THE STIGMA OF A MENTAL ILLNESS LABEL: ATTITUDES TOWARDS INDIVIDUALS WITH MENTAL ILLNESS

Thesis
Submitted to
The College of Arts and Sciences of the UNIVERSITY OF DAYTON

In Partial Fulfillment of the Requirements for
The Degree
Master of Arts in Psychology

By
Chinenye Ikeme

UNIVERSITY OF DAYTON

Dayton, Ohio
May, 2012
THE STIGMA OF A MENTAL ILLNESS LABEL: ATTITUDES TOWARDS INDIVIDUALS WITH MENTAL ILLNESS

Name: Ikeme, Chinemye Oluchukwu

APPROVED BY:

___________________________
Carolyn Roecker Phelps, Ph.D.
Committee Chair

___________________________
Lee Dixon, Ph.D.
Committee Member

___________________________
Mathew R. Montoya, Ph.D.
Committee Member

CONCURRENCE :

___________________________
Carolyn Roecker Phelps, Ph.D.
Chairperson, Department of Psychology
ABSTRACT

THE STIGMA OF A MENTAL ILLNESS LABEL: ATTITUDES TOWARDS INDIVIDUALS WITH MENTAL ILLNESS

Name: Ikeme, Chinenye Oluchukwu
University of Dayton

Advisor: Dr. Carolyn Rocker Phelps

The present study examined whether stigma toward individuals with mental illness will evidence itself in job performance evaluations. To enhance this potential effect of mental illness stigma, an additional “difference” of race was included as a factor that may affect perception of functioning and attitude towards the individual with a mental illness diagnosis. Additionally, general professed attitudes towards mental illness and direct attitudes when one is exposed to an individual with a mental illness diagnosis were considered. Participants were drawn from the undergraduate population of a midsize private university and responded to three questionnaires after viewing a video clip of an individual experiencing a moderately stressful day at work. Half the participants were given the information that the individual they viewed was undergoing treatment for a mental illness, and the other half were not given this information. Some of the
participants viewed an actor of the same race, while the others viewed an actor of a
different race. Data were analyzed by condition and race. The results of this study did not
support the hypotheses. Contrary to expectations, information that the actor had been
diagnosed with a mental illness did not influence job ratings or attitudes toward mental
illness. Similarly, results indicated that participants’ evaluations were not affected by
similarities and differences in the races of the observed and the observer. Finally,
attitudes to mental illness generally did predict participants’ direct attitudes toward an
individual who was presented as having a mental illness. Prior contact and experience
with individuals with mental illness did not moderate these results. Possible explanations
for the outcome of the study are discussed.
ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to those who made this thesis possible. I am heartily thankful to my supervisor, Dr. Carolyn Phelps, for her patient guidance, support, and encouragement from the initial to the final stages of this work.

I would also like to thank Dr. Lee Dixon and Dr. Matthew Montoya for serving on my committee and for contributing their time and knowledge to this project. My gratitude also goes to Dr. Jackson Goodnight and Jonathan Hentz for their assistance during statistical analysis of the data.

Finally, I am deeply thankful to my family who supported and encouraged me throughout this endeavor, and above all, to God for giving me the strength to complete this program.
# TABLE OF CONTENTS

ABSTRACT .......................................................................................................................... iii  

ACKNOWLEDGEMENTS .................................................................................................... v

LIST OF TABLES ................................................................................................................... viii

CHAPTER

I. INTRODUCTION ........................................................................................................... 1 
   Labels, Stigma and Mental Illness .............................................................................. 2 
   Self-Stigma .................................................................................................................... 4 
   Public Attitudes Toward Mental Illness .................................................................. 6 
   Social Categorization ............................................................................................... 9 
   Race and the Stigma of Mental Illness .................................................................... 10 
   The Present Study ...................................................................................................... 12

II. METHOD .................................................................................................................... 16 
   Participants ............................................................................................................... 16 
   Instruments .............................................................................................................. 16 
      Video Clip .............................................................................................................. 17 
      Job Candidate Evaluation Form (JCEF) ............................................................. 17 
      Attitudes to Mental Illness Questionnaire (AMIQ) .......................................... 18 
      The Perceived Stigma Questionnaire (PSQ) .................................................... 19 
   Procedure .................................................................................................................. 20
III. RESULTS.................................................................................................................22

IV. DISCUSSION........................................................................................................33
   Limitations.............................................................................................................39
   Strengths..............................................................................................................40
   Implications..........................................................................................................41

REFERENCES..............................................................................................................43

APPENDIX

A. DEMOGRAPHIC DATA FORM.................................................................53
B. VIDEO CLIP (SCRIPT).................................................................54
C. CANDIDATE EVALUATION FORM..............................................57
D. ATTITUDES TO MENTAL ILLNESS QUESTIONNAIRE........59
E. PERCEIVED STIGMA QUESTIONNAIRE......................................60
LIST OF TABLES

1. Descriptive statistics for variables ................................................................. 23
2. Descriptive statistics for measures ................................................................. 24
3. Interaction of presence of mental illness and race similarity on attitudes ........ 26
4. Interaction of presence of mental illness and race similarity on job ratings ........ 27
5. Summary of regression analysis for general attitudes (PSQ) on direct
   attitudes (AMIQ) testing experience as a moderator ....................................... 29
6. Attitudes for Caucasian-American actor versus African-American actor ........ 31
CHAPTER I
INTRODUCTION

In recent years, there have been efforts and attempts to combat stigma and discrimination experienced by individuals with mental illness, including outreach programs and campaigns. Outreach programs such as the Changing Minds Campaign described by Crisp, Gelder, and Rix (2000) and several outreach programs by the National Alliance on Mental illness (NAMI) have been organized to educate the public on the nature of mental illness in an effort to reduce the associated stigma. However, according to Lyons, Hopley, and Horrocks (2009), even with all the exposure and education, stigma and discrimination remain largely as strong and enduring as they were a decade ago. In the 1950s, the public viewed mental illness as a stigmatizing condition and displayed an unscientific understanding of mental illness (Phelan, Link, Stueve, & Pescosolido, 2000). A modern survey revealed that by 1996, Americans had achieved greater scientific understanding of mental illness; however, the increase in knowledge did not defuse social stigma (Phelan et al., 2000). In comparison with the 1950s, the public’s perception of mental illness more frequently incorporated violent behavior (Phelan et al., 2000). This was primarily true among those who defined mental illness to include psychosis (a view held by about one-third of the entire sample). Thirty-one percent of this group mentioned violence in its descriptions of mental illness in comparison with 13
percent in the 1950’s. In other words, the perception of people with psychosis as being
dangerous is stronger today than in the past (Phelan et al., 2000).

The issue of stigma associated with the label of mental illness is one that has been
discussed extensively in literature. On one hand, it has been argued that the stigma
associated with the label of mental illness negatively affects the lives of those bearing the
label (e.g., Socall & Holtgraves, 1992). On the other hand, the argument is that the
benefits of treatment outweigh any negative impact of the label (e.g., Gove, 1982). At the
present time, the focus seems to be turning toward a more integrative approach,
recognizing that there are both positive and negative consequences to seeking treatment
for mental illness (e.g. Rosenfield, 1997).

Stigma can be defined as a discrediting attitude toward a given attribute that
causes devaluation, marginalization, and dehumanization of an individual possessing the
revised Goffman’s definition of stigma and called it a “mark” or a “deviation from a
norm” that links the bearer to undesirable attributes that discredit him or her in the eyes
of others. In order for a group or an individual to be stigmatized, negative reaction or
devaluation must be shared by a large group of people or a culture (Jones et al., 1984).
Stigma is a term often used to convey prejudice or negative stereotyping and often
produces false information about people, fostering discriminatory acts against them
(Corrigan, Green, Lundin, Kubiak, & Penn, 2001).

**Labels, Stigma and Mental Illness**

Labels generated by people, even when there is no underlying malice, can
produce stigma. For instance, when mental health professionals provide psychiatric
diagnoses such as schizophrenia or bipolar affective disorder, stigma is a possible outcome (American Psychiatric Association, 2000). Negative behaviors that have been associated with a mental disorder may become linked to the individual even if manifestation of these behaviors are infrequent and do not apply in every case. Therefore, the label of mental illness may lead the individual to be stereotyped and possibly consequently stigmatized.

Some have proposed that a label of mental illness may cause people to behave in ways that suggest to others that they are mentally ill. According to labeling theory, people who are labeled as mentally ill behave in ways that fulfill society's negative conception of mental illness and society's negative reactions ultimately create the mental disorder (Scheff, 1974, 1986). Thus, negative stereotypes play a significant role in the development of mental disorders (Socall & Holtgraves, 1992). However, this is unlikely when we consider that diagnoses of mental disorder are ideally based on behavioral observation of symptoms of the disorder. Even though it has been observed that people actually respond to others based on what they think they know about their mental health status (Rosenhan, 1973), opponents of the labeling theory believe that a label does not necessarily create the disorder in someone who does not have a mental illness. Research indicates that it is more likely that negative societal reactions are the result, rather than the cause, of mentally ill behavior (Gove, 1982). Socall and Holtgraves (1992) found that participants rejected a confederate depicted as mentally ill more than a physically ill confederate who behaved identically, demonstrating that a label of mental illness can result in public rejection regardless of a person's behavior. This further supports the
position that the negative qualities associated with a label of mental illness affect the manner in which individuals with mental illness are treated by others.

When negative stereotypes lead to stigma, discrimination against individuals involved may follow. Making a cutting remark about an individual’s mental health condition or treatment is an obvious and direct act of discrimination against individuals with mental illness. The discrimination can also be subtle, such as someone assuming an individual with mental illness could be violent or less capable of performing duties because of the mental health condition. Some other harmful effects of the stigma of mental illness include rejection by family and friends, discrimination at work or school and other areas of life, difficulty finding housing, and being subjected to physical violence or harassment (Putnam, 2008). These and other forms of discrimination can leave the individual feeling angry, ashamed, frustrated, and can even lower their self-esteem (Cechnicki, & Bielańska, 2009). For someone with a mental illness, the consequences of stigma can be devastating.

Self-Stigma

When there is an awareness of public stigma, the affected individual usually suffers from forms of self-stigma. Self-stigma involves experiencing internalized feelings of guilt, shame, inferiority and the wish for secrecy (Goffman, 1963). Self-stigma can be an inhibiting factor that impedes help-seeking behaviors and the quality of treatment and life experienced by individuals with mental illness (Corrigan, 2004b; Corrigan, Edwards, Green, Diwan, & Penn, 2001; Jost & Banaji, 1994). Mentally ill persons can internalize the stigma that is prevalent within society and come to believe and act as if the stigma is real and legitimate (Corrigan, 2004b; Corrigan et al., 2003; Link et al., 2001; Miller &
Kaiser, 2001; Okazaki, 2000; Snowden, 2001; Snowden & Cheung, 1990; Stevens & Hall, 1988). That is to say, some individual’s with mental illness come to believe that they are less valued than others in society and literally devalue themselves and their real or potential contributions to society (Hudson, 2005). As a result, individuals with mental illness might avoid employment or choose not to be successful at some task or in a job because of fear of failure or internalized self-stigma, which can translate into self-abhorrence (Balsa & McGuire, 2003; Cool & Garrido, 2000; Cooper Patrick et al., 2002; Flores & Vega, 1998; Jones, 2003; LaVeist, Nickerson, & Bowie, 2000). Many individuals living with mental illnesses also experience lowered self-esteem, diminished self-efficacy, hopelessness (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001) and sometimes despair (Gary, Yarandi, & Scruggs, 2003). Numerous aspects of these mental states can lead to suicide, one of the most devastating outcomes associated with mental illness (Pompili, Mancinelli, & Tatarelli, 2003).

Stigma and discrimination can disrupt the lives of individuals living with mental illness, preventing or slowing down their opportunities to become productive citizens (Corrigan et al., 2004a, 2004b; Gary, 1991; Wahl & Harman, 1989). According to the U.S. Department of Health and Human Services (2001) and Health Resources and Services Administration (2003), individuals with mental illnesses are less likely to obtain the necessary physical health assessments and subsequent care they may need when compared with individuals without mental illnesses. It was also observed that individuals with mental illness receive fewer medical services than persons with similar conditions who do not have mental illnesses (U.S. Department of Health and Human Services, 1999,
Public Attitudes Toward Mental Illness

Research indicates that public attitudes toward mental illness are generally negative and have harmful effects on the lives of individuals who are affected (e.g., Phelan et al., 2000). Corrigan and Watson (2002) suggested that the central part of the mental illness stereotype is the perception of dangerousness and unpredictability. While less than 3% of mentally ill patients can be categorized as dangerous, 77% of mentally ill people depicted in the media are presented as dangerous (Corrigan & Watson, 2002). According to Corrigan and Watson (2002), the myth of dangerousness and unpredictability is perpetuated by sensational headlines in the media about the crimes committed by individuals who may be suffering from a mental illness.

Studies have furthermore found that people readily distinguish between mental and physical stigmas and generally view mental stigmas more negatively (e.g., Kendell, 2001; Bordieri & Drehmer, 1986). Esses and Beaufoy (1994) stated that one reason for the negative attitude towards mental illness is its potential to disrupt normal social interactions and its representation of real threat to others. The authors contended that most physical disabilities and diseases actually inhibit physical threat, whereas people assume mental illness leads to unpredictable and even physically threatening behavior (Esses & Beaufoy, 1994).

Interestingly, the stigma and negative opinion attached to various disorders are not always the same; for instance, people with schizophrenia and bipolar disorder are viewed more negatively than people with anxiety and depressive disorders (Griffiths,
This is probably due to the traits or characteristics relating to dangerousness and/or unpredictability. Regardless, individuals living with mental illness are often viewed as violent, unpredictable, hard to talk to, different from others (Crisp, Gelder, Goddard & Meltzer, 2005), incompetent in self-care and independent living (Corrigan et al., 2001; Okazaki, 2000) and responsible for their own disorders (Lefley, 1989). Even though some of the negative opinions held may be true for some disorders, they are often generalized to others. Stereotypes are difficult to eradicate (Balsa & McGuire, 2003; Byrd & Clayton, 2001) and can endure for years. Consequently, the negative effects of the label of mental illness can persist even beyond recovery (Millward, Lutte & Purvis, 2005).

Stereotyping involves categorizing information about certain groups of people and their behaviors (Corrigan & Penn, 1999; Gary, 1991; Hamilton & Sherman, 1994). Allport (1954) stated that, “it is a part of our basic cognitive nature to place things and people in categories, which are the cognitive buckets into which we pour various traits, physical features, expectations, and values.” (p. 11). In modern cognitive psychology, the “cognitive buckets” are referred to as “schemas” or internal representations of our world. Schemas are mental representations which are frameworks we utilize as an efficient means of categorizing information about people, things, and places (Fiske & Taylor, 1991). When we group people into categories based on mental representations, we are invariably stereotyping them. As a result, we may view each member of the group as having similar traits and characteristics as the other members even when this is not entirely the case. Stereotypes can be positive or negative. Negative stereotypes have gained attention in research because they can support prejudice and may lead to
discrimination against members of stereotyped groups (Gaertner & Dovidio, 1986). According to Allport (1954), prejudice is an antipathy based on faulty and inflexible generalization that may be felt or expressed and may be directed toward a group or an individual of that group. Prejudice may lead to discrimination, which is our behavioral response that contributes to the disadvantage of those being stereotyped (Gaertner & Dovidio, 1986; Schneider, 2004).

Crocker, Major, and Steele (1998) asserted that we reserve our strongest negative stereotypes for groups we do not like in order to provide a cognitive explanation for our negative affect. Accordingly, we can dislike almost any group, but we have a way of selecting certain groups as more deserving of our contempt (Crocker, Major & Steele, 1998). These groups are referred to as “stigmatized” groups, and an example of a stigmatized group in our society includes individuals with a mental illness diagnosis. Negative stereotypes are usually based on a combination of fear and false beliefs (Kelley-Soderholm, 2010). In the case of mental illness, these fears are rooted in unfounded beliefs that characterize people with mental illness as weak, bizarre, shameful, or violent (Kelley-Soderholm, 2010).

It is important to note that knowledge of a stereotype does not necessarily lead to prejudice and discrimination. According to Devine (1989), one may have knowledge of a stereotype but his or her personal beliefs may or may not be congruent with the stereotype. Therefore knowledge of the stereotype of a group does not imply prejudice toward that group. Devine (1989) differentiated between low and high prejudice persons who are equally knowledgeable about a stereotyped group, but maintained that low prejudice persons inhibit the automatically activated stereotype-congruent thoughts and
replace them with thoughts reflecting equality and negations of the stereotype (Devine, 1989). In order to understand how stereotypes develop, it is important for us to consider the social categorization process.

**Social Categorization**

Allport (1954) asserted that it is a part of our human nature to place people into categories to help us understand them better. According to the social identity theory developed by Tajfel and Turner (1979), social categorization is basic to developing a sense of social identity and is the first stage of the theory. Tajfel and Turner (1979) explain that a person’s sense of identity is based on his or her group membership. They proposed that the groups (e.g., race, gender, social class, family, sports team) to which people belong are an important source of pride and self-esteem and give a sense of social identity, a sense of belonging to the social world. According to the theory, in order to increase our self-image we enhance the status of the groups to which we belong and discriminate against the groups to which we do not belong. Therefore we divide the world into “us” (ingroup) and “them” (outgroup) based on a process of social categorization.

Tajfel and Turner (1979) proposed that there are three stages involved in the “ingroup” and “outgroup” categorization process. The first stage is **social categorization**. In this stage, we categorize people (including ourselves) in order to understand the social environment. We use social categories like black, white, mentally ill, rich and poor because they are useful. In the same way, we discover things about ourselves by knowing the categories to which we belong and referencing the norms of those groups. In the second stage, **social identification**, we adopt the identity of the group to which we have
categorized ourselves and conform to their norms. The final stage is social comparison. Once we have categorized and identified with a group we then tend to compare that group with other groups to maintain self-esteem.

Stereotyping, according to Tajfel and Turner (1979), is based on a normal cognitive process, the tendency to group things together. In doing this, however, we are inclined to exaggerate the differences between groups and the similarities within the same group. We categorize people viewing the group to which we belong (the ingroup) as being different from others (the outgroup), and members of the same group as being more similar than they probably actually are.

Knowledge of the social categorization process is helpful in order to understand the dynamics involved when we observe individuals who are different from us. Perhaps this is the case when we observe individuals with mental illness diagnoses, especially when there is no history of mental illness in our family or close friends. We may see the individual with mental illness as a member of an outgroup because we do not fully understand them. In the same way, it is possible that if the person with a mental illness diagnosis is different from us in more ways than just the mental illness, our perception of the individual will be even more obscure because we understand them even less. For instance, if a person has a mental illness diagnosis and is also of a different race, stigmatization may be even greater. This study seeks to explore that possibility.

Race and the Stigma of Mental Illness

Racial disparities in mental health care in the United States are well documented (Gaertner & Dovidio, 1986). On almost every indicator of health, education, and well-being racial minorities lag behind members of the majority group (Gaertner & Dovidio,
1986). As mentioned earlier, race is a factor that may additionally affect attitudes towards individuals that have been diagnosed with a mental illness. An individual’s race is an important factor to consider when assessing the stigma associated with mental illness, keeping in mind that mental health professionals will be assessing and diagnosing individuals who are of different racial and ethnic backgrounds than themselves.

Although limited, the literature suggests that African-Americans are more likely than Caucasians to believe that people with mental illnesses are dangerous (Anglin, Link, & Phelan, 2006). These authors analyzed respondent’s perceptions that an individual with mental illness would be violent. Anglin and colleagues (2006) found that African-Americans were more likely than Caucasians to believe that individuals with schizophrenia or major depression would do something violent to other people. At the same time they were less likely to believe these individuals should be blamed and punished for violent behavior (Anglin, Link, & Phelan, 2006).

According to Gary (2005), ethnic minority groups, who are already faced with prejudice and discrimination because of their group affiliation, suffer double stigma when faced with the burdens of mental illness. Gary (2005) asserts that the stigma of mental illness is one reason why some ethnic minority group members who would benefit from mental health services choose not to seek or adequately participate in treatment. The combination of stigma and membership in an ethnic minority group can impede treatment and well-being, creating preventable and treatable mortalities and morbidities (Gary, 2005). The stigma of racial inferiority may also have an adverse affect on the diagnosis and treatment of ethnic minority patients in the mental health system (Corrigan,Lickey, Campion, & Rashid, 2000; Lamb, Weinberger, & DeCuir, 2002; Shedler, Mayman, &
Manis, 1993). Ethnic minority mental health patients also end up experiencing higher rates of mortality, morbidity, and diminished well-being (Cooper, Corrigan, & Watson, 2003; Corrigan, 2004b; Marmot & Wilkinson, 1999).

The issue of additional difference is important to consider when assessing the stigma associated with mental illness because an individual with mental illness may be viewed in a more negative light than usual merely due to the fact that they are different in more ways from the observer than just the mental illness. Another example of additional difference is that of sexual orientation. Research is abundant regarding the issue of sexual minority groups being at an increased risk for multiple mental health problems compared to heterosexuals (Hatzenbuehler, 2009). In order to shed light on how stigma adversely affects mental health, Hatzenbuehler (2009) developed a theoretical framework that integrates the literature on sexual minority stigma and psychopathology, postulating that (a) sexual minorities confront increased stress exposure resulting from stigma; (b) this stigma-related stress creates elevations in general psychopathology; and (c) these processes in turn mediate the relationship between stigma-related stress and psychopathology. Therefore, mental illness stigma may be more of a problem than usual when one is different from other people in additional ways, especially when the other group is already stigmatized.

**The Present Study**

This study investigates how a label of mental illness affects other people’s attitudes and perception of the individuals functioning. More specifically, it investigates whether stigma toward individuals with mental illness will evidence itself in job performance evaluations. To enhance this effect, race was included as a factor that may
affect perception of functioning and attitude towards the individual with a mental illness diagnosis. It is speculated that by being a member of an outgroup two times over (by being mentally ill, and also being of a different race), the individual with the mental illness will be viewed more negatively than they would if there were fewer factors placing them in an outgroup.

This study also considers general professed attitudes towards mental illness and direct attitudes when one is exposed to an individual with a mental illness diagnosis. It may be the case that people think they are generally accepting of individuals with mental illness. However, it is possible that attitudes and behaviors may change when that person is exposed to individuals whom they realize have a mental illness diagnosis. In this study, the author examines differential evaluations of behavior based on the knowledge that one does or does not have a mental illness. To test for general attitudes versus direct attitudes, two stigma scales are used. One scale measures participant’s attitudes to mental illness in general while the other scale measures participant’s attitudes to specific interactions with an individual who has mental illness.

As mentioned earlier, people have different reactions and beliefs concerning individuals with different mental illness diagnosis. People may be seen as more or less dangerous or violent based on the disorder which they are diagnosed. This researcher chose to use bipolar disorder as the mental illness being assessed in this study for various reasons. First of all, of the more negatively viewed mental illnesses, several studies have used schizophrenia (e.g., Buizza et al., 2007; Lee, 2002), and alcohol/drug use (e.g., Luty, et al., 2006) to study attitudes towards mental illness. There are not very many studies that have used individuals with a bipolar diagnosis in attitude to mental illness studies.
Also, there is a lot of ambiguity in the general public about bipolar disorder, and the label is commonly used inappropriately by lay people to describe someone who has frequent mood swings. Additionally, the disorder is frequently over-diagnosed in the population by therapists (Iordache & Low, 2010). Finally bipolar disorder can be managed with appropriate treatment, and the individual can function adequately within the society.

In this study, participants viewed video clips of the individual they assessed instead of reading written case vignettes about them. This was intended to capture participants’ responses to actual observation of behavior as opposed to just reading about an individual’s mental illness. The work environment was used as a medium to assess other people’s perception and reaction to the individual with the bipolar disorder diagnosis. Specifically, the researcher examined how participants would evaluate the individual’s effectiveness in the workplace. The workplace was chosen because it is a setting that brings individuals in contact with other people who may evaluate them in different ways. Depending on the nature of the job, people may find that they have to interact with other coworkers, employers, and sometimes with clients or customers on a daily basis. This provides the opportunity to relate with a wide range of people, who will be observing and evaluating the individual’s behavior and their ability to adequately perform their job requirements.

This study tests the following hypothesis:

1.) Individuals identified as having a mental illness will be rated less favorably on an attitude towards mental illness scale and a job rating scale than individuals without mental illness.
2.) Individuals with mental illness who are of a different race from the observer will be rated less favorably on an attitude towards mental illness scale and a job rating scale than individuals of the same race.

3.) Individual’s general professed attitudes towards people with mental illness will be different from their attitude when they are exposed to an individual with a mental illness diagnosis.
CHAPTER II

METHOD

Participants

Participants were drawn from the undergraduate population of a midsize private university. A power analysis was conducted to determine the number of participants needed in this study (Cohen, 1988). Minimally 128 participants were needed to ensure that the results will have an 80% power to detect a medium effect size of .30 at the .05 significance level. The sample included 134 students, exceeding the minimum sample size requirements for the desired results. Of the 134 participants, 67 were male, 66 were female, and one participant listed gender as other. Gender differences in attitudes towards mental illness were observed and female’s responses to the items were more positive than males. The difference did not attain statistical significance and was not considered in the analysis for the hypotheses. Participants ranged between the ages of 18 and 26 with the median age of 19. Regarding race, 86.6% of the sample was Caucasian-American, but 53.7% of the entire sample viewed an actor that was of a different race than they were. In addition, 41% of the sample indicated that they had prior experience with mental illness (self or family member).

Instruments

Four instruments were used for this study: two 3-minute video clips, a job evaluation form, the Attitudes to Mental Illness Questionnaire, and the Perceived
Stigma Questionnaire. Additionally, participants were asked to complete a demographic questionnaire (See Appendix A) which includes questions regarding personal and family history of mental illness.

**Video Clip.** Two 3-minute video clips depicting an individual experiencing a stressful day at work were developed for this study. The videos were written and produced in conjunction with students in the theatre department. In each video, the individual arrives late to work, appears frustrated that things are not going smoothly (i.e., late report, spilled coffee), and tries to resolve the situation. One of the video clips depicted a Caucasian-American actor, while the other depicted an African-American actor. The video clips were identical except for the actors. (See Appendix B for video clip script).

**Job Candidate Evaluation Form (JCEF).** The JCEF is a scale developed to be utilized by potential employers to assess potential employee’s suitability for the job (Heathfield, 2004). The form can be customized to suit the needs of the employer or user and was modified to suit the purpose of this study. For instance, the original item “The candidate demonstrated to your satisfaction that he/she had the necessary technical skills to perform the job successfully”, was changed for this study to “Would you imagine that the candidate has the necessary technical skills to perform the job successfully?” The JCEF (See Appendix C) was used to obtain information regarding participant’s perception of the actor’s ability to adequately perform job responsibilities after observing his behavior. The JCEF has 8 items with 4 possible responses to each item; does not meet requirements, needs more training, meets requirements, and exceeds requirements. The responses have values ranging from one to four, and total scores ranged from a lowest
possible score of 8 to a highest possible score of 32. Responses were separated by a median split, with scores between 8 and 20 judged to represent a low rating of the actor and scores between 21 and 32 judged to represent a high rating.

**Attitudes to Mental Illness Questionnaire (AMIQ).** The AMIQ is a 5-item self-report questionnaire that measures an individual’s attitude towards mental illness (See Appendix D). The AMIQ was adapted from Cunningham, Sobell, and Chow (1993), and validated in a study by Luty and colleagues (Luty, Fakuda, & Umoh, 2006). Participants respond to each item on a 5-point Likert scale response system with scores ranging from a minimum of -2 to a maximum of +2. Items 1, 4 and 5 are reversed scored and scores on the five questions are added to give a total score ranging from -10 to +10. Higher scores indicate more positive attitude towards the individual viewed. The instrument is traditionally used by having participants read a fictional vignette describing a person with some form of mental illness or drug use problem and respond to the questions. In this study, participants responded to the questionnaire after viewing the video clips instead of reading case vignettes. Other instruments measuring attitudes toward mental illness are much longer, involve interviews, aim at getting information about general public opinion rather than an observer’s personal opinion [e.g., Opinions about Mental Illness Scale (Cohen & Struening, 1962)] or address the subjective experience of stigma by those with mental illness [e.g., the Internalized Stigma of Mental Illness Scale (Ritsher, Otilingam, & Grajales, 2003)]. The AMIQ was chosen over the other scales due to its brevity and ability to obtain an individual’s attitude towards mental illness rather than general public opinion or the stigmatized persons internalized feelings of stigma. The AMIQ has been found to have adequate psychometrics. Test-retest reliability at 2-4 weeks was $r = 0.70$
(n=256). The AMIQ demonstrated construct validity when compared with Corrigan’s Attributions Questionnaire (Corrigan et al., 2003). Spearman’s rank correlation was rho=0.704 (P<0.001). Cronbach’s alpha for the original sample was high [0.933 (n=879)] and according to Luty and colleagues (2006), although three of the items (items 1, 4 and 5) were based on other people’s expectations of the patients future and the other two items assessed social distance, these factors could not be identified separately on factor analysis (Luty et al., 2006). For this study, Cronbach’s alpha was 0.59.

The Perceived Stigma Questionnaire (PSQ). The original PSQ by Link (1989) is a 29-item questionnaire created to measure perceived stigma of participants on four scales. The scales are: devaluation-discrimination, secrecy, withdrawal, and education. In this study, only the section of the instrument that measures devaluation-discrimination was used. The devaluation-discrimination scale was designed to measure the extent to which respondents discriminate against individuals with mental illness. The secrecy, withdrawal, and education scales, designed to measure the coping styles of individuals with mental illness, were not used since this study is primarily focused on attitudes toward the mentally ill. This study utilizes a modified version of the devaluation-discrimination scale developed by Angermeyer, Link and Majcher-Angermeyer (1987) to assess attitudes of professionals who work with people who receive mental health services (see Appendix E). In the modified version, items were rewritten to reflect the opinion of the respondent with regards to what they would do as opposed to what most people would do. For instance, the original item “Most people would willingly accept a mental health consumer as a close friend” was changed to “I would willingly accept a person who receives mental health services as a close friend”. Participants are asked the
extent to which they agree with statements about individuals with mental illness, rated on a six-point Likert scale where 1 is strongly disagree, and 6 is strongly agree. Some of the items are reverse scored, and scores for all the items are added to obtain a total score ranging from 12 to 72. Lower scores on the scale indicate more devaluation-discrimination toward the mentally ill. Reliability coefficients for this scale range from .78 to .87 (Angermeyer et al., 1987; Link, 1987). Cronbach’s alpha for this study was .85.

The purpose of using the PSQ in addition to the AMIQ in this study was to obtain information regarding participant’s professed general attitudes towards individuals with mental illness as well as their attitudes toward an individual with mental illness with whom they may have to have direct contact.

**Procedure**

Participants signed up for the study and were randomly assigned to one of four different conditions: conditions differed by the label of a mental illness and by the race of the actor. In the first condition, participants received background information about the vignette including information that the individual to be viewed has bipolar disorder. Then, participants viewed the video clip with the Caucasian-American actor. In the second condition, participants received background information about the vignette without information regarding a mental illness and viewed the video clip depicting the same Caucasian-American actor. In the third condition, participants received background information about the vignette which included information that the individual to be viewed has bipolar disorder. Participants then viewed the video clip depicting the African-American actor. In the fourth condition, participants received background information about the vignette without information regarding a mental illness and viewed
the video clip depicting the same African-American actor. When a participant arrived, (s)he was escorted to a private room and provided with the informed consent. The participant subsequently viewed a video clip and responded to the instruments. After viewing the clip, the participant was asked to complete the demographic form and rate the actor’s functioning by responding to the JCEF, the AMIQ, and the PSQ. Questionnaires were administered in the same order for all participants. After responding to the questionnaires, participants were thanked for their time and course credit was awarded for participation.
CHAPTER III

RESULTS

Descriptive statistics, including means, standard deviations, and ranges, were obtained for the variables and measures. Prior experience with mental illness was included as a factor that could potentially influence the results of this study, because participants who may have a current mental illness diagnosis or a history of mental illness (self or family member), may respond differently from participants without prior history or experience with mental illness. Prior experience with mental illness was examined as a possible moderator to general attitudes towards individuals with mental illness, and the results are reported further in this chapter. The values from the descriptive statistics are summarized in Tables 1 and 2.
Table 1

Descriptive statistics for variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Levels</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>134</td>
<td>Male</td>
<td>67</td>
<td>50.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td>66</td>
<td>49.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Experience</td>
<td>134</td>
<td>No</td>
<td>79</td>
<td>59.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>55</td>
<td>41.0</td>
</tr>
<tr>
<td>Actor viewed</td>
<td>134</td>
<td>Same</td>
<td>62</td>
<td>46.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Different</td>
<td>72</td>
<td>53.7</td>
</tr>
<tr>
<td>Actor MI</td>
<td>134</td>
<td>No</td>
<td>67</td>
<td>50.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>67</td>
<td>50.0</td>
</tr>
</tbody>
</table>
Table 2

Descriptive statistics for measures

|            | N  | Min | Max | Mean  | Std. Deviation |
|------------|----|-----|-----|-------|               |
| JCEF*      | 134| 9   | 27  | 17.96 | 3.86           |
| AMIQ**     | 134| -5  | 8   | .65   | 2.67           |
| PSQ***     | 134| 18  | 69  | 51.54 | 9.01           |

*JCEF (Job Candidate Evaluation Form)
**AMIQ (Attitudes to Mental Illness Questionnaire)
***PSQ (Perceived Stigma Questionnaire)
The first hypothesis and second hypotheses were tested using a multivariate analysis of variance with presence of mental illness and similarity in race as the independent variables, and scores on the AMIQ (attitudes) and ratings on the JCEF (job ratings) as the dependent variables. The first hypothesis, proposed that individuals identified as having a mental illness would be rated less favorably on an attitude towards mental illness scale and a job rating scale than individuals without mental illness. It was anticipated that ratings of the actor will be significantly more favorable from the group that was not aware of a mental illness diagnosis than ratings from the group that was informed of the actor’s mental illness. As can be seen on Tables 3 and 4, the multivariate analysis of variance showed no significant difference in attitudes and job ratings between the group that viewed the actor described as having bipolar disorder and the group that viewed the actor not described as having bipolar disorder \([F(1, 130) = 1.54, p = \text{n.s.} \text{ for attitudes (Table 3), } F(1, 130) = .69, p = \text{n.s.} \text{ for job ratings (Table 4)}]\).

The second hypothesis proposed that individuals with mental illness who are of a different race from the observer will be rated less favorably on an attitude towards mental illness scale and a job rating scale than individuals of the same race. It was anticipated that there would be an interaction of presence of mental illness and racial similarity, and that ratings of the actor of a different race will be significantly less favorable than ratings of the group that viewed an actor of the same race. As can be seen on Tables 3 and 4, the multivariate analysis of variance showed no significant interaction of presence of mental illness and racial similarity between the actor and observer in attitudes and job ratings between groups \([F(1, 130) = .02, p = \text{n.s.}\text{ for attitudes (Table 3), } F(1, 130) = .61, p = \text{n.s.} \text{ for job ratings (Table 4)}]\).
Table 3

Interaction of presence of mental illness and race similarity on attitudes.

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of mental illness</td>
<td>11.11</td>
<td>1</td>
<td>11.11</td>
<td>1.54</td>
</tr>
<tr>
<td>Similarity of race</td>
<td>1.17</td>
<td>1</td>
<td>1.17</td>
<td>.16</td>
</tr>
<tr>
<td>Mental Illness x Race</td>
<td>.13</td>
<td>1</td>
<td>.13</td>
<td>.02</td>
</tr>
<tr>
<td>Within Groups</td>
<td>935.87</td>
<td>130</td>
<td>7.199</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1005.00</td>
<td>134</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**p < 0.01
Table 4

Interaction of presence of mental illness and race similarity on job ratings.

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of mental illness</td>
<td>10.37</td>
<td>1</td>
<td>10.37</td>
<td>.69</td>
</tr>
<tr>
<td>Similarity of race</td>
<td>2.87</td>
<td>1</td>
<td>2.87</td>
<td>.19</td>
</tr>
<tr>
<td>Mental Illness x Race</td>
<td>9.20</td>
<td>1</td>
<td>9.20</td>
<td>.61</td>
</tr>
<tr>
<td>Within Groups</td>
<td>1959.72</td>
<td>130</td>
<td>15.08</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>45184.00</td>
<td>134</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**p < 0.01
The third hypothesis, “Individual’s general professed attitudes towards people with mental illness will be different from their attitude when they are exposed to an individual with a mental illness diagnosis” was tested using multiple regression statistics to examine the relationship between AMIQ ratings and PSQ scores of participant’s who were told that the individual they viewed had a mental illness (for both races), and whether prior contact with an individual with mental illness would moderate general attitudes towards individuals with mental illness. It was anticipated that individuals who believe that they are generally accepting of people with mental illness may be less accepting when they come in direct contact with a person who has a mental illness diagnosis. Data from participants who were aware of the actor’s mental illness was used, and prior experience of mental illness (self or family member mental illness) was tested as a moderator. Regression analysis indicated that general attitudes significantly predicted direct attitudes ($\beta = .251, p<.05$), but prior experience did not moderate these effects ($\beta = -.194, p=\text{n.s.}$) as can be seen on Table 5.
Table 5

Summary of regression analysis for general attitudes (PSQ) on direct attitudes (AMIQ) testing experience as a moderator.

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE(B)</th>
<th>Beta</th>
<th>T</th>
<th>Sig.(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience</td>
<td>-.020</td>
<td>.340</td>
<td>-.007</td>
<td>-.058</td>
<td>.954</td>
</tr>
<tr>
<td>PSQ</td>
<td>.710</td>
<td>.342</td>
<td>.251</td>
<td>2.079</td>
<td>.042</td>
</tr>
<tr>
<td>ExpbyPSQ</td>
<td>-.549</td>
<td>.339</td>
<td>-.194</td>
<td>-1.618</td>
<td>.111</td>
</tr>
</tbody>
</table>

R²=.095
Additional analyses examined the role of race of the actor on ratings of attitudes and job performance without specifically considering sameness or difference of race between the observer and the observed. An analysis of variance was used to assess differences in ratings of the actors viewed with the Target (actor viewed) as the independent variable and scores on the AMIQ (attitudes) and ratings on the JCEF (job ratings) as the dependent variables.

As can be seen on Tables 6 and 7 an analysis of variance revealed that when job ratings were assessed for the target viewed, results were significant for job ratings (JCEF scores), but not for attitudes (AMIQ scores). \( F(1,132) = .40, p = \text{n.s.} \) for attitudes (Table 6), \( F(1,132) = 4.52, p < .05 \) for job ratings (Table 7). The mean (and standard deviation in parentheses) for job ratings of those who viewed the Caucasian-American actor was 18.65 (3.48) and for those who viewed the African-American actor was 17.24 (4.13). The mean (SD) for attitudes of those who viewed the Caucasian-American actor was .79 (2.95) and for those who viewed the African-American actor was .50 (2.37).
Table 6

*Attitudes for Caucasian-American actor versus African-American actor*

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2.90</td>
<td>1</td>
<td>2.90</td>
<td>.40</td>
</tr>
<tr>
<td>Within Groups</td>
<td>932.23</td>
<td>132</td>
<td>7.17</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>948.51</td>
<td>133</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**p < 0.01**
Table 7

Job Ratings for Caucasian-American actor versus African-American actor

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>66.08</td>
<td>1</td>
<td>66.08</td>
<td>4.52*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>1899.60</td>
<td>132</td>
<td>14.61</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1983.73</td>
<td>133</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < 0.05
CHAPTER IV
DISCUSSION

The purpose of this study was to examine how a label of mental illness affects other people’s attitudes and perception of the individuals’ functioning. The first hypothesis proposed that individuals identified as having a mental illness will be rated less favorably on an attitude towards mental illness scale and a job rating scale than individuals without mental illness. Contrary to expectations, the actor viewed, when described as having bipolar disorder, was not rated less favorably on the attitude towards mental illness scale and the job rating scale than when he was described without the label of mental illness.

It was also hypothesized that an individual with mental illness who is of a different race from the observer, would be rated less favorably on the attitude towards mental illness scale and job rating scale than an individual of the same race. This was anticipated because it was speculated that differences in race would enhance the difference between the observer and the actor and thus enhance the potential negative effect of having a mental illness. Results indicated that participants’ evaluations were not affected by similarities and differences in the races of the observed and the observer.

The third hypothesis that individual’s general professed attitudes towards people with mental illness would differ from attitudes regarding a specific individual with
mental illness (the actor) was also not supported. General attitudes to mental illness predicted direct attitudes and were not influenced by a brief observation of an individual who was presented as having a mental illness. In other words, individuals who professed to have positive attitudes to people with mental illness were found to have positive attitudes and make positive judgments of the individual they viewed identified as having a mental illness (and vice versa).

The above findings suggest that people’s attitudes towards individuals with mental illness are more favorable than previous research has indicated (e.g. Socall & Holtgraves, 1992). It is reassuring to find that people appear to be becoming more accepting and less stigmatizing of individuals with a mental illness diagnosis. Additionally, increased difference, in this case race, between the observer and actor did not impact the job performance ratings or attitudes toward an individual with mental illness. This finding is important because there are often differences between individuals and therapist, employer, assessors. It is reassuring to find evidence that attitudes may not be strongly influenced by these differences.

Prior experience with mental illness (self or family member mental illness) led to less devaluation-discrimination of individuals with mental illness (higher PSQ scores); however, prior experience did not influence people’s attitudes towards (AMIQ) and job ratings (JCEF) of the person with mental illness. In other words, people who had previous experience with mental illness were generally more accepting of individuals with mental illness, but this prior experience did not influence their evaluation of the particular individual they viewed. This suggests that they assessed the individual based on the behaviors observed and not the label of mental illness that he carried. Interestingly, the
brief exposure to mental illness from the group that viewed the actor described as having bipolar disorder seemed to have helped participants make more balanced judgments about the actor when rating him. Overall, job ratings were generally positive; indicating that respondents believed that the behavior of the individual they viewed was appropriate for the situation and not reflective of his ability to perform his job. It is possible that viewing the individual’s response to the stressful situation in the video clip may have resulted in the reasoning that most people would react in a comparable manner of frustration when faced with a similar stressful situation whether there was an underlying mental illness or not. This is consistent with literature which indicates that exposure, even brief exposure, may be helpful in reducing negative attitudes towards people with a mental illness diagnosis (e.g., Byrne, 2000). When people come in contact with someone who has a mental illness diagnosis, many misconceptions resulting from negative media portrayals or isolated negative experiences can be allayed. Stigma and discrimination are often a result of misconceptions due to lack of understanding of mental illness (Link & Cullen, 1986).

Based on the hypotheses, analyses were done regarding assessment of attitudes when considering similarity and differences between the race of the actor viewed and the observer. The results did not yield statistically significant differences; however, when job ratings were assessed for the target viewed (the focus was on the individual viewed—Caucasian-American versus African-American), results were significant for the JCEF (job ratings), but not for the AMIQ (attitudes). Participant’s job ratings of the Caucasian-American actor were generally significantly more positive than job ratings for the African-American actor, regardless of whether they were informed or not about the
actor’s mental illness diagnosis. No significant difference was detected between AMIQ scores (attitudes) when those who viewed the Caucasian-American actor were compared with those who viewed the African-American actor. This indicates that regarding assessment of attitudes, the Caucasian-American actor and the African-American actor were viewed in a similar light regardless of mental illness diagnosis, but when considering job ratings, participant’s responses were less positive for the African-American actor. It is important to bear in mind that the majority of the sample were Caucasian-American.

Even though the results of this study did not support the hypotheses, the results are reassuring with respect to mental illness. They suggest that a label of mental illness does not significantly influence one’s attitude regarding or job ratings of the individual observed. It would, however, be wrong to completely ignore these factors as potential problems. Previous research has documented the existence of the stigma associated with having a mental illness label (e.g., Crisp et al., 2005) and it is important that we keep seeking ways to reduce and, if possible, eliminate stigma and negative attitudes. Further analysis revealed that racial stigma existed within the sample. Differential assessment based on actor’s race was observed, and participant’s responses reflected less positive job ratings for the African-American actor, even when work-related behavior was identical to that of the Caucasian-American actor. Previous research indicates that racial differences can further exacerbate negative attitudes towards people with mental illness diagnoses (e.g., Gary, 2005). Even among mental health professionals, racial differences may play a role in the diagnostic label given to people presenting with symptoms of a mental illness. For instance, in a literature review of the racial bias in the diagnosis of psychological
disorders, Garb (1998) stated, “African-Americans and Hispanic (Puerto Rican) patients are less likely than White patients to be diagnosed as having a psychotic affective disorder and more likely to be diagnosed as having schizophrenia, even when measures of psychopathology do not indicate that a diagnosis of schizophrenia is justified” (p.101). These diagnostic differences were maintained even when clinicians made diagnostic judgments about minorities and Whites who presented with the same symptomatology (Garb, 1998). In order to provide an unbiased mental health care system, it is crucial to understand why these racial differences exist and to recognize how prejudice contributes to racial disparity in clinical decision-making, diagnosis and treatment of individuals with mental illness.

A few possible explanations are offered as to why the result of this study seems to contradict the literature regarding stigma against mental illness. First, a lot of recent and past attempts have been made to combat the stigma associated with having a mental illness including campaigns and outreach programs aimed at educating the public concerning the dynamics of mental illness. For instance, the Changing Minds Campaign described by Crisp, Gelder, and Rix (2000) and several outreach programs organized by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Alliance on Mental illness (NAMI), including NAMI Stigma Busters, have been aimed at combating stigma against mental illness. It is possible that these attempts have been effective in changing people’s attitudes regarding mental illness. Recent research indicates that attitudes towards mental illness may be changing towards increased acceptance of individuals with mental illness. According to a 2007 morbidity and mortality weekly report from Centers from Disease Control and Prevention, attitudes
toward people with mental illness appear to be improving in the United States (Manderscheid, et al., 2010). According to this report, more U.S. adults believed that mental health problems could improve with treatment. Attitudes towards mental illness seem to be improving in other countries. For instance, national statistics on attitudes to mental illness produced by the UK Department of Health and released in 2009 revealed greater tolerance, increased acceptance, and more willingness to integrate individual with mental illness (UK Department of Health, 2009). Furthermore, studies indicate that more people are diagnosed with mental illness today than before (Whitaker, 2010). It could be that this increased exposure to people with mental illness, many whom are functioning adequately in society, may have helped to settle some of the previously held misconceptions about people with mental illness. Additionally, there are a lot of movements focused on increasing diversity and cultural sensitivity among people within this society (Matus, 2003). People are encouraged to accept and interact positively with others who are different from self. Employers advertise positions as equal opportunity employment positions and our society in general has been making a move towards being more accepting of differences (in this case regarding mental health and racial differences). The success of these movements may be reflected in the results of this study. It is, however, still in our best interest not to ignore the less positive results of previous studies, and we cannot conclude that everyone has been influenced by these movements, campaigns and other kinds of exposure.

The population of the sample used is another factor that may have affected the results of this study. Considering that participants were all students of introductory psychology, they may have more knowledge about and interest in mental health issues
than the average person. In view of Devine’s (1989) observations, it may also be that the sample is inherently a low prejudice group, and they do not adequately reflect the attitudes of the general population toward mental illness.

Another possible consideration is the reliability of the AMIQ scale. The AMIQ demonstrated limited internal consistency for this study, even though the Cronbach’s alpha for the original sample was much higher than what was obtained here. It is also possible that the poor reliability quotient obtained was as a result of participants in this study responding to items in an inconsistent manner. If participant’s responses on the measures were inconsistent the results of this study may be misleading.

**Limitations**

There are a few limiting factors that may have impacted the results obtained in this study. First, the sample was not a representative sample of entire population and did not adequately represent diverse facets of the general population including differences in age, generation, race, religion, socioeconomic status, educational level, experience, and so on. Research has shown that demographic factors such as these often impact the development and exhibition of attitudes (Eagly, & Chaiken, 1993). Participants were mostly Caucasian-American, and were all drawn from a mid-size private university. This generally implies that they may be more educated than the average person and likely come from an upper middle-class socioeconomic status. Thus a limited variability among study participants may have limited the range of possible responses that were obtained. In this study, the influence of sameness or difference in the race of the observer and the observed was assessed to enhance any negative attitudes towards individuals with mental illness. However, this factor did not seem to have a negative impact in participant’s
responses. It is also possible that being undergraduate students, participants may not have had adequate work experience and may have limited knowledge regarding job requirements and expectations to assess another person’s work-related behavior.

Furthermore, even though the sample size used was sufficient to yield desired results according to the power analysis, if there indeed had been an attitude shift, differences may now be more subtle and may require a larger sample size to determine difference.

Another limitation is that experience with mental illness may play more of a role than this study examined. With the prevalence of various mental disorders, it is possible that participants had more “experience” with mental illness than was asked of them. The demographic questionnaire asked about mental illness history of self or family member but did not ask about close friends, extended relations, acquaintances, classmates or friends of friends. These exposures may indeed play a role in giving an individual better understanding of and less stigmatizing attitude toward individuals with mental illness.

**Strengths**

A major strength of this study involves the use of video clips as the stimuli. Other studies examining stigma of mental illness have used written case vignettes to assess attitudes. Participants were asked to view video clips of the individual they assessed as opposed to reading written case vignettes. This was intended to capture participants’ responses to actual observation of behavior as opposed to just reading about an individual’s mental illness. People generally base quick assessments on behavioral observations rather than written records of an individual, and using video allows for a more ecologically valid appraisal of the situation since observation of actual behavior is the case in the real world.
Another strength of the study is the use of job ratings as an avenue to obtain information regarding attitudes towards mental illness. Rather than asking directly about attitudes regarding an individual’s mental illness, work performance was assessed. An individual’s workplace is a setting that has specific behavioral expectations and often results in contact with other people (e.g., employees, co-workers, clients and so on) who may evaluate abilities and behaviors in different ways according to expectations that need to be met. The researcher used the work environment as a medium to assess other people’s perception and reaction to the individual with a mental illness diagnosis. This also provides external validity for the study.

**Implications**

The outcome of this study suggests that stigma toward individuals with mental illness does not outweigh an assessment of observed behavior. This may be due to greater exposure to individuals with mental illness. More people are diagnosed with mental illness today than in the past (Whitaker, 2010) and it seems that the mysteries and misconceptions about mental illness are probably gradually diminishing. Based on the results of this study, it appears that people are becoming more accepting of individuals with mental illness even when they are from a different race.

The outcome of this study indicates that exposure to mental illness and knowledge regarding mental illness helps to alleviate the stigma involved. Over 40 percent of the participants in this study had some experience with mental illness, either with self or family member. This experience did not include close friends, acquaintances or extended family members whom they may have observed in various settings. If other relationships were considered, possibly many more individuals would have been noted as having
experience with individuals with mental illness. With an increase in the diagnosis of mental illness, it seems that more people are exposed to individuals with mental illness, giving people more opportunities to interact and modify any misconceptions about mental illness.

The results of this study also have practical applications for hiring offices. This study indicates that seeing actual performance allows people to assess individuals based on actual behaviors they observe rather than preconceived notions about a mental illness diagnosis. Therefore, it may be beneficial to educate those in hiring positions regarding the importance of observing job related skills and enlightening them to factors that can potentially affect their judgment in assessment of prospective employees.
REFERENCES


APPENDIX A

DEMOGRAPHIC DATA FORM

Gender: ________________
Age: ________________

Race/Ethnicity: ___American Indian ___Hispanic or Latino
               ___Asian ___White
               ___Black or African American ___Other, Specify: ___________

Course of study: _____________
Year of study: _____________

Have you or anyone in your family ever been diagnosed with a mental illness (e.g. depression, obsessive compulsive disorder, ADHD)? Yes _______ No _______.

If yes, continue.

Self: Yes____ No____, If Yes, diagnosis ________________
Family: Yes____ No____, If Yes, Relationship__________, Diagnosis__________
APPENDIX B

VIDEO CLIP (SCRIPT)

1.) Background Information before viewing clip (Group 1)
(Actor described as having a mental illness)

Bill, a recently employed marketing analyst for Blooming Fields Consultancy Firm was given the responsibility of researching and procuring documents needed for a major presentation towards a multi-million-dollar contract that would be decided upon that day. Bill has been diagnosed with bipolar disorder, and is currently undergoing treatment for the disorder. Please view the video clip depicting the events of the morning of the presentation and honestly respond to the questionnaires that follow.

2.) Background Information before viewing clip (Group 2)
(No information on mental illness)

Bill, a recently employed marketing analyst for Blooming Fields Consultancy Firm was given the responsibility of researching and procuring documents needed for a major presentation towards a multi-million-dollar contract that would be decided upon that day. Please view the video clip depicting the events of the morning of the presentation and honestly respond to the questionnaires that follow.
Video Clip

Scene 1: At Work
Bill rushes into the office, to his cubicle. He sets his coffee on the table and puts his briefcase down.

Co-worker
(Peeping into Bill’s cubicle) Why are you so late? Boss isn’t happy.

Bill
Long story short, I went to bed late last night and didn’t hear the alarm this morning.
Where is the boss? I have to give him my report.

Co-worker
He’s in his office. I wouldn’t go in there just yet if I were you. He sounded pretty upset.

Bill freezes for 5 seconds, then turns on his computer, lets it boot up (looking impatient, i.e., tapping fingers, etc). Meanwhile He opens his brief case. His report is not there. He freezes, then begins to search his briefcase frantically (Mumbling). Then he scans the top of his desk, looks in his drawers, under papers and accidentally spills coffee over paper. He lets out a loud “uggh” in frustration and hurriedly tries to clean up the spill with a paper towel. The phone rings. It’s his boss.
Boss

Bill, I needed your report on my desk five minutes ago!

Bill

Yes Sir, it’s… (Bill is still looking desperately for the report) I have its here somewhere, I will be right… hello? Hello?

Bill curses under his breath, drops phone, picks it up again and dials home…

Bill

(Speaking to spouse) Hi… Yep… So far pretty rough. Listen… (voice tense) I left a report at home and need you to email me the file from my computer. It’s in the Work file under reports…should say Clampett (increasing frustration in voice, more short, curt. Frustration increasing)….try Markison….Darn it. Oh, okay, look in the Bronson file. Yes, that’s it. Okay…, (again short with spouse, rolls eyes)Yes, I needed that like ten minutes ago. Yeah? … (Starting to look impatient and irritated) Can we talk about that later? I really need to get this to the boss... Okay, Thanks.

Bill drops the phone, checks the computer, darts around the room impatiently for a minute (still cleaning up remnants of coffee mess). He sits back down, tapping fingers, grabs his temples and massages them for 5 seconds then checks again. Has a somewhat relieved look on his face, prints the document, grabs the papers and rushes out of the office.
Bill is a marketing analyst given the responsibility of researching and procuring documents needed for a major presentation towards a multi-million-dollar contract that would be decided upon that day.

Please indicate your perception of his possible qualifications and capacity to perform his job duties by circling the response that best describes your impressions.

**Skills (Technical)**
1. Would you imagine that the candidate has the necessary technical skills to perform the job successfully?

<table>
<thead>
<tr>
<th>Does not meet requirements</th>
<th>Needs more training</th>
<th>Meets requirements</th>
<th>Exceeds requirements</th>
</tr>
</thead>
</table>

**Leadership Skills**
2. Would you imagine that the candidate has the necessary leadership skills to perform the job successfully?

<table>
<thead>
<tr>
<th>Does not meet training</th>
<th>Needs more training</th>
<th>Meets training requirements</th>
<th>Exceeds training requirements</th>
</tr>
</thead>
</table>

**Interpersonal Skills**
3. Would you imagine that the candidate has necessary communication and interpersonal skills, and can articulate ideas clearly both written and orally?

<table>
<thead>
<tr>
<th>Does not meet training</th>
<th>Needs more training</th>
<th>Meets training requirements</th>
<th>Exceeds training requirements</th>
</tr>
</thead>
</table>
### Teamwork
4. Would you imagine that the candidate has the ability to work well in a team and with superiors, peers, and reporting staff?

<table>
<thead>
<tr>
<th>Does not meet requirements</th>
<th>Needs more training</th>
<th>Meets requirements</th>
<th>Exceeds requirements</th>
</tr>
</thead>
</table>

### Time Management
5. Would you imagine that the candidate has the ability to manage time independently and work efficiently?

<table>
<thead>
<tr>
<th>Does not meet requirements</th>
<th>Needs more training</th>
<th>Meets requirements</th>
<th>Exceeds requirements</th>
</tr>
</thead>
</table>

### Customer Service
6. Would you imagine that the candidate has the ability to be customer focused?

<table>
<thead>
<tr>
<th>Does not meet requirements</th>
<th>Needs more training</th>
<th>Meets requirements</th>
<th>Exceeds requirements</th>
</tr>
</thead>
</table>

### Motivation for the Job
7. Would you imagine that the candidate expressed interest and excitement about the job?

<table>
<thead>
<tr>
<th>Does not meet requirements</th>
<th>Needs more training</th>
<th>Meets requirements</th>
<th>Exceeds requirements</th>
</tr>
</thead>
</table>

### Problem Solving
8. Would you imagine that the candidate has the ability to design innovative solutions and solve problems?

<table>
<thead>
<tr>
<th>Does not meet requirements</th>
<th>Needs more training</th>
<th>Meets requirements</th>
<th>Exceeds requirements</th>
</tr>
</thead>
</table>

### Overall Recommendation for this job.

- _____ Highly recommend
- _____ Recommend
- _____ Need clarification of qualifications
- _____ Do not recommend
APPENDIX D

ATTITUDES TO MENTAL ILLNESS QUESTIONNAIRE (AMIQ)

(Luty et al, 2006)

Please circle, underline, or fill in the box for the answer which best reflects your opinion of the individual in the video clip you just viewed.

1. Do you think that this would damage Bill’s career?
   Strongly Agree □  Agree □  Neutral □  Disagree □  Strongly disagree □  Don’t know □

2. I would be comfortable if Bill was my colleague at work.
   Strongly Agree □  Agree □  Neutral □  Disagree □  Strongly disagree □  Don’t know □

3. I would be comfortable about inviting Bill to a dinner party.
   Strongly Agree □  Agree □  Neutral □  Disagree □  Strongly disagree □  Don’t know □

4. How likely do you think it would be for Bill’s wife to leave him?
   Very likely □  Quite likely □  Neutral □  Unlikely □  Very unlikely □  Don’t know □

5. How likely do you think it would be for Bill to get in trouble with the law?
   Very likely □  Quite likely □  Neutral □  Unlikely □  Very unlikely □  Don’t know □
APPENDIX E

PERCEIVED STIGMA QUESTIONNAIRE (PSQ)

Revised (Link, 1985)

Please fill in the blank with the number that best reflects your opinion

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Strongly Disagree Strongly Agree

1. I would willingly accept an individual who receives mental health services as a close friend. ___

2. I would believe that a person who has been in a mental hospital is just as intelligent as the average person. ___

3. I believe that an individual who receives mental health services is just as trustworthy as the average person. ___

4. I would accept a fully recovered individual who receives mental health services as a teacher of young children in a public school. ___

5. I believe that entering a mental hospital is a sign of personal failure. ___

6. I would not hire an individual who receives mental health services to take care of my children even if he/she has been well for some time. ___

7. I think less of a person who has been in a mental hospital. ___

8. I would hire an individual who receives mental health services if he or she is qualified for the job. ___
9. I would pass over the application of an individual who receives mental health services in favor of another applicant. ___

10. Most people in my community would treat a person who receives mental health services just as they would treat anyone else. ___

11. Most young people would be reluctant to date someone who has been hospitalized for a serious mental disorder. ___

12. Once I know a person is in a mental hospital, I will take his or her opinion less seriously. ___