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Harming the Help-Seeking: Necessity for Assessing Harmful and Biased Attitudes Toward Clients with Substance Use Disorder

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Abstract

Numerous times, as a new clinician, I have witnessed the substance use disorder population referred to as not being dependable, dangerous, burnt out, and even hopeless. Often times I have heard mental health professionals make statements amongst themselves that the client could not be helped, referred to them as a "frequent flyer," (meant to convey they frequently present for treatment, relapse, and return for treatment), and complain how tax dollars are being wasted to support the client. I felt empathy and a sense of hopelessness for these clients as they were seeking treatment in order to get help and yet they were faced with the potential of harm from clinicians with what appeared to be biased and negative attitudes. This project addresses the need to assess bias from the clinician's perspective and the construction of a scale to measure this bias. This population experiences bias and stigma from society and is at risk for harm if they experience that bias from the clinician whom they are seeking help from. My hope is that this scale will aid in raising awareness to this issue, reduce stigma, and thus reduce harm within the treatment of this population.

Approval Page

Acknowledgements

This project could not be possible without family and friends offering support, encouragement, prayers, and positive thoughts. This project feels very necessary for me in advocating for those who are suffering in this abyss of addiction. Growing up in Southeastern Kentucky, I was raised in a low socioeconomic household and thus exposed to many prejudices that accompanied that status. In addition, substance use disorder was prevalent in my family. Many families within the county I grew up in, knew of my family's struggles and their reputation for substance use. Thus I am aware of the stigma that accompanies addiction and how it generalizes to everyone within the family of someone who struggles with this issue. But my family taught me vital components of a successful life, in spite of their struggles. They were more than their behaviors related to addiction. They taught me how to be resilient, the value of forgiveness, compassion, empathy, how to build credit, change my tires, be conservative in dress and speech, importance of posture, the necessity to set boundaries, and the importance of an education. Unfortunately, my father and aunt lost their lives to complications due to this difficulty. So, I dedicate this project to them and in my endeavors I hope to bring awareness to bias against individuals who struggle with addiction. Clients with substance use disorder are not second class humans and they deserve compassionate and helpful intervention.

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Introduction

Substance misuse and addiction is pervasively sweeping our society. In 2017, the Substance Abuse and Mental Health Services Administration (SAMHSA) utilized the National Survey on Drug Use and Health (NSDUH) to collect data from United States civilians (ages 12 years and older) concerning the national estimation of substance use disorder. The data revealed that 51.79 million individuals misused drugs within the past year. The most frequently used illicit substances were marijuana (4.06 million), opioids (2.11 million), pain relievers (1.68 million), and cocaine (966,000). About 19.7 million individuals met DSM criteria for substance use disorder. Keep in mind that these numbers are interpreted with caution as exact estimations for substance use disorder are challenging to obtain due to social stigma and shame (Keen 2019).

The prevalence of this issue is very daunting. Research supports that we are at a level of crises with addiction, even so much so that President Obama signed the Comprehensive Addiction and Recovery Act of 2016 organized to target the national opiate crises. Just a few months later, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health was released by the U.S. Surgeon General (Dimoff, Sayette, & Norcoss 2017). With such numbers as within the aforementioned statistics, it is imperative to intervene and provide treatment for these individuals. In 2014, approximately 47,055 individuals died of overdose with 61% from opioid (Dimoff et al 2017). In 2016, 64,000 died from overdose (Park & Bloch, 2016), which is roughly 175 American every day. While there were larger concentrations in the Southwest and Appalachia (Park & Bloch, 2016), substance over dose in rural areas outpace those in urban areas (Dimoff et al, 2017) and the numbers continue to rise.

How did the issue of substance use get to this level of crises? Most of the overdose deaths in Appalachia were attributed to blue collar workers who were injured on the job, prescribed

opioids, and then the addiction began to rise. In fact, it was around the 1990s, when it became unacceptable for patients to experience pain and the pharmaceutical industry insisted that the prescribed opioids were safe, resulting in doctors prescribing these substances. As the laws within the last few years began to pass to address this prescription addiction, those clients who could no longer get their prescription (or afford it), turned to heroin. Overdoses began to ramp up as the heroin was often laced with an even more powerful substance called Fentanyl (Park & Bloch, 2016).

Stigma Experienced From the Client's Perspective

Despite the prevalence of this issue, our mental health clinics are not overrun with clients struggling with substance use disorder. One would think that clients with this deadly illness would be seeking help. In my opinion, there are likely many factors, including a trepidation to seek help, as this population experiences such bias and stigma from society, including those in the mental health professions.

Stigma is Greek for stigmata which translated means a mark of discredit; a stain or an identifying mark or characteristic (Overton & Medina, 2008). It has also been defined as derogatory attribution toward someone bearing detrimental social implications (Drake, Codd, & Terry, 2018). Our society stigmatizes substance misuse and the media portrays those who struggle with substance abuse disorder in a negative way. They are often depicted as lazy, weak, immoral, criminals, or even prostitutes. But addiction is an illness, just as diabetes, and until we view it as such, this negative attitude toward this population will continue. No matter how subtle, if an individual with an addiction perceives disdain or rejection, they may reject the health care offered. This may in turn cause the individual to never learn of interventions that could be helpful to them. It is vital that those struggling with addiction receive treatment through

nonjudgmental means from those in charge of their care. They must be treated with kindness and compassion in order to decrease harm and positively influence treatment outcomes (Bartlett, Brown, Shattell, Wright, & Lewallen, 2013).

Stigma is a barrier to general health care, mental health, and substance abuse treatment. (Ahern, Stuber, & Galea, 2006). While there is a preponderance of stigma research concerning mental health stigma, there is a lack of literature on substance use stigma (Dschaak & Juntunen, 2018). Said studies are necessary as research suggest that those with substance use disorder (SUD) may not seek treatment for fear of facing stigma (Luoma, Twohig, Walt, Hayes, Roget, Padilla, & Fisher, 2007). It may also increase isolation, and weaken self-esteem. Chronic exposure to stigma related stress can undermine an individual's ability to understand and manage their emotions. This is imperative to recognize since emotional dysregulation is a predictor of risky behaviors, such as substance misuse. More specifically, deficits within emotional regulation are predictors in alcohol use during and after intervention (Wang, Burtn, & Pachankis, 2008). Thus, stigma has emotional implications which can actually influence the misuse of substances.

Individuals with substance misuse concerns experience public stigma and self-stigma. Public stigma is the opinion of the public that an individual has adverse qualities or traits. Such adverse traits are associated with the following beliefs about those with substance misuse issues: they are to blame for their issues, they are to be feared, or they should be viewed as dangerous. Self-stigma is the internalization of the public stigma (Dschaak & Juntunen, 2018). So the individual with substance misuse concerns is not only exposed to those in society who believe negative stereotypes, but they also begin to believe these stereotypes about themselves. These beliefs, coupled with discriminatory behaviors, correlate with poor physical and mental health

amongst individuals with substance misuse. Further, rural areas may have more stigmatization issues, as additional barriers exist, such as lack of services and greater social visibility (Dschaak & Juntunen, 2018).

In addition to stigma, those who misuse substances may encounter discrimination. This may include major exclusions, put-downs, and slights. A study measured discrimination and stigma related to drug use, perceived devaluation, and alienation amongst 1,008 individuals who misused illicit drugs. Perceived devaluation was defined as beliefs held by the illicit drug users, such as the belief that most people believe common stereotypes about those who use drugs. Alienation was defined as the internalization of those stereotypes that drug users are marginal members of society. Results suggested that marginalized individuals who engaged in substance use experienced high levels of discrimination and stigma and these experiences were connected with poorer physical and mental health (Ahern, Stuber, & Galea, 2006).

An international study endorsed that stigma creates barriers for those who engage in substance misuse as it is frequently perceived that the individual is to blame for their condition and their substance misuse is in their control. In fact, a study involving health care professionals suggested that those referred to as "substance abusers," were more likely to be viewed as personally responsible for their difficulties and as requiring punitive measures when compared to those referred to as having a "substance use disorder" (Gray, 2010). Indeed, this study amongst counselors and health care professionals within a substance use clinic identified shame as prevalent in the therapeutic treatment. Further, it was compounded with stigma when the client was referred to in negative stereotypes such as "addicts" or "junkies" (Gray, 2010). In the mental health profession, we try to be client centered and avoid attaching a disorder to the client. For example, we do not refer to a client with an eating disorder as "bulimic" or an "anorexic." In

addition, we would not label a client with a diagnosis of paranoid schizophrenia as a, "schizophrenic," but we are still addressing clients with substance use disorder as "alcoholics" or "drug addicts." Until we separate the client from the diagnosis, we are at risk for perpetuating stigma as well as identifying the client as nothing more than their disorder.

Barriers to Intervention From Clinicians

A study within a twelve step program, suggested some obstacles to treatment included a lack of client motivation, a lack of readiness for change, and a no perceived need for help. One of the clinical implications for this study revealed that motivation for change needs to be addressed (Laudet, 2017). But literature also suggests that the old attitude of telling the client to come back when they are motivated to change is not only unhelpful, it is unacceptable behavior (Bartlett, Brown, Shattell, Wright, & Lewallen, 2013). And how can a clinician motivate someone to change if they do not believe they can change or hold a negative attitude about their client? Can you instill hope in someone you deem hopeless?

So what is the psychology field contributing to this devastating epidemic of SUD? Many suggest that psychologists, more specifically; clinical psychologists are well suited to treat addiction. It is asserted that clinical psychologists are known for their expertise in providing evidence based treatments and the clinical skills necessary to deliver interventions such as motivational interviewing and administering screening instruments. Psychology is even considered to be a "hub science," given the specialization of knowledge from multiple fields. Despite this and the prevalence of substance misuse, a study of clinical programs (PhD and PsyD) suggested 46 % did not offer any addiction training at all. This included no addiction focused faculty, no specialty clinics dedicated to addictions, and no grants (Dimoff, Sayette, & Norcoss, 2017).

A study suggested that the American Psychological Association Member directory listed only 54 out of 10,210 licensed psychologists as holding specialties in SUD treatment in 2011 (Mundon, Anderson, & Najavits, 2015). This number astounded me, given the rising number in those who meet criteria for the SUD diagnoses. This study suggested that despite psychologist's suitability (generalist training, training in motivational interviewing, and screening measures) to treat this population, most clients with SUD diagnosis are referred to specialized treatment programs or SUD counselors. In addition, the study indicated that psychologists may express low interest in treating this population due to a lack of training within this specialty (Mundon, Anderson, & Najavits, 2015).

Perhaps it is the negative stereotypes about this population that are influencing clinician's interest in working with them. Within the book, *Culturally Responsive Cognitive Behavior Therapy. Practice and Supervision*, authors Iwamasa & Hays (2019) indicated that bias can develop from the absence of experience with specific groups. It is suggested that this population is difficult to work with, they often deny or minimize their issues, and working with them may lead to burnout. They have been described as thankless, exhausting, frustrating, tiresome, and emotionally exhausting (Elman & Dowd, 1997). And despite our standards to hold professional values, mental health providers may express stigma about mental illness at a similar to higher level than the general public (Harris, Leskela, Lakhan, Usset, DeVries, Mittal, & Boyd, 2017).

The former U.S. Surgeon General, Dr. David Satcher described the stigma of mental illness as a vital issue and "the most formidable obstacle to future progress in the arena of mental illness and mental health." Stigma is interpreted as discrimination in power balance, stereotyping, labeling, separation, and status loss. There are many levels to stigma including, public stigma, perceived stigma, self-stigma, and structural stigma. In addition to these stigmas,

is the prevalence of provider-based stigma, which consists of overt or subtle negative beliefs, behaviors, and attitudes of mental health professionals toward their clients. The authors purported that the mental health professionals were not exempt from stigma as they were influenced by, frequently exposed to, or believe public stigma concerning stereotypes against those with mental illness, just as the general public. In fact, they could be more negative than those of the general public. Common endorsements of fear, dislike, anger and neglect were endorsed by those who worked as mental health professionals. This particular study investigated provider stigma of mental illness and the utilization of the Mental Health Provider Self-Assessment of Stigma Scale. It also referred to other measures of provider stigma such as Mental Illness Stigma Scale for Mental Health Professionals and Mental Health Provider Stigma Inventory. In addition, there are many provider stigma scales for health care professionals such as Mental Illness: Clinicians' Attitudes and Opening Minds Stigma Scale for Health Care Providers. (Charles & Bently, 2018). While these measures are a great start to support the presence of provider stigma toward general mental illness, there is still a necessity to gauge the stigma associated with substance use disorder. My hope is this project assists in this endeavor.

To further complicate matters, it is indicated in some research that when working with clients with severe mental illness, the clinician could be at risk for experiencing stigma. Associative stigma involves sharing the discredit of a stigmatized person by relation via the social structure to the stigmatized individual. This stigma may include diminished status, social avoidance, and demeaning social interactions (negative comments) within the community. This type of stigma may increase burnout and decrease empathy for the client over time (Yanos, DeLuca, Salyers, Fischer, Song, & Caro, 2019). An example would be a family member of an individual with HIV experiencing negative comments and being avoided by those within the

community. Research suggested that those who work with the stigmatized groups, such as those within the mental health field, may also experience associative stigma. An international survey indicated psychiatrist experienced stigma toward their profession (including a diminished status) when compared to general practitioners. In addition, when compared to general practitioners, mental health professionals experienced a higher level of negative stereotypes from the general public. This research further indicated that the experience of the associative stigma was significantly associated with diminished job satisfaction and emotional exhaustion. This in turn impacted work with their clients in that those who received mental health services from the clinicians who reported associative stigma also endorsed self-stigma (Yanos et al, 2019). This is monumental in that if the provider experiences negative emotions about working with a client, such as those with substance abuse, they can in turn influence that particular client to feel shameful and harbor other self-stigmatizing attitudes. This further supports my opinion, that we have to be aware of stigma as those emotions related to the stigma can impact the work with the client, and may even harm the client.

A review of literature suggested health care professionals considered individuals with substance use disorder to be difficult, unpleasant and unrewarding. They may be viewed as having severe character flaws, having issues that are self-inflicted, and having poor intervention outcomes (Luoma, Kulesza, Hayes, Kohlenberg, & Larimer, 2014). This stigma may occur due to the coexistence with dangerous behaviors (rash driving), other stigmatized health diagnoses (mental illness, hepatitis C, and HIV/Aids), and unacceptable social circumstances such as criminality and poverty (Mattoo, Sarker, Gupta, Nebhimani, Parakh, & Basu, 2015). Some studies suggest that stigma against substance use disorders is under investigated. In addition, the literature indicated that those individuals with substance use disorder experienced substantial

stigma and listed stigma as a major barrier to treatment (Luoma, Kulesza, Hayes, Kohlenberg, & Larimer, 2014).

Research suggested that as a result of the lack of specialized training, clinical students may be more apt to accept stigmatizing attitudes toward clients with substance use disorder (SUD) as dangerous, uneducated, immoral, unmotivated, weak-willed, unintelligent, hopeless, and personally to blame for their diagnosis. This study surveyed clinical psychology doctoral students with clinical vignettes and a survey instrument to assess three questions: (a) "Do they differ in their level of negative emotional reactions toward clients with SUD versus major depressive disorder (MDD)?"; (b) "Do they differ in their explanations ("attributions") for SUD versus MDD?"; and (c) "How do their negative emotional reactions and attributions impact their interest in pursuing SUD clinical work?" The students read the vignettes and then responded to a Rating of Emotional Attitudes to Clients by Treaters Scale (REACT) which is a self report survey that measured therapists' positive and negative emotional responses to clients with SUD. However, only the negative items from the scale were utilized to address the barriers to doctoral students working with clients with SUD. Results suggested that the students/trainees reported more negative emotional reactions toward clients with SUD than toward clients with MDD. Further these results suggested that clients with a diagnosis of SUD frequently induced more negative reactions and less compassion than clients with other mental health disorders. In addition, they were more likely to attribute poor will power (personal failure) for the cause of SUD when compared to the cause of MDD. However, results did not suggest that these attitudes impacted their level of interest with working with SUD clients. This could indicate that more training and exposure/experience (personal and professional) with working with these clients

could bolster empathy and understanding of this population and diagnosis (Mundon, Anderson, & Najavits, 2015).

While psychologists are well postured to provide treatment for substance abuse disorders, many refer such clientele to specialized programs. Furthermore, many doctoral training programs do not offer specialized training in substance abuse. In addition, there is a lack of encouragement and confidence to treat this population. However, the authors purport those psychologists are very suitable for substance abuse interventions given that these issues are frequently comorbid with other mental illness and vise versa. So, if psychologists refer such a client with comorbid issues to receive specialized addiction treatment, once the addiction is treated all other comorbidities still exist and are untreated by the specialized treatment. In addition, it is surmised that psychologists may be less likely to adopt the disease model during treatment, the intervention methods are psychological in nature (cognitive behavioral strategies, social skills training, behavioral marital therapy, and harm reduction strategies). Further, the authors assert that given its prevalence and comorbidity, psychologists should not, and realistically cannot, avoid providing intervention for substance use disorders. They stated that psychologists should keep in mind that there is no mystical art in providing treatment and assessment and the models in which we are trained have a lot to offer those within this population. For instance, motivational enhancement, accurate empathy, structured assessment, and coping skills training are effective in treatment. It is noted here that a key element in training psychologists in this specialty is to instill a positive attitude toward the study and intervention. In addition, the authors stated that psychologists need to have the competence and confidence to provide training. Indeed, they need to be exposed in practicum training to those within this

population and the most current and evidence based methods to assess and intervene (Miller & Brown, 1997).

The aforementioned literature supports that not only should mental health professionals have a knowledge base for working with clients with substance abuse, but in order to provide treatment, should be aware of their own biases, and-substance related concerns. This group is highly stigmatized and there are many factors that could influence a psychologist's interest or motivation to work with this group. With this project I hope to bring awareness to an additional barrier from the mental health professional's perspective, and that is, stigma from the provider. It is my opinion that this stigma could be preventing psychologists from offering intervention to this group. It is vital to assess the prevalence because if this provider stigma does in fact exist, and the psychologist offers intervention with this bias intact, they could potentially harm the client with substance use disorder.

The Impact of Stigma on Intervention

Studies suggest that attrition rates and relapse are higher for those who engage in substance misuse than those with psychological problems. Further, drop out (from treatment) rates amongst the addiction population are as high as 83% compared to the clinical population, ranging from 30%-60% (Raylu & Kaur, 2012). So it is imperative to investigate the contributing factor to the higher percentage amongst the addiction population. What are those particular clients experiencing in the treatment setting that is influencing the dropout rates? It is necessary to know what is helpful and what is harmful, from the client's perspective. Research indicated that there are not many studies available on the client's perspectives on what is considered helpful from their point of view (Brekke, Lien, & Biong, 2018).

In mental health training, clinicians are taught about the presence of bias and the impact it can have on therapeutic outcomes as well as the individual. Attitudes of mental health professionals toward an individual with a mental illness can perpetuate stigma and create new barriers to the client receiving treatment. Some studies suggested that well-trained mental health professionals even hold the same stereotypes about mental illness as the general public (Overton & Medina, 2008; Harris, Leskela, Lakhan, Usset, DeVries, Mittal, & Boyd, 2017).

Negative and stigmatized practices result in an unethical and untenable counseling process (Gray, 2010). So, it is imperative to investigate our biases and how they can influence our professional attitude in order to provide necessary interventions to those with addictive disorders. Further, it is important to look at the impact of bias or stigma on components of the intervention process such as building the therapeutic alliance, demonstrating empathy, and instilling hope.

It would be difficult, if not impossible to build a therapeutic alliance with a client in which we hold a bias against. As clinicians, we have a major role in therapeutic outcomes. Some literature supports that the therapist can account for 4-12% outcome variance (Artkoski & Saarnio, 2012). Mental health providers can affect the care they provide in that it will influence the type of care they believe should be implemented, the occurrence of over diagnosis, and recovery (Harris, Leskela, Lakhan, Usset, DeVries, Mittal, & Boyd, 2017). So, clinicians have a vital part to play in the end result. Further, therapeutic alliance is the framework to which further positive outcomes can be reached (Artkoski & Saarnio, 2012). So the question then deepens to what impacts the therapeutic alliance. A poor therapeutic alliance may be the most reliable predictor of attrition or premature termination of treatment and this finding has been supported

across multiple settings such as outpatient psychiatric clinics, private practice, research clinicians, and university training clinics (Anderson, Bautista, & Hope, 2019).

A study conducted by Linn-Walton and Pardasani (2014) indicated that dislike for your client or negative personal reactions to clients can negatively affect treatment outcomes. In addition, the clinician could experience negative countertransference and the emotions may even be on an unconscious level. Within the aforementioned study, countertransference is defined as the emotions felt toward the client (negative or positive), typically on an unconscious level, and frequently results in displaced emotions, originating from the previous life experience of the clinician. This research also suggested that interventions will suffer, because the therapeutic relationship will suffer, when the clinician is experiencing dislike, hatred, or countertransferential displacement. The research included a study of five individuals (two psychologists, substance abuse counselor/clinical social worker, a clinical social worker, and an emergency room physician) within the helping field were interviewed to identify themes concerning understanding both the nature and process of dislike in clinical relationships. These individuals were asked a series of open-ended questions concerning their experiences with clients they disliked and whether/how their reactions to the clients affected treatment, how they managed or coped, and if there were any identifiable commonalities amongst the cases of dislike. Results suggested that many factors affected dislike for their clients which could occur over time or instantaneously: questioning of the therapist's capabilities by a client, when the clinician felt the client was not making progress or meeting goals at the clinician's pace of acceptability, if the clinician did not feel physically safe (including if the client was belligerent or expressed physical/verbal intimidating behaviors) or emotionally secure with the client, or having dislike for certain populations or categories. Results for how these individuals coped with their feelings

of dislike indicated mostly negative coping skills such as refer client to another therapist, instead of seeking supervision. In addition, many of the therapists blamed the client for the feelings of dislike (this included calling the client names), minimized or controlled empathetic responses toward the client, the clinicians instilled fear in the client, if they were noncompliant, in order to emotionally deal with the difficult situations, and labeled the client as difficult to work with. (Linn-Walton & Pardasani, 2014). Clients in substance abuse treatment are very likely already dealing with negative feelings. Research suggested clients may experience self-criticism, non-coherence (lack of feeling wholeness), and self-hatred (Punzi, Tidefors, & Fahlke, 2016). Imagine going through treatment dealing with such heavy emotions, possibly battling the symptoms of withdrawal, and then feeling that those around you that are responsible for your treatment feel negatively about you or do not like you.

Despite the chronic or severe presentation of an illness or the prior unsuccessful interventions, it is our job, if we are going to treat a client, to instill hope, as this is a pivotal piece in the therapeutic alliance and successful treatment (Stiles-Shield et al, 2016). Substance use disorders are frequently notoriously chronic, severe and can include numerous previous attempts at interventions. Relapse and dropout are frequent occurrences within the substance use disorder populations (Frankyl, Philips, Bjorn, & Wennberg, 2014). So, a key element in treatment with this population is to remain vigilant in instilling hope. However, if clinicians hold bias or negative attitudes against the individual based on the characteristics of the substance abuse diagnoses, then instilling hope does not appear plausible.

Empirical literature suggested that the number of prior episodes and the duration of the illness might negatively influence engagement in intervention and the therapeutic alliance (Stiles-Shields, Bamford, Touyz, Grange, Hay & Lacey, 2016). Within that body of research

investigated the therapeutic alliance in the treatment of severe and enduring anorexia nervosa. The researchers determined that the expectation for the impact of intervention influenced the overall therapeutic alliance, which in turn influenced the results of the intervention. Those findings support the notion that clinicians should be very aware and cautious that the characteristics of a client's diagnosis (severity, duration of illness, prior unsuccessful intervention experiences) may impact successful outcomes. Instead, the clinician should focus on instilling hope as this is what the client is searching for in order to engage in the therapeutic alliance and for recovery (Stiles-Shields, Bamford, Touyz, Grange, Hay & Lacey, 2016). Clients come to mental health professionals seeking not just intervention for their difficulties, but also for a more significant reason. Clients are seeking to instill a sense of hope in their lives. Clinicians are taught that the therapeutic alliance is very important but part of that alliance is to build trust and hope within the client's intervention.

Another body of research defined therapeutic alliance as the emotional bond between the client and provider, their agreement on therapeutic goals, and their teamwork on therapeutic tasks (Chen, Bermgan, Grubbs, Fortney, Browne, Hudson, & Raue, 2019). A review of literature by Browne, Meyer-Kalos, Estroff, Mueser, Gottlieb, & Penn (2019) highlighted the importance of therapeutic alliance when working with individuals with psychosis. The review included that a better alliance was related to better social functioning, better adherence to treatment, and less severe disorganized and negative symptoms. In addition, the therapist alliance significantly predicted greater social contacts and experiences and was mediated by hopefulness. This suggested that successful interventions include therapist alliance but one that encompasses hope and optimism about the client and their future. In addition, the study endorsed that a better alliance was related to better outcomes when working with those clients diagnosed with

schizophrenia. These outcomes included an increase in mental health recovery, quality of life, and in psychological well-being at the end of the intervention (Browne, Meyer-Kalos, Estroff, Mueser, Gottlieb, & Penn, 2019). Clients diagnosed with severe mental illness (such as schizophrenia, psychosis) have been found to be a largely stigmatized group. These individuals often experience chronic and debilitating symptoms and due to the psychotic symptomatology, can be considered dangerous similar to the substance use disorder population. In fact the same body of work included the Survey of Attitudes Toward Mental Illness (Attitudes Survey) and it was constructed as an effort of the World Psychiatric Association Program to Reduce Stigma and Discrimination Because of Schizophrenia (Stacy, Stefanovics, & Rosenheck, 2016). Even in the face of chronic and severe symptomatology, the client's need for hope is still just as vital.

Having empathy for your client affects the intervention. Empathy was defined by Carl Rogers as the therapist's willingness and sensitive ability to understand the client's feelings, thoughts, and difficulties from the client's point of view (Schnur & Montgomery, 2010). He placed a focus on the relationship with the client, noting that the therapist must demonstrate empathy, congruency in what they say and how they act, and a positive regard for the client through overt respectfulness and warmth (Gray 2010). A review of studies with Schnur & Montgomery (2010) indicated that empathy improved the therapist-client relationship, helped clients to feel comfortable and more safe in self-disclosures of difficult subjects, reduced premature termination, helped them feel understood, and supported self healing efforts. Empathy is considered to be a vital part of various psychotherapy orientations. The Task Force on Empirically Supported Therapy Relationships identified empathy as one of four (therapeutic alliance, empathy, goal setting, and cohesion in group therapy) therapeutic relationship factors that impact intervention. It is made up of three parts: cognitive (accurately identifying the

client's experience), affective (sharing feelings of the client), and behavioral (expressing empathy to the client) (Schnur & Montgomery, 2010). One can infer how bias and stigma can thwart the efforts of these components of empathy and relationship factors. More specifically, how could a clinician accurately identify the client's needs if their opinion of the client is they are a bad person, a criminal, or a hopeless case?

The therapist's empathetic attitude to the client with substance use disorder is a pivotal factor in intervention. It is emphasized in motivational interviewing, predictive of good treatment outcomes, and imperative to the therapeutic working alliance (Saarino, 2010). Motivational interviewing is an empirically supported intervention for those with substance abuse disorders. Research examined the reason this method is successful in treatment. The collaboration between the client and therapist is an essential factor in motivational interviewing. Other factors included the therapeutic alliance which included the therapist exhibiting accurate empathy, understanding, and therapist affirmation. The client feeling understood and accepted by the therapist was essential for healing. Therapist characteristics that could harm the therapeutic alliance are a lack of attention to repairing ruptures in the working relationship, inaccurate interpretation, and inflexible adherence to treatment interventions (Moyers, Miller, & Hendrickson, 2005). Here we distinguish, that it is not enough to provide an empirically supported method, but the client also needs to feel understood and accepted by their clinician. We can infer that should the clinician hold negative attitudes or bias against the client, this would influence accepting and understanding the client and can render even empirically supported treatments as ineffective.

Research indicated that there are not many studies available on the client's perspectives on what is considered helpful from their point of view (Brekke, Lien, & Biong, 2018). One study included individuals (four women and four men) who were receiving mental health intervention

for substance misuse and mental health concerns. These individuals were asked open ended questions concerning what may lead to recovery and what recovery means in order to seek detailed and solid descriptions of the attributes and behaviors from professionals that support recovery. While the ability to build trust is the core of them all, results suggested four categories regarding recovery-supporting attributes and behaviors from professional helpers. Building trust via: commitment, hopefulness and loving concern, action and courage, and direct honestly and expectation. Building commitment was described as a continuous and long term relationship which consisted of the professional insisting on maintaining and making contact with the client and not accepting cancellations, standing by the client through relapse and mental distress, and following up with the client directly upon discharge from inpatient addiction treatment. Hopefulness and loving concern was described as expressing faith in the client that they can have a better life, believing in them, and communicating acceptance, respect, concern, and fundamental goodness (Brekke, Lien, & Biong, 2018). How can we build trust with the client, instill hope and loving concern, or engage in a long term therapeutic relationship with a client we hold negative attitudes or bias against? I do not believe that it is possible. However, from this study we can understand how important it is to be able to communicate that we respect the client, believe in them, and the possibility for them to get beyond their current substance misuse related issues, and have hope they can live a better life. If we cannot express a foundational belief of hope and change for the client, how can we expect the client to have these foundational beliefs and make changes in their lives? .

The Necessity for Gauging Stigma

Thus far, I hope you can surmise that negative attitudes, bias, or stigma is prevalent and can affect various components of intervention. So where do we go from here? Should we simply

offer more classes on substance use? Research supported that learning about substance abuse disorders is not enough to reduce stigmatizing feelings. Some suggest that it is reduced by the full experience of relating to another person (Sadow & Ryder, 2008). Some research supports that inviting students to consider their assumptions or attitudes can help them to more effectively view the skills and knowledge they acquired (Ballon & Skinner, 2008). While these are helpful suggestions, I think the first step in changing behavior is awareness. The goal of this project is to gauge the mental health provider's stigmatizing beliefs concerning clients with substance use disorder as appropriately captured by the following quote.

> "Counselors' attitudes toward clients and the treatment process are important because they shape the therapeutic relationship that is at the core of treatment for substance use disorders. Negative counselor attitudes need to be considered within the framework of stigma and its consequences for the counselor, the client and the field. Attitudes of treatment professional toward the multiple systems of bureaucracy with which they interact-agency priorities, clinic hierarchies, the criminal justice system, department of social services, community organizations-may also affect their ability to deliver effective treatment," (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2011).

Holding stigmatizing beliefs impairs a counselor/clinician from providing ethical intervention as it goes against many of the core competencies in treating this population. In 1998, SAMHSA published TAP 21, a comprehensive list of 123 competencies in cooperation with its Addiction Technology Transfer Center (ATTC) network. These competencies were intended for substance abuse treatment counselors in order to effectively treat the intended population. The competencies include four foundational frameworks including understanding addiction,

treatment knowledge, application to practice, and professional readiness. Each competency addresses the knowledge base (what clinicians are expected to learn and know) as well as an attitude portion which addresses the mindset that a provider should have in order to deliver the knowledge base. For example, Competency 19 requires the professional to understand the importance of self-awareness in one's personal, professional, and cultural life. The knowledge base is to know one's personal and professional strengths as well as being aware of cultural, ethnical, or gender biases. The attitudes portion requires that the professional be open to constructive supervision and have a willingness to grow and change personally and professionally (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2011).

Within TAP21, there were eight practice dimensions amongst the competencies based on professional practices suggested for addiction counselors. These included: 1.) Clinical evaluation, 2.) Treatment planning, 3.) Referral, 4.) Service coordination, 5.) Counseling, 6.) Client, family, and community education, 7.) Documentation, and 8.) Professional and Ethical Responsibilities. The authors stated that each of these competencies depends on its own set of knowledge, skills and attitudes that a counselor must be able to demonstrate in order to be effective. For example, Competency 24 addresses the importance of establishing rapport with the skill or demonstrating empathy, respect, and genuineness. This includes the belief that the counselor must recognize personal bias, values, and beliefs and their effect on intervention and communication. Competency 26 and 27 also includes an attitude with a willingness to be respectful toward the client. Competency 35 involves knowing your personal and professional limitation. Competency 39 requires skills of establishing a trusting relationship with the client. Competencies 41, 43, 47, 48, 49, 51, 52, 57, 60, 65, 67, 69, 75, 76, include attitudes of respect

for the client. Competence 57 includes an attitude requirement concerning awareness of personal biases that may affect work with the client. Competency 75 addressed that to offer individual counseling the counselor must establish a helping relationship with the client that is characterized by warmth, respect, genuineness, concreteness, and empathy. Competency 100 includes describing factors that increase the likelihood of an individual, community or group to be at risk or resilient to psychoactive substance use disorders. This requires the counselor to be able to present the issues in a nonjudgmental way. Competency 101 involves being aware of your own cultural biases. Competence 115 includes that the counselor maintain professional standards and safeguard the client. This included the attitudes that the counselor is open to change personal behavior and attitudes that conflict with ethical guidelines and be willing to participate in self, peer, and supervisory assessment of skills and practice. Competency 119 states that the counselor utilizes a range or supervisory options to process personal feelings and concerns about the client which includes the skill of developing a plan for resolution of improvement of feelings and concerns that my interfere with the counselor-client relationship. The counselor must be willing to accept feedback and accept the responsibility for personal and professional growth. Competence 120 addressed the need to conduct self-evaluations to assess the counselor's personal strengths, limitations, and weaknesses in order to practice self awareness that included the use of self assessment tools (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2011). In sum, we can assert that to competently offer intervention to those with substance use concerns, we must be aware of our biases and have a plan to resolve these feelings in order to be effective.

The Harm Reduction Coalition is a national advocacy group for individuals who have been affected by substance misuse. They have distinguished that social inequality affects individuals from diverse groups in different ways and they work to ensure that those who struggle with substance misuse or substance use disorders have their rights (including health care) honored. One study supported that viewing addiction as an illness, including harm reduction strategies, and evidence based interventions are the only ways we are going to improve upon clients with substance use concerns, getting the care they need. This includes compassionate and nonjudgmental attitudes on the side of provider (Bartlett, Brown, Shattell, Wright, & Lewallen, 2013).

Choosing to work within the mental health field does not make an individual immune to feelings of bias, discrimination, and prejudice to those they treat. A study addressing explicit and implicit stigma concerning the mentally ill suggested that psychiatrists and psychotherapists held negative implicit attitudes against the mentally ill (Kopera, Myszka, & Ilgen, 2015). So, one could surmise from this study that mental health professionals could be ambivalent or unaware of their own negative feelings toward the clients they treat. This makes increasing clinician awareness of their biases and negative attitudes toward clients (such as those with substance abuse), a top priority. In one study, stigmatizing attitudes about SUD clients were discussed. The authors suggested that stigma toward SUD clients was associated with negative impacts such as poor mental and physical health, a failure to complete treatment, and an impaired therapeutic alliance. In addition, substance abuse disorder (SUD) clients were more negatively perceived than any other mental health or medical illness amongst health care professionals (including psychological and behavioral professionals), apart from those professionals who worked within a substance abuse treatment center. Overall, this study suggested the need to assess implicit

attitudes as they may have a negative influence on treatment with a SUD client (Drake, Codd, & Terry, 2018).

Sadow and Ryder (2008) indicated that prejudice and negative assumptions can sabotage recovery and rehabilitation for those with mental illness. In addition, the authors purport that mental health providers and psychologists are not immune to such attitudes. They endorsed a study which demonstrated that psychologists distance themselves from those clients who held a personality disorder or psychosis diagnosis (Sadow & Ryder, 2008).

Measures of Stigma

If we recognize that bias or stigma is harmful and can impact intervention, it becomes vital that clinicians become aware of this bias. Therefore, there exists a need to create a measure that addresses bias from the provider's perspective. More specifically, I want to address the bias from mental health professionals, or provider stigma concerning the substance use disorder population. I believe this is important given the prevalence of substance use and the need to encourage psychologists to offer intervention. I will discuss some measures of bias, negative attitudes, and stigma that already exist in literature.

Some measures that address stigma include Mental Illness Stigma Scale for Mental Health Professional, Mental Illness: Clinician's Attitudes, Opening Minds Stigma Scale for Health Care Providers, and Mental Health Provider Stigma Inventory. In addition, the author mentions their own development of such a measure, Mental Health Provider Self-Assessment of Stigma Scale (Charles & Bently, 2018). While these measures are important and serve their purpose in mental health treatment, they do not include scales to address the current need of assessing bias or stigma against those with substance abuse related difficulties.

Studies conducted within medical settings indicated that health care professionals have negative views towards clients with a substance use disorder. The author describes this as provider stigma and hypothesized an association with this stigma and lower quality of care, job satisfaction, workplace climate, and burnout. This study used an adapted version of Perceived Discrimination and Devaluation Scale (PDDS) to evaluate provider stigma amongst treatment providers in a publicly funded addiction treatment facility. This scale, offered via the internet, asks the participant to respond to statements about how other people feel towards those with mental illness and substance abuse. It should be noted, the scale was adapted from the focus of statements addressing mental illness, to those addressing substance misuse. Results suggested that individuals, who significantly endorsed prejudice views towards clients with a history of SUDS, endorsed considerably worse opinions about workplace climate. Lower job satisfaction was significantly related to a higher provider stigma. However, results did not support findings that provider stigma was related to burnout (Kulesza, Hunter, Shearer & Booth, 2016). While this data is useful, it once again lends itself to the data that we already know amongst the medical community and we need more data on mental health providers' provider stigma, as they are also pivotal in the treatment of substance use disorder.

Behavioral manifestations, (including those that are denied, unrecognized, and subtle), may derive from stigma and impact the therapeutic alliance with a client with substance use disorder. Explicit self report measures offer the respondent the opportunity to give an answer that represents them in a way that they want to view themselves as well as how they want others to view them. Indeed, social desirability may cause the clinician to respond in a way that makes them appear egalitarian and compassionate. Another issue with explicit measures is that they do not address the unconscious attitudes outside of the individual's awareness. Thus a clinician may

hold biased attitudes that they are not even aware of that would not be picked up on by a self report measure. This bias would still manifest itself in treatment as the unconscious bias would contribute to professional judgments and responses to the client with substance use disorder. A good measure of implicit bias or bias that is out of our consciousness or awareness is the Implicit Attitude Test (IAT). This measure is a computerized measure that presents a combination of text and/or images, and then measures the reaction time to said stimuli. The IAT has already been utilized to measure many types of biased attitudes, even stigma-consistent stereotypes about mental illness. More specifically, it was utilized to investigate associations between mental illness and blameworthiness, negativity, and helplessness amongst college students. In addition, stigma against those with substance use disorder was assessed amongst treatment providers in order to investigate the impact of implicit stigma on measures of social distance and willingness to write letters of support for a client with substance use disorder (an explicit measure as well as an implicit measure were given). Results suggested the explicit measure of SUD stigma outperformed the implicit measures in one way and vise versa, but both were useful in measuring the stigma. Further, implicit bias was more beneficial in predicting willingness to write letters of support and the explicit measure was better in predicting social distance or willingness to interact with someone who has a substance use problem (Drake, Codd, & Terry, 2018). Therefore, I assume that implicit measures do not necessarily outperform the explicit measure. Indeed they were both useful in gauging stigma amongst the SUD group, despite a social desirability concern. However, an explicit measure may be more useful in predicting behaviors such as the willingness to simply interact with someone who struggles with substance use disorder which is more representative in a typical therapy session.

Attrition rates in substance use treatment were investigated from the client's and clinician's perspective (Palmer, Murphy, Piselli, & Ball, 2009). The investigators wanted to assess, what were the most common reported barriers to treatment from both perspectives and address patient related concerns (motivation and readiness to change, health concerns, negative reactions, and substance use recovery), program or staff related issues (staff limitations or connection issues, reactions and relations with other patients, confidentiality and privacy concerns, or programs services, expectations or rules), and external issues (life stressors, social supports, limited resources, and referral sources). Results suggested that clients credited dropout to staff attributes, while both clinician and clients reported more individual-level reasons than program-level reasons. Clinicians reported individual level reasons at significantly higher rates than clients. In addition, both groups reported motivation, substance use, transportation or financial difficulties, ambivalence, and staff connection issues. However, the clinician more substantially reported individual or client level issues such as motivation, limited support, minute hope in ability to change, physical or mental health motivation, and regret about behavior about the program (Palmer, Murphy, Piselli, & Ball, 2009). This study suggested some vital supports in the need to address the provider's level of negative and bias attitudes against clients with substance use disorder. This is yet another study indicating that drop out is a major issue with clients within this population. Another support is motivation and little hope in the client's ability to change. This is a concern because there are so many issues that could influence a client's motivation to change and part of the mental health and substance abuse counselors' goal should be to help incite motivation for change. How can a provider incite motivation to change when they believe, as clinicians did in this study, that there is little ability to change? Moreover, how can a client find motivation to change when there is little hope in the ability to change and they

feel the provider feels negatively about them? In my opinion, the study should have included questions concerning where the lack of motivation derives from as well as the little hope in that ability to change. For example, do they perceive it from the providers or feel as if their providers have not given them an intervention option that they can feel hopeful about? Do the clinicians essentially feel helpless or hopeless in the interventions? A study addressed research which indicated numerous professionals feel that behaviors such as alcoholism and addiction have a worse prognosis. They suggested that due to prevalence of substance misuse and a recovering client not typically checking a prior substance use disorder for fear of stigmatization, it is likely that the clinicians do not see that recovery is possible and develop a cognitive bias concerning their prognosis (Friedmann, 2008).

In sum, it appears that stigma has been investigated to some extent in the healthcare field with aforementioned measures. But there is definitely a lack of research or measures of stigma in the mental health domain from the provider's perspective. Further there is a lack of stigma related measures concerning mental health providers and the substance use disorder population. With stigma being listed as a major barrier to treatment (Luoma, Kulesza, Hayes, Kohlenberg, & Larimer, 2014), and substance use disorder at a crises level (Dimoff, Sayette, & Norcoss, 2017), this project hopes to offer some insight on provider stigma (from mental health professionals) and substance use disorder.

Recommendations for Those Who Receive a Score That Suggests Bias

It is not the purpose of this project or this scale to simply reveal the possible presence of provider stigma against this population without recommendations of how to proceed. While it may not be everyone's desire to offer intervention with this population, there are some cases in

which those employed at a mental health agency will have no other choice but to offer intervention such as in community care, crises units, hospitals, or in forensic settings (correctional facilities, drug court). In addition, comorbidities reduce the option to choose whether a psychologist wants to offer treatment or not, as it is common for clients diagnosed with a substance use disorder to have a co-occurring mental health illness (Mericle, Martin, Carise, & Love, 2012). So, my goal for this measure is to bring awareness to provider stigma in hopes that those who are going to work with this population can take action to reduce their stigma, thus reducing harm, through various options that I will discuss.

Previous approaches to reduce stigma include stigma reduction education or education by contact with people who manage mental health challenges. Additionally, social contact with this population works best if it is in person, though video contact has shown some improvement. Some research suggests that education and treating the client, via video contact can reduce the stigma (Harris, Leskela, Lakhan, Usset, DeVries, Mittal, & Boyd, 2017). Within this same body of work, a study evaluated the outcome of a program that targeted the reduction of stigma of mental health providers toward their clients. The program consisted of combining education with a focus on creating a culture of nondisclosure and continuous contact approaches. The purpose of the study was to reduce self report stigma toward clients and providers with lived experience and increase access to ongoing, continuous contact resources by creating a professional environment in which disclosure of mental health challenges were safe and welcomed. The interventions included in the study utilized education that focused on the breaking down of perceptions of providers and those managing mental health issues as “us,” and “them.” Education was provided for mental health service leadership and education for direct care. Results of the study suggested that changing the culture of nondisclosure may be effective in changing stigma amongst mental

health providers. There were significant reductions in stigma toward both client and providers with lived experience as well as significantly increased self-disclosure to professional peers (Harris, Leskela, Lakhan, Usset, DeVries, Mittal, & Boyd, 2017).

Unexamined values, beliefs, and attitudes can be influenced to come to one's awareness through reflection. Activities or exercises that involve self-reflections can help to unveil our deeply rooted beliefs and possibly incite students to shape their own professional and interpersonal behaviors. Within this study (Ballon & Skinner, 2008), psychiatry postgraduate training students completed reflection exercises (reflection discussion times, reflection journaling, and mandatory end-of-rotation reflection papers) to gauge if reflection techniques increased self-awareness of beliefs, values, and attitudes concerning working with clients with substance abuse or other addictive disorders. These students reported the reflection techniques were extremely valuable in the development of professional attitudes to engage and provide interventions for clients with addictive disorders. In addition, results suggested many students entered the substance abuse rotation with negative attitudes toward clients with substance abuse and viewed them as "mainly street people who they expected to be of low intelligence and education, low functioning ability, and low socioeconomic status." The reflection techniques helped the students to become aware of their own biases toward those with substance abuse and increased both their comfort level and efficacy in treating individuals with an addictive disorder (Ballon & Skinner, 2008).

A review of literature by Livingston, Milne, Fang, & Amari (2011) revealed that substance abuse concerns were viewed as criminal and moral issues rather than health issues, and individuals are more likely to be blamed, held responsible, and having personal control over their illness. More specifically, illegal substances were more negatively perceived than legal

substances. Substance use with drugs such as heroin, were considered crimes as well as deserving of moral condemnation and social disapproval. Within this same review of literature a study investigated how to reduce multiple stigmas, including structural stigma, toward clients with substance use disorders. Structural stigma was defined as rules, policies and procedures, of institutions that restrict opportunities and rights of the individuals within a stigmatized group. This would include the professionals, trainees, and students providing care or intervention to the individuals. This study suggested that effective strategies for reducing structural stigma included education programs (structured education and critical reflection techniques) that targeted medical students and other professionals (counselors, police) as well as contact-based training. For substance abuse counselors, stigma interventions targeted attitudes using multi-cultural training and Acceptance and Commitment Training (Livingston, Milne, Fang, & Amari, 2011).

Attribution Theory Framework For Item Development

When considering the construction of the scale to measure mental health professionals' bias and negative attitudes, I explored a social perspective. Our social interactions direct our behaviors and identify what is normal, acceptable, expected, or customary (Pescosolido, Martin, Lang, & Olafsdottir, 2008). So, one can assume that clinicians are not devoid of social influence, but like most individuals have been exposed to societies determinants of stereotypes, negative beliefs, prejudices, and discrimination. It behooves us to accept that clinicians are subject to biases from the environment influence. Further, mental health professionals are not exempt from stigma as they are influenced by and frequently exposed to or believe public stigma concerning stereotypes against those with mental illness, just as the general public are (Charles & Bently, 2018).

In researching the social implications of stigma, I looked further into social psychology and the attribution theory. By definition stigma encompasses derogatory attributes (Drake, Codd, & Terry, 2018) and studies suggested that those individuals with substance use disorder are believed to have negative attributes (Phillips & Shaw, 2013; Luoma, Kulesza, Hayes, Kohlenberg, & Larimer, 2014). For example, they were described in negative terms such as having bad character, being dangerous, and were blamed for their issues (Phillips & Shaw, 2013). In addition, research indicated that substance misuse conditions may be particularly susceptible to stigma via attributions of personal culpability associated with attribution theory (Kelly & Westerhoff, 2010).

The attribution theory, originally developed by Fritz Heider, describes the behavior of individuals and how they perceive, analyze, and respond to others (Ruybal & Siegel, 2019). However, Bernard Weiner took this theory an additional step by incorporating the following components in understanding behaviors: stability, locus, and controllability. The concept of stability is the extent to which behaviors can change (i.e. can the behavior be overcome). Controllability is the extent that the behavior is under the individual's control (willpower), and locus is the extent to which the cause of the behavior is due to internal or external factors (Kelly & Westerhoff, 2010; Ruybal & Siegel,2019). Therefore, this attribution theory suggests that if an individual has difficulties with substance misuse, the individual is to blame for their issues. This theory endorses that individuals should be able to control their behaviors, if they really want to, as the cause of their behaviors are attributed to factors that can be changed or controlled. Hence, if we view the individual who experienced these concerns in this way, the attribution theory suggests, the individual chooses to not stop the behavior. It becomes a matter of will and the individual is to blame for their own issues and if they are to blame, then we may be more apt to

use terminology to describe them in negative ways that could elicit judgment. For instance we may describe an individual as a "substance abuser," instead of an individual that has a substance abuse disorder. Unfortunately the term "substance abuser," is used amongst even highly trained mental health professional and can cause the professional to view the individual as being personally to blame, deserving a punishment, and their substance misuse viewed as a moral rather than medical condition (Kelly & Westerhoff, 2010). How can mental health professionals ethically offer mental health intervention to someone that they believe deserves punishment? And how can we be sure that those in the mental health profession are not subscribing to these beliefs and attitudes? It would then appear to be very necessary for those in the helping profession to gauge their own attitudes and judgments about those clients who struggle with substance misuse.

Attribution theory fits into this project as it provides a potential framework for examining the cause for both behavior and attitudes we may feel toward others, which can be generalized to those with substance use disorder and thus the presence of provider stigma. This is imperative to investigate as it may impact mental health professionals' interest or likelihood of helping or offering interventions to this population. Indeed, Weiner (1980) suggested that when the cause for "need," was controllable or internal to the individual they read about, the ratings of help were the lowest. In addition, avoidance behavior as well as negative feelings (such as anger and disgust), were increased when the student viewed the persons as having internal control over the current situation/difficulties whereas more positive effects such as sympathy were endorsed if the situations were seen as uncontrollable to the individual. Further, one study suggested that attributions direct our feelings while emotional reactions navigate the course of our behavior (Weiner, 1980). This can be generalized to clinicians working in a mental health setting, in that if

we attribute the client with substance use issues to be internally induced, unlikely to change, and their own fault, we may have more negative feelings toward them and avoid helping them.

Weiner (1980) believed that when an individual observes someone or an event, they look for causal factors that may enable them to better understand the circumstance or explain why it has happened. The attributions we acknowledge in those moments direct our emotions and behaviors that ensue. Helping behaviors are reduced when attribution results in negative emotions such as anger or disgust. In turn, helping behavior increases when attributions are connected with sympathy (Weiner, 1980; Ruybal & Siegel, 2018). For this project, I am generalizing helping behavior to mental health interventions, in hopes to buttress my hypothesis that psychologists are not immune to stigma and negative feelings toward clients with substance use disorder. Further, Weiner's attribution-emotion-action model of help gives us perspective in how negative feelings can reduce our helping behaviors if we consider the client to blame for their issues, if their issues are due to internal factors, or are unlikely to change over time. Hence, it makes sense to then create a scale to measure a clinician's opinion of the SUD client's locus of control, controllability, and stability to give the clinician a better understanding of their own stigma. And my hypothesis is that the higher levels of negative attributions, the more likely this is representative of biased feelings against the client.

My hope is that if the clinician completes this measure and produces results that suggest a bias, then the clinician can seek measures to face this stigma and hopefully reduce them and reduce bringing harm to this population and increase helping behaviors. It is imperative to gauge stigma by the attribution theory and measure the clinicians' feelings toward clients with substance use disorder according to content that focuses on locus of control, controllability, and

stability. With that in mind, I created a scale with content that I derived from each concept and the most commonly reported negative attributes found in the aforementioned literature review.

Scale Development

Undertaking the development of a new scale was quite daunting. Especially when there are several ways that one can develop a scale. One way is to locate a measure that closely relates to the scale you wish to create and contact the individual who created the scale and ask permission to use their measure in order to mirror their development. Another way is to research scale development and model one's measure from the model of development. After much research, I decided to go with the scale development and I found one that was user friendly, appropriate for creating new measures, and that did not confuse someone who was a novice to scale development. So I went with Lee Anna Clark and David Watsons (1995), scale development. There were many steps involved in this approach that hope aided in producing a valid and reliable measure. First, I developed a specific and detailed concept of the target construct grounded in a theoretical framework. For this particular project, the target construct was to gauge provider stigma. Provider stigma is defined as overt or subtle negative beliefs, behaviors, and attitudes of mental health professionals toward their client (Charles & Bentley, 2018). The theoretical framework that would support item formulation came after investigating the attribution theory. I felt it was the best framework to explain provider stigma and direct item content that gauged stigmatized attributes. Because the theory is based on a social psychology concept for the explanation of behavior and can influence helping behaviors, it was surmised that stigmatized beliefs of a client could be gauged from this theory. Therefore, I thought it was best to gauge provider stigma from the attribution theories dimensions of locus, controllability, and stability as presented by Weiner (1985).

Concerning the locus of control, I constructed items that focused on internal flaw based on common stereotypes in the body of the literature review of a client with SUD. For example, does the person have an addiction because they are innately bad, immoral, a criminal? As for the controllability factor, I formulated content that focused on if the clinician believed that the client was to blame for their issues and if they believed that addiction persists due to lack of will power, poor motivation, etc. Lastly, I wanted to include content that focused on stability or the clinician's belief in the likelihood that the person is likely to change their behaviors concerning addiction. For example, does the clinician believe it is no use to offer treatment or if they believe the client can change their behaviors and obtain sobriety? With all this in mind, I laid out the scale with the dimensions of attribution theory and the item content beneath each one.

The next step in the Clark and Watson development (1995) was to conduct the literature review. The goals were to gain information on the construct, and examine how others have investigated or approached the issue. For this particular step, I researched the prevalence of substance use disorder and thus, the need to offer intervention within the population. From there, I looked at barriers to treatment from the client's perspective in that they experience stigma from multiple angles (social, self, and providers). In addition, I looked at the possibility that provider stigma occurs not only in health care settings, but could also be generalized in the mental health setting to clinicians, who might also be prone to biases and stigma. In addition, I searched for various measures that assess for stigma concerning treatment of substance use disorder. I investigated self-report measures concerning self-stigma and social stigma. However, the measures that I found concerning the provider perspective were often pertaining to medical professionals, and did not specifically target stigma against substance use disorder from a mental health provider; or targeted both negative and positive emotions. Further, I found that the

attribution theory was utilized to understand stigma against other mental illnesses (Ruybal & Siegel, 2019). Within this literature review, I also gained a plethora of information concerning attributes in which clients with substance use disorder were negatively described.

The next step within the model was creating the items for the measure. The goal for this particular step was to sample all content that could be important to the target construct following two guidelines: the items should be more comprehensive and broader than one's theoretical view of the target construct and the items should include content that would not be unrelated or tangential. This process took several attempts to prevent the selection of double barreled concepts and other items that could influence validity or reliability. I began with over including items and through multiple revisions; the survey items were reduced to the current 31-items pool. It is important to note, I sent these items to those in my DSP committee and those outside my committee with either experience in test development or experience in working with substance use disorders. I ended up with one measure containing three subscales; locus of control, controllability, and stability.

I believe that the item pool is currently well supported by literature as numerous items were directly taken from research and studies concerning substance use disorder in describing this population. It is my opinion that because most of these descriptions were already indicated in research literature, they are supported as essential items to include in this measure. In addition, the items were assessed for being understandable, double barreled, and for appropriate phrasing. Further, after careful consideration, the choice of a Likert scale format was selected, since checklists are subject to response bias and a dichotomous option can lead to a distorted correlation result (Clark & Watson). I did not want to give the scale a dichotomous scoring as that would suggest that stigma either exists or it does not. In my opinion, stigma is a part of our

society, so it is impossible for one not to be influenced by it. Therefore, I suggested that the measure include a more realistic scoring involving a range of acknowledgment, a Likert scale of 1-5. (1= strongly disagree to 5= strongly agree) I also felt that this type of scale could decrease defensiveness and aid in the normalization of possessing these attitudes to some degree.

For the sake of this particular DSP, the remaining steps of the Clark and Watson (1995) which included addressing the structural validity and data collection were not included in this manuscript as it is beyond the goal of this particular project to collect and analyze data. Indeed, it was the purpose of this project to create a measure that is considered ready to pilot. However, it is my future goal to pilot this measure and collect data, as I believe this measure is greatly needed in mental health intervention, more specifically to those who have a history of passing these particular clients onto other helping professionals.

Those within the medical and mental health fields should complete this measure. The focus of this project was to raise awareness for the prevalence of provider stigma in the treatment of substance use disorder in order to advocate for resolving those biases and hopefully inciting more compassionate and helpful interventions. Moreover, I would like this project to aid in increasing awareness of those within the mental health profession, so that they can become more aware of any provider bias toward the substance use population. The hope is that more professionals will seek to resolve their biases toward this population and offer much needed intervention services. It is vital to assess mental health providers' various biased attitudes and stigma toward diverse populations for which they offer services. Thus, this measure should be given to all those who work within the mental health field. Given the prevalence of comorbidities and substance use, even those who are not interested in providing interventions to this specialty population should complete this measure. In addition, as stigma negatively impacts helping

behaviors, the therapeutic alliance, and empathy, it is imperative for clinicians to know their negative attitudes, and I believe it can be done by assessing clinician's attitudes toward the client in the context of examining their attributions about their clients' substance use e.g., Are they to blame for their issues? Can they change? Are they innately bad?

I believe that these measures should be included in continued education programs on a yearly basis, in tandem with substance use disorder related lectures, trainings, and conventions. My goal is to increase the awareness of this provider stigma in hopes that some clinicians will consider the results when choosing to treat or not to treat a client with substance use disorder. If the clinician receives a score that suggests a high attribution rate, and therefore a higher likelihood of stigmatized feelings, they should consider decreasing these attitudes through prescribed methods of multicultural training, ACT training, supervision and consultation, and reflection vignettes. I would also like to see this measure utilized by the Harm Reduction Coalition organization, as a part of the work that they are doing to advocate and protect clients with SUD. This population deserves compassionate, ethical, and unbiased care from mental health providers.

Information concerning what the meaning of individual scores will be determined in the future once data collection has been completed and analyzed. The purpose of this DSP was to produce a measure that would be ready to pilot for future data collection. Future endeavors are to collect data to address reliability and validity concerns. In addition, I have included post-questions to gain information on correlations between the scores and helping behaviors/advocacy.

APPENDIX A

Provider Assessment Stigma Scale (P.A.S.S.)

As you read each of the scale items below, think of an individual who has a substance use disorder and has presented for treatment at a local mental health facility. Carefully read each of the attributes listed and for each one, please rate the individual from 1-5 as having or not having the attributes. Scoring ranges from 1 (which means you strongly disagree) to 5 (which means you strongly agree).

Likert Score explained: 1 (Strongly Disagree) 2 (Moderately Disagree) 3 (Neutral) 4 (Moderately Agree) 5 (Strongly Agree)

Locus of control (Internal factors)

This individual…..

1. ____not a good person.
2. ____a druggie
3. ____a junkie
4. ____immoral
5. ____uneducated
6. ____worthless
7. ____dangerous
8. ____dishonest
9. ____a criminal
10. ____not reliable

Controllability (in control of their issues)

This individual…

11. ____is weak willed
12. ____lacks self-control
13. ____is to blame for their addictions
14. ____does not want to be helped
15. ____does not want to change their behavior
16. ____does not want a better life
17. ____choses to remain addicted.
18. ____chose to become addicted
19. ____could resist their cravings if they wanted to.
20. ____could endure withdrawal if they really wanted to be free from addiction.

Stability (Is this behavior likely to change)

This individual…

21. ____will relapse
22. ____will not benefit from therapeutic intervention.
23. ____will likely cancel their appointments frequently
24. ____will likely dropout of treatment.
25. ____will likely avoid dealing with core issues of their addiction.
26. ____is a hopeless case.
27. ____will likely keep using substances until they die.

As a provider I…..

28. _____will struggle to build rapport with this client that is necessary for intervention
29. _____will struggle to feel empathy for them that is necessary for intervention.
30. _____will not see positive outcomes in treatment with this client.
31. _____have seen successes amongst this population with intervention that target addictive behaviors

Post Questions to measure a correlation of helping behaviors

1.) What is your degree?

2.) What training do you have with empirically based treatments concerning substance use disorder? Please list treatment by name.

3.) What experience do you have with offering empirically based treatments to clients with substance use disorder? Please list treatment by name.

4.) Approximately how many clients with substance use disorder have you treated?

5.) Would you offer treatment to a client with substance use disorder?

6.) Would you refer a client with substance use disorder to another specialty?

7.) Approximately how many clients with substance use disorder have you referred to another specialty for treatment?

8.) How likely are you to advocate for this population?

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