

Mental Health Stigma in a Politically Polarized United States

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Abstract

This research examines the relationship between political views and mental health stigma. Though past research has examined the framing of mental illness and the predictive ability of political party affiliation in regard to mental health stigma separately, the current research seeks to combine the two in order to create a broader understanding of the connections between attitudes toward mental health and political affiliation and ideology. Two-hundred-and-fifty-one participants from the mid-Atlantic were randomly assigned to one of five groups: a control group answered a questionnaire with no vignette; experimental groups were presented with the questionnaire and one of the following vignettes: information about someone with treated depression, information about someone with untreated depression, information about someone with untreated heroin addiction, or information about someone with treated heroin addiction. Several ANOVAs revealed partial support for the hypotheses regarding political affiliation and mental health, framing effects, and gender. *T*-tests indicated partial support for hypotheses regarding experience with mental health and mental health stigma.

Keywords: *Mental Health, Stigma, Political affiliation, Vignettes*

Mental Health Stigma in a Politically Polarized United States

Mental health stigma is pervasive in society, and, as a result, many people are reluctant to disclose, or even talk about mental illness (Bharadwaj, Pai, & Suziedelyte 2017). This stigma also results in discrimination and violations of human rights toward those with mental illness (Muntaner, Ng, Chung, and Eaton, 2013; Corrigan, Markowitz and Watson, 2004; Sharac Mccrone, Clement and Thorincroft, 2009). Based on this research, it is important to identify the significant predictors of mental illness stigma to address these societal views and combat the stigma. On the same note, in today's political climate, it is also important to examine how political views may contribute to perceptions of mental illness to create policy change. Lastly, it is important to address how views toward mental illness differ on how mental illness are portrayed, for example as treated or not treated. With the increasing diagnoses of mental illness and increasing suicide rates, it is clear that education about mental illness needs to be presented in order create a more accepting and open society (Pompili, 2012; Weissman, Pratt, Miller, and Parker, 2015).

General Stigma

Corrigan et al. (1999) asked participants if they would sign a petition to fight against mental health stigma, and the results indicated that petition signers were less likely to believe that those with mental illness were to blame for their disorders and were less likely to believe that they should be avoided compared to their non-signing counterparts. However, this survey gave little information on the demographic predictors of signing the petition. Since then, more research has been allocated to the topic of mental

health stigma, and the results indicate there are many demographic predictors of mental health stigma.

Education level and economic standing have been shown to have a significant relationship with mental health stigma (Furr et al., 2003). Gonzales, Chan, and Yanos (2017) found that in New York State, higher levels of completed education were associated with less stigmatizing attitudes toward mental illness. On the other hand, neighborhoods that were at an economic disadvantage based on census data were associated with having more stigmatizing attitudes (Gonzales et al., 2017). Previously, Corrigan and Watson (2007) found similar results indicating that participants with higher education levels were also less likely to hold stigmatizing attitudes than less educated participants. Similarly, increased knowledge and support regarding PTSD was also associated with higher levels of education (Tsai et al., 2018).

Studies have shown that gender is associated with attitudes toward mental health (Furr, Usui and Hines-Martin, 2003). Kobau et al. (2009) found that men had higher scores on mental illness stereotypes, like “I believe a person with mental illness is a danger to others” than women. Concurrently, Corrigan and Watson (2007) found, after conducting a survey regarding mental health stigma, women were less likely to have stigmatizing attitudes compared to their male counterparts. On the same note, Tsai et al. (2018) examined attitudes and knowledge about posttraumatic stress disorder (PTSD) and found that women were more likely to have increased knowledge about PTSD as compared to males who were surveyed.

Race and ethnicity have also been shown to be significantly associated with views toward mental health. Kobau et al. (2009) found that higher scores on mental illness

stereotypes were amplified by being Hispanic or of another race, as compared to Caucasians or African Americans. Concurrently Corrigan and Watson (2007) found that nonwhite participants were more likely to hold stigmatizing attitudes as opposed to white participants. Furr et al. (2003) also found that European Americans were more likely to have a more positive outlook on mental health services as opposed to their counterparts.

Lastly, experience with mental illness plays a major role in predicting attitudes toward mental illness (McSween, 2002). Participants who reported to know someone with a mental illness and participants who reported having a mental illness had lower scores on mental illness stereotypes (Kobau et al., 2009). On the same note, Tsai et al. (2018) found that participants who had a personal history of suicide ideation were more likely to support research and have an increased knowledge about PTSD. Concurrently, personal experience with mental health issues was related to higher support for insurance parity as well as increased government spending regarding mental health (Barry and McGinty, 2014). However, Corrigan et al (2005) found that adolescents with more experience with mental illness were more likely to endorse the stigma surrounding mental illness.

Stigma around the world

World view is an important consideration to take into account when examining mental health stigma. While some of the predictors of attitudes toward mental illness may be the same in the United States as they are around the world, other predictors may be different or opposite entirely. Stigma is not just a United States problem; it is a world problem, so it is important to look at predictors of stigma from multiple angles.

Pescosolido, Medina, Martin, and Long (2013) examined prejudice and knowledge about mental illnesses data from sixteen countries who were given one of two vignettes about depression and schizophrenia respectively. Results indicated that respondents were able to recognize the mental illnesses, accept neurobiological attributions and endorsed treatment at high levels across nations (Pescosolido et al., 2013). However, stigma and prejudice ratings were significantly higher for schizophrenia as compared to depression in the items regarding being unpredictable and violent to one's self (Pescosolido et al., 2013). On the same note, most respondents believed that people with schizophrenia should not teach children and would be unwilling to allow someone with schizophrenia to watch their children or marry into their family (Pescosolido et al., 2013). Lastly, negative stigma toward schizophrenia and depression were highly correlated across countries (Pescosolido et al., 2013).

Mental health stigma varies around the world, for example, in Europe, Coppens et al. (2013) conducted a representative general population survey in Germany, Hungary, Ireland, and Portugal and assessed participant's attitudes toward depression and help-seeking in regard to mental illness. Results indicated that there was a moderate degree of personal stigma with regard to depression and a high degree of perceived stigma (Coppens et al., 2013). While a majority of the participants were open to seeking professional help for depression, only half of the participants perceived professional help as valuable. Concurrently, increased personal stigma was associated with being less open to seeking professional help as well as seeing less of a value of professional help (Coppens et al., 2013). Increased negative attitudes toward depression and help seeking were found in Hungary, and negative attitudes were associated with men, older age,

living alone, and having a lower educational level (Coppens et al., 2013). Concurrently, Tzouvara and Papadopoulos (2014) examined individuals who associated themselves with the Greek culture views on mental illness. Greek culture is seen as a traditional culture in that religiosity is influential in the formulation of world view and cultural values (Tzouvara and Papadopoulos, 2014). Results indicated that of the Greek population sampled, a medium high level believed that those with mental illness are inferior (Tzouvara and Papadopoulos, 2014). On the same note, results indicated a moderate level of belief that those with mental illness should be restricted and carefully controlled in society (Tzouvara and Papadopoulos, 2014). However, there was also a high level of benevolence in the sample, indicating sympathy toward people with mental illness (Tzouvara and Papadopoulos, 2014). Those with little knowledge and personal experience with mental illness, increased religiosity, and were educated in England as compared to Greece were most likely to hold stigmatizing attitudes (Tzouvara and Papadopoulos, 2014).

Comparatively, in Africa, Barke, Nyarko, and Klecha (2010) examined attitudes toward mental illness of the population of Ghana. Results indicated high levels of stigma in the population which may be attributed to the high levels of authoritarian and socially restrictive views (Barke et al., 2010). However, higher levels of education were associated with more positive attitudes toward mental illness (Barke et al., 2010). Patients with mental illness in Ghana reported high degrees of experience with stigma and often times they were secretive and reluctant to disclose their mental illness in order to cope with or prevent stigma from others (Barke et al., 2010).

In addition, in Asia, Ng, Nyunt, Chiam, and Kua (2011) surveyed elderly people of Singapore about personal experience with mental disorders and if they sought treatment as well as their religiosity. Results indicated that compared to those who reported no religious affiliation, elderly individuals of any religious affiliation showed increased prevalence of mental health problems, however they were less frequently treated by healthcare professionals (Ng et al., 2011). Concurrently, Hunter, Rice, MacDonald, and Madrid (2014) examined predictors of opinions toward mental illness among the Indian population. Results indicated that participants of older age were more likely to have positive views toward mental illness and less stigma, possibly due to being more likely to having experienced mental illness themselves or through a family member, resulting in more compassionate attitudes (Hunter et al., 2014). Gender was also found to be a significant predictor, with women reporting more positive views toward mental illness in general but also were more likely to remain socially distant toward those with mental illness due to fear (Hunter et al., 2014). On the same note, Indian women were more likely to receive treatment for mental illness compared to men (Hunter et al., 2014). Participants who grew up in authoritarian or authoritative households and are brought up to value personal responsibility, this may result in stronger feelings of negativity toward those with mental illness (Hunter et al., 2014). Lastly, results indicated that political affiliation was a predictor of opinions towards mental illness, with conservatives being more likely to hold stigmatizing attitudes as compared to their liberal counterparts (Hunter et al., 2014).

Though many predictors of views toward mental illness across nations and continents are similar, it is important to consider the diversity of opinion based on world

view. The environment influences how people see the world around them and how they react to different experiences. One thing that also impacts one's view of the world is political party and ideology.

Political Party, ideology and politics

Political party and ideology significantly predict many attitudes and ideas in society. For example, Metzl (2015) argued that due to the increase and prevalence of mass shootings in the United States, many believe that one of the core causes of these tragedies is mental illness, and that due to these assumptions stigma prevails, and the term mental illness is no longer a medical diagnosis but rather a sign of violence. Often studies have shown negative characteristics attributed to mental illness, like dangerousness and unpredictability, are associated with high levels of self-reported right-wing authoritarianism or conservatism (Deluca and Yanos, 2016; Furr et al., 2003; Gonzales et al., 2017; Deluca, Vaccaro, Seda and Yanos, 2018).

This idea was demonstrated in Watson, Corrigan, and Angell (2005), which examined predictors of public support for legally mandated mental health treatment. Respondents were given vignettes about an individual with mental illness and were asked if the individual should be forced to participate in mental health treatment (Watson et al., 2005). Results of the study indicated that a high perceived dangerousness and attribution of the mental illness to bad character were significant in predicting support for legally mandated treatment (Watson et al., 2005). Respondents who identified as having conservative political ideology were more likely to attribute the individual in the vignette's problem to bad character, and as an indirect result increasing support for legally mandated treatment and institutionalization (Watson et al., 2005).

Fodor (2006) examined the relationship between right-wing authoritarianism and managerial assessment of an individual who was A person with schizophrenia who was on medication. Half of participants were given background information that the candidate had left work for six months to receive treatment for schizophrenia whereas the other half received background information that the candidate did not work for six months due to a business slowdown (Fodor, 2006). Results indicated that participants who received high scores of right-wing authoritarianism and received the vignette that the candidate was schizophrenic gave lower appraisal ratings and expressed increased negative attitudes about the candidate as compared to other participants (Fodor, 2006). Concurrently, Fodor, Wick, Hartsen, and Preve (2008) examined the relationship between right-wing authoritarianism and proposed judicial action and attitudes toward a mother, who was schizophrenic and murdered her two young children. The woman was now functioning normally due to treatment (Fodor et al., 2008). Participants who scored higher in right-wing authoritarianism were more likely to recommend harsher sentencing, and express less sympathy as compared to participants who scored lower in right-wing authoritarianism (Fodor et al., 2008). On the same note, those with high right-wing authoritarianism were more likely frown while observing the interview and had lower affective attitudes toward the woman as compared to respondents who scored lower on right-wing authoritarianism (Fodor et al., 2008). However, it is important to note, that people with right-wing authoritarian ideology are more likely to side with the law regardless of the circumstances (Fodor et al., 2008).

Similarly, Barry and McGinty (2014) examined the opinions of United States citizen regarding stigma and support for government spending on mental health. Results

indicated that 69% of respondents supported insurance parity for mental health, and 59% supported increased government spending on mental health (Barry and McGinty, 2014). Compared to Republicans and Independents, Democrats were more supportive of government spending and insurance parity for mental health (Barry and McGinty, 2014). Respondents who held more stigmatizing attitudes were less likely to show support for the policies (Barry and McGinty, 2014). Similarly, Tsai et al (2018) found that between 76 and 94% of respondents endorsed increased federal funding for research and training in regard to PTSD and 76% believed that those with PTSD should have restricted firearm access. Knowledge and support for programs related PTSD was associated with Democratic political affiliation as compared to Republican and Independent political affiliation (Tsai et al., 2018).

Framing of Mental Illness

Vignettes are a valid way to examine whether the way mental illness is framed can influence how participants respond to stigma related factors regardless of their demographic predictors (McGinty, Goldman, Pescosolido, and Barry, 2015; Barry McGinty, Pescosolido, and Goldman, 2014; Link, Phelan, Besnahan, Stueve, and Pescosolido, 1999; Corrigan et al., 2005). McGinty et al. (2015) examined the effects of portraying persons with mental illness/drug addiction with untreated symptoms versus portrayal of persons with mental illness/drug addiction who had successful treatment and few symptoms. The researchers found that untreated portrayals of mental illness resulted in negative attitudes towards people with mental illness whereas treated portrayals of mental illness resulted in less willingness to discriminate against people with mental illness, higher belief in the effectiveness of treatment, and less desire for social distance.

Similarly, Barry et al. (2014) examined public attitudes about mental illness and drug addiction through a national opinion survey. Then, they compared the attitudes toward mental illness to the attitudes toward drug addiction (Barry et al., 2014). Results indicated that respondents held significantly more negative views regarding drug addiction as compared to mental illness (Barry et al., 2014). Compared to views toward mental illness, more respondents were unwilling to work with someone with drug addiction on a job or allow them to marry into their family (Barry et al., 2014). Respondents were also more accepting of discrimination toward persons with drug addiction (Barry et al., 2014). On the same note, respondents were more hesitant about the validity and effectiveness of drug addiction treatments and were more likely to oppose policies that helped or benefited those struggling with drug addiction versus other kinds of mental illness (Barry et al., 2014).

Concurrently, Link et al. (1999) examined public beliefs and ideas regarding mental illness. Participants were assigned to one of five vignettes, four of which depicted a psychiatric disorder (schizophrenia, major depression, alcohol dependence, drug dependence) meeting diagnostic criteria and one depicting a person with subclinical problems and worries (Link et al., 1999). Results indicated that the majority of the respondents were able to identify schizophrenia and depression, 88% and 69% respectively and that participants reported that there were multi-causal explanations for these disorders including biological and environmental factors (Link et al., 1999). However, those given the alcohol and drug dependence vignettes were less likely to associate these abuses with mental illness (Link et al., 1999). On the same note, symptoms of mental illness still have a strong connection to public fears about violence

and, as a result, there is a strong desire for limited social interaction with those with mental illnesses (Link et al., 1999). Concurrently, Corrigan et al (2005) had adolescents read one of four vignettes about a peer. The peer was either abusing alcohol, had been diagnosed with a mental illness, had been diagnosed with leukemia or had been diagnosed with a brain tumor, the participants were then asked to rate the peer on items like pity, avoidance, danger, and responsibility (Corrigan et al., 2005). Researchers found that while adolescents perceived peers with leukemia or a brain tumor more benignly, those who had a mental illness were more severely stigmatized and those who abuse alcohol the most stigmatized (Corrigan et al., 2005).

Purpose of the Current Research

The purpose of this research is to confirm and expand on the literature regarding mental health stigma, world view and political affiliation, and vignettes portraying mental illness. Though past research has examined the use of vignettes and the predictive ability of political party affiliation in regard to mental health stigma separately, the current research seeks to combine the two to create a broader picture of mental health views and its interactions with political affiliation.

Based on the reviewed literature, the research questions for the current study were: Is political affiliation associated with mental health stigma? Does the severity of mental illness or drug addiction impact mental health stigma? Is political affiliation associated with negative stereotypes toward mental illness? Does the severity of mental illness impact perception of recovery and outcomes for those with mental illness? Does the severity of mental illness impact rating of negative stereotypes regarding those with mental illness? Is political affiliation associated with perception of recovery and

outcomes regarding mental illness? Is there a significant difference between political parties and ideologies in regard to their amount of mental health stigma?

The researcher hypothesized participants would give higher ratings of stigma toward the vignettes describing debilitating mental illness and drug addiction, as compared to those who have a mental illness who are high functioning and treated, with the most stigma associated with drug addiction. The researcher also hypothesized higher stigma ratings would be given by participants who identify as conservative or Republican compared to their liberal and Democratic counterparts and that highest ratings of stigma for conservatives will be for those who received the vignettes regarding drug addiction. Lastly, the researcher hypothesized to confirm and concur with previous literature regarding demographic associations with mental health stigma, like gender and experience with mental illness.

To test these hypotheses, four experimental groups were used: One group received a vignette about someone who has struggled with depression in the past but is now functioning well; another group received a vignette about someone who struggles with the effects of depression without proper treatment or medication; another group received a vignette about someone who has been treated for drug addiction; and the last group received a vignette about someone who has an untreated addiction to drugs. There was also a control group asking the participant to complete the survey. They were also asked a series of demographic questions, including their political affiliation.

Method

Participants

Participants were 251 people living in the Mid-Atlantic region. Female identifying participants made up 78% ($N= 196$) of the sample, 18% ($N= 45$) identified as male and 4%

identified as non-binary ($N= 10$), ranging in age from 18 to 69, with a mean and median age of 30 and 23, respectively. In terms of race and ethnicity, 74.5% ($N= 187$) were Caucasian, 10% ($N= 25$) were African-American, 2.4% ($N= 6$) were Hispanic, 3.2% ($N= 8$) were Asian-American, 0% ($N= 0$) were Native American, 7.2% ($N= 18$) were multiple races and 2.8% ($N= 7$) reported Other. About Sixty percent of the sample identified as Christian ($N= 150$), .8% ($N= 2$) identified as Jewish, .8% ($N= 2$) identified as Muslim, 25.5% ($N= 64$) reported they were not religious or atheist, and 13.1% ($N= 33$) identified as other. Participants' annual income 0 and 1,000,000 dollars, with a mean and median amount of \$57,330.38 and \$20,000 respectively. Regarding political party affiliation, 43% ($N= 108$) identified as democrat, 23.9% identified as republican ($N= 60$), 25.1% identified as independent ($N=63$), 6.4% identified as other ($N= 16$), and 1.6% did not disclose their political party affiliation ($N= 4$). With regard to political ideology, 51.4% ($N= 129$) identified as liberal, 14.7% identified as centrist ($N= 37$), 20.7% identified as conservative ($N= 52$), 10% identified as other ($N= 25$), and 3.2% ($N= 8$) did not disclose their political ideology. 60.6% ($N= 152$) of participants identified that they have experienced a mental disorder, 92% of participants identified that someone close to them has experienced a mental disorder ($N= 231$), and 51.4% of participants sought help for an experienced mental disorder ($N=129$).

Materials and Procedure

Upon obtaining approval from the college's Institutional Review Board, a convenience sample of participants was given an informed consent form prior to their participation in the study with the use of *Qualtrics*. After reading the vignette and clicking the box that they wished to participate in the study, the participants were randomly assigned

to receive one of five possible vignettes. The first section of the survey included detailed instructions about the study, which included directions on how to complete the survey based on what they read in the vignettes. To obtain participants, the researcher used snowball sampling by reaching out to personal contacts and having them distribute the survey to their contacts as well as reaching out on social media in order to get a diverse adult population.

The next section consisted of one of five single-spaced written descriptions of the “life of Mary”, ranging from 60-80 words (Appendix A). The vignettes were obtained from McGinty et al. (2015) which replicated the General Social Survey (GSS) vignettes from 1996 and 2006 regarding untreated depression and schizophrenia, while also adding portrayals of treated depression and drug abuse/misuse, both treated and untreated. The current study used five of the vignettes, including a treated and untreated portrayal of depression, a treated and untreated portrayal of an addiction to heroin, and a control that did not receive a vignette (McGinty et al., 2015).

The next section asked participants to complete a survey based on the description they were given. The survey portion included an eleven-item survey from Kobau et al. (2009) that measures public attitudes toward severe mental illness. Questions were answered on a 5-point Likert scale (1=strongly disagree and 5=strongly agree) and covered ideas such as negative stereotypes and recovery and outcomes (Kobau et al., 2009). Analysis of the scale was found to have an acceptable estimate for internal consistency reliability with the negative stereotypes factor ($\alpha=.69$) and the recovery and outcomes factors ($\alpha=.66$) (Kobau et al., 2009). A confirmatory factor analysis found reliability coefficients of .70 and .69 for each of the factors respectively (Kobau et al., 2009).

Appendix B contains the original survey. Six questions assessed negative stereotypes toward mental illness (e.g., I believe a person with mental illness is a danger to others) and five questions regarding recovery and outcomes (e.g. I believe a person with mental illness can eventually recover) (Kobau et al., 2009). Ten demographic questions at the bottom of the evaluation form asked the participants for their gender, age, approximate yearly income, religious background, ethnicity, political party affiliation, political ideology, and personal and proxy experience with mental illness.

After the participants read the vignettes and completed the evaluation form, they were given a debriefing form that included contact information and mental health resources. Participants also were given the option to give an email address to be entered in a drawing to win a \$25-dollar *Amazon* gift card, and Hood College Psychology undergraduate students and Counseling master's students were offered extra credit from their professors. Ten participants were excluded from the study using listwise deletion because they failed to completely respond to the survey regarding attitudes toward mental health completely.

Four univariate ANOVAS were conducted to test for differences between the independent variables including: Experimental group, political ideology, political party affiliation and gender and the dependent variable: the mental health stigma survey. Tukey HSD post-hoc tests were also performed to distinguish differences between groups. Three independent samples *t*-tests were conducted to test for differences between independent variables including: "Someone I am close to has experienced a mental illness"; "Have you, yourself, ever experienced a mental illness?"; and "Have you ever sought help (i.e., counseling, therapy, etc.) for an experienced mental disorder?", and the dependent variable:

the mental health stigma survey. The Bonferroni correction was applied to the current study and the p value was lowered to $p < .0125$ in order to account for the fact that multiple ANOVAs and t -tests were conducted on the same data.

Results

The first research question this study proposed asked: Is political affiliation associated with mental health stigma? The study hypothesized that there would be higher stigma ratings for participants who identify as Republican or conservative compared to their Democratic or liberal counterparts. A one-way ANOVA compared the average amount participant of mental health stigma to their indicated political party (Democrat, Republican, Independent, Other), and another one-way ANOVA compared the average amount of participant mental health stigma to their political ideology (Liberal, Conservative, Centrist, Other). There was no statistically significant difference between political parties found for the mean score for mental health stigma at $p < .0125$: $F(3,243)$, $p = .79$, $\eta^2 = .004$ (Table 3) There was also no statistically significant differences found between groups regarding the stereotype items total: $F(3,243)$, $p = .146$, $\eta^2 = .022$ and the recovery and outcomes total: $F(3,243)$, $p = .204$, $\eta^2 = .019$ (Table 3)

There was no statistically significant difference between the groups of political ideology at $p < .0125$ in regard to the total sum of the responses to the dependent variable: $F(3,242)$, $p = .289$, $\eta^2 = .016$ (Table 4). However, the one-way ANOVA did reveal statistically significant differences between the groups at $p < .0125$ results for the stereotype items total: $F(3,242)$, $p < .001$, $\eta^2 = .066$ (Table 4). A Tukey HSD post-hoc test revealed that the significant differences could be found between Liberals ($M = 16.89$, $SD = 3.28$) and Conservatives ($M = 18.94$, $SD = 3.01$), with Liberals scoring an average of 2.05 points fewer on amount of stereotypes compared to Conservatives. Specific items

revealing significance within the stereotype subset include: “I believe a person with a mental illness is a danger to others”: $F(3,242)$, $p < .000$, $\eta^2 = .078$ and “I believe a person with mental illness is unpredictable”: $F(3,242)$, $p < .008$, $\eta^2 = .048$. A Tukey HSD post hoc test revealed the biggest differences were between Liberals and Conservatives. There were no statistically significant differences between groups regarding the recovery and outcomes total: $F(3,242)$, $p = .141$, $\eta^2 = .023$; however several specific items revealed statistical significance between groups within the recovery and outcomes subtotal including: “I believe a person with mental illness can be as successful at work as others”: $F(3,242)$, $p < .001$, $\eta^2 = .071$, and “treatment can help people with mental illness lead normal lives”: $F(3,242)$, $p < .006$, $\eta^2 = .051$. A Tukey HSD post hoc test revealed the biggest differences were between Liberals and Conservatives.

The next research question posed asked the following: Does the severity of mental illness or drug addiction impact mental health stigma? The study hypothesized participants would give higher ratings of stigma toward the vignettes describing debilitating mental illness and drug addiction, as compared to those who have a mental illness who are high functioning and treated, with the most stigma associated with drug addiction. A one-way ANOVA compared the vignette of severity of mental illness (Untreated depression; untreated heroin addiction; treated depression, treated heroin addiction, control) and revealed statistically significant differences between vignettes at $p < .0125$ for the combined subtotals of stereotypes and recovery and outcomes: $F(4, 250)$, $p < .000$, $\eta^2 = .082$ (Table 2). A Tukey HSD post hoc tests revealed several statistically significant differences between the vignettes including between a treated ($M = 31.79$, $SD = 4.39$) and untreated portrayal of depression ($M = 34.02$, $SD = 3.62$); a treated portrayal of

depression ($M= 31.79$, $SD= 4.39$) and untreated portrayal of heroin addiction ($M= 35.00$, $SD=3.96$); and a treated portrayal of depression ($M= 31.79$, $SD= 4.39$) and treated portrayal of heroin addiction ($M= 34.81$, $SD= 4.07$). However, this significance was driven by the statistical significance between the groups of the stereotype subtotal: $F(4, 250)$, $p<.000$, $\eta^2= .102$ (Table 2). There was no statistically significant difference between groups at the $p<.0125$ level for the recovery and outcomes subtotal: $F(4, 250)$, $p=.604$, $\eta^2= .011$ (Table 2). Tukey HSD post hoc tests on the stereotype subtotal revealed statistically significant differences between treated ($M= 15.79$, $SD= 3.27$) and untreated depression ($M= 17.81$, $SD= 2.88$); untreated heroin addiction ($M= 18.84$, $SD= 3.19$) and treated depression ($M= 15.79$, $SD= 3.27$); and treated depression ($M= 15.79$, $SD= 3.27$) and treated heroin addiction ($M= 18.22$, $SD= 2.86$).

The researcher hypothesized that this addition to the research would concur with previous findings regarding gender, and previous experiences with mental health disorders. An ANOVA compared the gender of the participant with the responses on the mental health stigma survey and revealed statistically significant differences between groups at $p<.0125$ for the combined subtotals of stereotypes and recovery and outcomes: $F(2, 250)$, $p<.000$, $\eta^2= .068$ (Table 5). A Tukey HSD post hoc tests revealed statistically significant differences between all three groups: male ($M= 35.69$, $SD= 4.93$) and female ($M= 33.58$, $SD= 3.72$), male ($M= 35.69$, $SD= 4.93$) and non-binary ($M=30.50$, $SD= 2.72$), and female ($M= 33.58$, $SD= 3.72$) and non-binary ($M=30.50$, $SD= 2.72$). However, this was driven by the statistically significant differences between groups regarding the stereotype subtotal $F(2, 250)$, $p<.000$, $\eta^2= .110$, and there was no statistically significant

differences between the groups regarding the recovery and outcomes subtotal $F(2, 250)$, $p=.847$, $\eta^2=.00$ (Table 5).

An independent t -test compared the participant's experiences with mental health with response on the mental health stigma survey. For "Someone I am close to has experienced a mental illness" there was no statistically significant difference between groups (yes, no) for the subtotals of stereotypes $t(249)=-1.75$, $p=.18$) and recovery and outcomes $t(249)=-.634$, $p=.52$) as well as the total: $t(249)=-1.05$, $p=.29$. However, some specific items yielded statistically significant differences between groups including: "I believe a person with mental illness is hard to talk with": $t(249)=-3.17$, $p<.002$, with participants who replied yes, someone close to them had experienced a mental illness reporting an average of 2.3 ($SD=.933$) compared to participants who replied no, someone close to them had not experienced a mental illness reported an average of 3.00 ($SD=1.12$); and "I believe a person with mental illness can be as successful at work as others": $t(249)=4.12$, $p<.000$, with participants who replied yes, someone close to them had experienced a mental illness reporting an average of 4.35 ($SD=.713$) compared to participants who replied no, someone close to them had not experienced a mental illness reported an average of 3.65 ($SD=.813$).

For "Have you, yourself, ever experienced a mental illness?" There was no statistically significant differences between the two groups (Yes, No) at the $p<.0125$ level for the total on the mental health stigma survey: $t(248)=-2.32$, $p=.021$, with participants reporting they had experienced a mental illness reporting an average score of 33.34 ($SD=3.86$) compared to participants who had not experienced a mental illness reporting an average score of 34.55 ($SD=4.27$). The stereotype subtotal, however, yielded

statistically significant differences between the groups at the $p < .0125$: $t(248) = -3.11$, $p < .002$, $\eta^2 = .038$, with participants reporting they had experienced a mental illness reporting an average score of 17.13 ($SD = 3.06$) compared to participants who had not experienced a mental illness reporting an average score of 18.41 ($SD = 3.32$). There were no statistically significant differences between the groups regarding the recovery and outcomes subtotal: $t(248) = .247$, $p = .805$; however one specific item within the scale reported statistically significant differences between the groups including: “I believe a person with mental illness only has himself/herself to blame for his/her condition”: $t(248) = -2.84$, $p < .005$, with participants reporting they had experienced a mental illness reporting an average score of 1.26 ($SD = .66$) compared to participants who had not experienced a mental illness reporting an average score of 1.53 ($SD = .86$).

Lastly, for “Have you ever sought help (i.e., counseling, therapy, etc.) for an experienced mental disorder?”, there was no statistically significant difference between groups (Yes, No) at $p < .0125$ for the total mental health stigma survey: $t(248) = -2.24$, $p = .026$. However, the stereotype subtotal yielded statistically significant differences between groups at the $p < .0125$: $t(248) = -3.14$, $p < .002$, $\eta^2 = .038$, with participants who had sought help, like counseling, reporting an average score of 17.02 ($SD = 3.06$), and participants who had not sought help, like counseling, reporting an average score of 18.28 ($SD = 3.27$). There were no statistically significant differences between groups for the recovery and outcomes total: $t(248) = .434$, $p = .665$; however, one specific item within the recovery and outcomes scale reported statistically significant differences between groups including: “I believe a person with mental illness only has himself/herself to blame for his/her condition”: $t(248) = -3.06$, $p < .002$, with participants reporting they had

experienced a mental illness reporting an average score of 1.22 ($SD=.56$) compared to participants who had not experienced a mental illness reporting an average score of 1.51 ($SD=.90$).

Discussion

This study examined the relationship between political party and ideology and views toward people with mental disorders. This research also compared the effect of vignettes framing mental illness on views toward people with mental disorders. The researcher used four experimental groups and one control group: for the control group, the participants were asked to complete the Health Styles Survey 2006 (Kobau et al., 2009) mental health attitudes survey, experimental group one was asked to read a vignette about someone experiencing untreated depression and then complete the survey, experimental group two was asked to read a vignette about someone experiencing untreated Heroin addiction and then complete the survey, experimental group three was asked to read a vignette about someone experiencing treated depression, and experimental group four was asked to read a vignette about someone experiencing treated heroin addiction. The hypotheses included (1) participants would give higher ratings of stigma toward the vignettes describing debilitating mental illness and drug addiction, as compared to those who have a mental illness who are high functioning and treated, with the most stigma associated with drug addiction; (2) higher stigma ratings for participants identifying as conservative or republican compared to their liberal and democratic counterparts and that highest levels of stigma for conservatives will be for drug addiction; and (3) to confirm and concur with previous literature regarding demographic

associations with mental health stigma, like gender and experience with mental illness. Data partially supported these hypotheses.

The current findings are consistent with previous literature about the impact of framing on mental health stigma. McGinty et al (2015) found that portrayals of untreated individuals were associated with negative attitudes toward people with mental illness as opposed to treated portrayals, which were associated with less discrimination against people with mental illness, higher belief in the effectiveness of treatment and less desire for social distance. The results found in the current study corroborated these results, finding statistically significant differences for the total stigma attitudes and stereotype attitudes; however, no statistically significant differences were found for the recovery and outcomes subscale. The differences were found in treated depression having a lower total stigma score than untreated depression, treated depression having a lower total stigma score than untreated heroin addiction, and treated depression having a lower total stigma score than treated heroin addiction. These corroborate the findings of McGinty et al (2015) that untreated portrayals resulted in more negative attitudes toward mental illness than treated portrayals. On the same note, Barry et al. (2014) found that respondents held significantly more negative attitudes toward drug addiction as opposed to mental illness. This study replicated those results with both treated and untreated portrayals of drug addiction having statistically significant higher stigma than the treated portrayal of depression. The results of this study may be related to the negative connotation of drug addiction in society, drug addiction is often seen as a choice as opposed to an illness and as a result, respondents who received either the treated or untreated vignettes regarding drug addiction may have experienced less empathy toward that particular vignette.

The current findings partially confirmed previous literature regarding mental health stigma and its relationship between political party affiliation and political ideology. Fodor (2006) found that participants who received high scores of right-wing authoritarianism and were assigned to a vignette about a managerial candidate who was schizophrenic, were more likely to give lower appraisal ratings and expressed increased negative attitudes about the candidate compared to other participants. On the same note, Fodor et al. (2008) found that participants who scored higher in right-wing authoritarianism were more likely to recommend harsher sentencing and express less sympathy for a schizophrenic mother who murdered her children as opposed to participants who scored lower in right-wing authoritarianism. The results from the current study partially corroborated these findings, finding no significant differences between the total amount of stigmatizing attitudes for both political party and political ideology; however, regarding the relationship between mental health stigma and political ideology there were statistically significant differences regarding the stereotype subtotal. The margin of difference was between liberals and conservatives with liberals scoring an average of 2.05 points less than conservatives on stigmatizing attitudes. Conservatives may have had statistically higher ratings of stereotypes for a couple of reasons. First, Watson et al. (2005) found that having a conservative political ideology was linked to being more likely to attribute mental health problems to bad character as opposed to an illness, therefore they may be more likely to give increased stereotype ratings to those with mental illness. Second, those with conservative attitudes may not have a sufficient working knowledge of mental illness, resulting in decreased support for those with mental illness (Tsai et al., 2018). Lastly, people with conservative ideologies are often

associated with having “pull yourself up by your boot straps” mentalities meaning that people should be able to handle personal struggles on their own, without personal help (Fodor, 2006; Fodor et al., 2008). For example, one specific item posited: “Treatment can help people with mental illness lead normal lives” and a Tukey HSD test revealed statistically significant differences between conservatives and liberals, with liberals indicating more agreement to the statement.

On the same note, specifically for the item “I believe a person with a mental illness is a danger to others” there was statistical significance for political ideology which confirms previous findings. Deluca and Yanos (2016), Furr et al. (2003), Gonzales et al.(2017), and Deluca et al. (2018) all found that negative attitudes toward mental illness, such as dangerousness and unpredictability are associated with high levels of self-reported right-wing authoritarianism and conservatism. The current study found differences between liberals and conservatives, with conservatives agreeing more with both statements for “I believe a person with a mental illness is a danger to others” and “I believe a person with a mental illness is unpredictable”. These results may be from the tendency for conservatives and Republicans to believe that the increase in prevalence of mass shootings in the United States is a result of mental illness, and as a result mental illness is seen as a sign of violence rather than a medical diagnosis (Metzl, 2015). On the same note, Republican and conservative viewpoints tend to be associated with support for legally mandated mental health treatment due to perceived dangerousness and unpredictability (Watson et al., 2005).

The current findings are consistent with previous literature regarding gender and attitudes toward mental health. Kobau et al. (2009) found that men had higher scores on

mental illness stereotypes, like “I believe a person with mental illness is a danger to others.” Corrigan and Watson also found that women were less likely to have stigmatizing attitudes toward mental illness than their male counterparts. My data concurred with these findings, revealing statistically significant differences between the total scores of mental health stigma and gender. Differences were found between men and women, with men scoring higher in stigmatizing attitudes, men and nonbinary people with men scoring higher in stigmatizing attitudes. This may be associated with the fact that western society gives men unrealistic expectations to be “strong”, and “tough” mentally, where certain feelings and emotions such as sadness are seen as weaknesses, therefore in this study men were more likely to have stigmatizing attitudes toward mental illness as opposed to women and nonbinary people (Rosenfield and Smith, 2010).

Previous literature has also examined the impact of experience with mental illness on stigmatizing attitudes. The results of the current study partially corroborated the previous studies. Kobau et al. (2009) found that participants who reported experiencing a personal mental illness and participants who reported to know someone with a mental illness had lower scores on stereotypes. In the current study, there were no significant differences between groups regarding mental health attitudes between people who know someone who is close to someone with a mental illness and people who stated they did not. There were no also statistically significant differences regarding mental health attitudes between participants who had personal experience with mental illness as opposed to participants who did not have personal experience with a mental illness. Similarly, those participants who had sought help for a personally experienced mental disorder did not significantly differently on stigmatizing attitudes than participants who

had not sought help for a personally experienced mental disorder. However, there were statistically significant differences in the stereotype subtotal for both, the personal experience with mental illness and those who had sought help for a mental disorder with those who had not sought help for a mental disorder scoring higher on stereotypes than those who had and those who had personal experience with a mental illness scoring lower on stereotypes than those who had not. These findings are not consistent with Corrigan et al. (2005), however, who found that adolescents with personal experience with mental illness were more likely to endorse mental health stigma. It is possible that the pattern of results in the current study can be attributed to the fact that people who have experienced mental illness and/or psychological treatment tend to be more empathetic and understanding of those who have also experienced mental illness (Kobau et al., 2009).

There were some limitations involved in this research. Data for this research was collected through Qualtrics, an online survey distribution site; therefore, the population was limited to people who had access to the internet. On the same note, this study also used snowball sampling to gather data through social media sharing and referrals, which may have created a biased sample because participants may have only recruited other participants they were friends with or knew well. It should also be noted that responses to the political party, ideology, and mental health attitudes scales may have been biased by social desirability and therefore might not accurately reflect participant attitudes toward mental illness. Self-report is also limited due to biases such as the understanding of the question or statement, fatigue, and social desirability concerns. Lastly, there was increased probability of a type one error, therefore a Bonferroni's correction was applied and the p level was lowered to $p < .0125$ to account for the fact that the statistical tests

were run on the same data set. The current study is also correlational and cross-sectional, therefore no causal and directional statements can be made.

Future research should strive to use random sampling as opposed to snowball sampling in order to get a more accurate representation of the population. Furthermore, scales to measure political ideologies and leanings may be useful to obtain a more accurate distribution of the political leanings of the population. Given the obvious stigma of mental illness and how it pertains to legislation and policy, future research should examine government officials' views toward mental illness in order to get a picture as to how stigma is impacting policy on the local, state and federal levels of government, and how framing of mental illness can impact these views. In a politically polarized climate, it is imperative to gauge the population's attitudes toward mental illness in order for organizations to frame mental illness in a more positive light in order to eradicate stigma and help those in need of mental health care.

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Appendix A

Control group: Did not receive a vignette

Untreated Depression: Mary is a white woman who has completed college. A year after college, Mary started feeling really down. She began waking up in the morning with a flat, heavy feeling that stuck with her all day long. She wasn't enjoying things the way she normally would. In fact, nothing seemed to give her pleasure. Even when good things happened, they didn't seem to make Mary happy. She pushed through her days, but it was really hard. The smallest tasks were difficult to accomplish. She found it hard to concentrate on anything. She felt out of energy and out of steam. Even though Mary felt tired, when night came she couldn't get to sleep. Mary felt pretty worthless, and very discouraged. Mary's family noticed that she hadn't been herself, and had pulled away from them. Mary just didn't feel like talking. She has been living this way for six months.

Untreated Heroin Addiction: Mary is a white woman who has completed college. A year after college, Mary went to a party and used heroin for the first time. After that, she started using heroin more regularly. At first she only used on weekends when she went to parties, but after a few weeks found that she increasingly felt the desire for more. Mary then began using heroin two or three times a week. She spent all of her savings and borrowed money from friends and family in order to buy more heroin. Each time she tried to cut down, she felt anxious and became sweaty and nauseated for hours on end and also could not sleep. These symptoms lasted until she resumed taking heroin. Her friends complained that she had become unreliable e making plans one day, and canceling them the next. Her family said she had changed and that they could no longer count on her. She has been living this way for six months

Treated Depression: Mary is a white woman who has completed college. A year after college, Mary started feeling really down. She began waking up in the morning with a flat, heavy feeling that stuck with her all day long. She wasn't enjoying things the way she normally would. In fact nothing seemed to give her pleasure. Even when good things happened, they didn't seem to make Mary happy. She pushed through her days, but it was really hard. The smallest tasks were difficult to accomplish. She found it hard to concentrate on anything. She felt out of energy and out of steam. Even though Mary felt tired, when night came she couldn't get to sleep. Mary felt pretty worthless, and very discouraged. Mary's family noticed that she hadn't been herself, and had pulled away from them. Mary just didn't feel like talking. She had been living this way for six months. At that point, Mary's family encouraged her to see a doctor. She started talking with a doctor regularly and taking appropriate medication. After three months of treatment, she felt good enough to start searching for a job. Since then, Mary has received steady treatment and her symptoms have been under control for the past three years. She lives with her family and enjoys spending time outdoors and taking part in various activities in her community. Mary works at a local store.

Treated Heroin Addiction: Mary is a white woman who has completed college. A year after college, Mary went to a party and used heroin for the first time. After that, she started using heroin more regularly. At first she only used on weekends when she went to parties, but after a few weeks found that she increasingly felt the desire for more. Mary then began using heroin two or three times a week. She spent all of her savings and borrowed money from friends and family in order to buy more heroin. Each time she tried to cut down, she felt anxious and became sweaty and nauseated for hours on end and also could not sleep. These symptoms lasted until she resumed taking heroin. Her friends complained that she had become unreliable e making plans one day, and canceling them the next. Her family said she had changed and that they could no longer count on her. She had been living this way for six months. At that point, Mary's family encouraged her to see a doctor. With her doctor's help, she entered a detox program to address her problem. After completing detox, she started talking with a doctor regularly and began taking appropriate medication. After three months of treatment, she felt good enough to start searching for a job. Since then, Mary has received steady treatment and her symptoms have been under control for the past three years. She lives with her family and enjoys spending time outdoors and taking part in various activities in her community. Mary works at a local store.

Appendix B

In this section, there are a number of statements with which you may or may not agree. For each statement listed, please indicate whether you personally agree or disagree with it. If you don't understand a statement or it is not applicable to you, please leave that row blank

I believe a person with mental illness is a danger to others

I believe a person with mental illness is unpredictable

I believe a person with mental illness is hard to talk with

I believe a person with mental illness would improve if given treatment and support

I believe a person with mental illness feels the way we all do at times

I believe a person with mental illness could pull himself or herself together if he or she wanted

I believe a person with mental illness can eventually recover

I believe a person with mental illness can be as successful at work as others

Treatment can help people with mental illness lead normal lives

People are generally caring and sympathetic to people with mental illness

I believe a person with mental illness has only himself/herself to blame for his/her condition

* All respondents were asked to indicate level of agreement on a 5-point Likert scale, where 1 = strongly disagree, and 5 = strongly agree

Appendix C

Demographics

Gender (circle one)

Male

Female

Nonbinary

Other (please specify)

Age

Please Specify: _____

Religious Background

Please Specify: _____

Ethnicity

Please Specify: _____

Approximate yearly income

Please Specify: _____

Political Party Affiliation (circle one)

Democrat

Republican

Independent

Other (please specify)

Political Ideology (circle one)

Liberal

Centrist

Conservative

Other (please specify)

Has someone close to you ever experienced a mental illness/ disorder? (circle one)

Yes No

Have you, yourself, ever experienced a mental illness/ disorder? (circle one)

Yes No

Have you ever sought help (ie counseling, therapy etc) for an experienced mental disorder? (circle one)

Yes No

Table 1
Descriptive Statistics

| | N | | | | |
|---|-------|---------|---------|---------|----------------|
| | Valid | Missing | Mean | Median | Std. Deviation |
| I believe a person with mental illness is a danger to others. | 251 | 0 | 2.36 | 2.00 | .946 |
| I believe a person with mental illness is unpredictable. | 251 | 0 | 3.05 | 3.00 | .995 |
| I believe a person with mental illness is hard to talk with | 251 | 0 | 2.35 | 2.00 | .966 |
| I believe a person with mental illness would improve if given treatment and support | 251 | 0 | 4.44 | 5.00 | .669 |
| I believe a person with mental illness feels the way we all do at times | 251 | 0 | 3.33 | 4.00 | 1.317 |
| I believe a person with mental illness could pull himself or herself together if he or she wanted | 251 | 0 | 2.11 | 2.00 | 1.016 |
| Stereotype total | 251 | 0 | 17.6454 | 18.0000 | 3.22332 |
| I believe a person with mental illness can eventually recover | 251 | 0 | 3.81 | 4.00 | .969 |
| I believe a person with mental illness can be as successful at work as others | 251 | 0 | 4.30 | 4.00 | .745 |
| Treatment can help people with mental illness lead normal lives | 251 | 0 | 4.37 | 4.00 | .659 |
| People are generally sympathetic and caring to people with mental illness | 251 | 0 | 2.35 | 2.00 | .892 |
| I believe a person with mental illness has only himself/herself to blame for his/her condition | 251 | 0 | 1.36 | 1.00 | .754 |
| Recovery and outcomes total | 251 | 0 | 16.1873 | 16.0000 | 2.11111 |
| Total | 251 | 0 | 33.8327 | 34.0000 | 4.06102 |

Table 2
ANOVA Vignettes

| | | Sum of Squares | df | Mean Square | F | Sig. |
|-----------------------------|-------------------|-------------------|-----|----------------|-------|------|
| Stereotype total | Between Groups | 264.540 | 4 | 66.135 | 6.974 | .000 |
| | Within Groups | 2332.903 | 246 | 9.483 | | |
| | Total | 2597.442 | 250 | | | |
| Recovery and outcomes total | Between Groups | 12.247 | 4 | 3.062 | .684 | .604 |
| | Within Groups | 1101.952 | 246 | 4.479 | | |
| | Total | 1114.199 | 250 | | | |
| Total | Between Groups | 336.515 | 4 | 84.129 | 5.466 | .000 |
| | Within Groups | 3786.457 | 246 | 15.392 | | |
| | Total | 4122.972 | 250 | | | |

Table 3

ANOVA Political Party

| | | Sum of Squares | df | Mean Square | F | Sig. |
|-----------------------------|-------------------|-------------------|-----|----------------|-------|------|
| Stereotype total | Between Groups | 56.127 | 3 | 18.709 | 1.811 | .146 |
| | Within Groups | 2509.857 | 243 | 10.329 | | |
| | Total | 2565.984 | 246 | | | |
| Recovery and outcomes total | Between Groups | 20.666 | 3 | 6.889 | 1.543 | .204 |
| | Within Groups | 1084.848 | 243 | 4.464 | | |
| | Total | 1105.514 | 246 | | | |
| Total | Between Groups | 17.666 | 3 | 5.889 | .352 | .787 |
| | Within Groups | 4060.213 | 243 | 16.709 | | |
| | Total | 4077.879 | 246 | | | |

Table 4

ANOVA Political ideology

| | | Sum of Squares | df | Mean Square | F | Sig. |
|-----------------------------|-------------------|-------------------|-----|----------------|-------|------|
| Stereotype total | Between Groups | 166.216 | 3 | 55.405 | 5.620 | .001 |
| | Within Groups | 2356.064 | 239 | 9.858 | | |
| | Total | 2522.280 | 242 | | | |
| Recovery and outcomes total | Between Groups | 24.683 | 3 | 8.228 | 1.839 | .141 |
| | Within Groups | 1069.350 | 239 | 4.474 | | |
| | Total | 1094.033 | 242 | | | |
| Total | Between Groups | 62.857 | 3 | 20.952 | 1.260 | .289 |
| | Within Groups | 3974.583 | 239 | 16.630 | | |
| | Total | 4037.440 | 242 | | | |

Table 5
ANOVA Gender

| | | Sum of Squares | df | Mean Square | F | Sig . |
|-----------------------------|-------------------|-------------------|-----|----------------|--------|----------|
| Stereotype total | Between Groups | 284.612 | 2 | 142.306 | 15.259 | .00 0 |
| | Within Groups | 2312.830 | 248 | 9.326 | | |
| | Total | 2597.442 | 250 | | | |
| Recovery and outcomes total | Between Groups | 1.491 | 2 | .746 | .166 | .84 7 |
| | Within Groups | 1112.708 | 248 | 4.487 | | |
| | Total | 1114.199 | 250 | | | |
| Total | Between Groups | 278.976 | 2 | 139.488 | 8.999 | .00 0 |
| | Within Groups | 3843.996 | 248 | 15.500 | | |
| | Total | 4122.972 | 250 | | | |

Table 6

Independent Samples Test- Has anyone close to you ever experienced a mental disorder?

| | | Levene's Test for Equality of Variances | | t-test for Equality of Means | | | | | | |
|--------------------------------|--------------------------------|---|------|------------------------------|--------|---------------------|--------------------|--------------------------|---|---------|
| | | F | Sig. | t | df | Sig. (2- tailed) | Mean Difference | Std. Error Difference | 95% Confidence Interval of the Difference | |
| | | | | | | | | | Lower | Upper |
| Stereotype total | Equal variances assumed | 3.754 | .054 | -1.749 | 249 | .081 | -1.30887 | .74823 | -2.78255 | .16480 |
| | Equal variances not assumed | | | -1.263 | 20.532 | .221 | -1.30887 | 1.03631 | -3.46699 | .84924 |
| Recovery and outcomes total | Equal variances assumed | .517 | .473 | .634 | 249 | .527 | .31212 | .49266 | -.65819 | 1.28243 |
| | Equal variances not assumed | | | .432 | 20.325 | .670 | .31212 | .72254 | -1.19353 | 1.81777 |
| Total | Equal variances assumed | 8.491 | .004 | -1.053 | 249 | .293 | -.99675 | .94636 | -2.86064 | .86714 |
| | Equal variances not assumed | | | -.604 | 19.839 | .552 | -.99675 | 1.64946 | -4.43925 | 2.44575 |

Table 7

Independent Samples Test- Have you ever experienced a mental disorder?

| | | Levene's Test for Equality of Variances | | t-test for Equality of Means | | | | | | |
|--------------------------------|--------------------------------|--|------|------------------------------|---------|---------------------|------------------------|--------------------------|---|---------|
| | | F | Sig. | t | df | Sig. (2- tailed) | Mean Differenc e | Std. Error Difference | 95% Confidence Interval of the Difference | |
| | | | | | | | | | Lower | Upper |
| Stereotype total | Equal variances assumed | .666 | .415 | -3.110 | 248 | .002 | -1.27658 | .41042 | -2.08493 | -.46824 |
| | Equal variances not assumed | | | -3.056 | 194.821 | .003 | -1.27658 | .41772 | -2.10042 | -.45275 |
| Recovery and outcomes total | Equal variances assumed | .028 | .867 | .247 | 248 | .805 | .06767 | .27448 | -.47294 | .60828 |
| | Equal variances not assumed | | | .243 | 196.839 | .808 | .06767 | .27855 | -.48166 | .61700 |
| Total | Equal variances assumed | .121 | .729 | -2.318 | 248 | .021 | -1.20892 | .52148 | -2.23601 | -.18182 |
| | Equal variances not assumed | | | -2.269 | 192.093 | .024 | -1.20892 | .53285 | -2.25991 | -.15793 |

Table 8

Independent Samples Test- Have you ever gotten help for a mental disorder?

| | | Levene's Test for Equality of Variances | | t-test for Equality of Means | | | | | | |
|--------------------------------|--------------------------------|---|------|------------------------------|---------|---------------------|--------------------|--------------------------|---|---------|
| | | F | Sig. | t | df | Sig. (2- tailed) | Mean Difference | Std. Error Difference | 95% Confidence Interval of the Difference | |
| | | | | | | | | | Lower | Upper |
| Stereotype total | Equal variances assumed | .347 | .556 | -3.138 | 248 | .002 | -1.25774 | .40080 | -2.04714 | -.46833 |
| | Equal variances not assumed | | | -3.131 | 243.836 | .002 | -1.25774 | .40166 | -2.04890 | -.46657 |
| Recovery and outcomes total | Equal variances assumed | .321 | .572 | .434 | 248 | .665 | .11634 | .26807 | -.41164 | .64432 |
| | Equal variances not assumed | | | .434 | 246.692 | .665 | .11634 | .26814 | -.41179 | .64448 |
| Total | Equal variances assumed | .570 | .451 | -2.239 | 248 | .026 | -1.14139 | .50980 | -2.14547 | -.13731 |
| | Equal variances not assumed | | | -2.227 | 235.583 | .027 | -1.14139 | .51253 | -2.15111 | -.13167 |

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