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# Changes in Nursing Student Attitudes Toward Mental Illness

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# Changes in Nursing Student Attitudes toward Mental Illness

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People who suffer from mental illness comprise a highly vulnerable population, and encounter adversity from two directions. Not only do they have to contend with their illness and the management of its symptoms, but they also have to brace themselves against the societal backlash and devaluation produced by the stigma that accompanies mental illness. Stigmatization can drastically alter the life chances of individuals with mental illness and have negative outcomes in regards to employment, income (Markowitz, 1998), social integration(Chan, 2004), self esteem(Blankertz, 2001), health care, insurance, and access to justice (Sayce, 1998.)

## THE CHALLENGE OF DEFINING STIGMA

The word "stigma" comes from the ancient Greek word "stig," meaning "to prick." Slavery was a common practice in ancient Greece, with slaves comprising over one-third of the entire population. Analogous to the practice of branding livestock, the Greeks used a pointed instrument to tattoo the skin of their slaves, making a mark referred to as a "stigma"(Falk, 2001 p.17).

The modern day use of the word "stigma" refers to the rejection of any person or group who deviate from societal norms and expectations. Not all people with mental illness will experience stigma with the same acuity (Link & Phelan, 2001). There are several competing conceptual models defining stigma, each having a different perspective on where to direct actions addressing stigma(Sayce, 1998). In Goffman=s 1963 work *Stigma: Notes on the Managment of Spoiled Identity*, he stated that stigmatization occurs when a person possesses an attribute that is incongruent with societal expectations, and therefore makes such a person appear undesirable, dangerous, or weak. Hence such a person is reduced "from a whole and usual person to a tainted, discounted one"(Goffman, 1963 p.3).

In simple terms, stigma may be viewed as social rejection(Garske, 1999), a mark of

shame(Sayce, 1998), discrediting or being singled out(Brunton, 1997). Liz Sayce(1998) argues that when stigma is viewed along the lines of shame, this conceptualization lays blame on the stigmatized rather than on those who disenfranchise them. Consequently, the focus of solving the problem lies in altering both the self-image and the perception of the labeled person. Changing the individual's attitude about themselves will do little to address existing patterns of social and economic exclusion, which are recognized to be associated with stigmatization. Sayce recommends considering the word "discrimination" in place of "stigma" as a term more suitable for describing the unfair treatment of the mentally ill, which may in turn lead to more effective strategies for promoting justice. She posits that "discrimination" more accurately lays blame on external forces which act to perpetuate injustice. With this concept in mind, interventions will be more effective in the long term focusing on addressing the attitudes of others, as well as current societal structures which have created barriers for the mentally ill.

Labeling theorists hold that the official label of mental illness can have detrimental outcomes for patients, enacting stereotypes and negative attitudes towards the mentally ill (Rosenfeld, 1997). Adhering to the medical model of thought, critics of the labeling theory assert that stigma itself has little affect on the life chances of those with mental illness. Such critics believe that it is the symptoms of a person's diagnosis that are to blame for rejection and other negative outcomes (Markowitz, 1998). These critics contend that negative reactions and attitudes from the general public are expected responses to disturbing behavior from those with mental illnesses(Phelan & Link, 2004). Challenging this dichotomy, Rosenfeld(1997) asserts that the labeling and psychiatric conceptual models each indicate their own unique course of treatment. In her study, she found that patients' perceived quality of life is negatively affected by perception of

stigma and positively affected by utilization of mental health services. Specifically, she concludes that patients who perceived the least amount of stigma and had access to high quality services ranked highest on overall life satisfaction. Thus, Rosenfeld suggests a fusion of the labeling theory and the medical model of thought for constructing future interventions.

Link and Phelan(2001) realized the complexity of stigma and constructed a conceptual model which aggregates several simpler, possibly reductionist, definitions into a more comprehensive concept. Stigma can affect multiple life chances and there are multiple stigmatizing factors that should be evaluated when analyzing outcomes. Therefore, they contend that stigma is a composite of stereotyping, labeling, status loss, separation and discrimination occurring in concert with an enabling power situation. Not only does this definition promote greater clarity as to the nature of stigma, it also illuminates the reason why stigma continues to persist and will be a challenge to eradicate:

> When powerful groups forcefully label and extensively stereotype a less powerful group, the range of mechanisms for achieving discriminatory outcomes is both flexible and extensive.
>
> (Link & Phelan, 2001 p.379)

There is a multitude of ways already in place to promote discrimination. When one of these ways is disrupted a new way will easily be instated. Hence, simply addressing issues of housing, employment, and social interaction on the individual level, will achieve only small and temporary victories. Stigma is clearly a systematic problem, and requires interventions directed at altering the current power structure, or at the very least, altering the attitudes and behaviors of those in power: the non-stigmatized majority.

When attempting to define stigma, there seems to be lack of consensus within the literature

as to identifying the cause of stigmatization. As each conceptualization has its own concept of where to lay the blame, each has its own indication for where to direct strategies designed to combat stigma. A more cohesive definition of stigma itself may in turn lead to a more focused effort to preventing stigmatization.

## THE EFFECTS OF STIGMATIZATION

Those with mental illnesses are faced with hardships in both the social and economic spheres of life. To many, the stigma and discrimination that accompany a diagnosis of mental illness are just as troublesome as the diagnosis itself(Sayce, 1998). Stigma has been shown to have a direct negative effect on perceived quality of life, with greater perceptions of discrimination yielding lower overall life satisfaction(Rosenfeld, 1997). Stigma can lead to rejection by family members, friends, coworkers, neighbors, and future employers, and this rejection may precipitate feelings of depression and loneliness(McReynolds & Garske, 2003). Compared to persons with other disabilities, those with mental illness are viewed as being among the least desirable for friendship(Gordon et al, 2004). Blankertz(2001) assessed the self esteem of individuals with severe mental illness and found that even though the sample had high education and employment rates, stigma was an overriding determinant in individuals with lower self esteem. Life satisfaction can be reduced by stigma as it tends to diminish one's sense of self-worth and self-efficacy(Rosenfeld, 1997).

The unemployment rate for those with severe mental illnesses is approximately 85% and the employment that they do find is usually low paying and of low status(Garske & Stewart, 1999). Job placements are most likely to be found in the areas of food service, gardening, laundry, and janitorial services, which are collectively known as the "Four F's": food, flowers, folding and

filth(Garske & Stewart, 1999). Persons suffering from mental illness are ranked among the least desirable of potential job applicants. In a study by Gouvier, Systma-Jordan, and Mayville(2003), a sample of 295 upper level business students were asked to assume the role of a corporate employer and rank four potential job applicants, each of whom had a different disability: back injury, head injury, developmentally disabled, and mental illness. The applicant with a mental illness rated lower on overall employability than the individual with a developmental disability.

The cost of health care coverage also may be a deterrent to employers. In one study, depressive illnesses cost more to employers than when compared to the costs of four other common chronic medical illnesses: diabetes, hypertension, heart disease, and back problems.(Druss, Rosenheck, & Sledge, 2000). Furthermore, those with depression and another medical condition can be even more costly to employers, incurring expenses 1.7 times greater than individuals with one of the comparison conditions alone.

The extant literature also questions the overall quality of care that the mentally ill receive, especially in the older adult population. There have been cases documented in which individuals in assisted living facilities have not had their needs for mental health services met, or have been subjected to abuse or neglect(Becker, Stiles, & Lawrence, 2002). A 4-year study of four primary care clinics of a large staff model HMO in Seattle found a disparity in the treatment of older adults with depression(Unutzer, 2000). The overall rate of treatment of depression was low, 4-7% of the entire sample, and when patients were treated, the intensity of treatment was low as well, with adequate use of antidepressants remaining below 30%(Unutzer, 2000).

Treatment approaches themselves may compound stigma and perceived loss of self by perpetuating passivity and helplessness in patients receiving mental health services. Davidson,

Stayner, Lambert, Smith, & Sledge(1997) conducted a study which examined the effectiveness of current strategies to decrease inpatient recidivism. Currently within the mental health field, inpatient recidivism is regarded strictly as a clinical matter. Interventions have been aimed at the management of symptoms as a means to decrease relapse and readmission. However, Davidson and associates expose the limitations of a purely clinical approach, as evidenced by data gathered from interviews with 12 recidivist patients. These patients viewed the hospital as a place that offered safety, food, shelter, respite and privacy. Many described harsh living conditions outside of the hospital (such as living in crowded homeless shelters) and lacked friends or supportive family members. Some also reported feeling powerless over their illness. Others felt that mental health services had little or no effect on their risk for rehospitalization. Davidson and associates stress that recovery should be rooted in understanding the experiences of the person with the disorder, which means utilizing the patient as a resource to focus their care. To not do so would be to ultimately reinforce their own feelings of hopelessness and powerlessness about their condition.

Many people with mental illness are denied insurance coverage or have limits placed on their benefits, like shorter inpatient hospital days covered. This disparity stems from the prevailing notion that they require more health care, leading to greater costs. This reasoning is not extended to other chronic illnesses like diabetes. Also the mentally ill are not extended the same coverage from Medicaid that is given to people with mental retardation living in group homes, halfway houses, or adult foster care(Koyanagi, 1990, as cited in Noe, 1997).

Families also suffer when a loved one is diagnosed with a mental illness. They are faced with difficult situations, such as the roller-coaster of emotions associated with cycles of symptom

exacerbation and remission, involuntary commitment proceedings, and role and occupational changes of the primary caregiver(Lefley, 1989). The stigma of mental illness can be extended to their family. In several theories, the causation of mental illness and its exacerbation are attributed to biological means or environmental triggers. Consequently, the family is often blamed, adding insult to injury in an already stressful situation(Lefley, 1989). As a result, they may face social isolation, a stigmatized reputation, and loss of relationships with friends and neighbors(Lefley, 1989).

## A DESIRE FOR DISTANCE

Historically, people have thought that mental illness results from weak moral character, punishment from God, or demonic possession(Garske & Stewart, 1999). The media has perpetuated violent and dangerous stereotypes in movies and television programming(Brunton, 1997) and news reporting often disproportionately reinforces the relationship between mental illness and violence(Sayce, 1998). So it comes as no surprise that a strong stereotype of dangerousness persists and the public desires social distance from the mentally ill (Link, Phelan, Bresnahan, Stueve, & Pescolido, 1999). The public's perception is clearly incongruent with existing research which shows that the actual numbers of violent persons with mental illness are quite low. It is also a widely held belief of the general public that those who suffer from mental illness never completely recover(Brunton, 1997). The findings of Harding, Brooks, Ashikaga, Straus, and Brier(1987), as cited in McReynolds and Garske(2003), show the contrary. People are able to recover from mental illness, and enjoy successful employment and meaningful lives. Unfortunately, the combination of the myths of violence and perceived unlikelihood of recovery continue to reinforce the existing stigma and the desire for distance from the mentally ill.

Recent research makes a strong case against the mythic pervasiveness of violence among those with mental illness. Applebaum, Robbins, & Monahan (2000) have shown that the presence of delusions, regardless of their content, is not an indicator of likelihood of violence. Link, Monahan, Stueve, & Cullen (1999) found psychotic and bipolar disorders to be independent of violence risk, and that the risk is situational rather than contingent on diagnosis. This study found that mental illness has the same odds as other indicators of violence, such as age, gender, and level of education.

> If a community were to use risk of violence as the sole basis for the exclusion of people with mental illnesses, such a community might just as well exclude men in favor of women, teenagers in favor of people who are 50 years old, and grade school graduates in favor of college graduates.
>
> (Link, Monahan, Stueve, & Cullen, 1999; p. 327)

The presence of mental illness alone is not a reliable factor for predicting violence risk. A much stronger indicator is the combination of substance abuse and medication noncompliance (Swartz, Swanson, Hiday, Borum, et al, 1998). A sample of 331 involuntarily admitted inpatients with severe mental illness participated in extensive face-to-face interviews. The data obtained revealed that the combination of alcohol or substance abuse problems and medication noncompliance was strongly associated with serious violent acts committed before admission. However, these factors were not found to be individual predictors of greater risk when analyzed separately.

## ERODING STIGMA

On the individual level, stigmatized persons may use certain defense mechanisms to dodge stigma. Some patients choose not to disclose their mental illness to family, friends, or coworkers or may be selective with whom they share this knowledge. Other patients may tell people as soon

as they meet in order to increase awareness and educate(Brunton, 1997). Some patients try to avoid stigma by choosing to not seek mental health services or to discontinue current treatment(Sirey, 2001). These strategies may provide temporary relief from stigma, but do not directly address stigma, and rather circumvent the issue. Professional nursing literature supports that two of the best options for unraveling stigma and improving public attitudes are: public education (Brunton, 1997; Garske & Stewart, 1999; Read & Law, 1999; Walker & Read, 2002) and increasing public contact with the mentally ill (Brunton, 1997; Phelan & Link, 2004; Walker & Read, 2002).

Mental illness and its causes have long been misunderstood and the general public still clings to several myths regarding its origins and manifestations. During medieval times, mental illness was viewed as a matter of moral weakness or demonic possession(Garske & Stewart, 1999). Previously, education efforts had been involved in a campaign to present mental illness as "an illness like any other," but this seems to have failed miserably in changing public attitudes (Read & Law, 1999; Walker & Read, 2002). Debate surrounds how to explain the cause of mental illness to effectively reduce stigma.

There is current literature which discourages the use of the biological model to explain the etiology of mental illness. Walker and Read (2002) surveyed attitudes in 126 mathematics students at a New Zealand university towards persons with mental illness. The students were given an attitude survey both before and after watching a 5-minute video of patients describing their symptoms, and a doctor explaining one of three causal theories: medical, psychosocial, or combined. The medical illness explanation did not improve attitudes, and in fact, was strongly associated with higher scores of unpredictability and dangerousness, thus reinforcing popular

negative stereotypes.

A similar study conducted by Read and Law(1999) parallels the findings of previous studies in that biogenetic causal theories are strongly associated with negative attitudes. This study showed that student attitudes improved after attending a lecture presenting a psychosocial perspective of mental illness, suggesting that it may be beneficial to incorporate such a framework in destigmatization programs. Their data also indicate that the fewer people with mental illnesses the respondents knew, the more likely they were to adhere to the biogenetic framework. The authors hypothesize that this may indicate that either personal contact fosters a more psychosocial perspective or that belief in the psychosocial framework makes one more willing to engage in contact with those who have mental illnesses. Hence, the two proposed keys to eroding stigma, education and contact, appear to be intertwined.

The effect of contact on attitudes towards stigmatized groups was formally conceptualized as the *contact hypothesis* by Allport(1954), as cited in Desforges, Lord, Ramsey, Mason, Van Leeuwen, West, & Lepper(1991). It was proposed that contact between stigmatized and non-stigmatized group members would result in positive outcomes when the situation providing contact gave all participants equivalent status and a shared objective. The attitude change was attributed to a three step process: expectation, adjustment, and generalization(Desforges et al, 1991). Before contact with a member of a stereotyped group, individuals have preconceived notions about a typical member. By engaging in equal status cooperative contact, the negatively stereotyped person conveys a more positive impression than was expected and then this positive impression is then generalized to the entirety of the stereotyped group(Desforges et al, 1991).

Studies indicate that contact with mentally ill patients correlates to improved

attitudes(Desforges et al, 1991; Mclaughlin, 1997) and decreased perceptions of danger(Phelan & Link, 2004). Previous contact, personal experience, and occupation/field of study are factors which influence the likelihood of engaging in contact and attitudes towards the mentally ill. Familiarity with mental illness indicates decreased likelihood of avoidance and increased chances of offering interpersonal help to those with mental illnesses(Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). In a study surveying 308 undergraduates from the University of Hong Kong, medical and dental students had attitudes which were more accepting of those with mental illness when compared to the attitudes of engineering and social science students. Of those medical and dental students, respondents who had previous contact with persons having mental illness were more open to interaction with a person labeled as mentally ill than were persons who had no previous contact(Chung, Chen, & Liu, 2001). These findings indicate that being educated in the health field has a correlation with positive attitudes towards the mentally ill and thus, provides evidence supporting strategies to increase public education and contact.

## NURSES AND THEIR ATTITUDES

Most nursing schools require that students complete a rotation in psychiatric nursing, which gives students exposure to classroom theory on mental illness and opportunity for clinical contact. Thus, student nurses are an excellent population to study the effects of learning and contact on attitude. Mclaughlin (1997) analyzed the perceptions of a group of 72 nursing students in a diploma program who attended 2-5 weeks of classroom education and then completed 4 weeks of clinical work. At the end of their classroom experience, students generally had overall positive attitudes in regard to the characteristics and treatment of patients. At the end of their clinical rotation, students still maintained positive attitudes regarding treatment, disagreeing that the

mentally ill should be institutionalized, and rather felt that it would be better for them to live in residential accommodation. However, their attitudes regarding the characteristics of the mentally ill returned to baseline values after their clinical rotation(McLaughlin, 1997). Contact was shown to promote both positive and negative changes in attitude. The overall findings suggest that classroom theory has a positive effect, which is supported by clinical practice.

A study of Chinese student nurses did not support the contact hypothesis(Callaghan, Siu Shan, Suk Yu, Wai Chung, & Kwan, 1997) Students in this study found previous contact with mental illness, either from a previous psychiatric course or having a family history, had no effect on their attitudes towards mental illness. Their overall attitudes were positive, but became less positive when issues of social distance were addressed. More than half of the students agreed that psychiatric hospitals should not be located in residential areas, and the same number also agreed that those with mental illness should not be allowed to have children. An overwhelming majority (96.7%) felt that every person with a mental illness should be institutionalized. The disparity between generally positive attitudes and the desire for distance when confronted with everyday issues may be partially attributed in this case to the cultural devaluation. Disabilities are considered shameful in Chinese culture and those with disabilities are often kept out of sight(Wong et al, 2004).

This explains the students' desire to have all mentally ill patients in hospitals away from residential communities. However, the discrepancy between idealistic attitudes and actual behavior is an issue facing all nurses and student nurses, regardless of culture. Changes in attitude do not necessitate behavioral changes in response to stereotypes, unless these stereotypes are consciously inhibited(Rogers & Kashima, 1998). A study assessing the responses of nurses to

scenarios involving clients with schizophrenia revealed many self-reporting that their actual responses were more negative and in conflict with their own personal standards(Rogers & Kashima, 1998). The responses of general and psychiatric nurses were compared and it was found that psychiatric nurses were more successful at maintaining congruency between their personal standards and their actual responses.

The stigma associated with mental illness acts as a barrier and prevents nurses from maintaining the same standard of care with every patient. This study will evaluate the effectiveness of education and patient contact as strategies aimed at reducing negative attitudes towards persons with mental illness. Specifically, this study will examine the influence of one semester of classroom theory and clinical practice experiences in psychiatric nursing on the attitudes of student nurses toward clients with mental illnesses. The primary research question is: do student attitudes towards people with mental illness change after completing a semester of classroom theory and clinical practice contact?

## METHOD

### Design

This study used a prospective, pre/post test design. Data were collected by administering a questionnaire at two separate collection points. Time 1 was the first day of class and Time 2 was the 11$^{th}$ week the semester.

### Sample

Thirty-three undergraduate senior nursing students from the WMU Bronson School of Nursing, where the researcher is a student, were invited to participate in the study. Inclusion criteria stipulated that participants needed to be undergraduate nursing students currently enrolled

in a psychiatric nursing course.

**Procedure**

Structure of the class

This class is the sixth nursing course in the Bronson School of Nursing undergraduate curriculum and is the student's first formal introduction to psychiatric nursing. The class is 13 weeks long, at the end of which, students are required to have logged a total of 52 classroom hours (4 per week) and 234 clinical hours (18 per week).

Data Collection

Each student was assigned a predetermined identification number, all of which were selected from a table of random numbers. On the first day of class, students were invited to complete a packet containing a demographics sheet and a questionnaire. On the 11$^{th}$ week of class, the students were again invited to complete a second packet containing the same questionnaire. Institutional review board approval was obtained before the study was initiated.

**Instrument**

To assess the students' attitudes toward clients with mental illness, The Attitudes to Mental Illness (AMI) questionnaire was used. The questionnaire was developed by Weller and Grunes(1988) and has been used in recent studies(Singh, Baxter, Standen, & Duggan, 1998; and Tay, Pariyasami, Ravindran, Ayyoo, & Rowsudeen, 2004). This is a 24-item scale on which persons respond to each item by selecting one of five responses: very much agree, agree, have no opinion, disagree, very much disagree. Lower scores are representative of favorable attitudes while higher scores indicate unfavorable attitudes. This scale has an internal consistency alpha of 0.79(Weller & Grunes, 1988). Chronbach's alpha for the AMI at time 1 and time 2 in this study

were .88 and .86, respectively. A brief demographics questionnaire designed by the researcher was given at Time 1.

**Data Analysis**

Data were entered and analyzed on SPSS 11.0 (SPSS, 1998). Descriptive statistics were used to describe gender, age, ethnicity, education, marital status, hours worked per week, number of credit hours, and number of other persons in the household. Correlations between key demographic variables and measures were examined to identified possible covariates. Paired t tests were used to compare scores between time points. For all tests, an alpha of .05 was designated a priori for significance.

**Results**

All(N=33) of the students were female, with a mean age of 23.7 (SD = 4.6). The majority of the students were white (n = 29, 87.9%), two were black (6.1%), one was Hispanic (3%), and one was multiracial (3%). Almost all of the students described themselves as "single, never married" (n = 27, 81.8%), with the remaining six (18.2%) students reporting that they were married. Twenty-nine (87.9%) students were working on their first degree, three (9.1%) had an associate's degree in a field other than nursing, and one (3%) had missing data. They averaged 20.2 (SD = 8) hours of work per week and 12.3 (SD = 2.1) credit hours for the current semester.

All of the students except one indicated that they were taking this class for the first time. It is also important to note that 16 students (48.5%) had already attended at least one psychiatric clinical practice experience prior to the first day of data collection. There was no significant difference in attitudes between students who had previously attended a psychiatric clinical experience and those who had not at Time 1(t=.521, df=31, p=n.s.).

In regards to their personal exposure to persons with mental illness, over half of students (n=19, 57.6%) reported that they have a family member with mental illness. Almost as many, (n=18, 54.5%) acknowledged that they have had at least one friend with a mental illness. A majority of the students(n=23, 69.7%) have held a job in the past where they worked with clients with mental illness. Many students (n=12, 36.4%) reported having lived with a person with mental illness in the past.

Scores from the AMI administered at Time 1 indicated the class overall possessed very positive attitudes (M=1.73, SD=0.39) before the intervention. Students who reported having family members with mental illness had more positive attitudes (M=1.65, SD=.40) than their cohorts (M=1.84, SD=.35), but this difference was not statistically significant (t=1.41, df=31, p=N.S.). Students who had a friend with mental illness (M= 1.60, SD=.30 ) had a more positive attitude than those who did not (M=1.89, SD=.43) and the difference was found to be significant (t=2.29 ,df=31 , p=.03 ). The same was true for students who had lived with a person with mental illness. Those who lived with a person with mental illness had more positive attitudes (M=1.53, SD=.21) than those who did not (M=1.84, SD=.42) and the difference was significant (t=2.42, df=31, p=.02).

At Time 2, the overall attitudes of the class remained positive after the intervention (M=1.86, SD=.41), but had shifted in a negative direction. To calculate the difference in student attitudes between Time 1 and Time 2, a change score was created by subtracting the Time 2 mean score from the Time 1 mean score (M= -.14, SD= .32) and this difference in attitudes was found to be statistically significant (t=-2.48, df=31, p=.019).

When change scores were computed, 21(63%) students had more attitudinal changes in a

negative direction, with change score values ranging from -.04 to -.79. Nine (27%)students had positive attitude changes, with change score values from .09 to .71. Two students(6%) had no change in overall AMI mean scores.

At Time 2, students who had previously reported having had a friend with mental illness still had more positive attitudes (M=1.7, SD=.32) than their counter parts who had not (M=2.01, SD=.47), but this difference was not significant (t=-1.97, df=30, p=n.s.). Similarly, students who had reported having lived with a person with mental illness also had more positive attitudes (M=1.68, SD=.22) than their classmates who had not (M=1.96, SD=.46). Again, however, this difference was not statistically significant (t=-1.97, df=30, p=n.s.). Students who reported having a family member with mental illness had slightly more positive attitudes (M=1.83, SD=.50) than students who did not (M=1.90, SD=.27). Just as the data suggested at Time 1, this difference at Time 2 was also not statistically significant (t=-.473, df=30, p=n.s.).

**Discussion**

The findings from this study are consistent with the findings of McLaughlin(1997) that student nurses generally have positive attitudes toward persons with mental illness, and that clinical contact can cause change in student attitudes, in either a positive or negative direction. The findings are inconsistent with research indicating that student attitudes show no change after clinical contact (Weller & Grunes, 1988). As suggested by Singh, Baxter, Standen, & Duggan(1998), changing attitudes involves a complex process, relying on many factors besides patient contact alone.

The findings described here are also contrary to the findings of Callaghan, Siu Shan, Suk Yu, Wai Chung, & Kwan(1997) who found that previous contact with mental illness for students

who had a family history with mental illness or who reported living with a family member with mental illness had no significant effect on student attitudes toward mental illness. In this study, it was found that there was a significant relationship at Time 1 between positive attitudes toward persons with mental illness and either having a friend with mental illness or having previously lived with a person with mental illness. Although not statistically significant, students who have a family member with mental illness, had more positive attitudes at Time 1. This may be clinically significant, while not statistically significant.

The negative shift in attitudes from Time 1 to Time 2 could be attributed to a "ceiling effect." The mean attitude scores were so low at Time 1, indicating very positive overall attitudes, that it was improbable that they could have scored much lower at Time 2. Thus, it was not very likely that their attitudes would have become even more positive at Time 2.

Another possible explanation for the decrease in favorable attitudes is that having such highly favorable attitudes before the intervention, the class had a very idealistic conceptualization of persons with mental illness. Comparable to the findings of Callaghan, Siu Shan, Suk Yu, Wai Chung, & Kwan(1997), contact with mental illness also presents the possibility of negative contact experiences. After their clinical contact experiences, it is possible that the students gained a more realistic perspective of persons with mental illness. Although most of the students reported already having previous contact with mental illness, through their clinical experiences they may have been exposed to patients with a higher acuity and more vivid exacerbations of mental illness. The students' idealism and extremely positive attitudes were tempered by the reality of clinical situations. According to the Hinshaw-Davis Model of Basic Student Socialization(1976), this collision between student expectations and real-life situations results in "dissonance" or "lack of

harmony"(Chitty, 2005.) The negative shift in attitudes could be attributed to this "dissonance."

**Limitations**

The sample for this study was from one university, its size was fairly small and the group was largely homogeneous along the lines of age, gender, and ethnicity. So the findings of from this study are not representative of all student nurses in the United States and their attitudes toward persons with mental illness. It is also possible that students may have answered the questionnaire with responses that they felt were socially acceptable or desirable. Anonymous questionnaires were used in this study and thus, the likelihood of response bias was decreased.

Also, it is highly probable that the students' rotation in psychiatric nursing was not their first exposure to persons with mental illness. Over half of the class had reported having a family member or at least one friend with mental illness, and more than two-thirds of the class reported having held a job in the past working with persons with mental illness. Within the context of their nursing curriculum, it is very likely that they have encountered clients with mental illness previous to their psychiatric clinical rotation, having already completed rotations in geriatrics, obstetrics, medical-surgical, and pediatrics. Clients with mental illness are not strictly limited to the arena of psychiatric nursing care and may be present in a variety of practice settings.

**Implications for practice and further research**

Nurses' attitudes toward persons with mental illness can affect the care they give to their patients. Stereotypes shape our perceptions of others and guide our behavior towards them, unless these stereotypes are actively inhibited (Rogers & Kashima, 1989). Generally, nursing students have positive attitudes towards mental illness, and these attitudes may develop long before students actually participate in a clinical rotation in psychiatric nursing. Further investigation of

the formation of student attitudes toward mental illness during their entire nursing school curriculum may help to identify factors that contribute to positive attitude formation. It would also be beneficial to compare the attitude of students to how they interact with persons who have mental illness, to assess if there is congruency between beliefs and behaviors.

**Conclusion**

In response to the original research question, this study found that after completing a semester of classroom theory and clinical contact, there are changes in nursing student attitudes toward persons with mental illness. The data suggest that student nurses generally have positive attitudes toward persons with mental illness, while clinical contact was shown to be a factor that contributed to a slight shift of student attitudes in a more negative direction. However, even after 11 weeks of clinical contact and classroom theory, student attitudes continued to remain positive overall.

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