Copyright © 2018

Dreyfus (1989) borrows Martin Heidegger's notion of Befindlickeit in German to describe how temperament, affect, mood, and emotion can potentially "colour" a person's experiential world. Befindlickeit refers to human emotions and moods as a kind of disposition that is intertwined with how one is situated in the world. When a little boy experiences humiliation from his parents, his emotional reaction (i.e., embarrassment) is not only capable of magnifying the situation, but also engulfing his total experience to become an ontological dimension in his lived-world. If this is a prominent feature of the boy's intersubjective contexts—that is, he experiences such embarrassment on a regular basis, his emotion can be arrested in its course and gradually transform into a dimension of his lived-world. Extreme intensity of singular emotional experience can also engulf a person's experience to become an ontological dimension, which is exemplified in cases where trauma is present.

The lived-body, as Merleau-Ponty (1962, 1964) suggests, corresponds with the lived-world. The boy's experiences associated with the humiliation gradually become sedimented, forming the foundation of his habitual postures and bodily gestures in ways that make his life embarrassment-prone, thus reinforcing a sense of self that is built upon an organising principle of anticipating and avoiding humiliation.

## Phenomenological Reconceptualization of the Unconscious

Distinct from classical psychoanalytic notions of the unconscious, phenomenology advocates for experience-near concepts to capture the commonly observed clinical phenomenon that most human beings are not aware of their deepest motivations. For example, the horizonal notion of the unconscious (Husserl, 2001) allows clinicians to explore the underlying meanings and motives of their clients' behaviour without making reference to any unobservable psychic entities. This phenomenological notion is a type of metaphoric characterisation which seeks to describe the conscious-unconscious phenomenon with common-sense metaphors.

The horizonal unconscious suggests that a person's issue would fall outside of his or her awareness if it has transformed into a dimension of the context in which all future objects and events are encountered. The issue is no longer experienced as a dated moment or event in life, but as a general manner of existence like an atmosphere.

The past is spread out in front of this person as an atmosphere of the present. If this dimension becomes a core one in his or her whole existential context, it will show up in this person's habitual and rigid ways of relating to objects and other people in the world (Dreyfus, 1989).

Stolorow and colleagues (2002) propose three interrelated realms of the unconscious based on the notion of horizon. The prereflective unconscious refers to emotional convictions and organising principles that shape and thematise a person's experiences but operate outside the realm of reflective self-awareness. Similar to the phenomenological notion of atmosphere, it pervades everywhere in the person's horizon such that it cannot be identified as a perspective with anything to contrast with it. The dynamic unconscious refers to experiences that were denied of articulation because they were perceived to threaten significant relationships from which one's sense of self emerged. . Such experiences are faded into the background of the horizon but continue to shape our conscious experiences in powerful ways. Lastly, the invalidated unconscious refers to experiences that could not be articulated because they never evoked the necessary validating responsiveness from the environment. These experiences are like fragments of a gestalt floating in the empty space along the horizon but loaded with strong emotional forces that also significantly shape our conscious experiences and relational strivings.

Stolorow and colleagues (1992) provide an alternative concept of "organizing principles" of experiential world, which guides clinicians to explore how our clients' experiential world is organized in ways that give rise to distinctive meaning and themes in life. In terms of psychoanalytic practice, the clinician would focus on the more or less unconscious and invariant organising principles that underlie their patients' recurrent themes in life.

## Tools to Understand Experience: Bracketing, Description, and Contextualization

The phenomenological approach to counselling and psychotherapy refutes the concepts of "decontextualized absolutes or universals…neutral or objective analysts…God's-eye views of anything or anyone" (Stolorow et al., 2002, p.76). From a phenomenological perspective, clinical understanding is built upon genuine respect of the client's utterances, an expansion from the contents into contexts (e.g., historical, relational, and dynamic), and a continuous reflection of an evolving therapeutic relationship. Bracketing, description, and contextualization are three interrelated intellectual exercises for clinicians inspired by phenomenology.

Bracketing allows clinicians to suspend their taken-for-granted beliefs in abstract theories and mechanisms underlying their clients' problems. It is a crucial mental maneuver that helps clinicians to shift toward an emphasis on understanding and describing their clients' experience as fully as possible. Contextualization refers to a committed exploration into the various contexts of the experience of clients. Their psychological and affective difficulties should be understood in terms of relevant historical and interpersonal contexts. The above epistemological tools are foundational to the phenomenological endeavour to understand human experience.

## Application I: Understanding the meaning of our clients' presenting problems

Presenting problems are only the client's initial attempt to articulate an aspect of his or her lived-world that precipitates the pursuit for counselling. Phenomenology suggests that human beings are always in meaningful relationships with the world. Even in so-called disordered conditions, there are meanings in what would generally be regarded as negative, maladaptive, or pathological in the client's presenting problems. Clinicians can move beyond the judgement categories, namely, normal or pathological, adaptive or maladaptive, rational or irrational, by focusing on the uniquely sophisticated ways in which clients interact with their surroundings. The traditional practice of psychotherapy emphasises the contents of presenting problems. In contrast, phenomenology calls for a continuous expansion of contents into contexts in clinical practice.

## The Case of Jenny: Presenting Problems

Jenny was a twenty-year-old female college sophomore student. She self-referred to the psychology clinic at her University in order to gain a better understanding about her negative emotions, thoughts and memories, which were essentially her presenting problems at the time. She complained about having repeated

episodes of uncontrollable emotional outburst in her social life, experiencing difficulties with meeting new friends in college, and suffering from a heightened level of anxiety. These presenting problems were considered by her parents as adjustment issues in college and possibly a biological-based emotional disorder. Jenny was in between consulting with a psychiatrist for medication advice and finding a psychotherapist to understand herself better.

To understand Jenny's lived-world, it is important to explore the historical and interpersonal contexts of her presenting problems. Jenny first began to experience an elevated level of hurtfulness, anger, and fear after a car accident that took place during the senior year of high school. On the night of the accident, she was one of the four passengers in the car with a driver who was under the influence of alcohol. She stated that the car had slipped on the icy road, hit a snow pile and flipped over. The impact immediately knocked her out of consciousness until her friends pulled her out of the car. She began feeling very disoriented and decided to walk home which was not far away from the accident site. At the door, Jenny recalled staring at her mother and said, "I am dead." Because she departed from the accident site, only her friends were present when the police arrived and investigated the scene. She later learned that her friends blamed her for the alcohols found in the car. Charges were pressed against her for illegal possession of alcohol and distributing alcohols to minor, which resulted in a yearlong parole and community service. Since then, she suffered from sustaining injuries on her back and legs. She also experienced occasional nightmares and a heightened level of anxiety about being in a car while imagining various kinds of disaster that could have happened. Interpersonally, she felt extremely angry and upset about her close friends' betrayal. Although Jenny began to meet new friends in college, her enduring and intense emotions made it difficult for sustaining and enjoying these new relationships.

As the above illustration shows, presenting problems can lead clinicians to an enriched understanding of the contexts in which their clients construct meanings in their lives. It also reveals how the meanings of the presentation problems are co-constructed by the client and the therapist, which is essentially an intersubjective clinical phenomenon participated by two human beings. The interplays between two embodied beings are what determine and shape the meanings of therapeutic communication, such as whether or not something can be expressed or made aware of. Highlighting that both the client and the clinician are embodied beings calls attention to the therapeutic exchanges at the level of bodily gestures, affect, and temperament.

It should be reminded that it is easy and tempting for clinicians to unintentionally dehumanise their clients by diagnosing, categorising, and theorising about them. Viewing the therapeutic situation as an intersubjective clinical phenomenon, the clinician's stance plays a central role in how the presenting problems are conceived. Generally, one can adopt many different stances when listening to the client's narratives such as introspective, empathic, problem-solving, and sceptical.
A sceptical stance, for instance, translates into paying a lot of attention to the truthfulness of the client's utterances as well as the motivation behind them. Hence, the presenting problems should always be understood as an interplay between the clinician's therapeutic stance, theoretical convictions and personal backgrounds, andthe client's backgrounds and motivations.

It is in this intersubjective context in which Jenny's presenting problems was understood initially by her clinician as a narrative in which she was a victim of an unfortunate event and its aftermath. However, this initial understanding was only the beginning of an ongoing interplay between them.

## Application II: Case Formulation from a Phenomenological Perspective

Traditionally, case formulation is defined as a distinctive activity where clinicians provide a written conceptualisation of clients based on initial clinical data gathered from diagnostic interviews and psychological assessments. From a phenomenological perspective, case formulation is not viewed as an isolated clinical activity independent of the ongoing process of clinical exchanges. Regardless of the theories adopted by clinicians, all the presenting problems, symptoms, and assessment data should be thoroughly contextualised.

## A Brief Case Formulation of Jenny

As counselling continued, the intersubjective contexts in which Jenny's problems emerged in life began to unfold. She was raised in a family in which her father was emotionally withdrawn, and her mother was mentally unpredictable partly due to multiple sclerosis. In Jenny's lived-world, she never experienced validation from her father who always disapproved of her decisions. She experienced some caring and love from her mother but in inconsistent and unpredictable ways, which led to immense feelings of ambiguity and uncertainty throughout her upbringing. She was also strongly convinced that her mother's "bad genes" were passed onto her. She perceived her brother as a very negative figure who never cared for and protected her when she needed most. She felt that he had been a bystander in all of her emotional and social struggles. Specifically, he never helped and protected her when she was constantly teased and bullied by his peers in the neighbourhood. Jenny's extended family was characterised by a long history of serious medical illnesses and deaths, which is a major theme in the historical and interpersonal contexts of her traumatic reactions toward the car accident. She talked about her unsettling feelings of having to anticipate and deal with the deaths and losses of close family members as she was growing up.

Jenny repeatedly talked about being the target of teasing and verbal abuses in her neighbourhood. The perpetrators were a group of young boys who were his brother's friends, and they often made fun of her appearance and weight and sometimes even threw hard objects at her. Jenny's victimisation was highlighted by an incident that took place when she was seven years old. One of the neighbourhood boys choked her on the neck until she almost fainted. Although she reported to her parents immediately afterwards, she felt that they did not take her seriously and downplayed her emotional reactions. Hence, she suffered not only from this traumatic experience but also a combination of her brother's betrayal and her parents' negligence.

In counselling, Jenny gradually acquired the insight that she was becoming more of an angry and hostile person after this incident. On the other hand, she increasingly despised any feelings and expressions of sadness and disappointment which were perceived as signs of weakness. To safeguard herself from being overwhelmed by strong feelings of vulnerability, she gradually became gravitated toward adopting a tough-girl identity which is her way of saying "I will rely on no one but myself." This identity was helpful in terms of regaining a sense of control in life, but it was loaded with intense anger, hurtfulness and disappointment. As such, she often found herself lashing out on those who had hurt her even in minor ways.

Copyright © 2018

From an intersubjective perspective, Jenny's presenting problems were rooted in a rigid relationship with the world in which most significant individuals in her life were readily failing or hurting her in some ways. Although her symptoms and difficulties were directly related to the car accident as well as its legal and interpersonal aftermath, the major invariant principles of her lived-world were beginning to unfold. As a seven-year-old little girl, she felt that she had no choice but to depend on harbouring a "tough" identity to ward off her sadness and hurtfulness. However, the colossal intensity of those emotions associated with the accident and its aftermath were too overwhelming for this habitual defensive self-identity to handle.

As time passed, Jenny gradually moved on and rebuilt a new social network in college. She also fell back on her tough-girl identity when facing new challenges in her social life. She reacted strongly with anger whenever she felt betrayed or belittled by others, as it gave her a sense of control and reinforced her toughness. Furthermore, her easily irritated mood and vigilant body gestures created a lot of interpersonal problems in college. Her lived-world was still one inhabited by individuals who were readily failing, betraying, disappointing and hurting her in some ways. Her traumatic and disappointing past, so to speak, was still living in the presence, as she was unable to free herself from these painful intersubjective experiences. Moreover, up till the point when she entered counselling for the first time, she had no alternative resolution but to rely on being an angry, tough girl in order to maintain a sense of control and power in a frustrating interpersonal world.

## Conclusion

For counsellors and psychotherapists, the presenting problems of clients are often the first organised set of narrative information gathered from beginning sessions, whereas an initial case formulation is generally their first attempt to integrate all the available clinical information and observations at a later stage. Both are considered important milestones in clinical practice that lay the foundation for effective counselling interventions. This paper illustrates how phenomenological concepts, despite its philosophical roots, can directly and concretely inform how clinicians can conduct these two foundational activities in routine practice.

## References

Dreyfus, H.L. (1989). Alternative Philosophical Conceptualizations of Psychopathology. In Harold A. Durfee (eds.), Phenomenology and beyond: The self and its language (pp.41-50). Dordrecht: Kluwer.
Husserl, E. (2001). Analyses Concerning Passive and Active Synthesis: Lectures on Transcendental logic (A. J. Steinbock, trans.). Dordrecht: Kluwer Academic Publishers.
Merleau-Ponty, M. (1964). The Primacy of Perception (J. Edie, eds.). Evanston:
Northwestern University Press
Merleau-Ponty, M. (1962). The Phenomenology of Perception (C.Smith, trans.). New York: Humanistic Press (Original published 1945).
Nisbett, R. (2003). The geography of thought: How Asians and Westerners think differently... and why. New York: Free Press.
Rogers, C. (1961). On becoming a person. Boston: Houghton Mifflin.
Stolorow, R.D., Atwood, G.E. & Orange, D.M. (2002). Worlds of experience: interweaving philosophical and clinical dimensions in psychoanalysis. New York: Basic Books.
Stolorow, R.D. & Atwood, G.E. (1992). Contexts of being: The intersubjective
foundations of psychological life. Psychoanalytic inquiry book series II. Hillsdale, NJ & London: The Analytic Press.
Stolorow, R.D., Brandchaft, B. & Atwood, G.E. (1987). Psychoanalytic treatment: an intersubjective approach. Hillsdale, NJ: The Analytic Press.


Copyright © 2018

Copyright © 2018

benefiting from counseling services.

The least important reason for not benefiting from the SCC services was “ Asking for counseling help means that I suffer from a mental disorder”. This finding is quite remarkable, since it shows that most students at SQU were aware of the role of counseling and they could recognize the difference between the counseling provided for students by the SCC and that provided by mental health medical services. The efforts that were made by the SCC staff to strengthen students’ awareness concerning the meaning of counseling and its goals, have led to positive results in students’ understanding. This is a very promising finding which could result in an increase in the number of students benefiting from counseling services in the future.

## Limitations of the Study

As with any research, the current study is not without limitations. First, utilizing a larger sample size in the study of students who benefited from SCC services, could have helped ensure a more accurate evaluation of the SCC. Second, in the current study, the quality of SCC services was assessed based only on the students’ point of view. Further studies could also assess the quality of these services from the perspectives of SCC counselors. Third, this study focused only on the services provided for students, but there are also some counseling services that are provided for SQU staff and the community. The quality of these services could be evaluated from the perspectives of counselees as well. Fourth, a self-report scale was used that might be affected by social desirability and bias, and, thus, students may tend to overestimate or underestimate the quality of the services provided. Thus, a qualitative design could be utilized, using open-ended questions or interviews.

## Conclusion

In conclusion, the current study has given an insight about the quality levels of services provide currently by the SCC. The results have indicated “high” to “ very high” level of quality to all services which highlights the study’s sample satisfaction about the center’s services. However, the researchers emphasized the importance of continuing with improving counseling services provided by the SCC and with evaluation of their qualities.

## References


Al-Darmaki, F. (2011). Problems and preferences for source of help among united Arab Emirates University students. International Journal for the advancement of Al-

Al-Darmaki, F., & Sulaiman, S. (2008). The counseling profession in tow Arab countries. In W.B. Walsh (Ed.) Biennial Review in Counseling Psychology. Thousand Oaks, CA: Sag counseling, 33, 293-308. DOI 10.1007/s10447-011-9136-2

Alkayumi, E., & Aldhafri, S. (2015). Common problem faced by first-year university students in Oman. Paper presented at International Journal of Arts & Sciences’ (IJAS) International Conference for Academic, Rome-Italy.

Almashhadani, S., & Alfazari, M. (2009). Taqeem jawdat alkadamat alershadya almuqadama fi markaz alershad altulabi be jamiat Alsultan Qaboos (The Sultanate of Oman) kama yaraha altalaba almutwaqa takarujhum [Assessing the quality of counseling services offered in the student counseling center at Sultan Qaboos University (The Sultanate of Oman) as perceived by expected graduate students]. Journal of College of Education, 19(3), 23-40.

Bundy, A., & Benshoff, J. (2000). Students’ perceptions of need for personal counseling services in community colleges. Journal of College Counseling, 3, 92-99.

Brince Sattam Bin Abdulaziz University. (2014). Guidance and Counseling. Retrieved October20, 2015 from https://www.psau.edu.sa/ar/site/400/46

Brinson, J., & Al-amri, S. (2005). Students’ Perceptions of Mental Health Counseling in the United Arab Emirates (UAE). International Journal for the Advancement of Counselling, 4, 495-512. 10.1007/s10447-005-8487-y

Brunner, J., Wallace, D., Reymann,L., Sellers, J., & Mccabe, A. (2014). College counseling today: Contemporary students and how counseling centers meet their needs. Journal of College Student Psychotherapy, 28(4), 257-324. doi:10.1080/87568225.2014.948770

Center for Collegiate Mental Health (CCMH). (2016). Annual Report: Penn State. Retrieved December 15- 2017 from https://sites.psu.edu/ccmh/files/2017/01/2016-Annual-Report-FINAL_2016_01_09-1gc2hj6.pdf

Deanship of Admission and Registration. (2015). Statistics of enrolled students at Sultan Qaboos university, Fall 2015.

Gaughf, N. W., Smith, P. L., & Williams, D. A. (2013). Faculty and student perceptions of academic counselling services at an academic health science center. Perspectives on Medical Education, 2(3), 165-170. doi:10.1007/s40037-013-0056-1

Kahn, J., Wood, A., & Wiesen, E., (1999). Student perceptions of college counseling center services. Journal of College Student Psychotherapy, 14(1), 69-80. DOI: 10.1300/J035v14n01_06

Lee, D., Olson, E. A., Locke, B., Michelson, S. T., & Odes, E. (2009). The effects of college counseling services on academic performance and retention. Journal of College Student Development, 50(3), 305-319.

Lucas, M., & Berkel, L. (2005). Counseling needs of students who seek help at a university counseling center: A closer look at gender and multicultural issues. Journal of College Student Development, 46(3), 251-266. doi:10.1353/csd.2005.0029

McEneaney, A., & Gross, J. (2009). Introduction to special issue: Group interventions in college counseling centers. International Journal of Group Psychotherapy, 59(4), 455-460.

Meilman, P. (2016). Pressures we face in running counseling centers on college and university campuses. Journal of College Student Psychotherapy, 30(1). 7-12.

Michigan State University. (n.d). Counseling center. Retrieved October 20, 2015 from http://counseling.msu.edu/

Brince Sattam Bin Abdulaziz University (KSA). (2015). Guidance and Counseling. Retrieved May20, 2015 from https://www.psau.edu.sa/ar/site/400/46

Queens Bourogh Community College (n.d). Counseling Center Student Satisfaction Survey. Retrieved August 8, 2014 from http://www.qcc.cuny.edu/Counseling/Student-Satisfaction-Survey.html

Russell, J., Thomson, G., & Rosenthal, D. (2008). International student use of university health and counselling services. Higher Education, 56(1), 59-75. doi:10.1007/s10734-007-9089-x

Saleem, S., Mahmood, Z., & Naz, M. (2013). Mental Health Problems in University Students: A Prevalence Study. FWU Journal of Social Sciences, 7, (2), 124-130.

SMU Counseling Center Client Satisfaction Survey. (2013). Samuel Merritt University Counseling Center. Retrieved August 8, 2014 from https://www.surveymonkey.com/r/?sm=cu%2fFjkugkUJAFdknph4Xug%3d%3d

Student counseling center. (2016a). SCC Handbook. Muscat: Student Counseling Center.


Copyright © 2018

Copyright © 2018

Student counseling center. (2016b). Faalyatna [Our services]. Muscat: Student Counseling Center.
Sulaiman, S. (2004, February15-16) The role of counseling centers in institutions of higher education: the role of student counseling center at SQU. Rustaq college, Ministry of Higher Education, Sultanate of Oman.
Sulaiman, S. (2006, July 16-21). Starting from scratch: College counseling in Oman: College counseling center in global perspective. Research Paper presented at the 26 th Congress of Applied Psychology. Athens, Greece.
Sulaiman, S., & Aldhadha, B. (2007). Almaayeer Almutabaha le marakez alershad alnafsi fi aljameaat alarabya: Dirasa nawiya [ The criteria used by counseling centers in Arab universities: A qualitative study]. College of Education Journal, 8, 307-332.
Tahhan, M., & Abu Eitah, S. (2002). Alhajat Alershadya lada talabat aljameah alhashimyah [The counseling needs of the Hashemite University students]. Studies-Educational studies-Jordan, 29(1), 129-154.
Turner, A. L., & Berry, T. R. (2000). Counseling center contributions to student retention and graduation: A longitudinal assessment. Journal of College Student Development, 41(6), 627-636.
Wlazelek, B. G., & Coulter, L. P. (1999). The role of counseling services for students in academic jeopardy: A preliminary study. Journal of College Counseling, 2(1), 33.
Wilson,S., Mason, T., & Ewing. M. (1997). Evaluation the impact of receiving university-based counseling services on student retention. Journal of Counseling Psychology,44. 316-320.
Xie, B. (2007). Chinese international students' perceptions and attitudes toward seeking psychological counseling services: A qualitative exploration (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Thesis Database. (UMI No. 3275059).
Yang, J. W., Yon, K. J., & Kim, J. K. (2013). An effect of a mandatory counseling program for college students on academic probation: A preliminary study. Asia Pacific Education Review, 14(4), 549-558. doi:10.1007/s12564-013-9287-4
Yi, J., Lin, J., & Kishimoto, Y. (2003). Utilization of counseling services by international students. Journal of Instructional Psychology, 30(4), 333-342.

Copyright © 2018

Copyright © 2018

# Stepping stones to resilience: Supporting children and young people through a life marked by family violence

**Christine Cresswell**[1]

The present paper shows how significant counselling is to children and young people who have been subjected to experience of ongoing violence within the family circle. The modality of Three-In-One-Concepts, used in conjunction with expressive therapies, has the potential to be a powerful therapeutic approach for bringing children and young people to a level of resilience where they are able to cope and distance themselves from the intensity of the impact of family violence.

**Keywords:** *Anterior Deltoid muscle, Attention Deficit Hyperactivity Disorder (ADHD), autism, resilience, family violence, Three-In-One-Concepts, One Brain Approach, vicarious trauma*

Family violence hurts kids, too - even if they don't see it. Evidence shows that living in a family where there is violence - physical or emotional - may have significant traumatic effects on children (Devaney, 2015; Domestic Violence prevention Centre, 2018; The Australian Domestic & Family Violence Clearinghouse, 2015). As noted by Campo (2015), in the past two decades, empirical evidence about the extent to which children are exposed to domestic and family violence and the negative effect this has on their development has created an impetus for policy responses to this issue. This is reflected in the recognition that exposure to family violence is a form of child abuse in some state and territory child protection frameworks - for example Queensland Child Protection Act 1999, (Office of the Queensland Parliamentary Council, 2005), the Australian Government's National Framework for Protecting Australia' Children 2009 - 2020 (Council Of Australian Governments [COAG], 2009/2014, and the federal Family Law Act 1975 (Office of Legislative Drafting and Publishing, Attorney-General's Department, 1975/2012).

As a result of family violence, children can experience powerful mixed and confusing feelings that may be difficult for them to express. However, despite the horrific emotional, psychological, and somatic impact that family violence has on children and young people, the effects on the individual are not irreversible if early and effective intervention occurs. A review of the literature profiles the effectiveness of counselling in providing a safe space where children and young people can express their feelings and come to acknowledge their thoughts and life experiences.

Corresponding Author: Christine Cresswell
Email: christine.cresswell@bigpond.com

[1] Christine Cresswell Counselling

Australian Counselling Research Journal ISSN1832-1135

As referenced by Irwin, Waugh, and Wilkinson (2002), children who have experienced domestic violence are more likely to:

- Exhibit aggressive behaviour;
- Experience anxiety;
- Exhibit symptoms of depression;
- Demonstrate diminished self-esteem;
- Tell lies, act disobediently, and act destructively;
- Reveal reduced social competence skills;
- Exhibit emotional distress;
- Demonstrate somatic complaints.

## One Avenue of Support

Children impacted by domestic violence can find support at The Centre for Women & Co. which is a Non-Government Organization (NGO) based in Queensland with branches in Logan and Redland City. The vision at the Centre for Woman & Co. is to deliver responsive, high quality and holistic women's services to the Logan and Redlands Regions. The mission of this NGO is to encompass domestic and family violence support services and women's health and wellbeing support services (personal communication, September21, 2018).

When an intake is done for children and young people, it is established that they have been witness to abusive relationships within the family system. A child's experience of family violence may be through the witnessing of violent acts and the consequences of physical violence: such as broken bones, blood, bruises or broken objects. They may become indirectly involved in the violence by being in close proximity to their mother when she is being abused or when they are intervening to protect her. They may also be the subject of abuse by the perpetrator.

For some, there may be responsibility of calling the ambulance or they may react in the moment by trying to stop the perpetrator from hurting the other parent. It is usually noted that the abuse has been on-going for many years and even though the family relationship may have broken down, the abuse is still continuing in some form. Children tend to become the scapegoat and can be very much caught up in a triangulated web where one parent is judging the other parent to the child and projecting their thoughts and emotions onto them.

Copyright © 2018

It has been found that children in this situation can be very vulnerable when it comes to taking on those emotions which can send them into feeling confused and overwhelmed by the whole scenario. They have been traumatised enough over the years with the violence and now they have the separation and the triangulation to try to work through. Many children make the comment, “I like both parents and I don’t know which side to take or who to choose”. On the other hand, there can be children who are caught up emotionally in a battle where the court has given both parents equal share of responsibility for their children but the children do not want to go to the other parent. Young people quite often present this as a huge dilemma in their lives.

## Research in Situ

Empirical data gathered over a period of 12 months testify to the effectiveness of Three-In-One-Concepts processes when working with children and young people who have experienced vicarious trauma through witnessing family violence. Unsolicited comments from children, mothers or primary caregivers, and teachers have been manually recorded. Evidence is embodied in statements that collectively portray an image of the power of therapeutic support and the impact this can have of the well-being of children and young people.

Young people refer to muscle testing as a “lie detector”. They explain that while they might be telling the counsellor that their presenting issue is one thing, the muscle indicates something different. Children and young people often say to their Mum and the receptionist, “How does she get all that information from my muscles? This is so cool. When am I coming again?” Children will also thank the counsellor for “fixing” them using the muscles.

Before the counselling session with children and young people, it is normal for the Mum to express, “[Johnny] is acting just like his Dad. He is aggressive at home and at school. The teacher says he is not concentrating and is becoming very disruptive in the class room”. After follow-up communication in the immediate days following sessions, mothers report how relaxed and calm their child is as compared to how they were acting before counselling. In addition, mothers whose children have a diagnosis of high functioning autism report that their children are having fewer meltdowns and are able to cope with the anxiety associated with going to school and participating in other general activities where there is potential for separation anxiety and their Mum is not present to give support and a much needed sense of security.

After receiving positive feedback from mothers, it is the counsellor’s understanding that children tend to feel “very good” and “balanced” after sessions. Therefore, it is noticeable at home and at school when the stress is beginning to mount and they are not “feeling good”. This is an indicator that the child needs to have another session. Also, after communicating with the child’s teacher, mothers will speak to the counsellor about how much the child’s behaviour and focus has improved in the classroom.

One reported incident relates to the situation where it was suggested to a mother that her son might have Attention Deficit Hyperactivity Disorder (ADHD). The mother stated that she was advised by school authorities to “get him tested and onto medication”. As an alternative to this radical measure, the mother chose to bring her son with her to counselling; as she knew that her child may find the support he needed. After one session using the Three-In-One-Concepts process, a change in behaviour was observed and remarked on by the teacher who is said to have asked the mother if she had been to the doctor to get medication, as her son’s behaviour had greatly improved.

## Three-in-one Concpets: An Overview

Three-In-One-Concepts was founded and created by Gordon Stokes (1929-2006): and while Three-In-One-Concepts, also referred to as “Three-In-One-Concepts ‘One Brain’ Stress Management Approach to Counselling”, uses muscle testing, it is to be noted that muscle testing is not testing muscles. It is testing the brain’s hemispheres. In 1976, Stokes officially created Three-In-One-Concepts, Inc. and in 1983, with his partners, Daniel Whiteside (1933-2013) and Candace Callaway (1949-2005), he began to fashion Three-In-One-Concepts\ into its current form: infusing the “One Brain” method with everything that peaked his interest throughout his life time - from Parent Effectiveness Training to Personology.

The “One Brain” stress management approach is gentle and non-invasive. The individual personhood of the client is respected with ethical consideration focused on integrity as related to achieving the highest good of oneself and the highest good of all. Three-In-One-Concepts developed and expanded to become a multidimensional therapeutic modality, focusing on the integration of Body, Mind, and Spirit as forming the “One Brain”. The modality was further developed to assist people resolve their personal experiences of emotional stress overwhelm in all areas of their life (Three In One Concepts, n.d.).

## Three-in-one Concpets: The Process

By placing hands on the outer wrist, the clinician can feel a wakening or a strengthening of the wrist muscle. While the clinician feels the movement in the wrist, it is actually the Anterior Deltoid muscle in the upper arm that is reacting. A weak response indicates that there is a stress source being held within the body.

When right and left arms are used simultaneously both cerebral hemispheres are activated to achieve whole brain response. As Stokes & Whiteside explain (1996), “With both brains working equally an honest read-out of how emotion affects the body is established” (p. 12). The body runs on an electrical system pouring through the body and fires the brain. The same system can be used through muscle testing to find out from the body what is causing the stress. When the client thinks of something that causes stress, the arms start to give way, causing a negative muscular response (Ainley, M, 2009). It is a safe and gentle way to identify and defuse old belief patterns, phobias and traumatic experiences that may have been stored in the memory bank for many years.

This gentle process allows biofeedback from the body/brain to identify and defuse suppressed negative emotions that wilfully destroy the positive changes that clients want in their lives. Stokes and Whiteside (1996), define the “One Brain” process as “dealing with all levels of awareness - body, mind, and spirit - at both conscious and subconscious levels; while getting more into what is hidden in the sub conscious, rather than what we think we know on the conscious level” (p. 10). According to Stokes and Whiteside (1996), when all levels of awareness are dealt with, right brain and left brain begin to communicate with each other allowing for integration of the right creative brain and the left logic brain. As a result, body, mind, and spirit are empowered to deal directly with self-doubt on any issue as well as the stress-overwhelm that hampers clear thinking and decreases freedom of choice.

## Three-in-one Concpets: In the Field

When working with young people, the counsellor may often "go with the flow" connecting with the child's reality incorporating complementary therapeutic approaches, and while working with the presenting issue the counsellor is also working with what the muscle indicates at the time. Quite often the young person will say, "Oh yes, that's right! That is what I would like to get the stress off". The stress may not be to do with the trauma they are experiencing at present, but could be related to something they have experienced in the past and which may feel very similar to the somatic sensation that is happening in the present. However, what is the same, is that there is a contributing critical incident that triggers a stress response that could be either traumatic in the moment or could present as secondary trauma (Wyder & Bland, 2014).

When using the muscle as the indicator, the counsellor will "age recess" (in counselling terms, more commonly referred to as age regression). This evokes release of a stored memory back to where the muscle response indicates an appropriate age for healing past trauma. This will be the age at which stress will be released and the brain re-balanced into thinking differently about the emotional experience at that age. The muscle determines the type of healing the body and mind require (Stokes & Whiteside, 1996)

A fundamental belief in working with children and young people is that each one is their own unique person. What they share is a life over shadowed with the trauma associated with family violence. Therefore, while Three-In-One-Concepts may be the primary "go to", it is, in practice the primary modality underpinning an over arching eclectic framework. Modalities incorporated in this structure include, reframing, visual association picture and word cards, non-directive sand play, directive sand tray, painting, drawing, feeling faces, visualization, child-centred play, power animals and positive affirmations. The muscle is again used to round off the process.

## Response to Therapy

It has been found that when working with children and young people, the way they acknowledge their traumatic experience can be very different. Some demonstrate extraverted behaviour and like to talk about the whole experience. Others can become quite withdrawn and do not like to talk about anything: they may even move into a state of selective muteness. A significant feature of the muscle testing approach is that the client does not need to engage verbally. The body knows. Experience demonstrates that children and young people love to be muscle tested. They love becoming aware of how much stress they are actually carrying and how the muscle helps them to tell their story. The muscle remembers what the brain may choose to forget: or as Bessel van der Kolk (2014) might say, "The body keeps the score".

This process keeps the brain in the present rather than focussing on experiences that have happened in the past and there seems to be no fixed rule on how many sessions a child or young person would require for keeping the brain in the present. Under general circumstances an affective timeframe has proved to be eight fortnightly sessions with a tapering down process.

## Conclusion

Healing can be an ongoing process. Therefore, the purpose of counselling is to bring children and young people to a level of resilience where they are able to cope and distance themselves from the ongoing impact of critical incidents in this life span. For so many, it is highly likely they are still living in an environment where abusive behaviour is the norm and where they are still caught in the web of family violence. It could be said that an eclectic approach, incorporating the "One Brain" Stress Management and muscle testing, combined with expressive therapies has potential to be the greatest gift in helping young people acknowledge their experience, and the emotions attached to the experience: even if they choose to not talk about it.

## References

Ainley, M. (2009).Introduction to Three-In-One Concepts™."One Brain" Stress Management System.[Utube.]. Retrieved from https://www.youtube.com/watch?v=RSE65lPAbBA
Bourke, D.(2007).Stories Of Stress: Feeling, Thinking And The Flourishing Of Life. [PhD Dissertation.].Brisbane, QLD: The University of Queensland.
Campo, M. (2015).Children's exposure to domestic and family violence: Key issues and responses. [CFCA PAPER NO. 36 2015]. Melbourne, AU: Australian Institute of Family Studies. Retrieved from https://aifs.gov.au/cfca/sites/default/files/publication-documents/cfca-36-children-exposure-fdv.pdf
Council of Australian Governments [COAG], 2014.Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020. Canberra, AU: Commonwealth of Australia. Retrieved from https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf (Original work published in 2009)
Devaney, J. (2015). Research Review: The Impact of Domestic Violence on Children. Irish probation journal, 12(October). [e publication]. Retrieved from https://pdfs.semanticscholar.org/506f/db2353976001352213a72baf3c48aaa743c0.pdf
Domestic Violence Prevention Centre.(2018). Impact of domestic violence on children and young people.[Blog.]. Gold Coast, AU. Retrieved from http://www.domesticviolence.com.au/pages/impact-of-domestic-violence-children-and-young-people.php
Irwin, J., Waugh, F.,& Wilkinson, M. (2002).Domestic Violence and Child Protection: a research report; a Collaborative Research Project. Sydney, AU: The Department of Social Work, Social Policy and Sociology, University of Sydney.
Office of the Queensland Parliamentary Council.(2005). Queensland Child Protection Act 1999. Brisbane, AU: State of Queensland. Retrieved from https://www.legislation.qld.gov.au/view/pdf/2005-04-29/act-1999-010
Office of Legislative Drafting and Publishing, Attorney-General's Department,1975/2012.Family Law Act 1975.[Act No. 53 of 1975 as amended]. Canberra, AU: Office of Legislative Drafting and Publishing. Retrieved from http://www.abc.net.au/cm/lb/4093556/data/family-law-act-1975-data.pdf
Stokes, G., & Whiteside, D. (1996).Tools of the trade. Burbank, CA: Three In One Concepts. (2016).Three In One Concepts: An Educational Corporation. Retrieved from http://www.3in1concepts.us/creators.php
The Australian Domestic & Family Violence Clearinghouse, (2011). The Impact of Domestic Violence on Children: A Literature Review. For The Benevolent Society, 1 August 2011. Sydney, AU: The University of New South Wales. Retrieved from http://earlytraumagrief.anu.edu.au/files/ImpactofDVonChildren.pdf
Three In One Concepts: An educational corporation, (n.d.).Electronic profile. Retrieved from https://www.3in1concepts.us/
Van der Kolk, B. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. New York, NY: Viking Penguin.

Copyright © 2018

# *"It helps us to understand that it's not particularly a patient's fault"*: Mental health professionals discuss their causal beliefs and perceptions of mental illness

**Josie Larkings[1]**

Mental health professionals' beliefs about the causes of mental illness are thought to impact their stigma and perceptions towards mental illness; however, there has been little research exploring this topic. This study aimed to examine the causal beliefs of mental health professionals and how these beliefs have developed, along with the impact that these beliefs have on perceptions of consumers. A thematic framework guided the analysis of semi-structured interviews with 17 mental health professionals. Multiple causes of mental illness were endorsed simultaneously, with most endorsing a combination of biogenetic, psychological and environmental factors. Causal beliefs influenced factors such as blame, compassion, empathy, and understanding. Mental health professionals identified that their causal beliefs impacted their perceptions of consumers with both positive (e.g., increasing empathy and compassion) and negative consequences (e.g., increase blame and frustration). Mental health professionals thought their beliefs were influenced primarily by their clinical experiences. Further research is needed to understand how mental health professionals' causal beliefs and perception towards consumers may impact the treatment process.

**Keywords:** *causal beliefs; mental health professionals; mental illness; stigma; professional experience; thematic analysis*

Reducing the stigma associated with mental illness is an important endeavour, given that stigma has been found to dramatically decrease the quality of life of people living with mental illness (Corrigan, Sokol, & Rüsch, 2013; Kvaale, Gottdiener, & Haslam, 2013). The bulk of research on mental illness stigma has focused on the general public, with the attitudes of mental health professionals receiving minimal attention by comparison (Blinded for review, 2017; Schulze, 2007). It is often assumed that mental health professionals have positive attitudes towards mental illness and, as such, they have played an important role in the fight against stigma (Adewuya & Oguntade, 2007). However, mental health professionals can still exhibit negative attitudes and stigma towards people with mental illness, such as viewing people with mental illness as being dangerous and having a desire for increased social distance (Kopera et al., 2015; Scholz, Bocking, & Happell, 2017; Wahl & Aroesty-Cohen, 2010). These negative attitudes may adversely impact the effectiveness of mental health promotion efforts and are likely to have a negative impact on treatment (Overton & Medina, 2008). Therefore, it is essential to understand what influences mental health professionals' attitudes, in order to reduce stigma and improve services provided.

Contact is one factor thought to impact stigma (Allport, 1954; Amir, 1969; Pettigrew & Tropp, 2006), with some stigma reduction programs based on the idea that interacting with people from the out-group (i.e., people with mental illness) will help to reduce stigma and improve attitudes (Corrigan, Larson, Sells, Niessen, & Watson, 2007). Lauber and colleagues (2006) found mental health professionals with more professional experience had a more positive attitudes towards people with mental illness, but that hours of working (part-time versus full-time) did not appear to influence stereotypical attitudes. However, contact alone does not seem to guarantee stigma reduction given that some mental health professionals, who have regular contact with consumers, still exhibit aspects of attitudes which reflect stigma. Consumer refers to an individual who has received or are receiving treatment for mental illness. This term was developed and used by people with mental illness and advocacy groups to encourage empowerment (Anthony, 1993; McLean, 1995).

Another factor thought to influence stigma are beliefs about the causes of mental illness, or causal beliefs (Haslam & Kvaale, 2015; blinded for review, 2012, 2017; blinded for review, 2017c). Over the past few decades, efforts to understand the psychopathology and aetiology of mental illness have increased, with a particular focus on understanding the biogenetic causes of mental illness (Kvaale et al., 2013; Lebowitz, 2014). In this paper, we place causal beliefs into three categories influenced by definitions provided by Ahn and colleagues (2009).

Corresponding Author: Josie Larkings
Email: required
[1] required

Australian Counselling Research Journal ISSN1832-1135

Copyright © 2018

Biogenetic refers to genetic or psycho-physiological factors that contribute to mental illness such as genetic predisposition, hereditary, brain structures/abnormalities, and chemical imbalances. Psychological causal beliefs refer to factors such as thoughts, emotions, behaviours, or identity-related factors such as stress, anxiety, or temperament. Environmental causal beliefs include current or past environmental factors such as early childhood experiences, trauma, and substance use.

Several anti-stigma campaigns have promoted biogenetic causes, with the hope that endorsement of biogenetic causes would help to reduce the blame associated with mental illness and thus reduce the stigma towards it in the general public (Wiesjahn, Jung, Kremser, Rief, & Lincoln, 2016). Schomerus and colleagues (2012) conducted a meta-analysis and found that endorsement of biogenetic causes, regarding schizophrenia and depression, increased significantly between 1990 and 2006. However, research that focused on the general public, suggests that endorsement of biogenetic beliefs does not guarantee a reduction in stigma (Angermeyer, Holzinger, Carta, & Schomerus, 2011; Kvaale et al., 2013; Read, Haslam, Sayce, & Davies, 2006).

Two opposing paradigms have generally been used to understand the relationships between causal beliefs (particularly biogenetic causes) and stigma. Attribution theory (Weiner, Perry, & Magnusson, 1988) predicts that causes perceived as outside an individual's control (e.g., biogenetic causes) will elicit emotions such as pity, and thus reduce blame and discrimination (Rüsch, Todd, Bodenhausen, & Corrigan, 2010). Alternatively, through a genetic essentialism lens, endorsing biogenetic factors would result in people with mental illness being viewed as having "bad genes" which are unchangeable (Dar-Nimrod & Heine, 2011). Thus, this perspective argues that endorsement of biogenetic causes would result in little or no improvement in attitudes and decreased optimism around recovery (Haslam, 2011). More recently, Haslam and Kvaale (2015) conducted two comprehensive meta-analyses investigating the impact of biogenetic causal beliefs on perceptions towards mental illness. Their findings prompted the proposal of the mixed-blessing model. This model provides a synthesis between attribution theory and genetic essentialism, and suggests that biogenetic explanations may contribute to reduced blame (as mental illness is viewed as outside an individual's control), but would also encourage essentialistic thinking (i.e. genes are unchangeable) and lead to an increase in stigma and prognostic pessimism.

Relatively little research has been conducted which explores the nature of causal beliefs endorsed by mental health professionals and the relationship between their causal beliefs and perceptions of mental illness (Blinded for review, 2017). Ahn and colleagues (2009) asked mental health professionals to rate the causes of 445 mental disorders, and concluded that mental health professionals place mental disorders on a continuum from strongly biological (and weakly psychological/environmental) to strongly psychological/environmental (and weakly biological). Our previous research, which explored causal beliefs and stigma in potential mental health professionals (psychology students), found that while a combination of beliefs were endorsed, potential mental health professionals endorsed biological causal explanations more than psychological and environmental factors. Moreover, results indicated that causal beliefs do impact mental illness stigma, with different causal beliefs having varying impacts on different elements of stigma. For instance, participants who endorsed biogenetic and environmental factors more strongly, viewed people with mental illness as inferior and more threatening (blinded for review, 2012). Grausgruber and colleagues (2007) found a non-significant relationship between mental health professionals' genetic causal beliefs and desire for social distance from people with schizophrenia. There are several implications associated with mental health professionals' causal beliefs, which could have a considerable impact on treatment outcomes and recovery. For example, mental health professionals' causal beliefs have been found to: influence their choice of treatment modality and perceived effectiveness of the treatment they recommend; and, affect emotional responses to consumers, such as empathy and blame (Goldstein & Rosselli, 2003; Hansson, Jormfeldt, Svedberg, & Svensson, 2013; Iselin & Addis, 2003; Blinded for review, 2012 Blinded for review, 2017a; Lebowitz & Ahn, 2014; Miresco & Kirmayer, 2006). T

The purpose of the current study is to examine the causal beliefs about mental illness that mental health professionals endorse, and factors that influence the development of these beliefs. In addition, this study aims to explore how mental health professionals' causal beliefs may influence their perceptions of people with mental illness. A qualitative approach was chosen as there is limited research on this topic and such an investigation should provide a more in-depth understanding of the mental health professionals' perspective.

## Method

### Recruitment

Approval for this project was received from the University of Canberra Committee for Ethics in Human Research. The first author conducted all the recruitment and interviews. The first author is a psychologist who works in the public mental health sector in Canberra. She used professional contacts and approached a number of mental health professionals regarding potential participation in this project, and recruitment was by means of snowballing. Potential participants were provided with information about the project and were asked to contact the first author if they wanted to take part in the study. Potential participants were also asked to distribute study information to other mental health professionals who may be interested in participation. Face-to-face individual interviews were then organised with the mental health professionals interested in participation at a location convenient to them – all participants chose their workplace. Informed consent was obtained prior to the interview and participants were aware that they could withdraw from the study at any time. Participants received movie ticket vouchers as a token of appreciation for their time.

### Participants

This study included 17 mental health professionals, who were employed in the public mental health system in Canberra, Australia. There were 14 females (82%) and three males (18%), aged between 26 and 59 years (M = 36.71, SD = 10.15). Years of experience working with people with mental illness ranged from one year to 29 years (M = 11, SD = 7.60). Mental health clinicians came from a range of different disciplines including: Psychiatry (n = 3), Psychology (n = 5), Nursing (n = 3), Occupational Therapy (n = 3), and Social work (n = 3).

Copyright © 2018

Copyright © 2018

## Data Collection

A semi-structured interview schedule was developed to explore mental health professionals' causal beliefs (see Table 1). Demographic information was collected along with questions which aimed to explore participants' beliefs about the causes of mental illness, the nature of these causal beliefs, factors that influenced the development of these causal beliefs and how these beliefs influence perceptions towards people with mental illness. The first author, who conducted all of the interviews, had a professional relationship with all the participants. As such, the interviews were conversational, attempting to be non-leading, curious, and non-judgemental to minimise the influence of social desirability. Following Hill (2005), mental health professionals were consulted in the development of the interview protocol and questions were modified as a result of feedback received. In addition, two pilot interviews were conducted, however, the interview protocol was not modified significantly as a result of these pilot interviews and data from these interviews were included in the study. The interviews yielded an abundance of rich data some of which was not analysed in the current study.

## Data Analysis

Transcripts of the interviews were analysed using thematic analysis, a method for identifying and analysing patterns and themes that emerge in qualitative data (Braun & Clarke, 2006). The first stage of analysis involved immersion in the data which included reading each transcript several times and then identifying possible codes. Next, similar codes were grouped together and explored in detail; these were then grouped into themes. Data were coded with a synthesis of inductive and deductive principles. Initially, coding followed an inductive approach, in which the author made no attempt to fit data into any preconceived codes or themes, but rather grouped similar data together. Then a deductive approach was used to explore causal beliefs in more detail and a "theory-driven" approach was used to code the causal beliefs into three categories (biogenetic, psychological, and environmental) guided by definitions presented by Ahn, et al. (2009). Finally, transcripts were reviewed to identify quotes that best represented the themes which had been identified. Coding consistency and inter-rater reliability were conducted to test coding reliability. Initially, coding of all transcripts was completed by the primary author, who then re-coded six clean (i.e., un-coded) transcripts to assess coding consistency over time (Richards, 2005). A second independent researcher also coded the same six (clean) transcripts, and then inter-rater reliability was assessed. Coding assignment was compared between coders with a calculated Kappa coefficient of .93, with values greater than .75 generally considered excellent (Landis & Koch, 1977).

For part of the analysis, mental health professionals were split into two groups based on their years of professional experience. The median years of experience (8 years) was used to divide the clinicians into two groups; eight years and below was considered to have less professional experience (n = 9), and above eight years was considered to have more professional experience (n = 8). The median split method to dichotomise data to form low and high groups is a common method used (MacCallum, Zhang, Preacher, & Rucker, 2002), and thus was thought to be appropriate for this analysis. Making comparisons between these groups was appropriate given the overall size on the sample was large enough that the size of each subgroup was still within the recommended size for qualitative research (Hill et al., 2005). The less professional experience group comprised of: a nurse (n = 1), occupational therapists (n = 2), social workers (n = 2), and psychologists (n = 4). The more professional experience group comprised of: an occupational therapist (n = 1), a social worker (n = 1), a psychologist (n = 1), nurses (n = 2), psychiatrists (n = 3). In line with the Consensual Qualitative Research Method (Hill et al., 2005), the frequency of participants responses were labelled to help determine the level of representativeness of responses and themes. Four frequency levels were used: few (less than 10%), some (10% to 50%), most (51% to 90%), and all (91% to 100%).

**Table 1.** Semi-structured interview schedule

| Research Area | Interview Question | Prompts/follow-up questions |
|---|---|---|
| Demographics | What is your age & gender?<br>What discipline are you from?<br>How many years of experience do you have? | |
| Own causal beliefs | What do you believe the causes of mental illness are? | You may believe there are many different causes of mental illness, what are some of the possible causes?<br>Do you think there are certain factors which are the main causes of mental illness?<br>Do you think different mental illnesses are caused by different causes? |
| Development of causal beliefs | What do you think has influenced the development of your causal beliefs? | Where you taught about the causes of mental illness in your training?<br>Has your clinical experience influenced your causal beliefs? How? |
| Causal beliefs and perceptions | Do you think that your beliefs about the causes of mental illness influence your view of people with mental illness? | In what ways?<br>Do your beliefs around the causes of mental illness impact any of your behaviours?<br>Do you think your beliefs have an impact on your prognosis? |

Please note that not all data from the semi-structured interview were included in this paper, and thus only the section of the interview schedule that pertains this is paper is presented in this table.

## Findings

There were four aspects prominent to the understanding mental health professionals' causal beliefs: the first related to the type of causal beliefs mental health professionals endorsed; the second focused on how these causal beliefs had developed; the third explored the impact that causal beliefs had on perceptions of mental illness; and, the final theme looked that how professionals' experience influenced causal beliefs and perceptions towards mental illness.

## Causal Beliefs

All mental health professionals identified a range of factors that contributed to mental illness, with each clinician mentioning an average of 7.88 causes (SD = 3.95). There were 58 distinct causes within the data that were coded into three types of causal beliefs: biogenetic, psychological, and environmental. All mental health professionals suggested more than one type of causal belief, with most participants mentioning biogenetic causes first when discussing their causal beliefs. It is possible that participants mentioning biogenetic causes in the first instance reflects the previous research which shows that there has been an increase in endorsement and awareness of biogenetic causes (Schomerus et al., 2012), and may also reflect training in a medical model framework.

All participants endorsed both biogenetic and environmental causes, with most clinicians endorsing a combination of biogenetic, psychological, and environmental causal beliefs, as the participant in Extract 1 discusses.

**Extract 1**

*Probably before studying mental health I couldn't, I don't know what I would have said then. But now I definitely say biopsychosocial. For all people there's some type of really strong biological component. Others have like a psychological predisposition/psychological experiences. And then social being the, what's going on in their life at that given time, and the social influences in the environment. Yeah, a combo [combination], and some are heavier [more significant] than others, but they're all interlinked to me.*

While the results clearly indicate that mental health professionals endorse more than one type of causal belief ("they're all interlinked"), most participants thought that there was a main cause or a stronger causal factor. Biogenetic causes were the most commonly reported main cause, for example, one participant simply stated: "I think the main cause is biological!". Most participants thought that different types of mental illness were caused by different factors or that the causal factors had differing weightings depending on the type of illness. For example, one participant stated, "If you just look at the amount of, or the significance, that genetics plays in different illnesses, you can clearly see that some of them [mental illnesses] are more genetic than others". Some participants thought that mental illness resulted from differences between individuals "it can be different for everyone", rather than particular causal factors resulting in a particular type of mental illness, with one participant stating:

**Extract 2**

*I think there's different things for everybody. I've seen older people who have a psychosis without any drug and alcohol use, other people who have been perfectly fine, use some drugs and then become unwell. So I think it can be different for everyone, but definitely that genetic factor probably contributes to that a lot. I mean, of course you see trends there, such things as trauma and then a personality disorder. There's definitely trends, but I think its individual at the end of the day.*

Previous research has suggested that mental health professionals' causal beliefs are on a continuum ranging from psychological to biological causes (Ahn et al., 2009). Our findings are not consistent with this research, and show that participants identified a wide range of causes and endorsed multiple causes simultaneously (see Extract 1). Despite endorsing a combination of causal beliefs, most participants tended to think that there was a main cause of mental illness "the main cause is biological" and that different mental illnesses were caused by different factors, "some of them [mental illnesses] are more genetic than others". Therefore, mental health professionals could put more emphasis on a particular cause depending on the diagnoses consumers presented with. This is consistent with previous research which has shown that mental health professionals believe that different mental illnesses are caused by different factors (Ahn et al., 2009).

## Development of Causal Beliefs

All participants were able to identify factors that influenced the development of their causal beliefs. Most participants thought that their causal beliefs were a result of a combination of their formal training and their clinical experience. Clinical experience was the most commonly reported influencing factor, with one participant explaining:

**Extract 3**

*Look, I mean, it's hard to unlearn what you've learned throughout your degree. I guess being taught about the biopsychosocial model really did influence my beliefs. I guess pre that, just seeing people around me who suffered from depression or anxiety, I could just, I guess, see from those examples that it's not just any one factor that leads to it. Then, in the work we do every day, I guess I can just see that it's not so simple as one factor causing any particular mental illness. I would say it's a whole combination of things that have led to me believing that it's [mental illness is caused by] a mix of factors.*

Some mental health professionals reported that they had received little or no training around the causes of mental illness, with participant saying "I really haven't had much training about the causes. It's always been about the treatment of, but yeah, not a lot around the causes". In the following extract, another participant expands on their understanding of mental illness causes.

**Extract 4**

*I think every family has mental illness within it. You'd have your own ideas about mental illness growing up. I think it touches every family. I think the thing that's majorly influenced my belief, sort of views on mental illness, is working in it, seeing friends as I've grown up develop it, and seeing family members suffer from it.*

As in Extract 4, some participants identified that contact in their personal life with mental illness influenced their understanding and causal beliefs. Relevant to more participants, however, were ongoing professional development activities that influenced their understanding and beliefs around what causes mental illness. Indeed, most participants reported that clinical experience had had the biggest impact on their causal beliefs, with one participant stating "My patients are my best teachers... I attend conferences. I speak with my colleagues. I do all of those professional bits, but still, my patients are still my best teachers". In addition, most mental health professionals explained that their clinical experience had changed their causal beliefs in some way with the majority of these participants explaining that through their clinical experience they had started to put more weighting on environmental factors, with the following participant explaining "The increased weight I put on trauma and life events has been through my experiences working with clients and spending time with them". As in Extract 5, some participants talked about how certain populations that they had worked with had increased their endorsement of certain causal factors.

**Extract 5**

*[Particularly] working with young people, seeing the influence of peers and how those environmental factors paired with particular periods of schooling, you know, when exam period comes on, that those are the times that I can see young people particularly suffering from anxiety or depression.*

The finding that not all participants' received training around the causes of mental illness "I really haven't had much training" is concerning, given the potential impact that causal beliefs have on stigma and treatment outcomes (Lebowitz & Ahn, 2014; Phelan, 2005). The majority of participants thought that the development of their causal beliefs was primarily influenced by their clinical experiences. Therefore, it seems likely that mental health professionals' working in different settings and with different populations may endorse different causal beliefs (see Extract 5). Overall, these findings highlight the need for further investigation into mental health professionals' causal beliefs, in order to explore how training and experience influence the development of causal beliefs and if there are differences across disciplines and work settings in regard to what causal beliefs are endorsed.

## Causal Beliefs and Perceptions of Mental Illness

Most mental health professionals identified that their beliefs about what causes mental illness have an impact on their perceptions towards people with mental illness, with one participant remarking "I probably like to say it [causal beliefs impacting perception] doesn't, but I think it probably does". Some mental health professionals felt as though their beliefs about the causes of mental illness did not influence their perception towards people with mental illness, with one occupational therapist saying "I don't think it [my causal beliefs] influences my view [of people with mental illness]". Some participants thought that their causal beliefs had a positive impact on how they viewed people with mental illness. Specifically, in line with attribution theory (Weiner et al., 1988), some participants reported that their causal beliefs helped to reduce the blame they placed on the individual, increased compassion and empathy, and increased understanding. For example, in Extract 6, a participant discusses his thoughts in response to being asked if causal beliefs had an impact on his perception towards people with mental illness.

**Extract 6**

*I guess they do, but I would hope not in a negative way. Umm, I suppose if you think everything's genetic then you adopt a very fatalistic response to everything. Whereas if you think everything's environmental, if causes are all environmental, then you think, well this person has made some choices that have led them to this. I think having a balance of both, which is probably more consistent to where mental disorders do originate from, it is a balance of both, it helps us to understand that it's not particularly a patient's fault. We don't choose our parents, as much as we'd like to [laughs]. Seeing that they [consumers] had no choice about that, so we can't blame, I think it helps us adopt a non-judgmental style of practice, understanding that causality, it clearly is beyond the patient's choice or willpower.*

The participant in Extract 6 thought that his causal beliefs had an overall positive influence, however, some participants reported that their causal beliefs at times had a negative impact on how they viewed people with mental illness (see Extract 7). Specifically, that at times their frustration with consumers increased and they would make assumptions about factors that contributed to the development of mental illness in their client (e.g., drug use).

**Extract 7**

*I'd like to say no [that causal beliefs don't influence my perception], but I think it probably does... I guess depending on the illness. You know, it's sometimes hard not to carry your own judgements about people and judgements about, you know, say if you've got a consumer with schizophrenia that has IV ice use and that sort of thing, your capacity to feel like your treating them well and treating them compassionately, it sort of diminishes a bit... I guess you sort of feel that they play a role in their own demise in many ways. That can be really frustrating.*

Extract 7 demonstrates that attributions of responsibility appear to increase blame and decrease compassion. Another factor that is thought to be influenced by causal beliefs is prognostic pessimism. Some participants thought that their causal beliefs did not influence their perception of prognosis, with one participant explaining "I don't think that my causal beliefs impact on prognosis. I think my own observation of working with people who experience schizophrenia might. I look at that being a lifelong hardship that people experience." However, some participants, such as the participant in Extract 8, thought that their causal beliefs had in impact on their perceptions of prognosis.

**Extract 8**

*Sometimes the cause may make me feel like, you know, it kind of doesn't matter what I do or say, this [mental illness] is just going to continue as it is, and not much is going to change it. Or, other causes I guess might make me feel a bit more hopeful about prognosis, or feel like there is definite steps [to take in treatment], and a distinct or a particular time frame that things could really improve.*

Copyright © 2018

In general, these findings suggest that mental health professionals' causal beliefs have an impact on perceptions towards consumers. However, our findings suggest that these relationships may be complex, with causal beliefs appearing to have both positive and negative consequences and which influence a range of variables. For instance, the participants in Extract 6, Extract 7, and Extract 8, highlight that, strong endorsement of environmental factors, may lead to viewing consumers as responsible for their illness and thus result in increased blame and reduced compassion, while strong endorsement of biogenetic factors appears to increase prognostic pessimism.

### Professional Experience, Causal Beliefs and Perceptions of Mental Illnesss

It was found that the more professional experience group mentioned more causal beliefs (M = 8.13, SD = 5.47) than the less professional experience group (M = 7.67, SD = 2.24). Given that participants commonly attributed the development of their causal beliefs to their clinical experience (see Extract 3), it would appear that with more clinical experience participants are exposed to a wider range of consumers who may present with different causal factors. Thus, mental health professionals' experience may increase the number of/types of causal factors that they endorse, and their beliefs may become more complex and varied over time. When looking at the types of causal beliefs endorsed, the groups did not appear to differ greatly, with most participants in each experience group endorsing a combination of biogenetic, psychological, and environmental causal beliefs and some participants in each group just endorsing biogenetic and environmental factors.

While participants endorsed multiple causal beliefs, most of the participants in the less professional experience group reported that they thought there was likely to be a main cause of mental illness, while most of the participants in the more professional experience group did not think that there was a main cause of mental illness (i.e., thought the causes were more complex). As previously mentioned, biogenetic causes were the most commonly reported main factor in this study. The increase in awareness and promotion of biogenetic causes over the past few decades has seen a rise in the endorsement of biogenetic causes in the general public (Schomerus et al., 2012). It is likely that mental health professionals go into their training and career endorsing similar causal beliefs to the general public, and then are likely taught a mental medical model of illness, and thus may view biogenetic causes as the main or stronger causal factor. It then appears that with more clinical experience mental health professionals endorse more causes and no longer view mental illness to be caused by a main factor.

When considering whether causal beliefs had an impact on perceptions towards people with mental illness, there appeared to be differences between the less professional experience and the more professional experience groups. In the less professional experience group, some participants thought that their causal beliefs had a positive impact on their perception towards people with mental illness, some participants reported that their causal beliefs had a negative impact on their perceptions towards people with mental illness, and most participants did not think that their causal beliefs influenced their perceptions towards people with mental illness. In the more professional experience group, most participants thought that their causal beliefs had a positive impact on how they view people with mental illness, with some participants reporting that they did not think their causal beliefs influenced their perceptions towards people with mental illness, and no participants reporting that their causal beliefs had a negative impact on how their view people with a mental illness. These results suggest that participants with more professional experience feel that their causal beliefs have less of a negative impact on their attitudes towards people with mental illness. A possible explanation of these findings is that endorsing a wider range of causal beliefs, without believing that there is a "main" cause which may improve perceptions and attitudes towards people with mental illness. Alternatively, it is possible that contact (in this case more professional experience), may act as a moderating factor between causal beliefs and attitudes towards people with mental illness.

## Discussion

This study explored mental health professionals' beliefs about the causes of mental illness and expands the current understanding of the relationships between causal beliefs and perceptions towards mental illness. First, we found that participants endorsed a range of causal beliefs simultaneously with the majority of participants endorsing a combination of biogenetic, psychological, and environmental causes. Despite endorsing a combination of causal beliefs, participants tended to believe there is a "main" cause of mental illness (with biogenetic causes being the most commonly reported main cause), and that different mental illnesses are caused by different factors. Second, participants thought that their causal beliefs were a result of a combination of their formal training and their clinical experience. However, several participants thought that they did not receive significant training around causes, with clinical experience having the biggest impact on the development of causal beliefs. Third, we found that participants thought that their causal beliefs influenced their attitudes and perceptions towards people with mental illness, and participants identified both positive and negative consequences of their causal beliefs. Last, participants who had more professional experience seemed to have a more complex belief system and endorsed a wider range of causal beliefs and were less likely to think that there was a "main" cause (compared to those with less professional experience). Participants with more professional experience also tended to think that their causal beliefs did not have a negative impact on their perceptions towards people with mental illness.

Attribution theory, genetic essentialism, and the mixed-blessing model (Dar-Nimrod & Heine, 2011; Haslam & Kvaale, 2015; Weiner et al., 1988), all propose that causal beliefs will have an impact on perceptions towards mental illness, in particular, stigma. Our results mirror this sentiment, with the majority of participants identifying that their causal beliefs impact their attitude towards people with mental illness. While this study was not designed to test the validity of different models, it does appear that results are more in line with the mixed-blessing model, as causal beliefs seemed to have both positive and negative consequences. The mixed-blessing model suggests that endorsement of biogenetic causal beliefs would reduce blame but would have a negative impact on other components of stigma such as prognostic pessimism (Haslam & Kvaale, 2015). In our study, participants often commented on how their causal beliefs reduced blame towards consumers and increased feelings of compassion and empathy. However, participants noted that their causal beliefs often had a negative impact on their view of prognosis.

Copyright © 2018

Copyright © 2018

Our study focused on causal beliefs in general rather than focussing only on biogenetic causes (as per mixed-blessings model). Further research is needed to explore the role that different types of causal beliefs have on perceptions of mental illness and to further explore the validity of the mixed-blessing model by controlling for the impact that other causal beliefs may contribute.

There are several clinical implications associated with our finding that mental health professionals' causal beliefs influence their view of consumers. Causal beliefs appear to impact mental health professionals' emotional response to consumers. For example, participants in our study stated that their causal beliefs shaped their feelings of compassion and empathy towards their consumers, which would likely have an impact on the therapeutic relationship. This conclusion is consistent with some of the previous limited research which also suggests that causal beliefs can have an impact on mental health professionals' emotional responses, such as empathy and blame (Lebowitz & Ahn, 2014; Miresco & Kirmayer, 2006). Empathy has previously been found to be an important factor which helps to enhance and build a therapeutic alliance, and also predicts therapeutic outcomes (Elliott, Bohart, Watson, & Greenberg, 2011). Therefore, it is important for mental health professionals to be aware of their own causal beliefs and to reflect on how these beliefs may influence important treatment factors such as therapeutic alliance. Consumers' causal beliefs have been found to influence their self-stigma and approach to treatment (blinded for review, 2017b; blinded for review, 2017c). Moreover, mental health professionals' causal beliefs would influence how they explain mental illness to their clients, which would play a role in shaping consumers' causal beliefs (Ahn et al., 2009; Lam, Salkovskis, & Warwick, 2005). Understanding the impact that mental health professionals' causal beliefs have on the therapy journey and the development of consumers' causal beliefs are important in future research.

Participants with more professional experience thought their causal beliefs had a more positive impact on their perceptions towards people with mental illness, suggesting that experience influences perceptions towards mental illness. Alternatively, it is possible that mental health professionals with negative perceptions of mental illness may stop working in the field, and thus people remaining (i.e., with more experience) may have more positive views. Contact and experience have previously been found to influence mental health professionals' perceptions towards people with mental illness (Lauber et al., 2006). Unfortunately, contact and experience are often difficult to control, as many mental health professionals have little control over the quantity or quality of contact they have with people with mental illness in their work environment. Contact may offer limited utility in trying to reduce stigma or improve perceptions towards people with mental illness in this context. On the other hand, causal beliefs may be easier to influence in training, thus if more attention is placed on causal beliefs in training, it may be helpful in the efforts to improve mental health professionals' perceptions towards people with mental illness.

It appears that participants adhere to the biopsychosocial model of mental illness (Engel, 1977), which has dominated the mental health field since it's conception in the 70's and argues that clinicians must attend simultaneously to biological, psychological, and social factors (Borrell-Carrió, Suchman, & Epstein, 2004). It is likely that some participants were taught the biopsychosocial model in their formal education, and the finding that most participants endorse a combination of biogenetic, psychological, and environmental factors suggests that they are still influenced by their formal education (see Extract 3). However, several mental health professionals identified that they received little or no training on causes of mental illness. Thus, more attention should be placed on learning about causes of mental illness and how to address these with consumers, during mental health professionals' formal education. In particular, formal education should focus on presenting information on a range of causes and encourage individuals to reflect on how their beliefs about causes may impact their view of people with mental illness. If mental health professionals receive training later in their career, it is likely that they will have already have formed strong views regarding causality and, as a result, attitudes may be harder to modify (Lam & Salkovskis, 2007).

While this study provides important insight into mental health professionals' causal beliefs, it is not without limitations. Past research has shown that there can be a difference in causal beliefs endorsed between different professional groups, and that different professional groups may have different levels of stigma (Kent & Read, 1998; Lauber et al., 2006). It is possible that results were influenced by the fact that we included a range of professional groups. However, we chose to include multiple disciplines to reflect community mental health services which are generally multidisciplinary. Future research would benefit from exploring differences between professional groups to help understand whether the type of training received influenced their causal beliefs. Another limitation of this study is that the primary researcher had a professional relationship with all the participants and knew them prior to conducting the interviews. As such participants would have been aware that they would have an ongoing professional relationship with the first author and this may have influenced the results. It is possible that participants gave responses that were more socially desirable than they would have been, if they had not known the interviewer or were responding to a questionnaire. As a result, negative perceptions of mental illness may have been under-reported. However, the results did imply that negative perceptions towards mental illness differed between the more and less professional experience groups. The division into more or less professional experience was not random, with different professional groups representing in the two groups, suggesting that participants may have been forthcoming with their responses and not influenced by knowing the primary researcher. Although the primary researcher having a professional relationship with participants may have also contributed to the depth and detail of data, participants all appeared comfortable and forthcoming with information during the interviews.

This study contributes to the very limited research on mental health professionals' causal beliefs and how these beliefs influence attitudes and perceptions towards consumers. Our results show that mental health professionals endorse a range of causal beliefs and that these beliefs are formed primarily through their clinical experiences as opposed to formal training. Most importantly, the results of this study show that mental health professionals' causal beliefs influence perceptions towards consumers and at times influence factors such as blame and prognosis which are likely to have an impact on treatment outcomes. These relationships should continue to be explored

in future research, and consideration should be given to how this knowledge could be utilised to help improve mental health professionals' attitudes and perceptions towards consumers. Moreover, an increased understanding of how mental health professionals' causal beliefs influence treatment-related factors is important for improving the treatment and services provided to consumers. It would also be important to explore consumers' causal beliefs and their experiences of causal beliefs in the treatment process.

## Acknowledgements

Thank you to Dr.??? for helping to test coding reliability. The first author also received support through an Australian Government Research Training Program Scholarship.

## Declaration of conflicting interests

The authors declare that there is no conflict of interest.

## Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

## References

Adewuya, A. O., & Oguntade, A. A. (2007). Doctors' attitude towards people with mental illness in Western Nigeria. Social Psychiatry and Psychiatric Epidemiology, 42, 931-936. Retrieved from doi:10.1007/s00127-007-0246-4

Ahn, W. K., Proctor, C. C., & Flanagan, E. H. (2009). Mental health clinicians' beliefs about the biological, psychological, and environmental bases of mental disorders. Cognitive Sciences, 33, 147-182. doi:10.1111/j.1551-6709.2009.01008.x

Allport, G. W. (1954). The Nature of Prejudice. New York: Addison-Wesley.

Amir, Y. (1969). Contact hypothesis in ethnic relations. Psychological Bulletin, 71, 319-342.

Angermeyer, M. C., Holzinger, A., Carta, M. G., & Schomerus, G. (2011). Biogenetic explanations and public acceptance of mental illness: systematic review of population studies. The British Journal of Psychiatry, 199, 367-372. doi:10.1192/bjb.bp.110.085563

Anthony, W. A. (1993(. Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. Psyosocial Rehabilitation Journal, 16, 11-23.

Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. The Annals of Family Medicine, 2, 576-582.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77-101. doi:-doi:10.1191/1478088706qp063oa

Corrigan, P. W., Larson, J., Sells, M., Niessen, N., & Watson, A. C. (2007). Will filmed presentations of education and contact diminish mental illness stigma? Community Mental Health Journal, 43, 171-181. doi:10.1007/s10597-006-9061-8

Corrigan, P. W., Sokol, K., & Rüsch, N. (2013). The impact of self-stigma and mutual help programs on the quality of life of people with serious mental illnesses. Community Mental Health Journal, 49, 1-6. doi:10.1007/s10597-011-9445-2

Dar-Nimrod, I., & Heine, S. J. (2011). Genetic essentialism: on the deceptive determinism of DNA. Psychological Bulletin, 137, 800-818. doi:10.1037/a0021860

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. In: Psychotherapy relationships that work. Psychotherapy, 48, 43-49. doi:http://dx.doi.org/10.1093/acprof:oso/9780199737208.001.0001

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. Science, 196, 129-136.

Goldstein, B., & Rosselli, F. (2003). Etiological paradigms of depression: the relationship between perceived causes, empowerment, treatment preferences, and stigma. Journal of Mental Health, 12, 551-563. doi:10.1080/09638230310001627919

Grausgruber, A., Meise, U., Katschnig, H., Schöny, W., & Fleischhacker, W. W. (2007). Patterns of social distance towards people suffering from schizophrenia in Austria: a comparison between the general public, relatives and mental health staff. Acta Psychiatrica Scandinavica, 115, 310-319. doi:10.1111/j.1600-0447.2006.00882.x

Hansson, L., Jormfeldt, H., Svedberg, P., & Svensson, B. (2013). Mental health professionals' attitudes towards people with mental illness: Do they differ from attitudes held by people with mental illness? International Journal of Social Psychiatry, 59, 48-54. doi:10.1177/0020764011423176

Haslam, N. (2011). Genetic essentialism, neuroessentialism, and stigma: Commentary on Dar-Nimrod and Heine (2011). Psychological Bulletin, 137, 819-824. doi:10.1037/a0022386

Haslam, N., & Kvaale, E. P. (2015). Biogenetic explanations of mental disorder: the mixed-blessings model. Current Directions in Psychological Science, 24, 399-404. doi:10.1177/0963721415588082

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. Journal of Counseling Psychology, 52, 196-205. doi:10.1037/0022-0167.52.2.196

Iselin, M. G., & Addis, M. E. (2003). Effects of etiology on perceived helpfulness of treatments for depression. Cognitive Therapy and Research, 27, 205-222. doi:10.1023/A:1023513310243

Kent, H., & Read, J. (1998). Measuring consumer participation in mental health services: are attitudes related to professional orientation? International Journal of Social Psychiatry, 44(4), 295-310. doi:10.1177/002076409804400406

Kopera, M., Suszek, H., Bonar, E., Myszka, M., Gmaj, B., Ilgen, M., & Wojnar, M. (2015). Evaluating explicit and implicit stigma of mental illness in mental health professionals and medical students Community Mental Health Journal, 51, 628-634. doi:10.1007/s10597-014-9796-6

Kvaale, E. P., Gottdiener, W. H., & Haslam, N. (2013). Biogenetic explanations and stigma: A meta-analytic review of associations among laypeople. Social Science & Medicine, 96, 95-103. Retrieved from http://dx.doi.org/10.1016/j.socscimed.2013.07.017

Lam, D., & Salkovskis, P. M. (2007). An experimental investigation of the impact of biological and psychological causal explanations on anxious and depressed patients' perception of a person with panic disorder. Behaviour Research and Therapy, 45, 405-411. doi:10.1016/j.brat.2006.03.005

Lam, D., Salkovskis, P. M., & Warwick, H. M. C. (2005). An experimental investigation of the impact of biological versus psychological explanations of the cause of "mental illness". Journal of Mental Health, 14, 453-464. doi:10.1080/09638230500270842

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. Biometrics, 33, 671-679. Retrieved from http://www.dentalage.co.uk/wp-content/uploads/2014/09/landis_jr__koch_gg_1977_kappa_and_observer_agreement.pdf

Blinded for review. (2012).

Blinded for review. (2017).

Copyright © 2018

Blinded for review. (2017a).
Blinded for review. (2017b).
Blinded for review. (2017c).
Lauber, C., Nordt, C., Braunschweig, C., & Rössler, W. (2006). Do mental health professionals stigmatize their patients? Acta Psychiatrica Scandinavica, 113, 51-59. doi:10.1111/j.1600-0447.2005.00718.x
Lebowitz, M. S. (2014). Biological conceptualizations of mental disorders among affected individuals: a review of correlates consequences. Clinicial Psychology: Science and Practice, 21, 67-83. doi:10.1111/cpsp.12056
Lebowitz, M. S., & Ahn, W. K. (2014). Effects of biological explanations for mental disorders on clinicians' empathy. Proceedings of the National Academy of Sciences of the United States of America - PNAS, 11, 17786-17790. doi:10.1073/pnas.1414058111
MacCallum, R. C., Zhang, S., Preacher, K. J., & Rucker, D. D. (2002). On the practice of dichotomization of quantitative variables. Psychological methods, 7, 19-40. doi:10.1037//1082-989X.7.1.19
McLean, A. (1995). Empowerment and the psychiatric consumer/ex-patient movement in the United States: Contradictions, crisis and change. Social Science & Medicine, 40, 1053-1071. doi: 10.1016/0277-9536(94)00179-W
Miresco, M. J., & Kirmayer, L. J. (2006). The persistence of mind-brain dualism in psychiatric reasoning about clinical scenarios. American Journal of Psychiatry, 163, 913-918.
Overton, S. L., & Medina, S. L. (2008). The stigma of mental illness. Journal of Counseling & Development, 86(2), 143-151.
Pettigrew, T. F., & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory. Journal of Personality and Social Psychology, 90, 751-783.
Phelan, J. C. (2005). Geneticization of deviant behavior and consequences for stigma: the case of mental illness. American Sociological Association, 46(4), 307-322. Retrieved from http://www.jstor.org/stable/4147660
Read, J., Haslam, N., Sayce, L., & Davies, E. (2006). Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach. Acta Psychiatrica Scandinavica, 114, 303-318. doi:10.1111/j.1600-0447.2006.00824.x
Richards, L. (2005). Handling Qualitative Data. London: SAGE.
Rüsch, N., Todd, A. R., Bodenhausen, G. V., & Corrigan, P. W. (2010). Biogenetic models of psychopathology, implicit guilt, and mental illness stigma. Psychiatry Research, 179, 328-332. doi:10.1016/S0924-9338(10)71241-4
Scholz, B., Bocking, J., & Happell, B. (2017). Breaking through the glass ceiling: Consumers in mental health organisations' hierarchies. Issues in mental health nursing, 38, 374-380. doi:10.1080/01612840.2017.1280106
Schomerus, G., Schwahan, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness; a systematic review and meta-analysis. Acta Psychiatrica Scandinavica, 125, 440-452. doi:10.1111/j.1600-0447.2012.01826.x
Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. International Review of Psychiatry, 2007(19), 137-155. doi:10.1080/09540260701278929
Wahl, O. F., & Aroesty-Cohen, E. (2010). Attitudes of mental health professionals about mental illness: a review of the recent literature. Journal of Community Psychology, 38, 49-62. doi: 10.1002/jcop.20351
Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional Analysis of reactions to stigmas. Journal of Personality and Social Psychology, 55, 738-748. doi:0022-3514/88/S00.75
Wiesjahn, M., Jung, E., Kremser, J. D., Rief, W., & Lincoln, T. M. (2016). The potenital of continuum versus biogenetic beliefs in reducing stigmatization against persons with schizophrenia: An experimental study. Journal of Behavior Therapy and Experimental Psychiatry, 50, 231-237. doi:10.1016/j.jbtep.2015.09.007

Copyright © 2018