied. In the “The development and psychometric properties of a new scale to measure mental illness related stigma by health care providers: The opening minds scale for Health Care Providers (OMS-HC),” the number of health care providers, including students, that responded were seven hundred and eighty-seven, the minimum score was 41, the maximum score was 96, and the mean score of the twenty item scale was 57.5 with a standard deviation from the mean being 4.8 (Kassam, Papish, Modgill, & Patten, 2012). Comparing those statistics with the results of this study reveal that the overall average score was lower in this study than in the development of the scale by Kassam et al. in 2012. The difference in the minimum and maximum scores, the range, in this study was also less, 31 for this study versus 55 in the developmental study by Kassam et al. While it may appear as though nursing students have less stigma than that of other health care providers and students, a relationship and accurate comparison can not be done because of the small sample size in this study. Repeating this study, using the same methods, running the data and retrieving the results the same way, and using either the same university or another college



or university, would be helpful because it would offer a larger sample size. Additionally, it would also assist with an accurate comparison and understanding of the extent of stigma among nursing students, and it would lead to more diversity if done in other parts of the United States or world because of cultural diversity in those responding to the survey/scale. By gaining a clear picture of the degree of stigma for caring for those with mental health issues in the student nurse community, a proper understanding of the current philosophies held by students can be done and help researchers to plan and further identify what can be done and what interventions can be made to reduce the stigma. This, in turn, might help to breed fewer negative attitudes by students and future healthcare professionals when it comes to caring for those with a mental illness.

In order to try to help assess mental illness stigma among student nurses, an assessment and measurement of the demographics and their association to the degree of stigma that is held is a starting place for researchers to see if they should target a specific population when planning and putting forth interventions to help lower stigma as much as possible. Three easy and measurable demographics that can tell researchers significant information about their population and their beliefs, within the student nurse community, is the participant's gender, their classification, and if they have completed a mental health nursing course within their program. Furthermore, not only are these three demographics easy and measurable, but they also exist in every nursing program. In this study, based on the Independent Variables Test to assess the association between gender and total score and the Analysis of Variance (ANOVA) Test to assess both the association between classification and total score and the association between mental health nursing course completion and total score, all three tests showed that there is not an association to a nursing student's total score on the scale to their gender, classification, or if they have completed the mental health nursing course, due to all of their significance levels

being above 0.05. As with the overall score, though, the sample size was small, and repetitiveness will help to gain a clear picture of the degree of mental health stigma associated with the three demographics measured.

A concept that is worth discussing when it comes to mental health stigma, nursing students, and the results of this study, is culture and what can be done to gain a clear picture and make conclusions that are multicultural and span across the United States and world. A major way of doing this is by repeating the study and doing it in different parts of the United States and world. This would be helpful to researchers in the future because it would allow for them to assess and measure where a significant amount of mental illness stigma in the student nurse community lies, which, in turn, could help them to plan certain interventions to be conducted in those parts of the United States or world.

As mentioned throughout the paragraphs above, repeating the study, doing the study in different parts of the United States and world, etc., could be done in the future. However, one item that has not been brought up that can make sense of the magnitude of student nurse mental illness stigma is by simply modifying the design and extending it. This study was simply a cross-sectional survey, which is a snapshot of what a population is thinking at that place in time, so a research design that could be used to truly understand this topic is by doing a longitudinal cohort study from the time that the students start nursing school to finishing nursing school to see how student nurse attitudes, perceptions, and philosophy change over time. This would help to bring everything that was looked at in this study full circle and help to make associations between student nurse demographics and stigma.

### **Conclusions**

While not many conclusions can be made as a result of this study, several studies can be done in the future to help expand the knowledge of the degree of student nurse stigma for caring for those with mental illness. By understanding the current attitudes and philosophies of students, the future of health care, in particular, how those with mental health issues are viewed and treated, can be impacted in a significant way. The reason for this is that nursing students represent the next generation of health care professionals, so, by instituting early interventions among nursing and other health care professional students, positive and progressive attitudes may be developed and carried on by these students as they go into practicing in their specific role (Bamgbade, Barner, & Ford, 2017). As a result, by truly taking care of the person as a whole without separating care domains and by having as little stigma as possible regarding any of those domains as a health care professional, optimal holistic health, which includes but is not limited to physical, mental, emotional, and spiritual health, can be attained by patients (Fowler, 2017).

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Figures

Total Score

**Descriptive Statistics**

	N	Minimum	Maximum	Mean	Std. Deviation
Total Score	37	28	59	43.62	8.251
Valid N (listwise)	37				

Figure 1: Statistics for Overall Scores

**T-Test: Gender**

**Group Statistics**

	Gender	N	Mean	Std. Deviation	Std. Error Mean
TotalScore	Female	33	43.15	8.460	1.473
	Male	4	47.50	5.568	2.784

Figure 2: Gender and Total Score Statistics

**Independent Samples Test**

		Levene's Test for Equality of Variances		t-test for Equality of Means			95% Confidence Interval			
TotalScore		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
		Equal variances assumed	1.374	.249	-.995	35	.326	-4.348	4.369	-13.218
	Equal variances not assumed			-1.381	4.878	.227	-4.348	3.149	-12.505	3.809

Figure 3: Independent Samples Test with Significance Level

**Descriptive**

Classification	Statistic	Std. Error
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STIGMA FOR CARING FOR THOSE WITH MENTAL HEALTH ISSUES IN THE STUDENT NURSE COMMUNITY: A SURVEY

Total Score	Junior	Mean	42.45	1.775			
		95% Confidence Interval for	Lower Bound	38.50			
		Mean	Upper Bound	46.41			
		5% Trimmed Mean		42.62			
		Median		43.00			
		Variance		34.673			
		Std. Deviation		5.888			
		Minimum		30			
		Maximum		52			
		Range		22			
		Interquartile Range		5			
		Skewness		-.676	.661		
		Kurtosis		1.203	1.279		
		Senior	Senior	Mean	44.30	1.839	
				95% Confidence Interval for	Lower Bound	40.49	
				Mean	Upper Bound	48.12	
				5% Trimmed Mean		44.39	
Median				45.00			
Variance				77.767			
Std. Deviation				8.819			
Minimum				28			
Maximum				59			
Range				31			
Interquartile Range				15			
Skewness				-.195	.481		
Kurtosis				-.899	.935		
Sophomor	Sophomor			Mean	42.67	7.796	
				95% Confidence Interval for	Lower Bound	9.12	
				Mean	Upper Bound	76.21	
				5% Trimmed Mean		.	
		Median		43.00			
		Variance		182.333			
		Std. Deviation		13.503			
		Minimum		29			
		Maximum		56			
		Range		27			
		Interquartile Range		.			

Skewness	-1.111	1.225
Kurtosis	.	.

Figure 4: Classification and Total Score Statistics

**Oneway ANOVA test: classification**

**ANOVA**

TotalScore

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	28.439	2	14.220	.200	.820
Within Groups	2422.264	34	71.243		
Total	2450.703	36			

Figure 5: Analysis of Variance (ANOVA) Test with Significance Level

**Descriptive**

		Statistic	Std. Error	
Total Score	Taken	Mean	45.80	
		95% Confidence Interval for Mean		
		Lower Bound	38.33	
		Upper Bound	53.27	
		5% Trimmed Mean	46.00	
		Median	48.00	
		Variance	36.200	
		Std. Deviation	6.017	
		Minimum	36	
		Maximum	52	
		Range	16	
		Interquartile Range	10	
		Skewness	-1.305	.913
		Kurtosis	2.253	2.000
Total Score	Not Take	Mean	41.69	
		95% Confidence Interval for Mean		
		Lower Bound	37.50	
		Upper Bound	45.89	
		5% Trimmed Mean	41.60	
		Median	42.00	
		Variance	48.231	

	Std. Deviation		6.945	
	Minimum		29	
	Maximum		56	
	Range		27	
	Interquartile Range		6	
	Skewness		-.121	.616
	Kurtosis		1.315	1.191
Taken	Mean		44.37	2.193
	95% Confidence Interval for Mean	Lower Bound	39.76	
		Upper Bound	48.98	
	5% Trimmed Mean		44.46	
	Median		45.00	
	Variance		91.357	
	Std. Deviation		9.558	
	Minimum		28	
	Maximum		59	
	Range		31	
	Interquartile Range		17	
	Skewness		-.208	.524
	Kurtosis		-1.171	1.014

Figure 6: Mental Health Nursing Course Completion and Total Score Statistics

### Oneway ANOVA test: Taken

**ANOVA**

TotalScore

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	82.712	2	41.356	.594	.558
Within Groups	2367.990	34	69.647		
Total	2450.703	36			

Figure 7: Analysis of Variance (ANOVA) Test with Significance Level

Appendix A

The Opening Minds Scale for Health Care Providers (OMS-HC)



Mental Health  
Commission  
of Canada

Commission de  
la santé mentale  
du Canada

Opening Minds Scale for Health Care Providers (OMS-HC)

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain or headache), I would likely attribute this to their mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. If a colleague with whom I work told me they had a managed mental illness, I would be just as willing to work with him/her.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I would see myself as weak if I had a mental illness and could not fix it myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I would be reluctant to seek help if I had a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Employers should hire a person with a managed mental illness if he/she is the best person for the job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I would still go to a physician if I knew that the physician had been treated for a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. If I had a mental illness, I would tell my friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. It is the responsibility of health care providers to inspire hope in people with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Despite my professional beliefs, I have negative reactions towards people who have mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. There is little I can do to help people with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. More than half of people with mental illness don't try hard enough to get better.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. People with mental illness seldom pose a risk to the public.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. The best treatment for mental illness is medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I would not want a person with a mental illness, even if it were appropriately managed, to work with children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Healthcare providers do not need to be advocates for people with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I would not mind if a person with a mental illness lived next door to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I struggle to feel compassion for a person with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>