Abstract

Background: Existing research has identified the phenomenon of associative stigma, but has not robustly illustrated that any stigmatisation of mental health professionals (MHPs) stems from association with clients. ***Aim:*** To examine whether public perceptions of MHPs mirror ideas about service users. ***Method:*** A mixed-methods approach incorporated statistical analysis of questionnaire results and thematic analysis of focus group transcripts. A convenience sample (N = 260) completed the questionnaire, rating 'typical' target professionals (some treating specified mental health conditions) on semantic differential scales. Three focus groups (N = 15) triangulated questionnaire findings. ***Results:*** Mirroring mental illness stereotypes, questionnaire participants rated counsellors and psychiatrists as more eccentric and unpredictable than GPs. Professionals specialising in treating substance abuse and schizophrenia were rated as less empathetic, agreeable, predictable and conventional than those treating depression, reflecting differing representations of these conditions. Specialists in depression and schizophrenia were rated as more withdrawn than those treating substance abuse. Focus group participants postulated that mental health problems may cause or result from mental health employment. ***Conclusion:*** MHPs seem stigmatised by association with clients. Future research should elucidate the origins of stigma to safeguard professionals' and clients' well-being.

Declaration of interest: none.

Keywords: mental health professionals, associative stigma

Schulze (2007) identified three roles for mental health professionals (MHPs) regarding mental illness stigma: 'stigmatisers', 'stigmatised', and 'destigmatisers'. The present study addresses their position as 'stigmatised', investigating whether the public stereotypes professionals based on their contact with mental health problems – a concept termed 'associative stigma' (Halter, 2008). Existing research, discussed below, demonstrates that stigmatisation of MHPs pervades popular culture and perceptions of service users, healthcare trainees and the public, bringing potentially pernicious consequences for the mental health services. However, little work directly considers the origins of this stigma, and how far it might relate to association with clients. The present study addresses this, using the mirroring of mental illness stereotypes onto MHPs as a marker for associative stigma (Halter, 2008).

Psychiatrists have long been depicted as 'mad' in film (Gabbard & Gabbard, 1999), cartoons (Redlich, 1950), and novels (Winick, 1963). Walter's (1992) analysis of 404 cartoons from 1941-1990 found that the 'mad' psychiatrist stereotype endured both over time and cross-culturally. Although such portrayals aim to entertain, they may reflect or influence public attitudes. Indeed, service users themselves have cited popular culture as influential, suggesting that stereotypes of MHPs motivate resistance to psychiatric services (Morgan, 2006). Similarly, Gabbard and Gabbard (1992) described how exposure to cinematic stereotypes of MHPs can influence professional-client interactions, for example leading service users to withdraw consent for electroconvulsive treatments. It seems that MHPs' poor public image may promote disengagement with psychiatric services - a notable global problem (Demyttenaere et al., 2004).

Like service users, healthcare trainees are exposed to negative stereotypes of MHPs. Medical students have often misconceived psychiatrists' role, lacking knowledge of psychiatric treatments, expecting them to 'read minds' (O'Brien et al., 2015), and

stereotyping psychiatrists as ‘often weird’, ‘emotionally unstable’, and ‘low status’ (Buchanan & Bhugra, 1992). This stigma may be off-putting for potential mental health specialists, contributing to staffing shortages. Recruitment to psychiatry and psychiatric nursing has declined globally (Garcia, Kennett, Quraishi, & Durcan, 2005; Katschnig, 2010; Sierles and Taylor, 1995), although demand for psychiatric services is expected to increase (Katschnig, 2010). In a survey of Australian medical students, only 15% reported a high likelihood of opting for psychiatry, compared with 19-49% for other specialities (Malhi et al., 2011). Even students likely to pursue psychiatry ranked it lowest on prestige, treatment effectiveness, and foundation in science. Further illustrating that stigma impedes recruitment to psychiatry, psychiatric trainees and nursing students report that family and friends react negatively to their choice of specialism, warning them that it could provoke later ‘madness’ (Kalra, 2012; Wells et al., 2000).

Additionally, stigmatisation may be a job stressor for MHPs, compromising their well-being and that of their clients. Internationally, psychiatrists have reported significantly higher perceived stigma and discrimination experiences than GPs, and perceived stigma predicts psychiatrists’ self-stigma (Gaebel et al., 2015). Multilevel analyses in one study linked self-reported associative stigma with depersonalisation, emotional exhaustion, and low job satisfaction amongst MHPs (Verhaeghe & Bracke, 2012). Furthermore, greater self-stigma and lower client satisfaction were reported by service users in centres where professionals experienced more associative stigma. Notably, the study’s cross-sectional design prohibits causal conclusions, and levels of associative stigma were generally low. Nevertheless, Verhaeghe and Bracke (2012) have highlighted the importance of further research into associative stigma, to preserve MHPs’ and clients’ well-being.

Importantly, MHPs have differing stereotypes. Samples of the public and various MHPs have consistently recommended psychiatrists for more serious cases than other

professionals (Koeske, Koeske, & Mallinger, 1993; Schindler, Berren, Hannah, Beigel, & Santiago, 1987; Warner & Bradley, 1991), perhaps due to perceptions of psychiatrists' greater expertise (Alperin & Benedict, 1985; Schindler et al., 1987; Warner & Bradley, 1991). Despite this, psychiatrists arguably experience the greatest stigma, and have been seen as colder (Alperin & Benedict, 1985; Koeske et al., 1993; Warner & Bradley, 1991), odder (Sharpley, 1986; Warner & Bradley, 1991), and less valuable (McGuire & Borowy, 1979; Nunnally & Kittross, 1958) than other MHPs. In contrast, counsellors have been perceived as helpful and caring listeners, but lacking in psychiatrists' expertise and status (Warner & Bradley, 1991).

Hence, it seems crucial to understand stigmatisation of MHPs to promote client engagement with mental health services, reduce staffing shortages, and protect professional and client well-being. Associative stigma offers a promising explanation for stigmatisation of MHPs, and may also drive the especially negative stereotyping of psychiatrists. Goffman (1963) defines 'courtesy stigma' as negative perceptions of individuals based on their connection with a stigmatised group. Substantial research demonstrates that people with mental health problems are stigmatised (e.g. Angermeyer, Beck, Dietrich, & Holzinger, 2004; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000); this stigma could diffuse to MHPs, possibly explaining psychiatrists' high stigma levels. Psychiatrists' perceived expertise, unique link with psychiatric medication, and association with the most severe cases (e.g. Schindler et al., 1987) could strengthen their connections with the most stigmatised clients, elevating associative stigma (e.g. Farberman, 1997).

Robust evidence has validated the concept of associative stigma. Research has identified familial associative stigma (Gray, 1993; Mehta & Farina, 1988; Östman & Kjellin, 2002), though expected heredity and learning connections within families could explain this (Neuberg, Smith, Hoffman, & Russell, 1994). However, perceptions of gay men's friends

reinforce evidence of associative stigma. Neuberg et al. (1994) found that male college students derogated male targets known to be heterosexual after watching footage of them with a homosexual friend, even when the heterosexual target was presented as likable. These findings demonstrate the existence and potential resilience of associative stigma, but cannot be generalised to MHPs.

Thus far, Halter (2008) has come closest to providing direct evidence that MHPs are subject to associative stigma. A convenience sample of American nurses rated 10 nursing specialities on eight attributes. Psychiatric nurses were the least likely to be rated as skilled, logical, dynamic or respected, and were rated as unlikely to be extraverted, autonomous, caring, and accepting. Halter argued that perceptions of psychiatric nurses mirrored mental illness stereotypes, namely 'incompetence' and 'character weakness' (Corrigan, 2004). However, this ultimately relies on retrospective postulation rather than empirically assessing whether nurses' stereotypes matched their clients'.

The present study aimed to address a gap in the literature, investigating associative stigma by assessing the extent to which public stereotyping of MHPs mirrors that of their clients. Research has identified greater stigmatisation of people with substance abuse or schizophrenia than depression, including perceptions that they are more unpredictable or dangerous (Angermeyer et al., 2004; Crisp et al., 2000; Jorm, Reavley, & Ross, 2012; Monteith & Pettit, 2011). The research design therefore examined associative stigma by comparing perceptions of MHPs specialising (albeit to an unrealistic extent) in different conditions, and considering perceptions of different kinds of professionals. The researchers broadly hypothesised that MHPs would be perceived more negatively than GPs, and that specialising in schizophrenia or substance abuse would bring greater stigma than specialising in depression. The exact nature of these differing levels of stigma was investigated in an exploratory manner.

The design was mixed-methods, comprising both quantitative and qualitative analysis. The researchers used quantitative questionnaire data to test for associative stigma and for differing perceptions of psychiatrists, counsellors and GPs. Qualitative focus group data complemented the questionnaire findings by providing a more detailed exploration of MHPs' public image, developed in contexts similar to real-world interactions and expressed in participants' frameworks of understanding.

Method

Participants

Approval was obtained from the University Psychology Research Ethics Committee. Convenience samples of adult volunteers were recruited for the questionnaire (N = 260) and focus groups (N = 15), through word-of-mouth, university email lists, social media, and research participation websites (see Table 1 for participant characteristics). No financial or academic incentives were offered, and anyone over 18 years of age could participate. The questionnaire was available online and on paper, so recruitment was not restricted by region or internet access.

TABLE 1

Materials and Procedure

Questionnaire. Respondents rated target professionals on nine characteristics. The eight target professionals were a hospital receptionist, GP, and psychiatrists and counsellors specialising in treating substance abuse, schizophrenia, or depression. Semantic differential scales measured the dependent variable, with participants asked to rate a 'typical example' of each professional on nine 7-point scales bounded by polar adjectives: competent/incompetent, helpful/unhelpful, trustworthy/untrustworthy, predictable/unpredictable, conventional/eccentric, emotionally stable/emotionally unstable,

outgoing/withdrawn, empathetic/non-empathetic, and agreeable/hostile. These adjectives were developed from existing scales assessing perceptions of MHPs (Halter, 2008; Nunnally & Kittross, 1958; Webb & Speer, 1986), and from research on mental illness stereotypes (Angermeyer et al., 2004; Crisp et al., 2000; Jorm et al., 2012; Monteith & Pettit, 2011).

Efforts were made to control for extraneous variables. The survey was piloted on a small sample (n = 4) to check and improve question clarity. To minimise demand characteristics, respondents were initially informed that the questionnaire addressed perceptions of healthcare professionals rather than MHPs. The distractor target, a 'hospital receptionist', was included to obscure the study's purpose, and was excluded from analyses. To control for order effects, the polar adjectives and questions addressing different professionals were randomised.

Focus groups. Three audio-taped focus groups were conducted, comprising four to six participants, each lasting approximately 60 minutes. The focus groups centred on the following discussion-based tasks (see Appendix A for the topic guide).

The 'life stories' task. Participants were asked what a GP, psychiatrist and counsellor might have been like at 18-years-old, and possible reasons for choosing each career. This deepened insights from the questionnaire, inviting participants to evaluate MHPs in the context of lifespan development rather than in the abstract.

The social distance task. Cards representing a GP, and counsellors and psychiatrists with three different specialisms (depression, schizophrenia, or substance abuse) were provided. Participants were asked to collaboratively rank these professionals as neighbours, social companions, friends and partners. These tasks were derived from Link, Phelan, Bresnahan, Stueve, and Pescosolido's (1999) social distance measures, and highlight how perceptions of MHPs influence people's desired interactions with them.

Direct questions: Perceived societal views. Questions addressed societal attitudes towards MHPs, possible reasons for these, differences in societal opinions of different MHPs, and sources of participants' perceptions of societal views. This further built on the questionnaire results, exploring possible sources of stigma.

Analysis

Questionnaire. To evaluate the associative stigma hypothesis, repeated-measures analyses of variance (ANOVAs) and Bonferroni's procedure were used to compare ratings of target professionals on each characteristic. Where the assumption of sphericity was violated, degrees of freedom were corrected using Greenhouse-Geisser estimates when $\mathcal{E} < .75$, and Huynh-Feldt adjustments when $\mathcal{E} > .75$ (Field, 2005).

Focus groups. Verbatim transcripts were produced from audio recordings of the focus groups, which were thematically analysed by one researcher and checked by another. Key ideas from each transcribed comment were used to establish initial codes, with recurrent ideas forming categories. Next, broader themes, subthemes, and relationships between them were identified, forming a thematic map. Themes were reviewed by both researchers for within-theme homogeneity,between-theme heterogeneity (Braun & Clarke, 2006), and relevance to the associative stigma hypothesis.

Results

Questionnaire

Using repeated-measures ANOVAs, significant differences between professionals' scores were identified on eight of the nine characteristics assessed (see Table 2).

TABLE 2

Perceptions of professionals regardless of their specialities were compared using repeated-measures ANOVAs with mean scores for GPs, psychiatrists, and counsellors (see Table 2 and Appendix B). Differences for emotional stability and trustworthiness were non-significant. Highly significant differences ($p < .001$) emerged for conventionality (large effect), empathy (medium-large effect), predictability and competence (small-medium effects). Small, but significant differences ($p < .05$) were identified for extraversion, agreeableness, and helpfulness. Bonferroni's procedure found that mean conventionality and predictability ratings for psychiatrists and counsellors were significantly lower than for GPs, reflecting stereotypes of individuals with mental illness as eccentric (Barrantes-Vidal, 2004; Sass, 2001) and unpredictable (e.g. Crisp et al., 2000). Psychiatrists were rated as significantly more competent and withdrawn than GPs or counsellors. Whilst higher competence ratings were expected for psychiatrists than counsellors, psychiatrists' ranking above GPs contradicts associative stigma, whereas extraversion scores suggest greater associative stigma for psychiatrists than counsellors. Supporting existing research (e.g. Warner & Bradley, 1991), counsellors received significantly higher helpfulness and agreeableness ratings than GPs or psychiatrists. Counsellors were rated as significantly higher in empathy than psychiatrists or GPs, and psychiatrists as significantly more empathetic than GPs. Again, this more positive perception of MHPs than GPs was unexpected, although views of counsellors as more empathetic than psychiatrists were predicted.

Differences between ratings of professionals specialising in different mental health problems were also assessed (Figure 1). Psychiatrists and counsellors specialising in the most stigmatised conditions – schizophrenia and substance abuse (e.g. Crisp et al., 2000) – were seen as less empathetic, agreeable, predictable, and conventional than their counterparts specialising in depression, providing evidence of associative stigma. Bonferroni's procedure showed the vast majority of these differences reached statistical significance ($p < .05$).

Significant differences between psychiatrists specialising in depression and either schizophrenia or substance abuse were found on predictability and conventionality ratings, and between psychiatrists specialising in depression and substance abuse only for empathy and agreeableness ratings. For predictability, conventionality, empathy and agreeableness, pairwise comparisons were significant for counsellors specialising in depression compared with either schizophrenia or substance abuse. Additionally, professionals specialising in depression or schizophrenia were rated as significantly more withdrawn than those treating substance abuse, mirroring the social withdrawal symptomatic of depression and schizophrenia but not substance abuse (American Psychiatric Association, 2013). Pairwise comparisons identified significant differences between psychiatrists specialising in substance abuse versus either schizophrenia or depression, and the same applied to counsellors.

FIGURE 1

However, associative stigma was relative: MHPs were generally rated positively, scoring above the midpoint (from low to high on each characteristic in Table 2) on all measures. For emotional stability, evidence of associative stigma emerged in counsellors', but not psychiatrists' ratings. Counsellors specialising in depression were rated as significantly more stable than those specialising in substance abuse. There were no significant pairwise comparisons between psychiatrists, for whom the pattern of results (Figure 1) was unexpected. Moreover, there was no evidence of associative stigma in ratings of trustworthiness, competence, or helpfulness.

Focus groups

The final thematic map (Figure 2) illustrates the overall categorisation of focus group data.

FIGURE 2

Reasons for pursing the profession. Across groups, personal experience of mental health problems was thought to motivate psychiatrists and counsellors, for example: "people who have had eating disorders, after they've like recovered then they kind of become interested in why it happened, or helping other people" (D, group 1). When the same issue was discussed with reference to societal perceptions, more stigmatising language was used: "People think things like "you're crazy", and that's why you want to work in this line" (A, group 1). Perhaps the belief that personal mental health problems drive MHPs denotes post-hoc rationalisation of associative stigma, or represents a source of MHPs' stigma based on shared experiences rather than contact with clients.

Participants discussed other factors motivating mental health careers: indirect exposure, empathy and status, and practicalities. Indirect exposure included "a problem like that in their family or like their wider circle of friends" (C, group 1), or relevant voluntary work, media exposure, or academic study. A trade-off between empathy and pursuit of money and status was discussed, with counsellors seen as more empathy-driven than psychiatrists and GPs, due to their lower earnings:

> E, group 1: They're paid really badly; you have to do it for the love if you're a counsellor 100%, whereas these guys [gestures to psychiatrists and GP cards], maybe they do, but maybe they don't, because they are paid quite well.

Participants also mentioned the influence of "practical reasons" like job availability (N, group 3) on professionals' career paths. By suggesting motivations for mental health careers other than personal mental illness, participants demonstrated perceptions extending beyond associative stigma.

The job's impact on the professional. Working in mental healthcare was expected to have a greater impact on professionals' well-being than employment as a GP. Psychiatrists' and counsellors' work was seen as "much much heavier to deal with" (O, group 3) and "more

affecting" (B, group 1) than GPs', suggesting that mental health employment results in psychological distress, and may even echo the idea that proximity to mental illness 'drives you mad'.

Psychiatrists' and counsellors' professional behaviour was also expected to extend to non-work interactions more than GPs'. Participants thought that MHPs might try to 'treat' their friends (group 1 interchange):

> E: With a counsellor, if you had a problem and you went to your friend would it kind of feel like a counselling session?
>
> C: It's the same for the psychiatrist!

Moreover, all three groups worried that psychiatrists would engage in 'mind-reading' in social contexts, for example (group 3 dialogue):

> O: I feel like a psychiatrist would read my mind more, which would make me quite scared.
>
> M: And like analyse you all the time, whereas a counsellor you could just go round and have a chat.

Both 'treating' friends and 'mind-reading' were viewed as inappropriately intrusive behaviours.

The groups agreed that the job titles of GP, psychiatrist, and counsellor affect individuals' societal status. GPs were typically perceived as "more prestigious" (J, group 2) than psychiatrists, with counsellors as the lowest status professional (group 1 exchange):

> A: You think of [psychiatrists] as doctors first, and so there's status, and like training involved, as opposed to a counsellor where it's just someone who probably got certified.
>
> D: Yeah, but I do think becoming a psychiatrist you do have less status, like some other branches of medicine will make fun of psychiatrists, saying like "oh they're all mad"…

The first comment links counsellors' inferior status with their training level; the second indicates that associative stigma contributes to psychiatrists' low status within medicine.

Participants discussed the stereotypes of 'counsellor' and 'psychiatrist'. While GPs were often described as "boring" (C & D, group 1), psychiatrists and counsellors were thought to be interesting but "eccentric" (C, group 1; G, group 2):

> G, group 2: In terms of socialising, I would perhaps place the GP after the psychiatrists and counsellors specialising in rarer psychological conditions. Just because I would find it more interesting personally to talk to them.
>
> K, group 3: The ones that I knew that went on to be psychiatrists, you could pick them out when they were 18. They wore slightly different clothes, like a bow tie or…slightly weird clothes.

The first comment apparently contradicts associative stigma, indicating a fascination with MHPs treating the most stigmatised conditions, perhaps related to their perceived eccentricity. Though intriguing, such unconventionality was typically viewed negatively, demonstrating associative stigma whereby people with mental illnesses are similarly viewed as eccentric (e.g. Barrantes-Vidal, 2004). Associative stigma also emerged in perceptions of MHPs as less "trusted" (E, group 1) and reliable than GPs:

> G, group 2: I just have a concept of counsellors and psychiatrists as perhaps a bit more eccentric and interesting people to perhaps spend, I don't know, to talk to, but having as a good friend, maybe the GP is sort of more, more reliable.

A trade-off emerges here, with trustworthiness and reliability weighing against interestingness and eccentricity, explaining preferences for short-term contact with MHPs and long-term contact with GPs (for social distance rankings, see Appendix C). Fascination with MHPs seems to accompany associative stigma: as Foucault (1961) said, "madness fascinates" (p.18).

Explanations for stigma. Ignorance was thought to underlie societal stigmatisation of MHPs:

> L, group 3: I think it's linked to the lack of understanding. I think people are like quite scared of some people with mental illness, particularly like schizophrenia or substance abuse, and see them as dangerous and maybe by association, because they don't understand it, they sort of get a bit suspicious about people whose job it is to deal with them.

Participants proposed that public ignorance leads people to "form opinions based on things they heard from other people and the media" (D, group 1), so media depictions of MHPs as "mad" (F, group 2) exacerbate associative stigma. One participant suggested that present-day associative stigma stems from historical beliefs about the humours:

> J, group 2: In the olden days there was um some sort of consensus that mental health was transferred by like bodily fluids, and like contact. So if people still have that strange mind-frame, then they might think that, you know, the mental health professional is somehow contaminated.

Moreover, this concept of physical contagion was seen as two-way, with clients also stigmatised by contact with MHPs:

> G, group 2: If you were to go to a mental health professional, people might be judging you inside, and that might put people off from asking for help and going to any of the mental health professionals.

By proposing that reciprocal professional-client associative stigma impedes treatment, participants highlighted the importance of understanding the processes underpinning MHPs' associative stigma so that it can be tackled.

Discussion

This study's primary hypothesis was supported: results from both the questionnaire and focus groups indicated that MHPs are stigmatised by association with clients. Matching clients' stereotypes (e.g. Barrantes-Vidal, 2004; Crisp et al., 2000), questionnaire respondents rated psychiatrists and counsellors as more eccentric and unpredictable than GPs. Consonant with prior research (e.g. Warner & Bradley, 1991), psychiatrists were rated as more competent than counsellors, but less outgoing, helpful, agreeable, and empathetic; arguably, psychiatrists' perceived expertise strengthens connections with more severe mental health problems, intensifying associative stigma. Mirroring the greater stigmatisation of substance abuse and schizophrenia (e.g. Crisp et al., 2000), professionals specialising in these

conditions were rated as less empathetic, agreeable, predictable and conventional than those specialising in depression. Professionals treating depression or schizophrenia were perceived as significantly more withdrawn than those treating substance abuse, reflecting the social withdrawal symptomatic of depression and schizophrenia (American Psychiatric Association, 2013).

Likewise, the focus groups provided evidence of MHPs' associative stigma. Psychiatrists' and counsellors' work was thought to deplete their societal status, and participants viewed MHPs as fascinating but undesirable for long-term contact. Like their clients, psychiatrists and counsellors were perceived as interesting and eccentric, but unreliable. Participants suggested that personal mental health problems or 'madness' motivate MHPs, perhaps rationalising pre-existing stereotypes of MHPs as similar to their clients. MHPs' work was seen as more affecting than GPs', acting as a source of mental distress in itself. Indeed, participants discussed a myriad of factors underlying associative stigma: the interaction of public ignorance, media stereotypes and archaic ideas of mental health contagion. Crucially, participants highlighted that reciprocal associative stigma between professionals and clients may form a barrier to treatment, contributing to reluctance to consult MHPs.

Yet evidence for associative stigma from the questionnaire has limits. Associative stigma was relative, as professionals were rated quite positively overall. Partial support emerged for emotional stability ratings, and trustworthiness, competence, and helpfulness ratings presented no associative stigma. 'Helpfulness' is not especially relevant to mental illness stereotypes, possibly explaining why this characteristic presented no associative stigma. The small differences between professionals' helpfulness ratings could reflect perceptions of substance abuse as less genetically-based, so more treatable than schizophrenia or depression (Link et al., 1999). Perhaps professional-specific stereotypes overrode

associative stigma regarding competence ratings. The researchers' associative stigma hypothesis predicted higher competence ratings for depression specialists, but the results (Figure 1) are better explained by stereotypes of psychiatrists as more competent than counsellors, especially in treating 'severe' or prototypical mental illnesses like schizophrenia (Link et al., 1999). Future research could investigate whether salient information about MHPs reduces associative stigma.

Similarly, the focus groups presented perceptions of MHPs besides associative stigma. Discussion of motivations for psychiatric and counselling careers covered personal mental illness, but also indirect exposure to mental health problems, empathy-status trade-offs, and practicalities. Additionally, the groups raised concerns about MHPs' intrusiveness, positing that they would 'read your mind' or try to 'treat' their friends. These negative perceptions do not reflect stereotypes of service users; future research should parse MHPs' associative stigma and that based on their perceived intrusiveness and power.

Conclusions

This study provides empirical evidence that public perceptions of MHPs mirror stereotypes of their clients identified in existing research – a marker of associative stigma. However, the data implicates a multiplicity of factors in this process, including ignorance, media exposure, concepts of physical contagion, and reasoned arguments that mental health problems motivate and/or result from mental health employment. Moreover, professional-client associative stigmatisation appears to be two-way. Evidently, associative stigma does not have a single root cause;further research is required to delineate its development, using more representative samples of the general public, but also of service users, prospective and current MHPs. This is especially salient as associative stigma may impede help-seeking for psychological distress (e.g. Morgan, 2006), contribute to mental health staff shortages (e.g.

Malhi et al., 2011), and compromise the well-being of both professionals and clients (Verhaeghe & Bracke, 2012). Thus, research on the associative stigmatisation of MHPs must play an important part in the battle to dismantle mental health stigma and improve services.

Appendix A

Focus group topic guide

Preliminaries

Distribute consent forms and information sheets. Give participants the opportunity to ask questions about the forms before handing them back. Start recording, and ask everyone to state their name. Clarify what will happen in the next hour: I'm going to ask some questions – the idea is for you to discuss your thoughts on these with each other. There are no right or wrong answers and it is okay to disagree with each other, as long as everyone respects each other's views. Check if participants have any questions before proceeding.

Discussion of professionals' life stories

1. Give the group cards saying 'a psychiatrist', 'a counsellor', and 'a GP'.
2. What might each professional have been like when they were 18?
3. Why might they have chosen this profession?
4. What might lead MHPs to specialise in different mental health problems – specifically depression, schizophrenia, and substance abuse?

Rank ordering the professionals

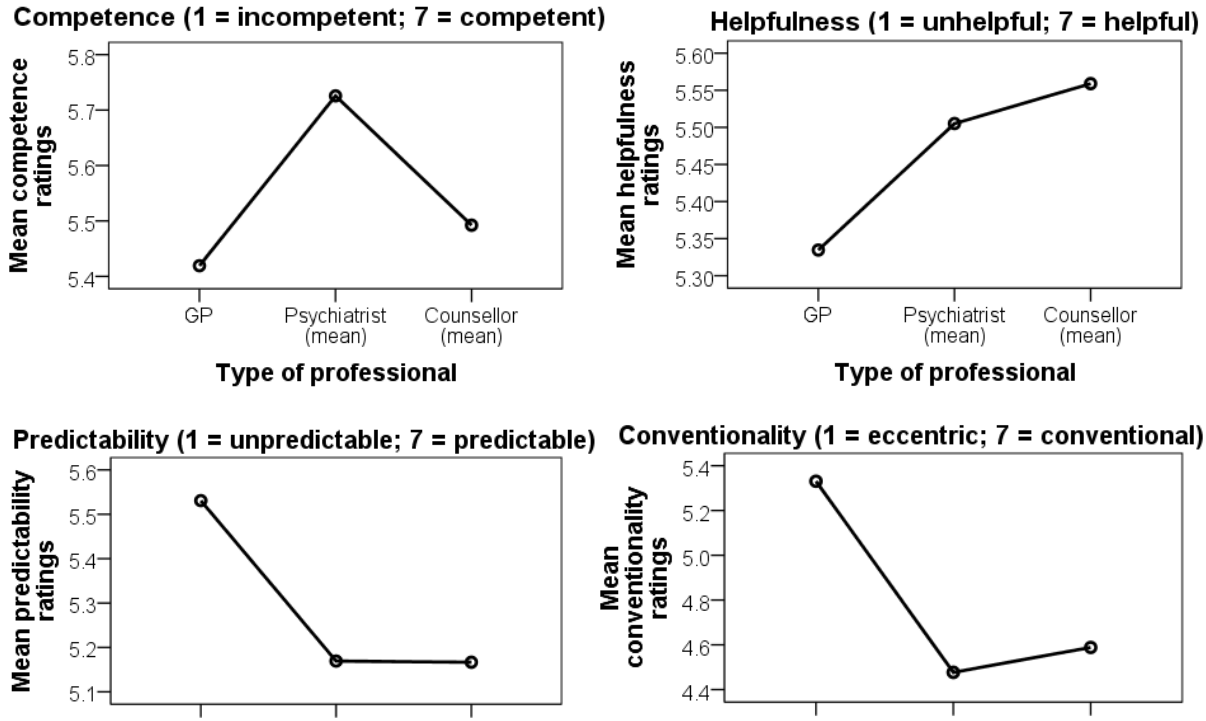
1. Give the group cards denoting the professionals, this time including the specialisms.
2. Please order the cards in terms of how much you would like to:
    a. Move next door to them
    b. Spend an evening socialising with them
    c. Make friends with them
    d. Have them marry into the family

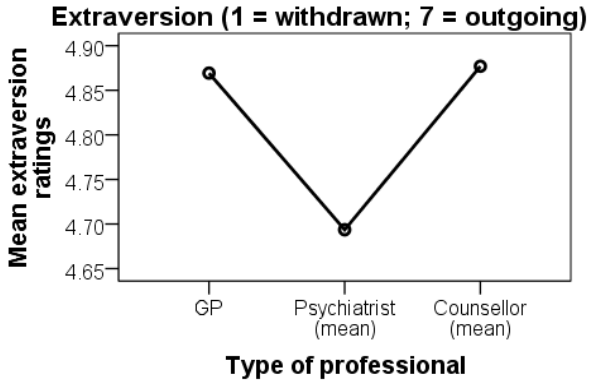
Direct questions: society's perception of MHPs

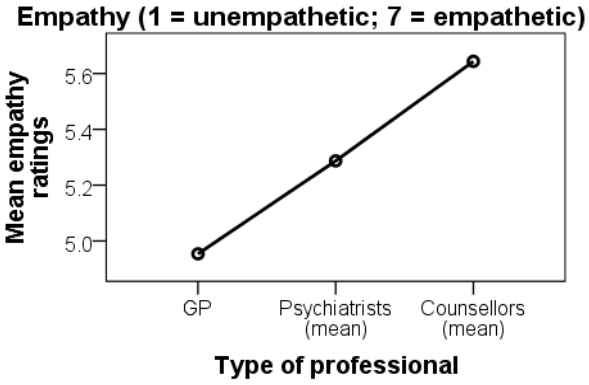
1. What do you think society's perception of MHPs is?
2. If society stigmatises MHPs, why do you think this might be?
3. Are all MHPs stigmatised/valued equally by society, or are some viewed in a better light than others?
4. If you do not mind sharing this information, what are your impressions based on?
5. Is there anything else you would like to add?

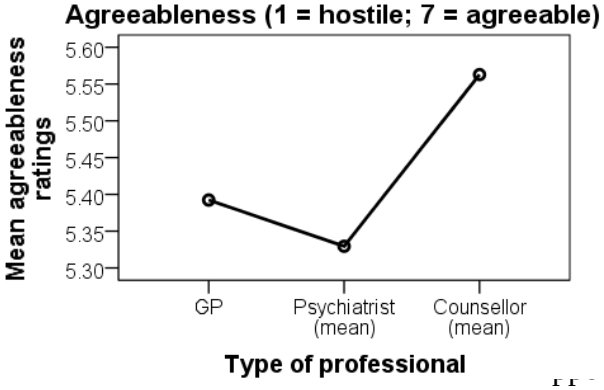
Appendix B

Graphs of repeated-measures ANOVAs, showing significant differences between ratings of GPs and mean scores for both psychiatrists and counsellors on each of seven characteristics.









Appendix C

Social distance rankings from the focus groups for seven target professionals (from most to least favoured).

Key

GP: General practitioner
PsyD: Psychiatrist specialising in treating depression
PsyS: Psychiatrist specialising in treating schizophrenia
PsySA: Psychiatrist specialising in treating substance abuse
CoD: Counsellor specialising in treating depression
CoS: Counsellor specialising in treating schizophrenia
CoSA: Counsellor specialising in treating substance abuse

	Focus group 1	Focus group 2	Focus group 3
Move in next door	GP, CoD, CoSA,	GP, then the rest in	GP, CoD, PsyD,

	CoS, PsyD, PsySA, PsyS	no particular order	PsyS, PsySA, CoSA, CoS
Spend an evening socialising	CoD, CoSA, CoS, GP, PsyD, PsySA, PsyS	Psychiatrists and counsellors over GP, possibly SA and S specialists over D	GP, CoS, PsyD, CoSA, PsyS, CoD, PsySA
Become friends	GP, PsyD, PsySA, PsyS, CoD, CoSA, CoS	GP, then the rest in no particular order	CoD, GP, PsyS, CoSA,CoS,PsyD, PsySA
Marry into the family	GP, CoD, CoSA, CoS PsyD, PsySA, PsyS	GP, then the rest in no particular order	GP, PsyD, PsySA, CoD, PsyS, CoSA, CoS

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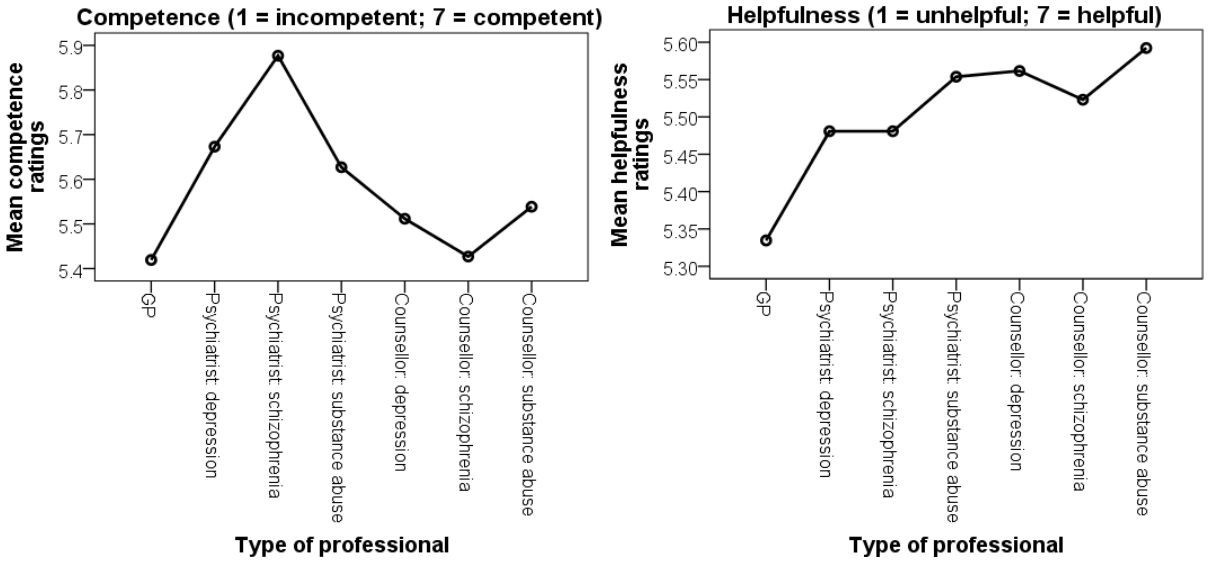
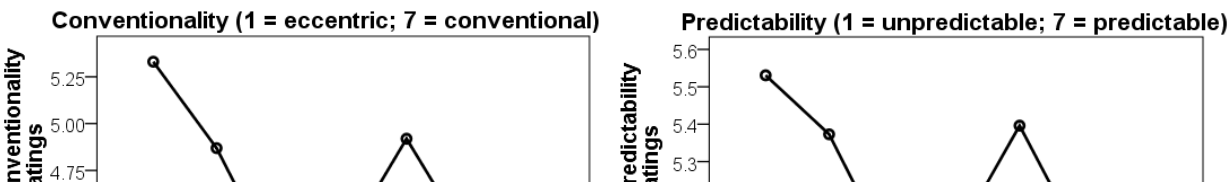
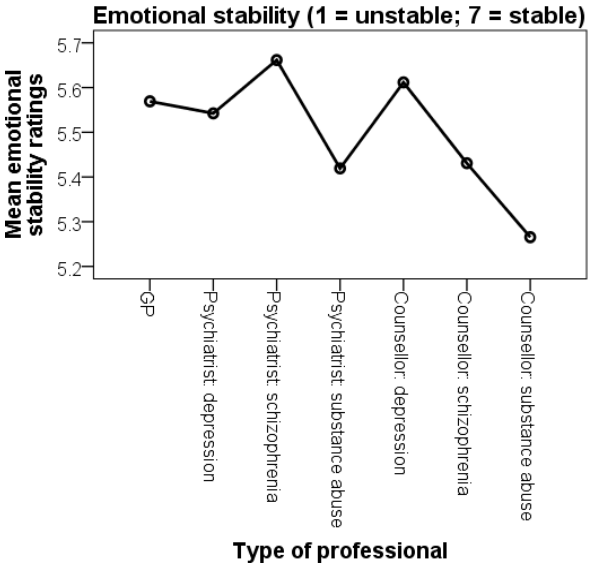
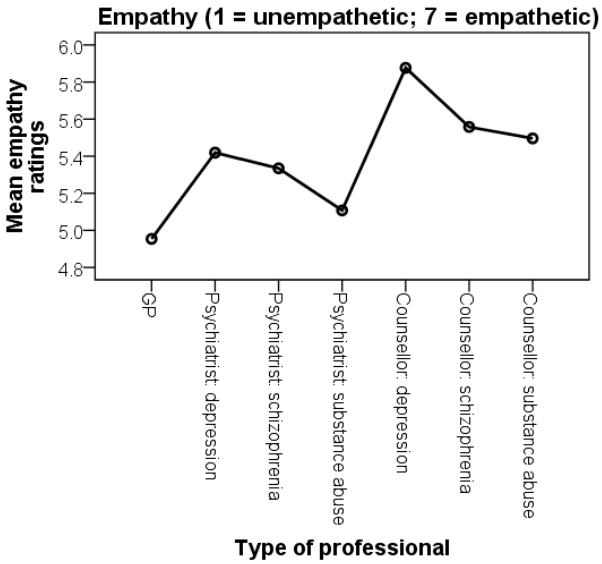








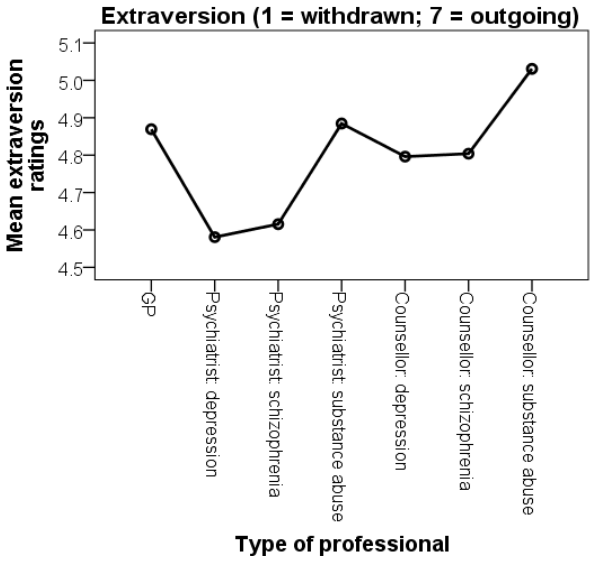


Figure 1 (continued overleaf).

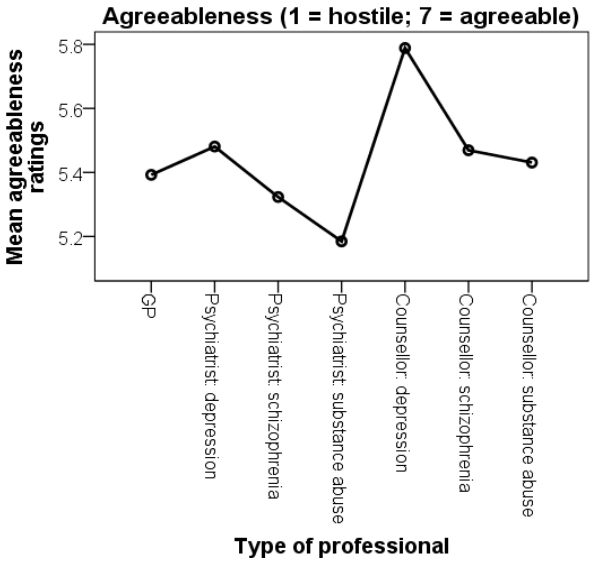
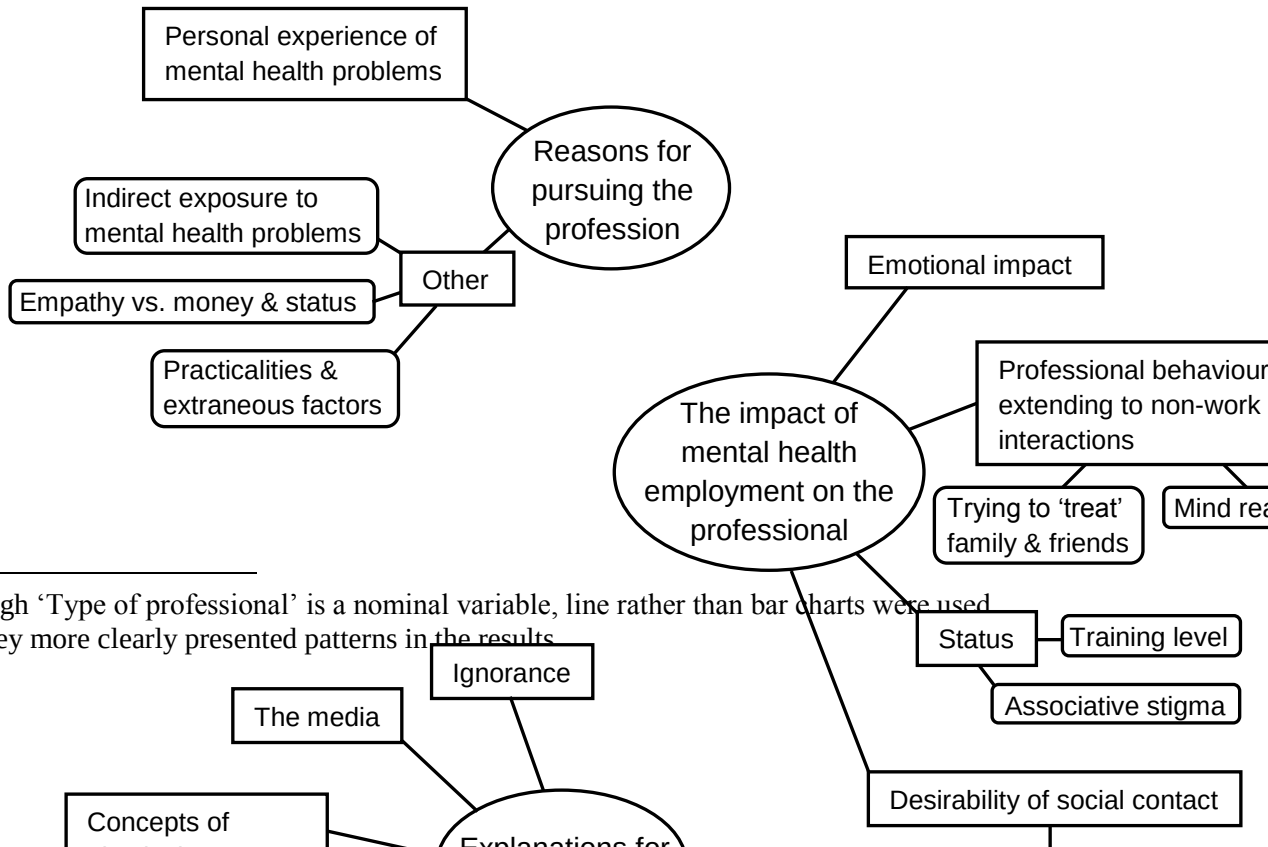


Figure 1. Repeated-measures ANOVA graphs, showing significant differences between ratings of professionals on eight characteristics.[1]



[1] Although 'Type of professional' is a nominal variable, line rather than bar charts were used because they more clearly presented patterns in the results.

Figure 2. Thematic map developed from the focus groups.

Table 1

Participant characteristics

	Questionnaire participants (*N* = 260)		Focus group participants (*N* = 15)	
Characteristic	Demographic	%	Demographic	%
Age *	18-20 years	27.03	18-20 years	33.33
	21-30 years	36.29	21-30 years	60.00
	31-50 years	12.74	31-50 years	0.00
	51-60 years	14.67	51-60 years	6.67

	61-81 years	9.27	61-81 years	0.00
Gender	Female	67.69	Female	93.33
	Male	31.54	Male	6.67
	Other	0.77	Other	0.00
Completed	No formal qualifications	0.77	No formal qualifications	0.00
educational	School at 16 years of age	1.93	School at 16 years of age	0.00
qualifications	School at 18 years of age	47.49	School at 18 years of age	86.67
	Undergraduate degree	28.96	Undergraduate degree	6.67
	Postgraduate degree	13.90	Postgraduate degree	6.67
	Other	6.95	Other	0.00
Occupation	Professional/managerial	19.09	Professional/managerial	0.00
	Routine/supervisory/technical	17.84	Routine/supervisory/technical	20.00
	Unemployed	11.20	Unemployed	0.00
	Student	51.87	Student	80.00**
Prior contact with	Yes	44.23	Yes	***
psychiatrists	No	53.85	No	
	Prefer not to say	1.92	Prefer not to say	
Prior contact with	Yes	60.77	Yes	***
counsellors	No	37.69	No	
	Prefer not to say	1.54	Prefer not to say	

*For questionnaire participants, the mean age was 33.28 years (*SD* = 16.87); for focus group participants, the mean age was 22.93 years (*SD* = 8.61).

** Of the student focus group participants, 58.55% were studying psychology, and the remainder represented a diverse range of degree disciplines.

***Focus group participants were not asked whether they had prior contact with psychiatrists or counsellors.

Table 2

Repeated-measures ANOVAs: Differences Between Ratings of Professionals on Nine Characteristics

	Comparison of scores for GPs, three specialist psychiatrists, and three specialist counsellors				Comparison of ratings for GPs, mean scores for psychiatrists, and mean scores for counsellors			
Characteristic	*df*	*F*	η_p^2	*p*	*df*	*F*	η_p^2	*p*
Competence	4.97	9.83**	.037	< .001	1.54	11.21**	.041	< .001
Helpfulness	5.18	2.29*	.009	.042	1.64	5.12*	.019	.010
Trustworthiness	5.07	1.55	-	.172	1.65	.313	-	.688

Predictability	5.65	12.01**	.044	< .001	1.55	19.33**	.069	< .001
Conventionality	5.37	33.09**	.113	< .001	1.66	66.92**	.205	< .001
Emotional stability	5.85	5.55**	.021	< .001	1.66	2.45	-	.097
Extraversion	5.46	8.24**	.031	< .001	1.57	5.39*	.020	.009
Empathy	5.33	22.35**	.079	< .001	1.61	38.66**	.130	< .001
Agreeableness	5.24	11.38**	.042	< .001	1.65	6.60*	.025	.003

Note. *$p < .05$. **$p < .001$.