University of Northern Colorado
Scholarship & Creative Works @ Digital UNC

Undergraduate Honors Theses | Student Research

5-2018

Stigma Surrounding Mental Illness and Its Reduction: What Sort of Information Is Most Effective?

Natalie S. Tanner

Follow this and additional works at: https://digscholarship.unco.edu/honors

Recommended Citation

Tanner, Natalie S., "Stigma Surrounding Mental Illness and Its Reduction: What Sort of Information Is Most Effective?" (2018). *Undergraduate Honors Theses* . 7.
https://digscholarship.unco.edu/honors/7

This Article is brought to you for free and open access by the Student Research at Scholarship & Creative Works @ Digital UNC. It has been accepted for inclusion in Undergraduate Honors Theses by an authorized administrator of Scholarship & Creative Works @ Digital UNC. For more information, please contact Jane.Monson@unco.edu.

University of Northern Colorado

Greeley, Colorado

Stigma Surrounding Mental Illness and Its Reduction: What Sort of Information is Most Effective?

A Thesis Submitted in Partial Fulfillment for

Graduation with Honors Distinction and the Degree of Bachelor of Arts

Natalie S. Tanner

School of Psychology

May 2018

Signature Page

Stigma Surrounding Mental Illness and Its Reduction: What Sort of Information is Most Effective?

Prepared by: ____
Natalie Tanner

Approved by: ____
Dr. James Kole

Honors Liaison: ____
Dr. Melissa Lea

Honors Director:____
Loree Crow

RECEIVED BY THE UNIVERSITY THESIS/CAPSTONE PROJECT COMMITTEE ON:

May 5, 2018

Acknowledgements

I would like to acknowledge the University of Northern Colorado's Honors Department for assisting me throughout the research process. I would like to thank Loree Crow, the head of the Honors Department, as well as, Dr. Kevin Pugh, my departmental liaison. Most importantly, I would like to my thesis advisor, Dr. James Kole.

Table of Contents

Table of Contents

Abstract 5

Stigma and Reduction 6

Review of the Literature 7

History of Mental Illness and Stigma 9

Mental Illness and Stigma in the Present 11

How Does Stigma Affect Individuals with a Mental Illness? 12

Hope for the Future and Reduction of Stigmas 14

Method 19

Participants 19

Materials 19

Procedure 20

Design 20

Results 21

General Discussion 23

References 25

Appendix A 29

Consent Form 29

Appendix B 31

Debriefing Statement 31

Appendix C 32

Article used in the educational group of the quantitative study. 32

Appendix D 35

Article used in the control group of the quantitative study. 35

Appendix E 37

Mental health stigmatization survey used for the quantitative study. 37

Abstract

The purpose of this mixed-methods study was to examine whether or not an educational intervention can reduce mental health stigmatization. The quantitative piece of this project is a randomized experiment; participants were assigned to one of three conditions: 1. an experimental group that read an article about mental health stigmatization, 2. an active control group that read an article on anxiety, and 3. an inactive control that did not read any material. Mental health stigmatization was measured via survey both pre and post intervention. Although the results were not significant, the educational intervention group showed less bias immediately afterwards than the active and inactive control groups, and the educational intervention group and active control group showed less increase in bias over the 1-week delay than the inactive control group. This project may potentially inform future research and programming to reduce mental illness stigma.

Stigma Surrounding Mental Illness and Its Reduction: What Sort of Information is Most Effective?

Stigma and Reduction

The stigma surrounding mental illness and mental health treatment are important issues because they serve as barriers to treatment seeking. According to the National Alliance on Mental Illness, nearly 1 in 5 adults in the United States (18.5% or 43.8 million people) experience mental illness in a given year (NAMI, 2015). While effective treatments exist for many mental disorders, nearly half of those with a severe mental illness do not seek treatment (SoRelle, 2000). In a recent study by the American Psychological Association, which used a random sample of 1,000 Americans, it was found that 30% of respondents had concerns about others finding out that they had sought mental health treatment, and 20% said that stigma is an important reason to avoid seeking help from mental health professionals (Chamberlin, 2004). The failure to seek treatment for mental disorders not only has detrimental effects on the individual, but on society as well. It has been estimated that mental illness costs the United States $193.2 billion in lost earnings annually (NAMI, 2015). In addition to financial costs, it is estimated that of those homeless adults residing in shelters, 26% live with serious mental illness, and 46% of those are classified as severe mental illness (NAMI, 2015).

Stigma reduction programs can (and have been) be created to reduce the stigma surrounding mental illness and treatment, with the intent that reducing this stigmatization would increase treatment seeking. It is thus important for the programs

to be effective; however, it is unclear what type of program is most important to reducing stigma. The present study focuses on metacognitive factors in stigma reduction and investigates whether or not an awareness of such stigmatization reduces it. In the literature review section of this thesis, I will review studies on mental health stigma. Of special focus is how stigma has been measured, and the efficacy of various types of intervention employed to reduce stigmatization.

Review of the Literature

According to *The Psychology of Prejudice* by Todd D. Nelson, stigma is the possession of a characteristic or attribute that conveys a negative social identity. Stigma can also be defined as "a mark of disgrace that sets a person apart. When a person is labelled by their illness they are seen as a part of a stereotyped group. Negative attitudes create prejudice which leads to negative actions and discrimination" (Australian Government). Parker and Aggleton argue that stigma must be regarded as a social process in which people out of fear of the disease want to maintain social control by contrasting those who are normal with those who are different (Neema, 2012). According to *Psychology Today*, there are two main types of mental health stigma. These distinct types are social stigma and perceived stigma/self-stigma. Social stigma is categorized by discriminatory behavior and prejudicial attitudes towards people with mental illness/mental health problems due to the psychiatric label associated with them. Self-stigma or perceived stigma is caused by the internalization of both the psychiatric label an individual with a mental health concern has and the perceptions of discrimination (Davey, 2013). Stigma can make people feel and experience things such

as shame, blame, hopelessness, distress, and misrepresentation in the media, reluctance to seek and/or accept necessary help (Owen et al., 2012).

Stigma takes on many forms. Some of these forms include prejudice, discrimination, fear, distrust, and stereotyping. Stigmatizing actions also take place. These stigmatizing actions include ignoring, avoiding, and being unwilling to work with those who fall into the stigmatized out-group. The table below, created by researcher Nicholas Rusch (2012), shows the various components of public or social stigma and self-stigma. Public/social stigma as described previously is discriminatory behaviors and prejudicial attitudes towards individuals with mental illness causing that individual to feel stigma and other negative emotions. Self-stigma is the mental health sufferer's perception of their illness and how others treat them.

Table 1.

Components of Public and Self-Stigma

Public Stigma:	Self-Stigma:
Negative belief about a group such as	Stereotype:
Incompetence	Negative belief about the self-such as
Character weakness	Incompetence
Dangerousness	Character weakness
Prejudice:	Dangerousness
Agreement with belief and/or	Prejudice:
Negative emotional reaction such as	Agreement with belief
Anger or Fear	Negative emotional reaction such as
Discrimination:	Low self-esteem or
Behavior response to prejudice such as:	Low self-efficacy
Avoidance of work and housing opportunities	Discrimination:
Withholding help	Behavior response to prejudice such as:
	Fails to pursue work and housing opportunities and Does not seek help

Stigmas are a learned behavior. This means that individuals are taught the behavior throughout their lives through modeling. Discrimination, stigma, and prejudice are modeled by

parents, teachers, friends, and even strangers.

History of Mental Illness and Stigma

Stereotypes and stigmas about those with a mental illness began as xenophobia. Most people who had a mental illness or knew someone with a mental illness were shamed because there was no science or reasoning behind the illness at first. In ancient civilizations, mental health problems were considered to be of a religious nature. Some thought a person with a mental disorder may be possessed by demons, thus prescribing exorcism as a form of treatment. During the 5th century BC, Greek physician Hippocrates, however, believed that mental illness was physiologically affiliated. As a result, his methods involved a change in environment, living conditions, or occupations (Dual Diagnosis, 2014). According to the U.S. National Library of Medicine, mental illness in the United States started in the following way: Family members in early American communities cared for the mentally ill within their families. With very intense or severe cases of mental illness families would bring their mentally ill family member either to an almshouse, or the family member may end up in jail. During this time people generally believe that mental illnesses were caused by a spiritual or moral failing so the mentally ill were often shamed and punished by society. Often times the shame would spread to the family of the mentally ill as well. As communities grew and became more settled mental illness became a much larger social issue. In order to solve this issue, community institutions were created to help handle the needs to mentally ill individuals as a whole.

The community institutions that were created were often referred to as insane asylums. European ideas about the care and treatment of the mentally ill were brought to the United

States of America as asylums begin to open (D'Antonio, 2016). These European ideas were referred to as the "moral treatment," and they promised a cure for mental illnesses to those who sought treatment. Asylums followed the moral treatment, which assumed that individuals suffering from mental illness would be able to find their own way to recovery and a cure to their illness if they were treated kindly. The moral treatment also said that by treating individuals with mental illness kindly, one was appealing to the parts of the mind that were still rational. For patients who did not get better, the moral treatment assumed that they were not trying hard enough to heal, so long periods of isolations and harsh restraints were used in order to discourage the destructive behaviors of patients with mental illness. (D'Anontio, 2016).

The first official asylum to be created was called the Pennsylvania Hospital for the Insane. It opened its doors in 1856. This hospital remained open until 1998, and changed names multiple times. This hospital, being the first, set the beginning standards for how those affected by mental illnesses should be handled and treated. According to the U.S. National Library of Medicine, the standards in which the Pennsylvania Hospital set included providing basement rooms complete with shackles attached to the walls to be the home for a small number of patients affected by mental illnesses.

Although society now has very different views on how people affected by mental illness should be treated and handled, the negativity and stigma still surrounds the affected. A study was done in 1993 by Huxley, which showed that shame overrides even the most extreme symptoms of mental illness. Two identical UK public opinion surveys were done by Huxley (2009). The surveys showed that little change was recorded over 10 years, with over 80%

endorsing the statement that “most people are embarrassed by mentally ill people”, and about 30% agreeing “I am embarrassed by mentally ill persons” (Sharma, 2016). These views remain almost the same in today’s society. Intense stigmatization of mental illness in America throughout history has lead to continued beliefs and perceptions about mentally ill individuals and have therefore continued the cycle of stigmatization.

Mental Illness and Stigma in the Present

Attitudes of fear and shame continue to create stigma for those affected by mental illness today. On many occasions family members and friends sometimes endure a stigma by association, referred to as “courtesy stigma” (Goffman, 1963). This secrecy and fear continue to perpetuate stigmatization of those with mental illnesses. In a study done by Phelan et al. in 1998, 156 parents and spouses of first-admission patients, half reported making efforts to conceal the illness from others. In today’s society secrecy creates as an obstacle surrounding mental health. Today because of fear and shame, individuals affected by mental illness generally, try and conceal what is happening to them and more often than not, are afraid to seek treatment due to stigma.

Stigma in present times is much less overt then it has been in the past. In modern society, individuals with mental health will not be sent to insane asylums or treated as if they are a lunatic. Individuals with mental illness in present times will be subjected to lingering stigmas from the past, and will be discriminated against. In one study, researchers found that three dimensions are still important in accounting for rejection based upon and surrounding mental illness. These dimensions are the rarity of the illness, personal responsibility for the

illness, and overall dangerousness of the individual and the illness (Feldman & Crandall, 2007). Rarity of illness means that frequency of occurrence in the general population. Personal responsibility for the illness is whether or not control can be exerted over symptoms, and dangerousness is if the individual is prone to violent acts.

How Does Stigma Affect Individuals with a Mental Illness?

Due to the secrecy and stigmatization of mental illness there are many complications that arise not only in treatment but in other aspects of a patient's life. Complications begin with public attitudes towards individuals with a mental illness. These public attitudes include various aspects of life including social, physical, and economic-standing. The attitudes of the general public are pervasive and seep into everything that happens within a community. This means that as a group, the mentally ill become an out-group in a community. The individuals with mental illness are avoided in working, living, and general social environments. They are discriminated against in classrooms and on occasion by health care physicians, such as doctors and therapists (Schulze, 2007).

A large reason why these stigmatizing attitudes are a problem is because they can lead to discrimination in areas of employment, and just as often in housing opportunities. Beyond that, the biggest problem created by stigma is that it allows for the devaluation of individuals, which is harmful to both the in-group and out-group. The devaluation of the stigmatized group is also how stereotypes about these groups are created. Stereotypes that are often held about individuals with a mental illness are that they are useless in the workforce, unreliable, dangerous, and incompetent in other aspects of life, such as relationships. Gordon Allport once

stated that stereotypes hold a kernel of truth, but always are extremely incorrect in almost all ways (Nelson, 2006). An example of these stereotypes is stated throughout a study done by Wahl (1999). Wahl examined the extent to which people with mental health problems encounter stigma in their daily lives. Wahl developed a questionnaire based on stigmatization experiences commonly reported in personal accounts of mental illness and questioned 1,301 mental health consumers from across the U.S. and Canada. Respondents reported having witnessed stigmatizing comments or depictions of mental illness, having been treated as less competent by others once their illness was disclosed, being shunned or avoided, and being advised to lower their expectations in life.

Corrigan, Druss, and Perlick (2014) very clearly sum up the affects individuals with mental feel due to stigma. They said that, “from a public standpoint, stereotypes depicting people with mental illness as being dangerous, unpredictable, responsible for their illness, or generally incompetent can lead to active discrimination, such as excluding people with these conditions from employment and social or educational opportunities.” Corrigan, Druss, and Perlick also saw these affects in medical settings and noticed that, “negative stereotypes can make providers less likely to focus on the patient rather than the disease, endorse recovery as an outcome of care, or refer patients to needed consultations and follow-up services.”

Discrimination can lead individuals with mental illness to internalize negative thoughts and feelings and began self-stigmatization (Corrigan, Druss, & Perlick, 2014). Self-stigma can make individuals feel like they may be unable to recover, undeserving of care, dangerous, or responsible for their illnesses. “Self-stigma can also lead to the development of the ‘why try’

effect, whereby people believe that they are unable to recover and live normally so 'why try?'" (Corrigan, Druss, & Perlick, 2014).

Hope for the Future and Reduction of Stigmas

Most individuals who have a mental illness will go on to be successful after receiving treatment. These individuals have bright futures including having a good job, going to school, owning a home, having children, and being successful in relationships. The goal of reduction of stereotypes to help all of society. The two main ways reduction of stigmas can help is by positively affecting individuals with mental illness and by positively affecting those who do not have a mental illness.

Stereotypes are embarrassing and humiliating, and even more so they are painful, and lead to discrimination. Perhaps worst of all, stigma keeps people from seeking help (Carter, 2010). Another study done at Cambridge University found that more than 70% of adults and young people globally do not receive treatment due to "expectations of discrimination against people who have a diagnosis of mental illness" (Thornicroft, 2008). This is why reduction to stereotypes is vastly important. Individuals with mental illness must deal with secrecy, shame, and ridicule just to receive the treatment that they need in order to no longer be stigmatized. Stigma is a hindrance to everyone. It allows for societal division and if it is reduced everyone will be better off.

Table II.

Stigma-reduction strategies.Level Strategies

Intrapersonal level Treatment

Counselling

Cognitive – behavioral therapy

Empowerment

Group counseling

Self-help, advocacy and support groups

Interpersonal level Care and support

Home care teams

Community-based rehabilitation

Organizational/institutional level

Training programs

(New) policies, like patient-centered and

integrated approaches

Community level

Education

Contact

Advocacy

Protest

Governmental/structural level

Legal and policy interventions

Rights-based approaches

As noted above in the chart by Heijnders and Van Der Meij (2007), there are a multitude of ways in which researchers have looked at reducing stigmas. The methods above have been experimented and tested, allowing future researchers to look through them and see which is the most attainable and the most effective. A literature review done by Dalky (2011) evaluated various methods of stigma reduction and their effectiveness in relation to mental illness. The literature that was reviewed was everything involving stigma reduction methods between 1998 and 2008 and used PubMed, CINALH, Scopus, Medline, and PsychINFO datbases. The review results showed that contact-based and educational stigma reduction programs created the strongest advances in knowledge. Educational and contact-based methods also created the most positive changes in behavior and attitude which in turn decreased stigma associated with mental illness (Dalky, 2011).

Organizations such as the National Alliance on Mental Illness have even created campaigns to end mental health stigma and discrimination. The campaign created by NAMI challenges participants take the first step on learning about mental health issues and educating others. The second step in their campaign is to have participants, “see the person and not the illness.” The final steps include taking action on mental health issues and taking a pledge to be stigma free. NAMI is not the only organization out there trying to end mental health stigmas. NAMI has also been “particularly successful… in the US.” NAMI uses “a group of family members and persons with mental illness, [to] educate the public in order to diminish stigmatizing conditions; e.g. by pressing for better legal protection for persons with mental illness in the areas of housing and work” (Rusch, 2005).

Another organization trying to make a difference is Active Minds. Active Minds is a group whose mission is to change the conversation about mental health. Their current campaign is the National Day Without Stigma. The slogan for this day is, “Stigma is shame. Shame causes silence. Silence hurts us all. “Similar to NAMI, they ask participants to join into a three step program. The steps include changing your language, chalking your support, and reaching others. Included in the National Day Without Stigma campaign, there is a chapter action kit, a community action kit, and a place where individuals can take a pledge to be stigma free.

While campaigns like these are extremely important, larger and more universal stigma reduction steps have been taking place. According to the 2001, World Health Organization Report there are many steps that can be taken in order to reduce the stigma surrounding mental health and mental illness. The first step that is listed is to provide treatment in primary care. Other steps include making psychotropic drugs available, giving care in the community, and educating the public. The list also includes involving communities, families, and consumers, as well as, establishing national policies, programs, and legislation, and developing human resources. The final steps in stigma reduction as created by the WHO are linking with other sectors, monitoring community health, and supporting more research. The World Health Organization hosted a World Health Day in 2001 which was themed, “Stop exclusion-Dare to care.” “Its theme was that there is no justification for excluding people with a mental illness or brain disorder from our communities – there is room for everyone.”

The stigma reduction method that will be used in this study will be similar to other educational reduction methods. For the study, participants will be randomly assigned to one of three conditions: education-based intervention group, active control, or inactive control. Participants in the education-based intervention group will first read the article describing mental health stigmatization, and afterwards will immediately complete a survey measuring mental health stigmatization. Participants will return 1 week later and will complete the same survey a second time. The procedure for the active control group will be the same as for the education-based intervention group, however, instead of reading the article on mental health stigmatization, they will instead read the control article on anxiety. The inactive group will not read any material; they will complete the survey during the first session, and again during the second session held one week later. It will be different from other educational stigma reduction methods because instead of just looking at effectiveness in the moment, it will look at effectiveness over a period of time.

Method

Participants

Participants included 14 volunteers from the introductory psychology pool (PSY 120) at the University of Northern Colorado. Participants received course credit for their participation. The tasks were described as presented in the consent form (see Appendix A); participants were assured of their confidentiality. No special populations were investigated, and all participants were thoroughly debriefed. The attached debriefing statement is Appendix B. All participants were treated in accordance with ethical guidelines from the University of Northern Colorado as well as the American Psychological Association (2002).

Materials

The first piece of material used for this experiment was an article from *Psychology Today*, entitled, “Mental health & stigma: Mental health symptoms are still viewed as threatening and uncomfortable”. This article is 1215 words in length, and discusses the stigma that surrounds mental illness, as well as factors underlying the stigmatization of mental illness. The article also addresses two dimensions of stigmatization, personal responsibility and dangerousness (see Appendix C).

The control article being used for this experiment is also from *Psychology Today* and is entitled, “What is anxiety?”. This article was written by the same author who wrote the previously described article on stigmatization and is 1146 words in length. The article was selected because the two articles are approximately the same length, have common authorship,

and both deal with mental illness. The control article discusses anxiety and the pitfalls that are associated with it (see Appendix D).

A survey created by Mind for Better Mental Health and Rethink Mental Illness will be used to assess mental health stigmatization. The survey includes 52 items and has been used in previous studies (see Appendix E).

Procedure

For the study, participants were randomly assigned to one of three conditions: education-based intervention group, active control, or inactive control. Participants in the education-based intervention group first read the article describing mental health stigmatization, and afterwards immediately completed a survey measuring mental health stigmatization. Participants returned 1 week later and completed the same survey a second time. The procedure for the active group was the same as for the education-based intervention group; however, instead of reading the article on mental health stigmatization, they instead read the control article on anxiety. The inactive control group did not read any material; they completed the survey during the first session, and again during the second session held one week later.

Design

The quantitative study utilizes a mixed-factorial design, with the intervention condition (education-based, active control, inactive control) a between-subjects factor and test (immediate, one-week delay) a within-subjects factor. The dependent variable is total score on the mental health stigmatization survey.

Results

An analysis was conducted to test the internal consistency reliability of the mental health stigmatization survey. This analysis found that reliability was less than the desired range of greater than .7 (α = .646). The reliability analysis also showed three question that served as a drag on reliability. Thus, a second reliability analysis was conducted excluding those three items, which boosted Cronbach's alpha to .791. Total scores for participants were calculated excluding these three items.

For these items, the average score was 3.31 ($s = .433$). This value indicates that on average subjects were neutral on the statements, neither stigmatizing nor rejecting stigmatizing statements about mental illness.

To test the efficacy of the educational intervention, a mixed-factorial ANOVA was conducted including the between subjects factor of condition (educational intervention, active control, inactive control) and time (immediate test, delayed test). On average, there was a slight increase in stigmatization scores from the end of the first session ($M = 3.085$) to the second session ($M = 3.538$); however, this increase was not significant, $F(1, 11) = 1.73$, $p > .05$. Further, although the main effect of condition was not significant, the pattern of means was somewhat as predicted with the educational intervention group showing the lowest level of mental health stigmatization across both sessions ($M = 2.958$), followed by the active control ($M = 3.390$) and the inactive control ($M = 3.446$), $F(2, 11) = 2.64$, $p > .05$. Finally, the interaction between condition and time was not significant, but the pattern was such that the average increase in stigmatization score was smaller for the educational intervention condition (M

= .104) and the active control (M = .039) than for the inactive control (M = .467), $F(2, 11) = 1.27$, $p < .05$.

General Discussion

Results were not significant due to the number of participants in the study. The results leaned towards the educational method being effective over a week-long period which means that with more participants it is possible that using educational reading material over a week-long period could be useful in the reduction of mental health stigmatization. In the experiment, participants were randomly assigned to one of three conditions: education-based intervention group, active control, or inactive control. Participants in the education-based intervention group first read the article describing mental health stigmatization, and afterwards immediately completed a survey measuring mental health stigmatization. Participants returned 1 week later and completed the same survey a second time. The procedure for the active group was the same as for the education-based intervention group; however, instead of reading the article on mental health stigmatization, they instead read the control article on anxiety. The inactive control group did not read any material; they completed the survey during the first session, and again during the second session held one week later.

The results also indicated that the mental health stigmatization survey was a reliable instrument to measure this construct, excluding three items. The results, as previously mentioned were not significant due to the number of participants in the study. However, in general the results are promising given the large literature in other domains, such as problem solving and reasoning, demonstrating that de-biasing individuals is difficult to achieve. It was believed that it would be easier to obtain more participants. Due to the timeline for the project, I was unable to take more time to get more participants in order to try and have significant results. If I were able to continue working on the study, I would continue to obtain and test

participants. One improvement to the experimental design would be to have an exact plan to keep track of all participants and their login ID for the survey.

Continued research in this area could help reduce the stigmatization of mental health and mental illness. This research study can be used as a stepping stone to create further research on stigma, mental health, and stigmatization surrounding mental well-being and illness.

References

Byrne, P. (2000, January 6). Stigma of Mental Illness and Ways of Diminishing it | BJPsych Advances. Retrieved March 05, 2016, from http://apt.rcpsych.org/content/6/1/65.short

Carter, R., Golant, S. K., & Cade, K. E. (2010). Within our reach: ending the mental health crisis. Emmaus, Penn.: Rodale.

Chamberlin, J. (2004, July/August). Survey says: More Americans are seeking mental health treatment. Retrieved April 16, 2016, from http://www.apa.org/monitor/julaug04/survey.aspx

Corrigan, Druss, & Perlick. (2014, August 01). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. Retrieved April 18, 2016, from http://www.psychologicalscience.org/index.php/publications/mental-illness-stigma.html

Dalky, H. F. (2011). Mental Illness Stigma Reduction Interventions. Western Journal of Nursing Research, 34(4), 520-547. doi:10.1177/0193945911400638

D'Antonio, P., PhD & RN. (2016). History of Psychiatric Hospitals. Retrieved April 16, 2016, from http://www.nursing.upenn.edu/nhhc/Pages/HistoryofPsychiatricHospitals.aspx

Davey, G., PhD. (2013, August 20). Mental Health & Stigma. Retrieved March 05, 2016, from https://www.psychologytoday.com/blog/why-we-worry/201308/mental-health-stigma

Dual Diagnosis. (2014). History of Mental Health Treatment | Dual Diagnosis. Retrieved April 17, 2016, from http://www.dualdiagnosis.org/mental-health-and-addiction/history/

Feldman, D., & Crandall, C. (2007). Dimensions of Mental Illness Stigma: What About Mental Illness Causes Social Rejection? Retrieved March 05, 2016, from http://guilfordjournals.com/doi/abs/10.1521/jscp.2007.26.2.137

Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. Englewood Cliffs, NJ: Prentice Hall.

Heijinders, M., & Van Der Meij, S. (2007, January 23). The fight against stigma: An overview of stigma-reduction strategies and interventions. Retrieved March 05, 2016, from http://www.tandfonline.com/doi/abs/10.1080/13548500600595327?journalCode=cphm20

Peter Huxley (2009) Location and stigma: A survey of community attitudes to mental illness - Part 1. Enlightenment and stigma, Journal of Mental Health, 2:1, 73-80, DOI: 10.3109/09638239309016956

Owen, J., Thomas, L., & Rodolfa, E. (2012). Stigma for Seeking Therapy. The Counseling Psychologist, 41(6), 857-880. doi:10.1177/0011000012459365

N. (2015). NAMI: National Alliance on Mental Illness. Retrieved March 05, 2016, from https://www.nami.org/

NAMI: National Alliance on Mental Illness. (2015). Mental Health By the Numbers. Retrieved April 16, 2016, from https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

Neema, S., Atuyambe, L., Otolok-Tanga, E., Twijukye, C., Kambugu, A., Thayer, L., & McAdam, K. (2012, June). Using a clinic based creativity initiative to reduce HIV related stigma at the Infectious Diseases Institute, Mulago National Referral Hospital, Uganda. Retrieved April 15, 2016, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3462528/

Nelson, T. D. (2006). The Psychology of Prejudice (2nd ed.). Boston: Pearson Allyn and Bacon.

Phelan, J. C., Link, B. G., Stueve, A., & Pescosolido, B. A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared? Journal of Health and Social Behavior, 41, 188-207.

Rusch, N. (2004, April). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. Retrieved March 5, 2015, from http://www.europsy-journal.com/article/S0924-9338(05)00090- 8/abstract

Rush, B., MD. (2015, March 24). Diseases of the Mind: Highlights of American Psychiatry through 1900 - Early Psychiatric Hospitals and Asylums. Retrieved March 05, 2016, from https://www.nlm.nih.gov/hmd/diseases/early.html

Schulze, B. (2002). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. Retrieved March 5, 2015, from https://www.uic.edu/com/mdphd/Retreat_2006/Subjective_experiences_of_stigma_a_focus_group.pdf

Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. International Review of Psychiatry, 19(2), 137-155. doi:10.1080/09540260701278929

Sharma, M. (2016). Experiencing stigma: Nepalese perspectives. Retrieved March 06, 2016,

From http://www.academia.edu/1473139/Experiencing_stigma_Nepalese_perspectives

SoRelle, R., MPH. (2000). Nearly Half of Americans With Severe Mental Illness Do Not Seek Treatment. Retrieved April 16, 2016, from http://circ.ahajournals.org/content/101/5/e66.full

Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. Epidemiologia E Psichiatria Sociale, 17(1), 14-19. doi:10.1017/S1121189X00002621

Wahl. O. F. (2003) News Media Portrayal of Mental Illness: Implications for Public Policy. American Behavioral Scientist, 46, 1594-1600.

What is Stigma? (2010). Retrieved March 05, 2016, from http://www.mentalhealth.wa.gov.au/mental_illness_and_health/mh_stigma.aspx

World Health Organization. (2001). The World Health Report 2001: Mental Health : New Understanding, New Hope. Retrieved March 05, 2016, from https://books.google.com/books?hl=en

Appendix A

Consent Form

College of Education and Behavioral Sciences
School of Psychological Sciences
Informed Consent for Participation in Research
University of Northern Colorado
Project Title: Stigmatization of Mental Illness
Researcher: Natalie S. Tanner
School of Psychological Sciences
Phone: 970-689-4254 email: tann1498@bears.unco.edu
Advisor: James Kole
Phone: 970-351-2422 email: James.Kole@unco.edu

The purpose of this study is to examine the perceptions that surround mental health and mental illness. This study involves responding to survey questions and potentially reading an article. This study includes two sessions, spaced one week apart. Participation is expected to take approximately 60 minutes for both sessions (40 minutes during the first session, 20 minutes during the second session).

All of your responses will be anonymous and strictly confidential. To ensure anonymity, please do not write your name or any identifying information on any portion of the packet. All responses will be completely anonymous; your name will not be recorded, and it will not be possible to match the data to you in any way. Results of the study will be presented in group form only (e.g., averages) and all original paperwork will be kept in locked offices on campus.

Your decision to participate in this study is completely voluntary. Participation in this study is only one way to satisfy the research experience requirement for your PSY 120 class or to gain extra credit in another class, and you may, if you choose, select an alternative assignment instead of being a research participant. Your participation in this study is unlikely to result in any direct benefits to you as an individual; however, your participation will contribute to the knowledge of mental health stigmatization. In this project, there are no known economic, legal, physical, psychological, or social risks to participants in either immediate or long-range outcomes. I understand that it is not possible to identify all potential risks in an experimental procedure, but I believe that reasonable safeguards have been taken to minimize both the known and the potential, but unknown risks. You may withdraw your consent and discontinue your participation at any time without penalty.

Page 1 of 2 _______please initial

Appendix A, cont.

Participation is voluntary. You may decide not to participate in this study, and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Your completion and return of this questionnaire indicates consent to participate in the study. This form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact Sherry May, IRB Administrator, in the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639: 970.351.1910.

____

Subject's Signature Date

____

Researcher's Signature Date

Appendix B

Debriefing Statement

The study in which you have participated is called “Stigmatization of Mental Illness”. In this study, we examine beliefs and perceptions surrounding mental health and illness, and whether or not providing information regarding mental health stigmatization reduces it both short- and long-term. Thank you for your participation! Your contribution is greatly appreciated. If you have any questions or concerns, please contact me at any time.

Natalie S. Tanner
School of Psychological Sciences
University of Northern Colorado
Greeley, CO 80639
Phone: (970)-689-4254
Email: tann1498@bears.unco.edu

Appendix C

Article used in the educational group of the quantitative study.

Mental health symptoms are still viewed as threatening and uncomfortable
Graham C. L. Davey, PhD
There are still attitudes within most societies that view symptoms of psychopathology as threatening and uncomfortable, and these attitudes frequently foster stigma and discrimination towards people with mental health problems. Such reactions are common when people are brave enough to admit they have a mental health problem, and they can often lead on to various forms of exclusion or discrimination – either within social circles or within the workplace.
Who holds stigmatizing beliefs about mental health problems? Perhaps surprisingly, stigmatizing beliefs about individuals with mental health problems are held by a broad range of individuals within society, regardless of whether they know someone with a mental health problem, have a family member with a mental health problem, or have a good knowledge and experience of mental health problems (Crisp et al., 2000; Moses, 2010; Wallace, 2010). For example, Moses (2010) found that stigma directed at adolescents with mental health problems came from family members, peers, and teachers. 46% of these adolescents described experiencing stigmatization by family members in the form of unwarranted assumptions (e.g., the sufferer was being manipulative), distrust, avoidance, pity and gossip, 62% experienced stigma from peers which often led to friendship losses and social rejection (Connolly, Geller, Marton & Kutcher, 1992), and 35% reported stigma perpetrated by teachers and school staff, who expressed fear, dislike, avoidance, and under-estimation of abilities. Mental health stigma is even widespread in the medical profession, at least in part because it is given a low priority during the training of physicians and GPs (Wallace, 2010).

What factors cause stigma? The social stigma associated with mental health problems almost certainly has multiple causes. Throughout history people with mental health problems have been treated differently, excluded and even brutalized. This treatment may come from the misguided views that people with mental health problems may be more violent or unpredictable than people without such problems, or somehow just “different”, but none of these beliefs has any basis in fact (e.g., Swanson, Holzer, Ganju & Jono, 1990). Similarly, early beliefs about the causes of mental health problems, such as demonic or spirit possession, were ‘explanations’ that would almost certainly give rise to reactions of caution, fear and discrimination. Even the medical model of mental health problems is itself an unwitting source of stigmatizing beliefs. First, the medical model implies that mental health problems are on a par with physical illnesses and may result from medical or physical dysfunction in some way (when many may not be simply reducible to biological or medical causes). This itself implies that people with mental health problems are in some way ‘different’ from ‘normally’ functioning individuals. Secondly, the medical model implies diagnosis, and diagnosis implies a label that is applied to a ‘patient’. That label may well be associated with undesirable attributes (e.g., ‘mad’ people cannot function properly in society, or can sometimes be violent), and this

Appendix C, cont.

again will perpetuate the view that people with mental health problems are different and should be treated with caution.

I will discuss ways in which stigma can be addressed below, but it must also be acknowledged here that the media regularly play a role in perpetuating stigmatizing stereotypes of people with mental health problems. The popular press is a branch of the media that is frequently criticized for perpetuating these stereotypes. Blame can also be levelled at the entertainment media. For example, cinematic depictions of schizophrenia are often stereotypic and characterized by misinformation about symptoms, causes and treatment. In an analysis of English-language movies released between 1990-2010 that depicted at least one character with schizophrenia, Owen (2012) found that most schizophrenic characters displayed violent behaviour, one-third of these violent characters engaged in homicidal behaviour, and a quarter committed suicide. This suggests that negative portrayals of schizophrenia in contemporary movies are common and are sure to reinforce biased beliefs and stigmatizing attitudes towards people with mental health problems. While the media may be getting better at increasing their portrayal of anti-stigmatising material over recent years, studies suggest that there has been no proportional decrease in the news media's publication of stigmatising articles, suggesting that the media is still a significant source of stigma-relevant misinformation (Thornicroft, Goulden, Shefer, Rhydderch et al., 2013.

Why does stigma matter? Stigma embraces both prejudicial attitudes and discriminating behaviour towards individuals with mental health problems, and the social effects of this include exclusion, poor social support, poorer subjective quality of life, and low self-esteem (Livingston & Boyd, 2010). As well as it's affect on the quality of daily living, stigma also has a detrimental affect on treatment outcomes, and so hinders efficient and effective recovery from mental health problems (Perlick, Rosenheck, Clarkin, Sirey et al., 2001). In particular, self-stigma is correlated with poorer vocational outcomes (employment success) and increased social isolation (Yanos, Roe & Lysaker, 2010). These factors alone represent significant reasons for attempting to eradicate mental health stigma and ensure that social inclusion is facilitated and recovery can be efficiently achieved.

How can we eliminate stigma?: We now have a good knowledge of what mental health stigma is and how it affects sufferers, both in terms of their role in society and their route to recovery. It is not surprising, then, that attention has most recently turned to developing ways in which stigma and discrimination can be reduced. As we have already described, people tend to hold these negative beliefs about mental health problems regardless of their age, regardless of what knowledge they have of mental health problems, and regardless of whether they know someone who has a mental health problem. The fact that such negative attitudes appear to be so entrenched suggests that campaigns to change these beliefs will have to be multifaceted, will have to do more than just impart knowledge about mental health problems, and will need to challenge existing negative stereotypes especially as they are portrayed in the general media

Appendix C, cont.

(Pinfold, Toulmin, Thornicroft, Huxley et al., 2003). In the UK, the "Time to Change" campaign is one of the biggest programmes attempting to address mental health stigma and is supported by both charities and mental health service providers (http://www.time-to-change.org.uk. This programme provides blogs, videos, TV advertisements, and promotional events to help raise awareness of mental health stigma and the detrimental affect this has on mental health sufferers. However, raising awareness of mental health problems simply by providing information about these problems may not be a simple solution – especially since individuals who are most knowledgeable about mental health problems (e.g. psychiatrists, mental health nurses) regularly hold strong stigmatizing beliefs about mental health themselves! (Schlosberg, 1993; Caldwell & Jorm, 2001). As a consequence, attention has turned towards some methods identified in the social psychology literature for improving inter-group relations and reducing prejudice (Brown, 2010). These methods aim to promote events encouraging mass participation social contact between individuals with and without mental health problems and to facilitate positive intergroup contact and disclosure of mental health problems (one example is the "Time to Change" Roadshow, which sets up events in prominent town centre locations with high footfall). Analysis of these kinds of inter-group events suggests that they (1) improve attitudes towards people with mental health problems, (2) increase future willingness to disclose mental health problems, and (3) promote behaviours associated with anti-stigma engagement (Evans-Lacko, London, Japhet, Rusch et al., 2012; Thornicroft, Brohan, Kassam & Lewis-Holmes, 2008).

Appendix D

Article used in the control group of the quantitative study.

What is anxiety?
Graham C. L. Davey, PhD
Anxiety-based problems are very common, and around 30-40% of individuals in Western societies will develop a problem that is anxiety related at some point in their lives. So prevalent are anxiety problems in modern society that in 2014 'What is anxiety?' was one of the top 10 most Googled search phrases in the UK.
So what exactly is anxiety, and why do some people find that anxiety becomes something that blights their life? For many people, anxiety is a distressing experience that prevents them undertaking many ordinary day-to-day activities such as going to work, educating themselves, looking after their families, and socializing.
First, let's begin by being clear that anxiety is not an abnormal experience. We all experience feelings of anxiety quite naturally in many situations – such as just before an important exam, while making a presentation at work or college, at an interview, or on a first date. It's an emotion that can have beneficial effects by making you alert and focused when faced with potential challenges in your life - if anxiety didn't have this adaptive function, then it's unlikely that it would have evolved and it certainly wouldn't be as big a part of our emotional repertoire as it is today.
We experience anxiety in a number of ways both physically and mentally. The physical reactions include tense muscles and a dry mouth, sweating and trembling and difficulty swallowing. Your heart beats faster and you feel continually alert and vigilant.
But let's be clear, anxiety isn't the same thing as fear. Fear is a very basic emotion, and many of your fear reactions are reflexive responses to immediate threats that have been biologically pre-wired over many thousands of years of selective evolution. These reactions include startle and physiological arousal as a result of sudden loud noises, looming shadows, rapid movements towards you, and even staring eyes! Did you spot the common link between all those reactions? Yes, they're all characteristics we'd be likely to spot if we were being pounced on by a predatory animal – and with survival against predators being an urgent business - pre-wired reflexive responses that make you alert to and avoid these physical threats have evolved.
However, anxiety is a little different. The modern world is made up of many more potential threats and challenges than the threat posed by predatory animals so we have developed a more flexible system for managing potential threats, and this is what anxiety is. Anxiety is not a response to immediate threats (like being attacked by a predatory animal), but a response to anticipated threats (like a surgical operation you're due to have in the next few months). It is a bit like fear, but with an added 'thinking' element designed to identify future threats and challenges and help you prepare for them.
Many people can use anxiety adaptively in this way. It helps them to identify potential future threats and challenges, and gives them time to think about how to manage or cope with those events. But there are at least three potential pitfalls with this process that can lead you to develop forms of anxiety that can be pervasive and distressing.

1. Because anxiety is an emotion evolved to deal with future anticipated threats and challenges that have not yet happened, we might easily think that some events are going to be threatening or challenging when in fact they turn out not to be so. For example, we may worry about starting a new job because the people we will have to work with may not like us, but once we do start, everything is fine. The catch with anxiety is that once it becomes a regularly experienced emotion, it makes you search for reasons why things might be bad or problematic. Breaking that vicious cycle is difficult, but once you've identified this process in yourself, it can be managed using a variety of therapeutic techniques including CBT for anxiety.
2. Pervasive anxiety can also exaggerate threats and challenges that are in reality only mild ones that should not concern us too much. For example, once we've felt anxious for a period of time, we come to expect bad things to happen –you think life will hand you more lemons more often than in fact it does! A related effect of anxiety is that it causes us to make mountains out of molehills – when we think we've identified a future threat, our worrying causes us to catastrophise what might happen. So a persistently anxious individual will be living day to day with problems the size of 'mountains' that many other non-anxious individuals would see only as 'molehills'.
3. Thirdly, because anxiety is designed to help you think about and manage future threats and challenges, how successful you are at this will depend on what coping resources you have available to you, and how good you are at generating practical, successful solutions. Different people will have different approaches to coping with a future threat or challenge. Some people will be problem-oriented and try to find a solution that will effectively deal with the threat (e.g., by devising a revision strategy for a difficult forthcoming exam). But others may be less resourceful, and try to manage future negative events by simply avoiding them (e.g., deciding not to go to a dinner party where they think there are likely to be some conversations they will find difficult or embarrassing). But there is a very important consequence of using avoidance as a way of coping with future threats. This is, if you continue to avoid, you will never find out if the threat is a real one, or simply an imagined or exaggerated one, and as a result it will be something that will continue to be a persistent source of anxiety (for example, think about what might happen if you combine point 1 above, with the processes of avoidance we've outlined here in point 3). Pervasive avoidance of things we find anxiety provoking can have significant long-term consequences, because the individual will often develop quite ingrained beliefs that something is threatening when in reality it isn't. These beliefs then act to generate and prolong further anxiety, which is why 'facing your fears' and disconfirming these beliefs is an important process in relieving distressing anxiety.

These three pitfalls associated with anxiety that turn it from an adaptive emotion into a distressing one are not directly to do with the physiological characteristics of anxiety, but with the 'thinking' component that anxiety brings to our attempts to manage future anticipated threats. That's the bad news. The good news is that modern psychological interventions for anxiety (such as CBT) can be highly successful by helping you to identify the kinds of 'thinking' that creates distressing anxiety (described in the three points above), and will help you to change or manage these ways of thinking to relieve distressing anxiety.

Appendix E

Mental health stigmatization survey used for the quantitative study.

Please tell how much you agree or disagree with each one...
01: Agree strongly
02: Agree slightly
03: Neither agree nor disagree
04: Disagree slightly
05: Disagree strongly
1. One of the main causes of mental illness is a lack of self-discipline and will-power.
2. There is something about people with mental illness that makes it easy to tell them from normal people.
3. As soon as a person shows signs of mental disturbance, they should be hospitalized.
4. Mental illness is an illness like any other.
5. Less emphasis should be placed on protecting the public from people with mental illness.
6. Mental hospitals are an outdated means of treating people with mental illness.
7. Virtually anyone can become mentally ill.
8. We need to adopt a far more tolerant attitude toward people with mental illness in our society.
9. We have a responsibility to provide the best possible care for people with mental illness.
10. People with mental illness don't deserve our sympathy.
11. People with mental illness are a burden on society.
12. Increased spending on mental health services is a waste of money.
13. There are sufficient existing services for people with mental illness.
14. People with mental illness should not be given any responsibility.
15. I would not want to live next door to someone who has been mentally ill.
16. Anyone with a history of mental problems should be excluded from taking public office.
17. No one has the right to exclude people with mental illness from their neighborhood.
18. People with mental illness are far less of a danger than most people suppose.
19. The best therapy for many people with mental illness is to be part of a normal community.
20. As far as possible, mental health services should be provided through community based facilities.

Which of these do you feel usually describes a person who is mentally ill?
01: Agree strongly
02: Agree slightly
03: Neither agree nor disagree
04: Disagree slightly
05: Disagree strongly
Someone who has serious bouts of depression
Someone who is incapable of making simple decisions about his or her own life
Someone who has a split personality

Appendix E, cont.

Someone who is born with some abnormality affecting the way the brain works
Someone who cannot be held responsible for his or her own actions
Someone prone to violence
Someone who is suffering from schizophrenia
Someone who has to be kept in a psychiatric or mental hospital

The following questions ask about your experiences and views in relation to people who have mental health problems. By this I mean people who have been seen by healthcare staff for a mental health problem.

01: Yes
02: No
Are you currently living with, or have you ever lived with, someone with a mental health problem?
Are you currently working, or have you ever worked, with someone with a mental health problem?
Do you currently, or have you ever, had a neighbor with a mental health problem?
Do you currently have, or have you ever had, a close friend with a mental health problem?

Please say to what extent you agree or disagree that each of the following conditions is a type of mental illness...

01: Agree strongly
02: Agree slightly
03: Neither agree nor disagree
04: Disagree slightly
05: Disagree strongly

Depression
Stress
Schizophrenia
Bipolar disorder
Drug addiction
Grief

In the list below please circle the types of people who you personally know, who have a mental illness.
01: Immediate family (spouse\child\sister\brother\parent etc.)
02: Partner (living with you)
03: Partner (not living with you)
Appendix E, cont.

04: Other family (uncle\aunt\cousin\grand parent etc.)
05: Friend
06: Acquaintance
07: Work colleague
08: Self
09: No one known
If you felt that you had a mental health problem, how likely would you be to go to your General Physician for help?
01: Very likely
02: Quite likely
03: Neither likely nor unlikely
04: Quite unlikely
05: Very unlikely
In general, how comfortable would you feel talking to a friend or family member about your mental health, for example telling them you have a mental health diagnosis and how it affects you?
01: Very uncomfortable
02: Moderately uncomfortable
03: Slightly uncomfortable
04: Neither comfortable nor uncomfortable
05: Fairly comfortable
06: Moderately comfortable
07: Very comfortable
In general, how comfortable would you feel talking to a current or prospective employer about your mental health, for example telling them you have a mental health diagnosis and how it affects you?
01: Very uncomfortable
02: Moderately uncomfortable
03: Slightly uncomfortable
04: Neither comfortable nor uncomfortable
05: Fairly comfortable
06: Moderately comfortable
07: Very comfortable
(Not applicable)

Do you think that people with mental illness experience stigma and discrimination nowadays, because of their mental health problems?
01: Yes- a lot of stigma and discrimination
02: Yes- a little stigma and discrimination
03: No
Do you think mental health-related stigma and discrimination has changed in the past year?
01: Yes - increased
Appendix E, cont.

02: Yes – decreased
03: No

Demographic Information:
Please list your gender.
Please list your ethnicity.
Please list your age.